Interim Policy in Effect

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Administration for Children's Services

Policy and Procedure
2016/xx

Family Treatment/Rehabilitation Program –
Revised Casework Contact and Practice Requirements for Service Providers

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SUMMARY:
This policy, which replaces the 2012 memorandum entitled "*Family Treatment and Rehabilitation (FT/R) Program Casework Contact Guidance*," provides new casework contact requirements for families receiving Family Treatment/Rehabilitation (FT/R) preventive services; modifies the minimum qualification requirements for supervisors; provides guidance and clarifies expectations for documentation; standardizes the use of clinical diagnostic team (CDT) assessment tools for FT/R preventive services providers; and clarifies the roles, responsibilities, and referral processes for staff of the Administration for Children's Services (ACS) and preventive services provider agencies.
SCOPE:
This policy applies to FT/R provider agency staff and staff of the ACS Office of Child Welfare Programs, which includes the divisions of Child Protection (DCP) and Preventive Services (DPS).

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I. INTRODUCTION

A. This policy, which replaces the 2012 memorandum entitled "*Family Treatment and Rehabilitation (FT/R) Program Casework Contact Guidance (Revised)*," provides new casework contact requirements for families receiving Family Treatment/Rehabilitation (FT/R) preventive services.[1] Specifically, this policy reduces the minimum number of casework contacts in the initial phase of the FT/R treatment plan from eight (8) monthly visits to six (6) monthly visits. The policy also modifies the minimum qualification requirements for supervisors; provides guidance and clarifies expectations for documentation; standardizes the use of clinical diagnostic team (CDT) assessment tools for FT/R preventive services providers; and clarifies the roles, responsibilities, and referral processes for staff, such as Administration for Children's Services (ACS) Division of Child Protection (DCP) child protective specialists (CPS), clinical consultants, credentialed alcoholism and substance abuse counselors (CASACs), and preventive services provider agency staff.

B. The FT/R program is designed to work with families who have one (1) or more members with a substance use disorder[2] and/or mental health disorder. The program addresses the safety and well-being of a child when a parent's or caretaker's substance use or mental health disorder places the child at risk of removal from the parent or caretaker and/or also when another child[3] in the home misuses substances or has a mental health disorder (*see Preventive Services Quality Assurance Standards and Indicators*, September, 2011). Preventive Services Quality Assurance Standards and Indicators[4]

C. The FT/R model utilizes a team approach to assess, diagnose, and treat each family member by providing clinical interventions in the home and/or at an FT/R preventive services provider's office. The FT/R model also utilizes the CDT, a CASAC (see Section IIA), as well as other providers of specialized rehabilitative services, and other services who work with a family to assist in the development of the initial treatment and service plans. A service plan is guided by a set of comprehensive assessments.

D. The FT/R program has three (3) phases – initial, baseline, and stabilization – and has an expected duration of 12 months. However, in some cases, it may be completed in fewer than 12 months or last longer than 12 months. See Section V below for additional information about the phases of the FT/R program.

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[1] See 18 NYCRR Part 423 for additional information about preventive services programs. See also the Preventive Services Quality Assurance Standards and Indicators (September 2011) for additional information about preventive services programs and requirements, including the FT/R program.

[2] See 18 NYCRR Part 822 for information about chemical dependence outpatient treatment programs.

[3] The treatment of minors must comply with the requirements in New York State Mental Hygiene Law § 22.11.

[4] See URL for the Preventive Services Quality Assurance Standards and Indicators and updated addenda – evidenced-based models: http://10.239.3.195:8080/docushare/dsweb/Get/Document-201055/Preventive%20Services%20Quality%20Assurance%20Standards%20and%20Indicators%20-%20September%202011.pdf

II. DEFINITIONS

A. Providers of specialized rehabilitative services

Providers of specialized rehabilitative services provide interventions, such as diagnostic assessments, testing, psychotherapy, and specialized therapies delivered as a component of a service plan to a child and/or family. These interventions are administered by either a) a licensed clinical social worker (LCSW) who has experience in diagnosis, psychotherapy, and assessment-based treatment planning acceptable to the New York State Education Department,[5] or b) a licensed master social worker (LMSW) who has at least three (3) years of clinical experience, or c) a licensed equivalent human services graduate degree level practitioner. An approved graduate level practitioner may include, but is not limited to the following: a case planner, casework supervisor, nurse practitioner, licensed psychologist, and licensed psychiatrist.

B. Supportive services

Supportive services are provided as a component of a service plan to a child and/or family. Supportive services include, but are not limited to the following: parent aide services, homemaker services, home health aide services, parent training services, housekeeping and personal care services, and home management services.

C. Clinical Diagnostic Team (CDT)

A CDT consists of both specialized rehabilitative and supportive services providers. See Section VI below for additional information about the composition of the CDT.

D. Protective capacity

Protective capacity means behavioral, cognitive, and emotional characteristics that can be specifically and directly associated with a person's ability to care for a child and keep a child safe.

III. CHILD PROTECTIVE SPECIALIST REFERRALS

A. Referrals to the Clinical Consultation Program (CCP) and Credentialed Alcohol and Substance Abuse Counselor (CASAC)

1. The CCP provides a team of specialized clinicians (domestic violence, medical, and mental health) who are co-located in ACS borough offices to assist CPS with their safety and risk assessments of families.

[5] This criterion is based on the New York State Education Department Board of Regents requirements for an LCSW.

2. CASACs are available to provide assessments and referrals in cases involving substance use disorder concerns.[6]

3. A CPS must consult with the clinical consultant on cases with domestic violence, medical, and mental health concerns. For cases with substance use disorder concerns, CPS must submit referrals to a CASAC.

4. The *NYC ACS Division of Child Protection Casework Practice Requirements Manual* provides more information about the process of CPS referring cases for clinical consultation; the *Intake Procedures for Referrals to Preventive Services by the Division of Child Protection* policy addresses the referral process from child protection to preventive services; and the ACS policy *Credentialed Alcohol and Substance Abuse Counselors (*CASACs*)* provides information about CPS referrals to CASACs. These documents can be found on Docushare through the following links:
   CASAC Policy 2014.
   Intake Procedures for Referrals to Preventive Services by the DCP

5. In accordance with ACS policy, a CPS must document all CCP and CASACs referrals in CONNECTIONS (CNNX) in a timely manner, so that information about the referrals is available for service planning. Information documented in CNNX must include, but is not limited to, the following:

   a. The reason for obtaining the request for an assessment;
   b. The result of the assessment and the clinical consultant's report of the client;
   c. The outcome of the CASAC assessment and the status of the ongoing treatment with the Purchase Preventive Services (PPRS) case planner; and
   d. The outcome of the referral and follow up, with actions completed as a result of the referral outcome.

B. Referrals to Family Treatment/Rehabilitation (FT/R) Service Providers

1. Referrals by a CPS to an FT/R preventive services provider agency must be consistent with the processes described in ACS' *Intake Procedures for Referrals to Preventive Services by the Division of Child Protection* and the *NYC ACS Division of Child Protection Casework Practice Requirements Manual*.

2. Referrals require the completion and submission of the Service Connect Instrument (SCI)[7] and the family's service plan. The service plan incorporates the CPS' initial assessment of each child's safety and risk factors and developmental and

[6] In instances where there is no CASAC assigned to the borough office, please contact the Director of Substance Use Disorders Policy, Planning and Services for directives.
[7] The SCI is an online tool created to help staff select the appropriate service model for each family.

permanency needs, as well as all assessments and reviews by the co-located clinical consultants.

IV. FAMILY TREATMENT/REHABILITATION GENERAL REQUIREMENTS

A. FT/R Assessment and Screening Tools

1. The clinical diagnostic forms used by the FT/R preventive services provider agencies are comprehensive screening instruments that align a family's needs with interventions designed to achieve the best outcomes for the family.

   a. *The Clinical Diagnostic Team (CDT) Screening/Assessment Cover Sheet* (Attachment A) is used by the CDT as a checklist to verify that all the referral documents are included in the referral package.

   b. The *CDT Meeting Form* (Attachment B) must be used during the first 30 days of the initial treatment phase to inform a family's treatment plan. The *CDT Meeting Form* determines the most appropriate treatment goal(s) for each child and family member based on assessed needs and/or recommendations from the CPS.

   c. *The CDT Meeting Form* must be used before any phase changes occur. At a provider's discretion, the form can also be used to prepare for family team conferences (FTCs), address family engagement challenges, and determine next steps when there has been no progress.

2. The Stability and Recovery Screening Tools

   a. FT/R preventive services provider agencies are required to use the screening tools listed below during the initial phase of treatment in order to produce a service plan that will meet the needs of the family:

      i. Modified Mini Screen[8] (see Attachment C);
      ii. The UNCOPE screening[9] (see Attachment D);
      iii. The CRAFFT[10] screening (see Attachment E); and
      iv. ACS' Domestic Violence Screening Tool

[8] The Modified Mini Screen (MMS) is a mental health assessment tool.
[9] UNCOPE is a substance use disorder assessment tool.
[10] CRAFFT is a behavioral health screening tool to be used with youth under the age of 21 years.

B. Medical Consent

1. The FT/R preventive services provider agency staff must use their consent forms to get the parents' and caretakers' informed consent to receive services.

C. Observations of Interactions

1. The CDT and case planners of FT/R preventive services provider agencies must observe parents and caretakers with their child (ren) as an essential part of assessing safety and risk. Case planners must contemporaneously document their observations, which must include, but are not limited to, observations of the following:

   a. Aggressive behaviors;
   b. Defiant, disobedient, and hostile behaviors; or
   c. Reckless and risk-taking behaviors.

D. FT/R Casework Contact Requirements

1. Program Casework Contacts

   a. FT/R preventive services providers must:

      i. Monitor child safety, risk, and well-being during each casework contact and throughout the life of a case;

      ii. Never reduce the number of contacts below the minimum number of contacts identified in Section IV and delineated on Table #1, entitled *Family Treatment/Rehabilitation Casework Contact Grid* [11](Attachment F*)*, of this policy;

      iii. Increase the number of contacts with a family as warranted by the current circumstances of the family;

      iv. Use regular documented communication and consultation with the CDT to inform the FT/R preventive services provider agency's assessment of the number of contacts needed; and

      v. Confirm that all casework contacts, assessments of safety, risk, and well-being of child (ren), and observable behavioral indicators of parents and

[11] The Family Treatment/Rehabilitation Casework Contact Grid shows the minimum required contacts. However, special circumstances (e. g. age of the children in the family) may require more contacts.

caretakers are contemporaneously documented in CNNX and the Preventive Organization Management Information System (PROMIS).

2. Minimum Required FT/R Casework Contacts Grid

   Table #1 below shows the minimum number of required casework contacts, the type of required contact, and indicates who is authorized or permitted to make the required contact. See Section V for further information and a detailed description of the three (3) treatment phases. Note also that special circumstances (e.g., the age of the child, the presence of safety concerns and risk factors, and the parent or caretaker's diagnosis[12]) will further modify and dictate the number and type of required contacts in the given phases (see paragraphs #3 and #4 in this section and Section V).

[12] This refers to a diagnosis of substance use disorder or mental health disorder.

Table #1

Family Treatment/Rehabilitation Casework Contact Grid

Treatment Phase	Total Minimum # of Casework Contacts	Total Minimum # of Home Visits	Minimum # of Casework Contacts that must be conducted by Case Planner	Maximum # of Casework Contacts that may be conducted by Specialized Rehab Provider/ Supportive Service Provider (e.g., CASAC, or Parent or Case Aide)
Initial Phase *(ordinarily the first 4 weeks of treatment or the period following a relapse)*	6 contacts per month: 1 contact/week by the case planner AND 2 additional contacts/month	1 home visit/week	1 contact/week (must be a home visit)	2 contacts/month
			1 casework contact in the home, per week, by the case planner, 2 additional contacts, per month, by any of the following: CASAC, licensed therapist, psychologist and/or psychiatrist consultant or parent/case aide.	
Baseline Phase	4 contacts per month: 1 contact/week	At least 2 home visits in a 4-week period	At least 2 home visits in a 4-week period	Up to 2 contacts in a 4-week period
Stabilization Phase	2 contacts per month (both contacts must be home visits)	2 home visits/ month	1 home visit/month	1 home visit/month

3. Best Practices for Cases Involving Infants and Young Children

   a. Infants[13] and young children[14] are one of the most vulnerable populations for maltreatment. Infants or young children who are not enrolled in school or in a full-time child care program and/or whose parents or caretakers have a diagnosis of substance use and/or mental health disorder may be particularly vulnerable. These children must be closely monitored and assessed by the case planner and supervisor for safety and risk factors in all phases of treatment.

[13] The term refers to young children between the ages of birth and 12 months.
[14] The term refers to children 5 years and younger.

b. In situations where there is an infant or young child, or where safety concerns or risk factors are present, the case planner and supervisor must assess the vulnerability of the infant and young child, and discuss in weekly supervision to jointly determine whether increased visits or other types of interventions (i.e. a safe sleep assessment) are needed in order to maintain child safety and well-being.

4. Best Practices When Relapse or Decompensation Occurs

a. In the event that a parent or caretaker relapses or decompensates, the *CDT* will convene to assess the current safety of and risk to any child(ren) residing with the parent or caretaker.

b. The FT/R preventive services provider will determine if it's necessary to return to the higher number of casework contacts[15] required during the initial phase of service, or in the baseline phase of sobriety, or to remain at the lower number of required casework contacts ordinarily held during the stability phase.

c. FT/R preventive services provider agency case planner will monitor the safety, risk, and well-being of the child (ren) residing with the parent or caretaker during this critical phase of recovery in weekly supervision.

E. <u>Documentation by the Provider Agency Supervisor</u>

1. The FT/R preventive services provider agency supervisor and/or program director must document in CNNX, within five (5) business days, all decisions made regarding a phase change.[16] Documentation is required in all three (3) phases.

2. For each case, the FT/R preventive services provider agency supervisor must clearly and promptly document the following in the CNNX progress notes:

a. The CDT assessment that supports the decision to increase or decrease the frequency of casework contacts and/or home visits; and

b. The current frequency of contacts in accordance with the minimum standards in this policy and/or the provider's decision to move the family to a higher level of contact.

3. The FT/R preventive services provider agency supervisor must promptly document information about monthly case reviews and team meetings, including the family's functioning at the time of each case review or team meeting, in CNNX and PROMIS.

[15] See Section V (B)(1).
[16] Phase change refers to the movement of a family member from one phase of treatment to another.

V. FAMILY TREATMENT/REHABILITATION PHASES

A. Assessing the Safety of Each Child in the Home

1. FT/R providers are expected to observe and assess the safety, risk, and well-being of all children during all phases of treatment.

   a. ACS mandates that, when there is a newborn[17] or a medically fragile/special needs and/or homebound parent or child in the home, case planners must conduct safety and risk assessments, which may include safe sleep assessments, for all children in the household, and discuss their assessments with their supervisors.

   b. Based on the assessments, the case planner and supervisor should jointly determine whether increased visits or other types of interventions are needed.

   c. The provider must use various approaches to observe and assess the child's safety and well-being, such as collateral contacts with a school staff member or child care provider[18]. Efforts to meet this expectation must be clearly documented in CNNX throughout the life of a case.

B. Criteria and Casework Contacts for the Initial Phase of Service Provision

1. The initial phase occurs during the first four (4) weeks of treatment. This is the beginning phase of treatment until a baseline of sobriety or stability is obtained, or following a relapse/decompensation occurrence as determined by the CDT.

2. Casework contacts during this period are as follows:

   a. A minimum of one (1) weekly home-based casework contact by the case planner and a total of six (6) casework contacts per month. Two (2) of the six (6) required monthly contacts may be made by supportive services staff, while the other four (4) contacts must be made by the case planner or otherwise determined by the CDT. If the specialized rehabilitative and supportive service staff members are unable to make the visits, then the case planner is responsible for making the visits.

   b. Two (2) of the six (6) required monthly casework contacts may be held outside of the home, in the agency office or another location, and may be made either by the specialized rehabilitative and supportive services staff.

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[17] A newborn is any child under the age of six (6) months old.

[18] The provider agency must get the parent's consent at the initial engagement and update the consent form later in order to facilitate diligent efforts with collaterals, such as schools and child care providers.

c. More frequent casework contacts may be required for children under the age of five (5) years.

   i. If safety concerns and risk factors are present, then following a comprehensive assessment by the CDT, the number of monthly casework contacts must be increased to an appropriate level; and

   ii. All casework contacts during this critical period must include close monitoring of safety concerns and risk factors.

d. If the CDT has determined that an increased number of contacts per week is required, any additional required home-based visit must be made by the case planner. Other visits may be made by specialized rehabilitative or supportive services provider staff.

e. The FT/R preventive services provider agency must determine whether to increase the number of casework contacts per week for a particular family member who receives a diagnosis of a substance use or mental health disorder during the initial phase of service. This determination must be based on a comprehensive assessment that takes into account the following factors:

   i. The circumstances that led to the referral

      For CPS referrals, the provider is expected to review the results of the investigation in CNNX and discuss with the CPS how she or he assessed safety and risk in the family before making a decision that the family requires one (1) or more additional contacts per week during the initial phase of service.

   ii. The age of the child(ren)

      The provider agency must complete an assessment of the family member with a diagnosis of substance use disorder or mental health disorder and the impact of the family member's disorder on the child(ren), as well as an assessment of the family's support system, the support system's availability, and the ability of the support system to protect the child(ren) from maltreatment or abuse.

   iii. The relevance of the family member's diagnosis to the current situation

      The provider must assess the family member's current involvement in treatment and how the family member's behavior impacts her or his functioning.

iv. If the family member has already completed a period of treatment and has established a baseline of sobriety or stability, the provider must conduct a comprehensive assessment to determine whether to increase, decrease, or maintain the minimum number of weekly casework contacts. The provider must consider triggers and crisis-related events that could impair family member functioning and assess how the individual is coping and whether additional supports are needed.

v. Whether the family member with a diagnosis is an adolescent

The case planner must assess how the adolescent's behavior impacts the safety of and risk to any younger child(ren) in the home when the adolescent is left to care for her or his siblings. Additionally, the case planner must assess how the adolescent's behavior affects her or his parent's or caretaker's ability to safeguard younger child(ren) from the adolescent.

vi. Whether the parent with a diagnosis is presently residing outside the home

The case planner must make diligent efforts to assess the behavior of a parent who lives outside the home and has access to the child(ren), to determine if the parent's behavior impacts the safety of and risk to the child(ren). The case planner must verify that the parent is presently residing outside the home. If the parent is living outside the home, and if, when in the child(ren)'s company, her or his behavior does not negatively affect the safety of the child(ren), then the provider may transition the family to the next phase of service.

C. Determining a Baseline of Sobriety and/or Stability

1. FT/R providers must consider a range of factors in determining whether a baseline of sobriety or stability has been achieved.

2. The parent or caretaker with a **substance use disorder** may be said to have achieved a baseline of sobriety and/or stability when she or he has met the following criteria:

   a. Meaningfully engaged in treatment for the substance use disorder (this must be confirmed by the treatment provider);[19]
   b. Taken responsibility for her or his actions;
   c. Established a pattern, over time, of negative urine tests:
      i. Provider agencies must obtain copies of toxicology reports (as needed per treatment plan);

[19] Provider agencies must have signed consent forms by the individual or parent to request monthly and/or bi-weekly progress reports, as needed, based on the provider's treatment plan.

d. Exhibited improved patterns of interactions with others, including family members and children, in ways that can be observed and documented by the provider agency staff.

3. The parent or caretaker with a **mental health disorder** may be said to have achieved a baseline of stability when she or he has met the following criteria:

   a. Demonstrated diminished mental health symptoms and/or behaviors;
   b. Demonstrated diminished safety and risk factors and increased protective capacity;
   c. Taken responsibility for her or his actions;
   d. Improved patterns of interaction with others—for adults, especially interactions with children—in ways that can be observed by the provider agency staff;
   e. Established a pattern, over time, of being engaged in treatment when medication is prescribed in a compliant manner, as appropriate; and
   f. Demonstrated a willingness to advocate for self with mental health providers.

4. For **adolescents having a diagnosis of substance use and/or a mental disorder**, additional determining factors must be considered when establishing a baseline of sobriety and/or stability, including:

   a. Improved school attendance;
   b. Improved school performance;
   c. Ability to interact and relate positively with others;
   d. Ability to comply with adults' requests or rules; and
   e. Marked decrease in aggressive, defiant, deceitful, disobedient, hostile behaviors and/or reckless and risk-taking acts.

5. A client with **co-occurring severe, persistent mental illness and substance use disorder** will exhibit more severe symptoms of mental illness, may be more frequently hospitalized, and may have more frequent relapses than a client with a single diagnosis.[20] Therefore, ACS expects FT/R providers to consider the range of factors for both categories in determining whether a baseline of sobriety and/or stability has been achieved for clients with co-occurring psychiatric and substance use disorders.

[20] Bellack, A.S., Bennett, M.E., & Gearon, J.S. (2007). *Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals*, New York: Taylor & Francis Group, LLC.

D. Criteria and Casework Contacts for the Baseline Phase of Service Provision

1. Criteria for Baseline Phase

   The baseline phase is achieved when a family has been in treatment for at least four (4) weeks and the provider has determined that the family has reached a baseline of sobriety or stability. See Section (V)(E) for additional information on determining whether a baseline has been achieved.

2. Number of Casework Contacts for Baseline Phase

   a. A minimum of four (4) casework contacts must be made within a four-week period in the baseline phase. For all cases in the baseline phase of service, the case planner must make at least two (2) home-based contacts within a four-week period with the family. The other two (2) contacts may be made by the specialized rehabilitative services provider and/or supportive services staff. If the specialized rehabilitative and supportive service staff members are unable to make the visits, then the case planner is responsible for making the visits.

      i. More frequent casework contacts may be required if the family includes a child or children under the age of five (5) years.

   b. If the family has been referred because of an adolescent's mental health needs, and the adolescent does not provide care for a younger child, and the adolescent's behavior is not negatively impacting any child(ren) in the home, the provider may assess whether two (2) of these contacts may be held in an alternative location. In such cases, the case planner must make at least two (2) home-based contacts per month.

   c. Where the CDT has determined that an increased number of contacts are required, any additional required home-based visits must be made by the case planner. Other visits may be made by specialized rehabilitative or supportive services provider staff.

E. Criteria and Casework Contacts for the Stabilization Phase of Service Provision

1. The stabilization phase is achieved when a family has made sufficient progress toward service planning goals and risks to the child(ren) have been significantly reduced.[21]

[21] Any move into the stabilization phase must be based on a family's assessed needs and risks to the child(ren).

2. Number of Casework Contacts for the Stabilization Phase

    a. The minimum number of casework contacts for the stabilization phase is two (2) per month, both of which must be in the home, and each child must be seen at least once.
    b. The case planner must make at least one (1) of the required home-based visits per month; and
    c. If the specialized rehabilitative and supportive service staff members are unable to make the visits, then the case planner is responsible for making the visits.
    d. The second required visit may be made by either the case planner or the specialized rehabilitative or supportive services staff.
    e. If the CDT has determined that an increased number of contacts per week are required, any additional required home-based visits must be made by the case planner. Other visits may be made by specialized rehabilitative or supportive services provider staff.

VI. FAMILY TREATMENT/REHABILITATION STAFFING

A. The FT/R Full-Time Staff

FT/R full-time staff is comprised of the following:

1. A program director with a Master's of Social Work (MSW) degree or an equivalent human services graduate degree,[22] and relevant administrative and supervisory experience. This is a required position.

2. A supervisor with an LMSW credential and three (3) years of clinical experience or a licensed equivalent human services graduate degree and documented relevant experience. This is a required position.

3. A licensed mental health clinician with an LCSW credential or a mental health professional (e.g., a licensed therapist specializing in marriage and family, art, or drama; a mental health practitioner; a psychiatric nurse; or a psychologist). This position is required if there is no established partnership with a mental health provider.

4. A case planner with a Bachelor of Arts (BA), Bachelor of Science (BS), Bachelor of Social Work (BSW), or MSW degree, or an equivalent human services graduate degree and at least one (1) year of documented relevant child welfare experience. This is a required position.

[22] Examples of equivalent human services degrees include, but are not limited to, degrees in anthropology, child development, education, or sociology.

5. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) or Credentialed Alcoholism and Substance Abuse Counselor-Trainee (CASAC-T) is a required position. The CASAC or CASAC-T may, but is not required to, have a bachelor's degree in a social science, such as psychology, social work, or sociology, or a master's degree in a related field and two (2) to three (3) years of child welfare experience. The CASAC must have a current CASAC certification to provide assessments of substance use and substance use disorders. A CASAC-T has one (1) year to obtain full CASAC certification.

6. The case aide/parent aide is a recommended position. The case aide/parent aide must have a high school diploma or general equivalency diploma (GED) and at least one (1) year of appropriate experience working with a similar population or successful completion of and graduation from an ACS-contracted FT/R or similar program (i.e., former FT/R program). Aides working with clients in substance use disorder treatment or recovery must have graduated from a substance use disorder treatment program and have at least two (2) years of sobriety.

7. A family team conference specialist is a recommended position. FT/R preventive services provider agencies may use their discretion to assign responsibility for the facilitation of family team conferences in a manner that will enable them to successfully implement the FT/R model. If a dedicated position is created, that staff person must have an MSW degree or equivalent human services graduate degree, or two (2) years of casework experience and one (1) year of group work experience, and (2) years of documented relevant child welfare experience.

8. An intake worker is a recommended position. An intake worker must have a BA/BS/BSW, MSW, or equivalent human services graduate degree (preferred) with at least two (2) years of documented relevant child welfare experience.

B. <u>The FT/R Part-Time Clinical Staff or Consultants</u>

FT/R part-time staff is comprised of the following clinical professionals or consultants:

1. A licensed psychologist responsible for conducting psychological evaluations, making recommendations for treatment, and assisting with staff training; and

2. A licensed psychiatrist responsible for conducting psychiatric evaluations, making recommendations for treatment, and assisting with staff training.

Note: all consultants contracted by providers of specialized rehabilitative services must participate in team meetings (in person or by video or telephone conference).

DPS-015 A
REV. 8/14

NYC Administration for Children's Services

Attachment A

Office of Preventive Services
Family Treatment Rehabilitation (FTR)
CDT Screening/Assessment Cover Sheet

MANDATED SCREENINGS

☐ DV Screening Date: MM/DD/YY

☐ Psychosocial Date: MM/DD/YY

ACS Required Screening Tools: *(One or more screening tools are required.)*

☐ Modified Mini Screen (MMS) Date: MM/DD/YY

☐ UNCOPE Date: MM/DD/YY

☐ CRAFFT Date: MM/DD/YY

Optional *(In addition to one or more of the above.)*

Other: Date: MM/DD/YY

OTHER REQUIRED ASSESSMENTS

☐ Mental Health Assessment Date: MM/DD/YY

☐ CASAC Assessment Date: MM/DD/YY

☐ Toxicology Date: MM/DD/YY

Other: ☐ Yes Date: MM/DD/YY

SCREENING/ASSESSMENT/TOXICOLOGY REPORTS

If not completed state why.

DPS-015 B
REV. 8/14

Administration for Children's Services

Attachment B

Office of Preventive Services
Family Treatment Rehabilitation (FTR)
Clinical Diagnostic Team Meeting Tool

The CDT MUST be used during the initial treatment phase, any phase changes and for any safety and risk concerns. (At the agency discretion, the CDT can be used to prep for FTCs, engagement challenges, lack of progress).

Date: MM/DD/YY

Case Name:

Current Phase:

Case Number:

CDT Phase Change to:

Phase Change Effective Date: MM/DD/YY

Purpose of the Meeting:

Adults in the home:

	Name	Relationship
1		
2		
3		

Children:

	Name
1	
2	
3	

	Name
4	
5	
6	

Biological parents out of the home:

External supports out of the home:

	Name	Relationship
1		
2		
3		

Administration for Children's Services

CDT Participants:

Name	Title/Role

Presenting Issues and Concerns:

Family's Strengths/Progress:

Recommendations/Next Steps:

	What	By Whom	When
1			
2			
3			
4			
5			
6			

Case Planner's Signature: _____ Date: MM/DD/YY

Supervisor's Signature: _____ Date: MM/DD/YY

Please note that the CDT meeting must be documented and entered by the supervisor into connections.

SAVE PRINT

Attachment C

Modified Mini Screen (MMS)

Client Name: _____ OASAS ID _____

Weeks since admission _____ Interviewer _____

Today's Date_____ Supervisor Initials (Optional)_____

SECTION A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	YES	NO
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES	NO
3. Have you felt sad, low or depressed most of the time for the last two years?	YES	NO
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES	NO
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	YES	NO
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6		

SECTION B

7. Note this question is in 2 parts. a. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? YES NO b. If yes, did these intense feelings get to be their worst within 10 minutes? YES NO Interviewer: If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO.	YES	NO
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: ❑ Being in a crowd ❑ Standing in a line ❑ Being alone away from home or alone at home ❑ Crossing a bridge ❑ Traveling in a bus, train or car	YES	NO
9. Have you worried excessively or been anxious about several things over the past 6 months? Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.	YES	NO
10. Are these worries present most days?	YES	NO
11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: ❑ Speaking in public ❑ Eating in public or with others ❑ Writing while someone watches ❑ Being in social situations	YES	NO
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: ❑ Were you afraid that you would act on some impulse that would be really shocking? ❑ Did you worry a lot about being dirty, contaminated or having germs? ❑ Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ❑ Did you have any fears or superstitions that you would be responsible for things going wrong? ❑ Were you obsessed with sexual thoughts, images or impulses? ❑ Did you hoard or collect lots of things? ❑ Did you have religious practice obsessions?	YES	NO

SECTION B (CONTINUED)

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: ❑ Washing or cleaning excessively ❑ Counting or checking things over and over ❑ Repeating, collecting, or arranging things ❑ Other superstitious rituals	YES	NO
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples Include: ❑ Serious accidents ❑ Sexual or physical assault ❑ Terrorist attack ❑ Being held hostage ❑ Kidnapping ❑ Fire ❑ Discovering a body ❑ Sudden death of someone close to you ❑ War ❑ Natural disaster	YES	NO
15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ❑ Dreams ❑ Intense recollections ❑ Flashbacks ❑ Physical reactions	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15		

SECTION C

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	YES	NO
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	YES	NO
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	YES	NO
19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	YES	NO
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?	YES	NO
21. Have you ever heard things other people couldn't hear, such as voices?	YES	NO
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 16-22		

SCORING THE SCREEN

NUMBER OF "YES" RESPONSES FROM SECTION A	
NUMBER OF "YES" RESPONSES FROM SECTION B	
NUMBER OF "YES" RESPONSES FROM SECTION C	
TOTAL NUMBER OF "YES" RESPONSES FROM SECTIONS A, B, AND C • Score ≥ 10, assessment needed • Score ≥ 6 & ≤ 9, assessment need should be determined by treatment team • Score ≤ 5, no action necessary unless determined by treatment team	
YES RESPONSE TO QUESTION #4 • If score = 1, assessment is needed	
YES RESPONSES TO QUESTIONS #14 AND #15 • If score = 2, assessment is needed	

SCORE INDICATED NEED FOR AN ASSESSMENT? (CIRCLE) YES NO

IF NO, DID TREATMENT TEAM DETERMINE
THAT AN ASSESSMENT WAS NEEDED? (CIRCLE) YES NO

ATTACHMENT D

RECOVERY: Life Beyond Addiction
An Outpatient Substance Abuse
and Behavioral Addiction Treatment Program

Helping to Identify Adults At-Risk for Substance Addiction

The UNCOPE

The UNCOPE is a six item addiction screen. Hoffman and colleagues developed this in 1999 to identify adults at-risk for substance addiction. The UNCOPE questions are available free of charge for anyone to use. A score of at least 2 is indicative of abuse; 4 or more is indicative of dependency.

U Have you spent more time drinking or **USING** than you intended to?

N Have you ever **NEGLECTED** some of your usual responsibilities because of using alcohol or drugs?

C Have you felt you wanted or needed to **CUT** down on your drinking or drug use?

O Has anyone **OBJECTED** to your drinking or drug use?

P Have you found yourself **PREOCCUPIED** with drinking or using?

E Have you ever used alcohol or drugs to relieve **EMOTIONAL** discomfort, such as sadness, anger, or boredom?

References

Hoffmann, N. G., Hunt, D. E., Rhodes, W. M., Riley, K. J. (2003). UNCOPE: A Brief Substance Dependence Screen for Use with Arrestees. *Journal of Drug Issues*, 33 (1), 29-44.

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

Part B	No	Yes
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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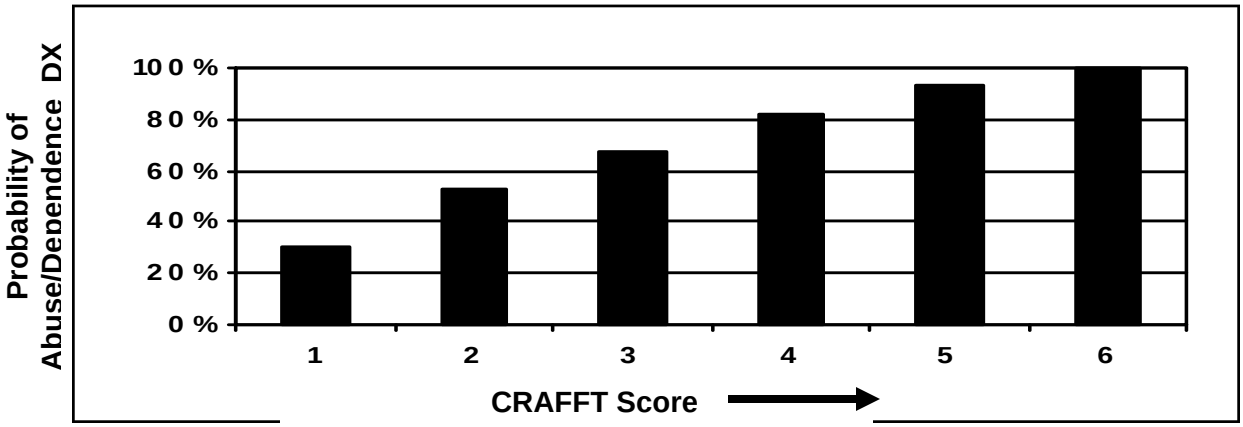
SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

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References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

Attachment F

Family Treatment/Rehabilitation Casework Contact Grid

Treatment Phase	Total Minimum # of Casework Contacts	Total Minimum # of Home Visits	Minimum # of Casework Contacts that must be conducted by Case Planner	Maximum # of Casework Contacts that may be conducted by Specialized Rehab Provider/ Supportive Service Provider (e.g., CASAC, or Parent or Case Aide)
Initial Phase *(ordinarily the first 4 weeks of treatment or the period following a relapse)*	6 contacts per month: 1 contact/week by the case planner AND 2 additional contacts/month	1 home visit/week	1 contact/week (must be a home visit)	2 contacts/month
			1 casework contact in the home, per week, by the case planner, 2 additional contacts, per month, by any of the following: CASAC, licensed therapist, psychologist and/or psychiatrist consultant or parent/case aide.	
Baseline Phase	4 contacts per month: 1 contact/week	At least 2 home visits in a 4-week period	At least 2 home visits in a 4-week period	Up to 2 contacts in a 4-week period
Stabilization Phase	2 contacts per month (both contacts must be home visits)	2 home visits/ month	1 home visit/month	1 home visit/month