I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To provide continued clinical case management for offenders who are subject to State probation or parole supervision, who present with mental health and/or substance use treatment needs.

III. APPLICATION: Assistant Commissioner of Rehabilitative Services, Assistant Commissioner of Community Supervision, Correctional Administrators, rehabilitative services staff, community supervision staff, and probationers and parolees.

IV. DEFINITIONS:

A. Biopsychosocial Assessment: A comprehensive assessment designed to match an offender's criminogenic, mental health, and substance use treatment needs with the appropriate treatment services.

B. Client Services Care Plan: A document that identifies the care needs of the individuals served, listing the strategy for providing services to meet those needs, documenting care goals and objectives, and outlining the criteria for terminating specified interventions.

C. Community Treatment Collaborative (CTC) Program: A program funded through an interagency agreement between TDOC and the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). The CTC program is a collaborative effort to divert at-risk probation and parole technical violators with substance use and co-occurring disorders from returning to state prison.

D. Crisis Stabilization Unit: Designated locations within the facilities that offer intensive, short-term stabilization for someone experiencing a mental health emergency and who is willing to receive services.

E. Forensic Social Worker (FSW): A social worker with a Master's degree in social work from an accredited college or university, who has specialized knowledge of screening, assessment, and referral processes for offenders who present mental health and/or substance use problems and who are involved with the criminal justice system.

F. FSW Case File: Documentation and other confidential information retained by the FSW pertaining to the parolee or probationer's treatment with the FSW and/or other Community Resources.

G. Mobile Crisis: A community mental health service which provides immediate-response emergency mental health intervention where there is an indication of a person's risk of self-inflicted harm.

H. Offender Management System (OMS): A management information system designed to track offender populations and characteristics throughout TDOC.

I. Referral: The process of connecting an offender with consultation, treatment or other ancillary services and supports that appear to be indicated for the offender's presenting condition.

J. TCU Drug Screen (TCUDS): An assessment based on the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM), that screens for mild to severe substance use disorders and is particularly useful when determining placement and level of intensity for substance use treatment.

K. Tennessee Web Information Technology System (TN-WITS): An electronic system for referring offenders to CTC-funded community substance use treatment services.

V. POLICY: Probationers and parolees under the supervision of the TDOC shall be assessed and referred to treatment and ancillary support services that are reasonably indicated for the offender's presenting mental health and/or substance use needs.

VI. PROCEDURES:

A. Referral

1. Offenders with identified mental health and/or substance use needs shall be referred to the FSW by the probation/parole officer (PPO) or correctional counselor (CC). A Board of Parole determination, court order, or imposed sanction may also constitute a referral to the FSW.

2. The PPO or CC shall complete the referral to the forensic social worker in the vendor software, ensure the contact code FSWR is in the OMS, as well as, schedule the appointment in accordance with the procedure designated by the local field office.

3. If the offender fails to appear for two consecutive scheduled appointments, the referral shall be closed as unsuccessful by the FSW.

B. Intake Screening and Assessment

1. The FSW will complete a Biopsychosocial Assessment Form (BAF), CR-3393, for each offender referred for mental health or substance use services. If a BAF is unable to be completed, the reason will be documented in the OMS.

2. The FSW will administer the most recent version of the TCUDS for each offender referred for substance use services and enter the results on the OMS utilizing the vender software.

C. Client Service Care Plan, Referral, and Implementation of Services

1. The FSW shall refer offenders to community treatment providers, psychoeducational groups, or day reporting centers (DRCs) as indicated by the completed biopsychosocial assessment. The FSW shall assist the offender in accessing community resources to address areas of need identified during the assessment.

2. A Client Services Care Plan**,** CR-4252, will be developed at each initial appointment outlining treatment recommendations and shall be signed by the offender and FSW. A copy will be provided to the offender and PPO by the FSW.

3. An Authorization for Release of Health Services Information, CR-1885, as well as an Authorization for Release of Substance Use Treatment Information, CR-1974, must be completed and signed by the offender and FSW before a referral is made to any treatment provider.

4. The FSW shall enter documentation of offender compliance with treatment in the OMS utilizing progress reports the FSW receives from the treatment provider. The FSW shall notify the PPO when they become aware of non-compliance or when an offender is discharged from a provider's care.

5. Crisis Intervention: When presented with an offender who is experiencing a mental health crisis, the FSW shall make a referral, as deemed appropriate, to:

   a. Mobile Crisis, or

   b. Crisis Stabilization Unit (CSU)

6. When an offender is found to be clinically appropriate to receive services utilizing CTC funding, the FSW shall complete specific TN-WITS sections:

   a. Client Profile

   b. Intake Transaction

   c. Consent

   d. Referral

D. Psychoeducational Groups and Follow-Up Services

1. The FSW shall provide psychoeducational groups and follow-up services to offenders.

2. The FSW shall utilize evidence-based curricula in the conduct of psychoeducational group therapy. Groups may be targeted to a certain population according to gender or behavior or could be inclusive of special needs.

3. Offenders may be referred by the PPO for psychoeducational groups or the FSW may recommend a group as part of the Client Services Care Plan, which is indicated from the Risk Needs Assessment (RNA) and the Case Plan generated from the RNA.

4. The FSW shall evaluate each referral to assess the offender's need and appropriateness for psychoeducational group involvement. In situations where an insufficient number of offenders exist to conduct a psychoeducational group, the FSW may present the information in an individual contact format.

5. Each group participant shall sign and date the Psychoeducational Group Participant Agreement**,** CR-4128, indicating an understanding and willingness to abide by group rules and work toward successful completion. An offender's failure to sign this document shall result in termination from the group.

6. Groups shall be facilitated within the Community Supervision offices, other designated locations, or via video platform or telephonically in order to provide a structured environment.

7. The FSW shall enter offender group attendance in the OMS and vendor software and will notify the PPO regarding compliance with attendance requirements.

8. Successful discharge from a group will occur when the offender has completed all requirements as outlined in the group rules and criteria. Suspensions and unsuccessful discharges shall be documented in the vendor software by the FSW and in the OMS.

9. A referral for an individual contact session may be made by the PPO to the FSW. The indicators that may generate a referral include a positive UDS, self-report of substance use or a use disorder, a history of mental health treatment or issues, reported current history of psychotropic medications, mental health hospitalizations, and request for mental health services or assistance. The FSW shall meet with offenders for brief individual contact sessions, according to priority and need. The FSW shall make a referral to a community mental health provider for any offender that presents with a need for individual counseling that is outside the FSW's scope of practice.

E. Documentation

1. The FSW prepares appropriate and necessary documents that accurately reflect the delivery of all direct services in accordance with policy guidelines. Confidentiality of these records shall be maintained in accordance with Policy #113.50.

2. The FSW shall make required OMS entries within three working days of any contact with the offender, collateral sources, or PPO.

3. The FSW Case File shall contain, as applicable:

   a. Legal documentation (Parole/Probation order, and other court records)

   b. Signed Authorization for Release of Health Services Information, CR-1885

   c. Authorization for Release of Substance Use Treatment Information, CR-1974

   d. A&D Screening Instrument (TCUDS)

   e. Biopsychosocial Assessment, CR-3393

   f. Previous treatment information, correspondence/letter(s)

   g. Treatment Provider Progress Notes/Correspondence

h. Previous Psychiatric Evaluations

i. Client Services Care Plan, CR-4252

j. Psychoeducational Group Participant Agreement, CR-4128

4. Record Retention/Disposition

a. The PPO will notify the FSW when an active case is being transferred to another field office in the state of Tennessee.

b. When a community supervision case is transferred to another state, a copy of the FSW case file shall be sent to the receiving state and appropriate supervision entity upon receipt of the appropriate authorization for release of information.

c. All inactive records of offenders shall be maintained separate from the active offender records, following the same procedures on storage, access, disposition, and release of the health record as indicated by Policy #113.50. Records will be retained and disposed of in accordance with the assigned Records Disposition Authorization (RDA).

VII. ACA STANDARDS: 4-APPFS-2A-02, 4-APPFS-2A-06, 4-APPFS-2A-08, and 4-APPFS-3D-29.

VIII. EXPIRATION DATE: June 15, 2024

TENNESSEE DEPARTMENT OF CORRECTION

AUTHORIZATION FOR RELEASE OF HEALTH SERVICES INFORMATION

_____
INSTITUTION

INMATE NAME (PRINTED): _____ TDOC ID: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH _____ GENDER _____

☐ I hereby authorize _____ to release the information
(NAME OF PROVIDER/FACILITY)

indicated below to the Tennessee Department of Correction (TDOC) regarding my clinical treatment.

TDOC Facility Name/Community Supervision Office: _____

Facility Address: _____

Phone Number: _____ Fax Number: _____

☐ I hereby authorize the Tennessee Department of Correction to release clinical information to the persons/entities indicated below for:

Name: _____ Relationship to Inmate: _____

Address: _____

Address 2: _____

Phone Number: _____ Fax Number: _____

Please release the following information (Check "✓" all that apply):

☐ Health Record ☐ Infectious Disease Record ☐ Dental Record ☐ Mental Health Record ☐ Psychotherapy Notes
☐ Substance Use Diagnosis/Treatment ☐ Other: Dates: _____/_____/_____ thru _____/_____/_____

Note: An authorization for the release of psychotherapy notes cannot be made in conjunction with an authorization for the release of any other confidential health information. An authorization to release psychotherapy notes must be executed separately from any other authorization for disclosure.

Purpose of the disclosure: _____

- This authorization expires six (6) months from the date of the signature below and covers only information created prior to that date. I understand that I may retract this authorization at any time, in writing, to the attention of TDOC Division of Records Management, 2nd Floor, 320 Sixth Avenue North, Nashville, TN 37243-0465.
- I understand that my release, which was made prior to a retraction hereof, and based on this signed authorization, will not constitute a breach of my privacy rights.
- I understand that this authorization is necessary to release information that is deemed private and confidential by law (health records, TCA 10-7-504, mental health records, TCA 33-3-103).
- I understand that a provider may not condition treatment on whether or not I sign this authorization.
- Although the recipient should obtain my authorization before releasing my private information, I understand that if the recipient chooses to re-disclose this information, TDOC cannot ensure its protection by privacy laws.

The subject of the information must sign this authorization. If the subject is under 18 years of age, it must be signed by a parent or legally appointed guardian. If the subject is not legally competent to sign, or is unable to sign, an Authorized Representative (a legally appointed conservator, guardian, or attorney-in-fact appointed pursuant to a durable power of attorney for healthcare) must sign this authorization.

Inmate Signature	Date	Signature of Parent (if minor) or Authorized Representative	Date
Witness Signature	Date		

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

AUTHORIZATION FOR RELEASE OF SUBSTANCE USE-TREATMENT INFORMATION

_____
INSTITUTION / DRC

Participant's Name _____ TDOC ID _____ Gender _____
Please Print

Last 4-digits of Social Security Number _____ Date of Birth _____

I, _____ authorize _____ to
(Participant's Name) (Name of specific program)

disclose _____
(Kind and amount of information to be disclosed)

_____

to _____
(Name of specific person, program, or organization)

for the following purpose(s): _____
(Specify, e.g., parole referral and supervision, aftercare treatment, etc.)

_____

Expiration:

This authorization expires twelve (12) months from the date of signature below and covers information only prior to that date. I understand that I may revoke this consent at any time. I also understand that any disclosure which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. I also understand that the information disclosed pursuant to this authorization cannot be redisclosed by the recipient named above unless I specifically authorize such further disclosure in writing.

Authorization must be signed by the inmate. If the inmate is under 18 years of age or is not legally competent or is unable to sign, the parent or designated conservator must provide authorization.

I hereby release the provider, facility, or program disclosing this information upon my authorization from any liability:

_____ _____
Signature of Participant Signature of Parent/Authorized Representative & Relationship

_____ _____
Witness Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

TENNESSEE DEPARTMENT OF CORRECTION

PSYCHOEDUCATIONAL GROUP PARTICIPANT AGREEMENT

I, _____ understand that I have been enrolled in _____ group as a condition of my supervision. I acknowledge the following items and agree to them. (Please initial each item.)

_____ Group participation requires basic ground rules; violation of these rules can result in group termination.

_____ It is necessary to arrive on time for each group session. Late arrivals will not be allowed.

_____ More than two absences will result in termination from the group.

_____ I understand that all matters discussed in group sessions and that the identities of all group members are absolutely confidential. I will not share this information with nonmembers.

_____ I will treat all other group members with respect. I will not interrupt, blame, or use aggressive language.

_____ I will report to each session prepared, and ready to participate.

_____ I understand that the status of my group attendance status will be shared with my supervising officer.

_____ Participant Signature

_____ Date

TENNESSEE DEPARTMENT OF CORRECTION

Client Services Care Plan

The **Care Plan** is completed with the offender present. The **SMART** system will be utilized for the treatment plan goals. The Goals should be **S**=specific, **M**=measurable, **A**=attainable, **R**=realistic and **T**=timely. The Care Plan is to include all goals agreed upon with the offender and FSW. A Care Plan will be completed when new treatment needs are indicated.

OFFENDER DEMOGRAPHICS

Offender Name: *(First, Middle and Last)*	TDOC ID:	Initial: ☐ Continuing: ☐
Appointment date:	PPO Referral Date:	Reason for Referral**:**

PRESENTING PROBLEMS

- Explain the precipitating events that led the offender to seek treatment and a referral:

TREATMENT PLAN GOALS

- Treatment Plan Goals (*SMART*):

Forensic Social Worker Signature: **Offender Signature:**

Date: **Date:**

TENNESSEE DEPARTMENT OF CORRECTION

BIOPSYCHOSOCIAL ASSESSMENT

Assessment Date: _____ Time: _____ Location: _____

DEMOGRAPHICS

Client's Name: _____ Date of Birth: _____ TDOC ID: _____

Social Security Number: _____ Race/Gender: _____ Primary Language: _____

Address Correct on Referral: YES/NO _____

Contact Number: _____ Emergency Contact: _____ Health Insurance: Yes/No Type: _____

Veteran: YES/NO Branch: _____ Type of Discharge: _____

OFFENDER CASE/LEGAL INFORMATION

Referral Date: _____ Referral Received from Officer: YES/NO Previous FSW Referral: YES/NO

Reason for FSW Referral: _____

Level of Supervision: PROBATION/PAROLE Officer: _____ Sanctioned: YES/NO

Special Conditions, if applicable: _____

Current Conviction: _____

Past Offenses: _____

History of Violations: YES/NO Number of Violations: _____ Date of Most Recent Violation: _____

Previous Alcohol/Drug Related Charges: YES/NO History of DUI: YES/NO

Have you ever been a member or alleged member of a gang: YES/NO Affiliation: _____

Additional comments regarding referral:

_____

TENNESSEE DEPARTMENT OF CORRECTION

BIOPSYCHOSOCIAL ASSESSMENT

Substance	Method Last Used	Age of First Use	Date Last Used	Frequency	Use While Incarcerated?
Alcohol: YES/NO					
Cocaine: POWDER YES/NO CRACK YES/NO					
Amphetamines: YES/NO **Methamphetamine**: YES/NO					
Benzodiazepines: YES/NO (select all that apple) Xanax, Klonopin, Valium Other: _____					
Heroin: YES/NO					
Suboxone: YES/NO					
Hallucinogens: YES/NO					
Marijuana: YES/NO					
Opioids: Yes (Pain Medications taken without prescriptions) Type:_____					
Methadone: YES/NO					
Other: YES/ NO (Inhalants, Bath Salts, MDMA, Synthetic Marijuana..) Type: _____					

SUBSTANCE USE TREATMENT:

History of Substance Use Treatment or Support Group (AA/NA): YES/NO
Currently Attending Substance Use Treatment or Support Group (AA/NA): YES/NO
Completed Substance Use Treatment While Incarcerated: YES/ NO

NAME OF PROGRAM	DATES	COMPLETE
_____	_____	YES/NO
_____	_____	YES/NO
_____	_____	YES/NO
_____	_____	YES/NO

TENNESSEE DEPARTMENT OF CORRECTION

BIOPSYCHOSOCIAL ASSESSMENT

MEDICAL CONDITIONS OR COMPLICATIONS

Major Medical Issues:

_____

_____

_____

List current prescribed medications/indications/dosage, if applicable:

_____

_____

_____

EMOTIONAL/BEHAVIORAL CONDITIONS or COMPLICATIONS

Mental Health issues/concerns:

Anxiety	YES/NO	Poor Concentration	YES/NO	Bizarre Behavior	YES/NO
Panic Attacks	YES/NO	Eating Disorder	YES/NO	Self-Injury	YES/NO
Impulsivity	YES/NO	Sleeping Deficits	YES/NO	High Hostility	YES/NO
Delusions	YES/NO	Hallucinations	YES/NO	Confusion	YES/NO
Weight Loss	YES/NO	PTSD	YES/NO	Sad – Mood	YES/NO
Poor Hygiene	YES/NO	Racing Thoughts	YES/NO	Poor Appetite	YES/NO

CHECK ALL THAT APPLY:

___ Client declined coordination of mental health care
___ Mental health condition requiring on-going treatment
___ Currently taking medication for mental health condition
___ No evidence of a current or past mental health condition
___ Client expressing Homicidal/Suicidal Ideation
___ Mental/physical/sexual abuse (Victim or Perpetrator)

Comments/Notes: _____

_____

_____

SOCIAL ENVIRONMENT

CURRENT RELATIONSHIPS: (Check Best Fitting Response)

Married: ☐ Single: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐ Significant Other: ☐

Number of marriages: _____ Number of children: _____ Children in home: YES/NO

Frequency of Contact with children: _____

Household Members: _____

Supportive Environment: YES/NO Drug Free Environment: YES/NO Source of Transportation: _____

Other Sources of Support (family, friends, church, etc.): _____

_____

Comments/Notes: _____

EMPLOYMENT/EDUCATION:

Highest grade/Level of education: _____ Are you currently employed? YES/NO

Most Recent Employer: _____ Current Work Hours: _____

FSW RECOMMENDATIONS/REFERRALS/NOTES

ASSESSMENT OUTCOME:

_____ No Treatment Recommended
_____ Further Drug Screening and Monitoring by PO
_____ Follow-Up with FSW — Appointment Date: _____
_____ Relapse Prevention Referral
_____ Psychoeducational Group Referral — Agency/Class: _____
_____ Community Mental Health Referral — Agency/Appointment Date: _____
_____ Mobil Crisis/CSU — Agency: _____
_____ IOP — Agency/Appointment Date: _____
_____ Inpatient Treatment — Agency/Appointment Date: _____
_____ CTC Grant Funded Treatment
_____ Other _____

Notes:

_____

Forensic Social Worker's Signature: _____