Connecticut Substance Use Disorders Services Policy and Clinical Assumptions Grid

Residential Levels of Care

All Providers must adhere to state licensing requirements for their respective level(s) of care. As set forth in the Connecticut Medical Assistance Program (CMAP) provider enrollment agreement, providers must comply with all applicable federal and state statutes, regulation, and other requirements. All treatment services and interventions outlined within are included in the all-inclusive rates unless otherwise specified.

Qualified practitioners must operate within their scope of practice as applicable under state law, ensuring appropriate licensure and supervision as applicable. Qualified practitioners whose credentials exceed the minimum expectations outlined in this document may provide the services identified so long as they continue to operate within their scope of practice as applicable under state law.

***For programs serving JBCSSD clients, see p. 21 for additional contractor requirements.**

	Clinically Managed Medium-Intensity Residential (Adolescent Criteria ASAM 3.5)
Ages Served	Age 13 and older
Brief Service Description	Level 3.5 adolescent programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. Residential programs offer at least twenty (20) hours per week of a combination of medium-intensity clinical and recovery-focused services specifically focused on individuals who have significant social and psychological problems. These programs provide at least twenty (20) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least ten (10) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • SUD residential programs are characterized by their utilization of the treatment community as a therapeutic agent. • Treatment goals are to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in individuals' lifestyles, attitudes, and values. Individuals typically have multiple deficits, which include SUDs and may include criminal activity, psychological problems, impaired

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	functioning, and disaffiliation from mainstream values. Their mental health conditions may involve those which are serious and chronic. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the twenty hours of weekly programming provided by the facility. • All facilities are licensed by the State licensure agency.
Admission criteria	Level 3.5 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The adolescent who is appropriately placed in Level 3.5 care typically has impaired functioning across a broad range of psychosocial domains. These impairments may be expressed as disruptive behaviors, delinquency and juvenile justice involvement, educational difficulties, family conflicts and chaotic home situations, developmental immaturity, and psychological problems. Level 3.5 is also appropriate for the adolescent whose presenting problems include delinquency and juvenile justice involvement. The adolescent who is appropriately placed in a Level 3.5 program meets the diagnostic criteria for a substance use disorder of moderate to high severity as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission. If the adolescent's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others). **Note:** Individuals in Level 3.5 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.5 programs are expected to be co-occurring capable. Adolescents who are not diagnosed with psychiatric disorders (either because they do not meet full diagnostic criteria, or because they have not yet had a formal psychiatric evaluation) may have problems in Dimension 3 that render treatment ineffective at less intensive levels of care. **DIMENSION 1: Acute Intoxication and/or Withdrawal Potential** Mild to moderate withdrawal, or at risk, not requiring frequent management/monitoring Alternatively, the adolescent has a history of failure in treatment at the same or a less intensive level of care. **DIMENSION 2: Biomedical Conditions and Complications** None, or stable, receiving medical monitoring

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	DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications The adolescent's status is characterized by at least one of the following: A) Dangerousness/Lethality, B) Interference with Addiction and/or Mental Health Recovery Efforts, C) Social Functioning, D) Ability for Self-Care, E) Course of Illness **All 3.5 programs are co-occurring capable** such that those who have any Dimension 3 conditions are not excluded from admission. Medium intensity 24-hour monitoring or treatment **DIMENSION 4: Readiness to change** Needs intensive motivating strategies in 24-hour structured program **DIMENSION 5: Relapse, Continued Use or Continued Problem Potential** Continued substance use poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support **DIMENSION 6: Recovery/Living Environment** Needs residential treatment to promote recovery Problems in this dimension may include a chaotic home environment in which substance use, illegal behaviors, abuse, neglect, or lack of supervision are prominent, or a broader community in which substance use and crime are endemic. These social influences may represent a sense of hopelessness or an acceptance of deviance as normative. There may not be readily apparent role models for the rewards of abstinence. Many adolescents have a social network composed primarily or even exclusively of family or peers who are involved in substance use or criminal behaviors. Some adolescents may have had no experience of a living environment conducive to healthy psychosocial development.
Interventions	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan. ○ Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • An initial withdrawal assessment, including a medical evaluation and referral within the 48 hours preceding admission (or if a step down from another residential setting, within 7 days preceding admission). • An alcohol or other drug-focused nursing assessment is completed by a registered nurse within 72 hours of admission. • Daily withdrawal monitoring assessments. • Ongoing screening for medical and nursing needs, with such medical and nursing services available as needed through consultation or referral. • An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 48 hours of admission which substantiates appropriate placement at Level 3.5. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals.

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	○ The assessment is conducted or updated by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • An individualized treatment plan, which includes problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. ○ The plan is initiated at the time of admission, is developed in collaboration with the individual and completed within 72 hours of admission. The plan reflects the individual's personal goals, while considering the individual's strengths, capabilities and existing recovery resources available to achieve the individual's personal goals. ○ The treatment plan reflects case management conducted by onsite staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. ○ Because treatment plans are individualized, fixed lengths of stay are inappropriate. The intensity and duration of clinical and habilitative or rehabilitative services, rather than medical services, are the defining characteristics of Level 3.5 programs. ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ The clinical supervisor has reviewed and signed the individual's treatment plan. ○ Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly. • Discharge/transfer planning begins at admission and should be documented as such in the individual's record. ○ The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. ○ Transfer or Discharge Plan required except in an emergency, or when an individual leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. ○ There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to.

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	• Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. ○ Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.

Documentation	Level 3.5 programs will maintain individualized records which shall include:
	• The individual's Medicaid eligibility status
	• A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.
	• Initial intake evaluation, including screening for a cooccurring psychiatric disorder**.**
	• Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment.
	• An individualized, comprehensive bio-psychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM.
	  ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations
	  ○ Completion within 48 hours of admission
	  ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
	  ○ Credentials of the completing practitioner must be documented on the assessment.
	  ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	• Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals.
	  ○ Discharge planning is integrated into the treatment plan.
	  ○ Initiated at the time of admission and completed within 72 hours of admission
	  ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.
	  ○ Credentials of the completing practitioner must be documented on the treatment plan.
	  ○ The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	  ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress
	• Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.
	  ○ Credentials of the practitioner completing

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	○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor. • Administration of toxicology screens and the test results. • Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall: ○ Address original reason for referral. ○ Indicate the individual's progress towards the established plan. ○ Describe the type, frequency and duration of treatment or services. ○ Specify reason(s) for discharge ○ Indicate the individual's participation in discharge planning. ○ Includes information regarding release(s) of information obtained and aftercare services referred to. ○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. • Document and report every critical incident in accordance with regulations set for by the Department of Public Health.
Treatment Services	Level 3.5 adolescent residential programs offer 24-hour direct care and delivers medium-intensity services. Programs are characterized by their reliance on the treatment community as a therapeutic agent. Treatment is directed toward ameliorating individuals' limitations through targeted interventions and is accomplished by providing specialty modalities and skills training while the individual is in a safe and structured environment, thus providing an opportunity for continued improvement. • For adolescents, critical treatment interventions may require intensity and persistence over extended periods of time, such as modeling prosocial patterns of behavior and adaptive patterns of emotional responsiveness. Just as important can be the induction into a healthy peer group, with the formation of a group identity that emphasizes recovery and overcoming adversity. • Treatment goals are to stabilize the individual who is in imminent danger if not in a 24-hour treatment setting. It is also to promote abstinence from substance use and antisocial behavior and to effect a global change in individuals' lifestyles, attitudes, and values. Goals of treatment may also include overcoming oppositionality through a combination of confrontation, motivational enhancement, and supportive limit setting; anger management and acquisition of conflict resolution skills; values clarification and moral habilitation; character molding and education; development of effective behavioral contingency strategies; establishment of a reliable response to external structure; and the internalization of structure through self-regulation skills. • Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.

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	• Daily programming in accordance with the individual's treatment plan, which shall include a minimum of twenty (20) hours of SUD services per week. At least ten (10) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or graduate-level intern, at least one (1) hour of which must include individual/family therapy.
	  ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services.
	• Daily programming includes a combination of clinical and recovery-focused education services to improve the individual's ability to structure and organize the tasks of daily living and recovery and to develop and practice prosocial behaviors.
	• The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment (MAT), educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities.
	• Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness and desire to change. Motivational therapies and other evidence-based practices are used in preference to confrontational strategies.
	• Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living.
	  ○ Activities related to community reintegration must be specific to the individual's needs and outlined in the individual's treatment plan.
	• Planned community reinforcement designed to foster prosocial values, a prosocial milieu, and community living skills.
	• Monitoring of the individual's adherence in taking any prescribed medications, including MAT and/or any permitted over-the-counter (OTC) medications or supplements.
	• Opportunities for the individual to be introduced to the potential benefits of MAT as a tool to manage their substance use disorder(s).
	• Access to MAT. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing.
	• Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases).
	• Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.
	• Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. Note: these meetings do not count toward the 20 hours of weekly programming each individual receives.
	• Case management services to facilitate individuals' reintegration into the larger community.
	• In addition to the therapies detailed above for all programs, educational services are provided in accordance with local regulations (typically on-site) and are designed to maintain the

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Provider Qualifications/ Staffing	educational and intellectual development of the adolescent and, when indicated, to provide opportunities to remedy deficits in the educational level of adolescents who have fallen behind because of their involvement with alcohol and other drugs. Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times − For facilities with multiple adolescent residential programs at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. − If programs are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. − Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.5 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on cooccurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility. • Psychiatric services must be made available on-site or via telemedicine per the state's telemedicine policy, as needed and as appropriate to the severity and urgency of the individual's condition. ○ Such services include medications for addiction treatment (MAT) • A physician (or NP/PA) is available on-site or via telemedicine per the state's telemedicine policy to review, identify, and manage risk factors that may contribute to adverse health outcomes for the individual.

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	○ The physician (or NP/PA) shall participate in treatment team meetings and case consultations to review the individual's care and provide guidance on identifying risk factors while in treatment. ○ The physician (or NP/PA) provides oversight to the nursing staff who carry out the medical orders. Orders should not exceed the nurse or ordering practitioner's scope of practice. ○ Telephone or in-person consultation with a physician, a physician assistant or nurse practitioner and emergency services are available 24/7. • Nursing staff (RN or LPN) onsite 40 hours per week per 16 residents. Facilities greater than 64 residents will not be required to have more than four (4) total nurses. ○ At least one nurse shall be an RN ○ The RN works under the direction and orders of a licensed physician (or NP/PA). Orders should not exceed the nurse or ordering practitioner's scope of practice. • Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline. ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of ten (10) hours (out of the total 20 hours of weekly programming) of clinical treatment per week. At least one (1) of these hours include individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site during the day. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than 12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members.

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	○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are onsite, awake, and monitoring individuals needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs. • Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment. ○ Certification must be obtained by one of the state-approved certification boards. ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program: ▪ 0-32 beds: 1 peer onsite at least 40 hours per week ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each ▪ 65+ beds: 3 peers onsite at least 40 hours per week each ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by: ▪ The Clinical Supervisor (as defined above); ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services. • A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare. ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or “wrap-around” services to build/maintain recovery capital. ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts. ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer. • Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.
Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of

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	full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision from the Tech Supervisor or other leadership position for 30 minutes for every 40 hours worked. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.
Target Length of Stay	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills

	Clinically Managed Low-Intensity Residential Services (Adolescent Criteria ASAM 3.1)
Ages Served	Age 13 and older
Brief Service Description	Level 3.1 residential programs provide a structured recovery residence environment, staffed 24 hours a day, which provides sufficient stability to prevent or minimize relapse or continued use and continued problem potential. • Residential programs offer at least five (5) hours per week of a combination of low-intensity clinical and recovery-focused services. These programs provide at least five (5) hours a week of individual, group, family therapy, medication management, and psychoeducation. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • Level 3.1 programs often are considered appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. The functional limitations found in individuals typically treated at Level 3.1 include problems in the application of recovery skills, self-efficacy, or lack of connection to the community systems of work, education, or family life. Individuals have an opportunity to develop and practice their interpersonal and group living skills, strengthen their recovery skills, reintegrate into the community and family, and begin or resume employment or academic pursuits. • Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. • Mutual/self-help meetings usually are available onsite or are easily accessible in the community and are not included in the five hours of weekly programming provided by the facility. • Does not include sober houses, boarding houses, or group homes where treatment services are not provided (e.g., halfway house, group home or other supportive living environment with 24-hour staff and close integration with clinical services is not an ASAM 3.1 facility). • All facilities are licensed by the State of Connecticut (Connecticut or State) licensure agency.
Admission criteria	Level 3.1 programs are expected to accept admissions at least 16 hours per day, 7 days per week. Individuals meeting the below criteria shall be admitted regardless of the environment they are coming from (e.g., the community, other levels of care). The adolescent who is appropriately placed in a Level 3.1 program meets the diagnostic criteria for a moderate or severe substance use disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or

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other standardized and widely accepted criteria, as well as the American Society of Addiction Medicine (ASAM) dimensional criteria for admission.
If the adolescent's presenting history is inadequate to substantiate such a diagnosis, the probability of such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

Note: Individuals in Level 3.1 programs may have co-occurring mental health disorders; or difficulties with mood, behavior, or cognition related to a substance use, other addictive, or mental health disorder; or emotional, behavioral, or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental health disorder. Therefore, all Level 3.1 programs are expected to be co-occurring capable.

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential
The adolescent's status in Dimension 1 is characterized by problems with intoxication or withdrawal (if any) that are being managed through concurrent placement at another level of care for withdrawal management (typically Level 1, Level 2.1, or Level 2.5).
If residential placement in a Level 3.1 program is being used to support withdrawal management at a non-residential level of care, then the adolescent is considered to have met specifications in Dimension 1.

DIMENSION 2: Biomedical Conditions and Complications
The adolescent's status in Dimension 2 is characterized by one of the following:

a. Biomedical conditions distract from recovery efforts and require limited residential supervision to ensure their adequate treatment or to provide support to overcome the distraction. Adequate nursing or medical monitoring can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medications or procedures, with available supervision;

or

b. Continued substance use would place the adolescent at risk of serious damage to their physical health because of a biomedical condition (such as pregnancy or HIV) or an imminently dangerous pattern of high-risk use (such as continued use of shared injection apparatus). Adequate nursing or medical monitoring for biomedical conditions can be provided through an arrangement with another provider. The adolescent is capable of self-administering any prescribed medications or procedures, with available supervision.

DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications
The adolescent's status in Dimension 3 is characterized by at least one of the following (requiring 24-hour supervision):

a. ***Dangerousness/Lethality***: The adolescent is at risk of dangerous consequences because of the lack of a stable living environment (for example, exposure to the elements, risk of assault, risk of prostitution, and the like). They need a stable residential setting for protection.

b. ***Interference with Addiction Recovery Efforts***: The adolescent needs a stable living environment to promote a sustained focus on recovery tasks (for example, recovery efforts are hindered by the adolescent's preoccupying worries about shelter).

c. ***Social Functioning***: The adolescent's emotional, behavioral, or cognitive problem results in moderate impairment in social functioning. They therefore need limited 24-hour supervision, which can be provided by program staff or in combination with a Level 1 or Level 2 program. This might involve protection from antisocial peer influences in a motivated adolescent, reinforcement of improving behavior self-

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management techniques, support of increasingly independent functions (such as school or work), and the like.

d. ***Ability for Self-Care***: The adolescent has moderate impairment in their ability to manage the activities of daily living and thus needs limited 24-hour supervision, which can be provided by program staff or through coordination with a Level 1 or Level 2 program. The adolescent's impairments might require the provision of food and shelter, prompting for self-care, or supervised self-administration of medications.

e. ***Course of Illness***: The adolescent's history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without 24-hour supervision (for example, an adolescent who experiences rapid, dangerous exacerbation if he or she misses a few doses of medicine or if they have even a minor relapse to substance use).

or

f. The adolescent's emotional, behavioral, or cognitive condition suggests the need for low-intensity and/or longer-term reinforcement and practice of recovery skills in a controlled environment.

DIMENSION 4: Readiness to change

The adolescent's status in Dimension 4 is characterized by at least one of the following:

a. The adolescent acknowledges the existence of a psychiatric condition and/or substance use problem. They recognize specific negative consequences and dysfunctional behaviors and their effect on their desire to change. They are sufficiently ready to change and cooperative enough to respond to treatment at Level 3.1;

or

b. The adolescent is assessed as appropriately placed at Level 1 or 2 and is receiving Level 3.1 services concurrently. The adolescent may be at an early stage of readiness to change and thus in need of engagement and motivational strategies;

or

c. The adolescent requires a 24-hour structured milieu to promote treatment progress and recovery, because motivating interventions have failed in the past and such interventions are assessed as not likely to succeed in an outpatient setting;

or

d. The adolescent's perspective impairs their ability to make behavior changes without the support of a structured environment. For example, the adolescent attributes their alcohol, other drug, or mental health problem to other persons or external events, rather than to a substance use or mental disorder. Interventions are assessed as not likely to succeed in an outpatient setting.

DIMENSION 5: Relapse, Continued Use or Continued Problem Potential

The adolescent's status in Dimension 5 is characterized by at least one of the following:

a. The adolescent demonstrates limited coping skills to address relapse triggers and urges and/or deteriorating mental functioning. They are in imminent danger of relapse, with dangerous emotional, behavioral, or cognitive consequences, and needs 24-hour structure to help them apply recovery and coping skills;

or

b. The adolescent understands their substance use disorder and/or mental disorder but is at risk of relapse in a less structured level of care because they are unable to consistently address either or both;

or

c. The adolescent needs staff support to maintain engagement in their recovery program while transitioning to life in the community;

or

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	d. The adolescent is at high risk of substance use, addictive behavior, or deteriorated mental functioning, with dangerous emotional, behavioral, or cognitive consequences, in the absence of close 24-hour structured support (as evidenced, for example, by lack of awareness of relapse triggers, difficulty in postponing immediate gratification or ambivalence toward or low interest in treatment), and these issues are being addressed concurrently in a Level 2 program. **DIMENSION 6: Recovery/Living Environment** The adolescent's status in Dimension 6 is characterized by at least one of the following: a. The adolescent has been living in an environment in which there is a high risk of neglect, or initiation or repetition of physical, sexual, or severe emotional abuse, such that the adolescent is assessed as being unable to achieve or maintain recovery without residential secure placement; ***or*** b. The adolescent has a family or other household member who has an active substance use disorder, or substance use is endemic in their home environment or broader social network, so that recovery goals are assessed as unachievable without residential secure placement; ***or*** c. The adolescent's home environment or social network is too chaotic or ineffective to support or sustain treatment goals, so that recovery is assessed as unachievable without residential support. For example, the adolescent's family reinforces antisocial norms and values, or the family cannot sustain treatment engagement or school attendance, or the family is experiencing significant social isolation or withdrawal; ***or*** d. Logistical impediments (such as distance from a treatment facility, mobility limitations, lack of transportation, and the like) preclude participation in treatment at a less intensive level of care. **Transfer to another LOC** • When assessment indicates that an individual no longer meets the placement criteria noted above, they can be transferred to the next appropriate level of care based on a reassessment of their severity of illness and rehabilitative needs.
Interventions	• A toxicology screen and a tuberculosis screen are required within 72 hours of admission and as directed by the treatment plan and are considered covered under the rates paid to the provider. Random drug screening as clinically necessary to reinforce treatment gains and as appropriate to the individual's treatment plan. - Note: DSS will establish upper limit on number of lab tests that can be sent out. Refer to associated lab policy for additional guidance. • An individualized, comprehensive biopsychosocial assessment of the individual is completed or updated within 72 hours of admission which substantiates appropriate placement at Level 3.1. This assessment also helps to guide the individualized treatment planning process, which is focused on the individual's strengths, needs, abilities, preferences, and desired goals. - Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders. - Credentials of the completing practitioner must be documented on the assessment. - The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.

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	• A documented physical exam one month prior to admission or an appointment scheduled no later than five days after admission and the appointment for the physical cannot be more than 30 days from the date of admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination. • An individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals. - The plan is initiated at the time of admission, is developed in collaboration with the individual and is completed within 72 hours of admission. The plan reflects the individual's personal goals while considering the individual's strengths, capabilities, and existing recovery resources available to achieve the individual's personal goals. - The treatment plan reflects case management conducted by on-site staff; coordination of related addiction treatment, health care, mental health, recovery support services, social, vocational, or housing services (provided concurrently); and the integration of services at this and other levels of care. - Because treatment plans are individualized, fixed lengths of stay are inappropriate. - Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. - Credentials of the completing practitioner must be documented on the treatment plan. - The treatment plan must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. - Complete and document a review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress. • Discharge/transfer planning begins at admission and is documented in the individual's record. - The duration of treatment always depends on individual progress and outcome. Because treatment plans should be individualized, lengths of stay should be flexible and individualized to meet the needs of each individual, not based on predetermined lengths of stay. - Transfer or Discharge Plan required except in an emergency, or when a client leaves of their own accord or against program advice. Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports. Plans are written in conjunction with the individual and their primary counselor and service coordinator. - There are concrete plans for community reintegration and transition to the next appropriate level of care and treatment support and services documented including the aftercare the individual is being discharged to. • Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services. - Provide an orientation to and facilitate connections to recovery resources and community supports, including referrals to self-help programs for identified psychiatric, substance use and co-occurring disorders as appropriate and for the continuation of appropriate treatment.
Treatment Services	Level 3.1 residential programs offer 24-hour direct care and delivers low-intensity services. Treatment services facilitate the application of recovery skills, relapse prevention, and emotional coping strategies. They promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life.

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	• Provide SUD services, in accordance with the individual's treatment plan, for a minimum of five (5) hours per week. At least two (2) of these hours must be provided by an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern, at least one (1) hour of which must include individual/family therapy. • In Level 3.1, the treatment services are focused on improving the individual's readiness to change (Dimension 4) and/or functioning and coping skills in Dimensions 5 and 6. Services may include individual, group, and family therapy; medication management and medication education; mental health evaluation and treatment; vocational rehabilitation and job placement; and either introductory or remedial life skills workshops. • The program offers a range of evidence-based cognitive, behavioral, and other therapies administered on an individual and group basis, medication education and management, medication for addiction treatment, educational skill building groups, and occupational or recreational activities, adapted to the individual's developmental stage and level of comprehension, understanding, and physical abilities. • Services designed to improve the individual's ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance, and punctuality. • Motivational enhancement and engagement strategies appropriate to the individual's stage of readiness to change, which are used in preference to confrontational approaches. • Counseling and clinical monitoring to promote successful initial involvement or re-involvement in regular, productive daily activity, such as work or school and, as indicated, successful reintegration into family living. • Direct affiliations with other levels of care (such as IOP for purposes of discharge planning) and other services (such as supported employment, literacy training, and adult education). • Promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life. • Provide onsite peer support, including at a minimum, alumni groups and recovery groups or linkage to 12-step groups that ideally are welcoming to people with co-occurring disorders. Note: these meetings do not count toward the five hours of weekly programming each individual receives. • Facilitate connections to recovery resources and community supports. • Monitoring of the individual's adherence in self-administering any prescribed medications, including medication for addiction treatment (MAT), and/or any permitted over-the-counter (OTC) medications or supplements. • Opportunities for the individual to be introduced to the potential benefits of medication for addiction treatment as a tool to manage their substance use disorder(s). • Access to medication for addiction treatment. The program does not preclude admission of individuals based on MAT profile and active medication prescriptions. If agency cannot support a medication need internally, they have policies in place to ensure communication with prescribing physician is ongoing. • Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g., HIV, hepatitis C, sexually transmitted diseases) • Services, as appropriate and whenever possible with the individual's consent, for the individual's family and significant others to promote positive contribution to the individual's treatment and recovery.
Documentation	Level 3.1 programs will maintain individualized records which shall include: • The individual's Medicaid eligibility status • A physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.

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	• Initial intake evaluation, including screening for a co-occurring psychiatric disorder. A physician (or PA/NP) should review all admissions, indicate agreement with the level of care recommended and document this in the individual's medical record.
	• Information regarding the individual meeting ASAM placement criteria for the purpose of authorization and continued eligibility. ASAM 6 dimensions of care assessment tool score upon entry and documentation in the treatment plan for continued stay at each reassessment.
	• An individualized, comprehensive biopsychosocial assessment which includes assessment in each of the ASAM six dimensions; this assessment must be compliant with the most recent edition of ASAM.
	  ○ Documentation of any mental health and SUD diagnoses as well as any cognitive limitations
	  ○ Completion within 72 hours of admission
	  ○ Staff conducting or updating the assessment shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. Such staff shall be knowledgeable about addiction treatment and co-occurring disorders.
	  ○ Credentials of the completing practitioner must be documented on the assessment.
	  ○ The assessment must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	• Individualized treatment plan, which involves problem formulation, needs, strengths, skills, and articulation of short-term, measurable treatment goals, and activities designed to achieve those goals.
	  ○ Discharge planning is integrated into the treatment plan.
	  ○ Initiated at the time of admission and completed within 72 hours of admission
	  ○ Staff developing the treatment plan shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern.
	  ○ Credentials of the completing practitioner must be documented on the treatment plan.
	  ○ Plans must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor.
	  ○ Review of the treatment plan and determine the appropriateness of the individual's continued placement every 30 days and revise accordingly to reflect the individual's clinical progress
	• Individualized progress notes that clearly reflect implementation of the treatment plan and the individual's response to therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan.
	  ○ Credentials of the practitioner completing
	  ○ Notes for clinical services provided by an associate licensed practitioner or graduate-level intern shall have the review and signature of an independently licensed behavioral health practitioner/clinical supervisor.
	• Administration of toxicology screens and the test results.
	• Discharge summary which has been written within 15 working days of the individual leaving the program. This summary shall:
	  ○ Address original reason for referral.
	  ○ Indicate the individual's progress towards the established plan.
	  ○ Describe the type, frequency and duration of treatment or services.
	  ○ Specify reason(s) for discharge
	  ○ Indicate the individual's participation in discharge planning.
	  ○ Includes information regarding release(s) of information obtained and aftercare services referred to.

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Provider Qualifications/ Staffing	○ Staff completing the discharge summary shall be an independently licensed or associate licensed behavioral health practitioner or a graduate-level intern. ○ Credentials of the completing practitioner must be documented on the discharge summary. ○ The discharge summary must be reviewed and signed by an independently licensed behavioral health practitioner/clinical supervisor. Level 3.1 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified peers and technicians operating within their scope of practice to provide services appropriate to the biopsychosocial needs of individuals being admitted to the program. Facility's staffing pattern is gender responsive and trauma informed. In addition to the specifications for staff for all services, staff should be knowledgeable about adolescent development and experienced in engaging and working with adolescents. Experience in adolescent medicine is ideal. • Minimum on-site staffing requirements (not counting on-call hours) shall be maintained 24 hours per day, 7 days per week as outlined below: ○ 0-24 beds: 2 staff minimum at all times ○ 25-64 beds: 3 staff minimum at all times ○ 65-99 beds: 4 staff minimum at all times ○ 100+ beds: 5 staff minimum at all times - For facilities with multiple levels of care at the same physical address and within the same building and floor, minimum staff ratios can be shared between programs. - If programs share the same address and are separated on different floors or different buildings, the minimum staff requirement shall apply to each floor and building. An exception to this is a 0-24 bed program located in one building in which there are resident rooms on multiple levels of the building (e.g. a house-like setting); only the minimum staffing of two persons would be required. - Any requests to waive the above criteria must be submitted to The Departments for review and approval. • Level 3.1 programs must be able to provide 24-hour staff support. Ensure staff who have client contact receive training on cooccurring mental health and substance use disorders, including prevalence, signs/symptoms, assessment, treatment and the impact of one's own attitudes/beliefs on the delivery of services and the use of naloxone in response to an opioid overdose. • Where on-call coverage is indicated for any of the below positions, such coverage can be combined across programs within the same agency. • Medical, psychiatric, psychological, laboratory and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the individual's condition. • Psychiatric services are available on-site or through telemedicine per the state's telemedicine policy, as appropriate to the severity and urgency of the individual's condition. ○ Such services include medication for addiction treatment (e.g., buprenorphine, naltrexone, acamprosate, disulfiram). • Physician (or NP/PA): Although they are not required to provide direct services, the physician is part of the interdisciplinary team either through employment or contractual arrangement. ○ A physician (or NP/PA) shall review all admissions, indicate agreement with the level of care recommended and document this in the individual's medical record.

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	○ Telephone or in person consultation with a physician, physician assistant or nurse practitioner and emergency services is available 24/7. • Executive Director: Each facility shall have an executive director who is accountable to the governing authority. The executive director shall be responsible for the management of the facility • Employs a clinical supervisor with authority over all behavioral health treatment services, who shall have a minimum of a master's degree in a behavioral health treatment services field, at least three years of full-time work experience in SUD services and be independently licensed by the State in their respective discipline. ○ The Clinical Supervisor must be on-site at least 40 hours per week with at least one evening shift per week. Larger programs may require additional clinical supervisor hours to ensure all supervision requirements are met as detailed in the "Supervision Requirements" section below. ○ The Clinical Supervisor conducts and documents face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. ○ There shall be 24-hour on-call coverage by telephone during those hours when the clinical supervisor is not physically present. • An independently licensed or associate licensed behavioral health practitioner is available to provide a minimum of two (2) hours (out of the total five hours of weekly programming) of clinical treatment per week. At least one (1) of these hours includes individual/family therapy. ○ Up to 25 percent of clinical treatment hours may be provided by a graduate-level intern whose accredited graduate degree program requires their students to participate in intern placements for clinical training in the provision of behavioral health services. ○ At least one behavioral health practitioner per 16 residents is on-site 40 hours per week. ○ Any behavioral health practitioner who is not independently licensed must be working under a licensed independent behavioral health practitioner who must sign off on clinical documentation and provide supervision. ○ Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment. Clinical staff should be able to identify the signs and symptoms of acute psychiatric conditions, including psychiatric decompensation. ○ Clinical groups should be limited to no more than12 group members regardless of payer. Psychoeducational and non-clinical groups should be limited to no more than 25 group members. ○ At least one behavioral health practitioner with competence in the treatment of substance use and mental health disorders is available by telephone 24 hours a day, seven days a week when not on-site. • House manager awake and on-site during evenings, weekends and overnight to supervise activities of the facility. This person is required to have adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed • Technicians are available onsite, as needed, to ensure minimum staffing requirements are met and are awake and monitoring individuals' needs at all times. ○ Technicians may provide the additional remaining hours of weekly programming ○ Technicians report to a Tech Supervisor (or other leadership position) with at least 6 months experience in residential SUD programs.

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	• Certified Peers may provide the additional remaining hours of weekly programming and may meet with residents individually and/or in group formats to support their ongoing engagement, retention and progress in treatment.
	  ○ Certification must be obtained by one of the state-approved certification boards.
	  ○ Certified Peers should be onsite while residents are awake, including presence on evenings and weekends. Number of Certified Peers required depends on the size of the program:
	  ▪ 0-32 beds: 1 peer onsite at least 40 hours per week
	  ▪ 33-64 beds: 2 peers onsite at least 40 hours per week each
	  ▪ 65+ beds: 3 peers onsite at least 40 hours per week each
	  ○ Certified peers receive one hour of clinical supervision weekly, of which group supervision may be utilized once a month. This supervision can be provided by:
	  ▪ The Clinical Supervisor (as defined above);
	  ▪ An independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or
	  ▪ A Certified Peer with at least 2 years of full-time experience in providing peer support services.
	• A dedicated Service Coordinator that manages incoming referrals and discharge plans is required for each facility. The purpose of the Service Coordinator is to promote engagement and retention in treatment and facilitate an effective discharge plan whereby the individual successfully connects to the next level of care. The service coordinator facilitates referral arrangements and coordination with aftercare.
	  ○ The Service Coordinator can also assist in networking individuals into community-based ancillary or “wrap-around” services to build/maintain recovery capital.
	  ○ The service coordinator shall be on-site weekdays during 1st shift for at least 80% of the time. The other 20% may be done second, third or weekend shifts.
	  ○ The Service Coordinator may be a licensed practitioner, unlicensed counselor, or certified peer.
	• Each facility shall have at least one staff person in each building, when a resident is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations. This is inclusive of the positions described above.

Supervision Requirements	Supervisors conduct and document face-to-face clinical supervision a minimum of one hour each week for all clinical staff with or without a professional license. Group supervision may be utilized once a month. Certified peers with lived experience receive clinical supervision 1 hour weekly, of which group supervision may be utilized once a month – this can be from: the Clinical Supervisor; an independently licensed or associate licensed behavioral health practitioner with at least 2 years of full-time work experience in SUD services; or a Certified Peer with at least 2 years of full-time experience in providing peer support services. Technicians receive supervision from the Tech Supervisor or other leadership position for 30 minutes for every 40 hours worked. Tech administrative supervision can be in a group setting for all but one time a month. Techs must receive monthly group clinical supervision with a potential shift overlap (All staff meeting at least once a month). There should be a shift report or hand off for every shift or staggered starts.
Target Length of Stay	As medically necessary, or dependent on time needed to sustain and further therapeutic gains and master the application of coping and recovery skills

JBCSSD Contractor Requirements

Conduct statewide JBCSSD client screenings **within two weeks of the date of referral.** Screenings may occur at probation offices, courts or DOC facilities.

Immediately following the screening period the referral source must be notified in writing of program acceptance or denial. If the client is denied, state the reasons why and discharge client in CDCS as "ineligible for program". If accepted, supply an acceptance letter to the referral source and, when possible, indicate to the referral source when a bed will be available.

Provide transportation to and from court appearance, probation offices, offsite evaluations etc.

Provide court reports to Bail staff **2 days prior to the scheduled court appearance.**

When planning aftercare for all JBCSSD clients leaving treatment, please coordinate with local JBCSSD staff and whenever possible, utilize the **JBCSSD contracted network of programs**.

UPDATE CDCS

- Scheduled screening and admission dates should be updated in CDCS **no later than 24 hours** from the time the date is scheduled
- Actual screening and admission dates should be updated in CDCS **no later than 24 hours** from the time the action took place
- Discharge dates should be updated in CDCS **no later than 24 hours from the time the client left your program**
- Acknowledge JBCSSD referrals in CDCS **within 24 hours**

REPORTING

- Immediate notification by phone to the referral source and by phone or email to JBCSSD central office for **all incidents** including when a JBCSSD client leaves the program AMA or absconds; followed by a written incident report within 24 hours.
- Provide Monthly reports to probation officers by the 10th day of the month.
- Provide notification/communication with referral source around non-compliance at the time of occurrence. When possible, include the referral source in sanctioning.

SECURITY

- Conduct searches of clients, visitors and packages. Search all JBCSSD clients when returning to the building. All visits should be supervised.
- Room searches shall be conducted randomly, weekly at minimum and documented in a log. Perimeter checks shall be conducted minimally once per shift.
- Random urinalysis (weekly), immediate notification by phone to referral source if positive, follow up with written **notification within 24 hours**. Additional urinalysis shall be conducted upon client return from pass or if substance use is suspected.

PRE-TRIAL CLIENTS

Pre-trial clients will not be discharged unsuccessfully for non-compliance of programs rules without court approval.

If wishing to be relieved of supervision of a JBCSSD pre-trial client, place a redocket request in writing to the appropriate bail commissioner. The request must include the reasons for the request for relief of supervision and must be clearly stated. It is recommended that the agency is represented at court on the date of the appearance to answer any questions regarding the request.

A redocket/request for removal from the program is NOT a guarantee that the client will not be returned to your program. The decision rests with the court.