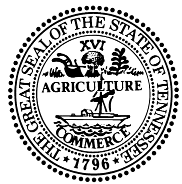
<table>
<tr><td rowspan="4"></td><td rowspan="4">ADMINISTRATIVE POLICIES
AND PROCEDURES
State of Tennessee
Department of Correction</td><td>Index #: 513.07.2</td><td>Page 1 of 12</td></tr>
<tr><td colspan="2">Effective Date: April 15, 2023</td></tr>
<tr><td colspan="2">Distribution: B</td></tr>
<tr><td colspan="2" rowspan="2">Supersedes: 513.07.2 (4/1/19)
PCN 20-19 (6/15/20)</td></tr>
<tr><td colspan="2">Approved by:</td></tr>
<tr><td colspan="4">Subject: SUBSTANCE USE OUTPATIENT TREATMENT PROGRAMS</td></tr>
</table>

I. AUTHORITY: TCA 4-6-102, TCA 4-3-606, TCA 33-10-407, and TCA 68-24-601, and Title 42, CRF Chapter 2, Diagnostic and Statistical Manual of Mental Health Disorders-5 (DSM-5).

II. PURPOSE: To identify and provide a continuum of cost-effective substance use outpatient treatment and programming services for convicted felons who have or have had a history of a substance use disorder.

III. APPLICATION: All Tennessee Department of Correction (TDOC) inmates and institutional staff, and privately managed facilities.

IV. DEFINITIONS:

A. Addiction Treatment Program Director: A qualified licensed substance use staff member who has direct clinical oversight and administration of addiction treatment programs and recovery services.

B. Aftercare: The phase of treatment that begins when a participant has achieved substance use treatment goals and has successfully completed a substance use treatment program.

C. Cardinal Rules: Critical rules that govern all substance use treatment programs, and if violated, result in program termination.

D. Clinical File: A file that is specifically for substance use treatment programming with the documentation being maintained by treatment counselors for each participant on their caseload.

E . Criminogenic Needs: Internal and external attributes of offenders that are directly linked to criminal behavior and subsequent recidivism.

F. Facility Treatment Team: A group of institutional personnel that should include (but is not limited to) the behavioral health administrator, health administrator, addiction treatment program director, unit manager, treatment counselors, drug testing coordinator, inmate jobs coordinator, licensed alcohol, and drug addiction counselor (LADAC), Associate Warden of Treatment (AWT) or Assistant Warden at privately managed facilities, building security supervisor and chief counselor. This team is responsible for the oversight of the substance use treatment programs at each institution and meets bi-weekly to discuss participant issues and progress.

G. Group Therapy: A medium intensive outpatient form of substance use counseling.

H. Learning Experiences: Actions employed to address less serious negative behaviors that usually include persistent non-compliance with community expectations.

I. Participant: For the purposes of this policy, any inmate who is actively enrolled in a substance use treatment program.

J. Program Rules: All rules, program or facility-based, not considered a cardinal rule violation.

K. Qualified Licensed Substance Use Personnel: Correctional staff licensed or certified as alcohol and drug counselors (LADAC I, II, ICRC, NAADAC I, II, or Master level NAADAC certification) or those seeking licensure by reciprocity as a LADAC I or II who meet the qualifications by holding a current license from another state in which the other state's standards for licensure must be comparable to or exceed the requirements for the level of licensure sought in Tennessee. (licensed clinical social workers (LCSW), licensed professional counselors (LPC), licensed psychological examiners (LPE), or licensed marriage and family therapists (LMFT) with a minimum of one-year documented experience working with substance use disorder treatment programs).

L. Substance Use Behavioral Program Intake and Interpretive Summary (CR-3720): A comprehensive compilation of essential historical and criminogenic needs information designed to determine the extent of behavioral health needs, and/or substance use problems and match the inmate with the appropriate treatment service.

M. Substance Use Initial Treatment Plan [(CR-3752) and Substance Use Individual Treatment Plan (CR-3753)]: A clinical plan of care that specifies the goals and objectives of substance use treatment, the methods to be used in the treatment process, and a schedule for assessing and updating progress.

N. Substance Use Treatment Transition Accountability Plan (CR-4153): Strategic plan developed by the participant, with input from treatment counselors, to identify offender's needs.

O. Substance Use Treatment Program: Formal organized behavioral therapies such as individual or group counseling, cognitive skills therapy, or psychotherapy for inmates who have used alcohol and other drugs. These services are designed to address specific physical, mental, or social issues related to the use of mood-altering substances.

P. Substance Use Treatment Program Alternative Disciplinary (CR-3754): Additional sanctions given to participants for negative behaviors which are punitive in nature and are accompanied by a Learning Experience. These sanctions are used as a progressive disciplinary sanction at the addiction treatment program director's discretion.

Q. Texas Christian University Drug Screen (TCUDS): A screening assessment based on the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) screening for mild to severe substance use disorders and is particularly useful when determining level of intensity for substance use treatment.

R. Treatment Counselors: All non-licensed alcohol and drug counselors who are actively pursuing licensure and working in a substance use treatment and recovery services program and who are being clinically supervised by qualified licensed substance use personnel.

V. POLICY: The TDOC shall provide the opportunity for inmates to receive intensive outpatient and individual-based addiction, treatment, and recovery services that impact their entire life structure (values, habits, relationships, cognition, behavior, and attitudes) within the limitations imposed by available resources.

VI. PROCEDURES:

A. Mission Statement/Treatment Philosophy: The mission of the TDOC's outpatient addiction, treatment, and recovery services programs is to break the cycle of substance use, criminal behavior, and incarceration, in order to provide a safe and substance-free living and working environment both within state correctional facilities as well as in the local communities to which offenders return. Each program shall develop and maintain a philosophy of treatment and therapeutic goals for their respective programs that is approved by the Director of Addiction, Treatment, and Recovery Services or designee.

B. Intensive Outpatient Addiction, Treatment, and Recovery Services: Program services shall be offered to inmates (where resources permit) who are parole mandated or have a documented need-based TCU Drug Screen V or evidence of current clinical need. Depending on the length of his/her sentence and program availability, inmates shall be provided with the opportunity to participate in addiction, treatment, and recovery services prior to release from the institution.

C. Outpatient Treatment Programs

1. Intensive Outpatient Group Therapy (Group Counseling): Intensive outpatient group therapy shall be provided by qualified licensed substance use staff as defined in Section IV. All group therapy programs must provide an evidence-based treatment approach that addresses the participant's individual criminogenic needs. Group therapy programs will be open ended. All group therapy programs shall provide, at a minimum, 150 hours of structured evidence-based treatment services. Group therapy will satisfy the Board of Parole's requirements for Substance Use Group Therapy, Cognitive Behavioral Therapy and Anger Management. Program services include:

a. Substance Use Counseling

b. Cognitive Behavioral Therapy

c. Criminal Thinking Awareness

d. Individual Counseling

e. Relapse Prevention Skills Building

f. Victim Impact Awareness

g. Re-entry Planning

h. Anger Management

2. Outpatient Group Therapy (Low Intensity Group or individual counseling): This treatment service shall be offered when and where resources permit. All Outpatient Group Therapy Treatment Programs must provide an evidence-based treatment approach that addresses criminogenic needs and provide, at a minimum, 90 hours of structured evidenced based treatment services. Outpatient Group Therapy Treatment Programs will satisfy the Board of Parole's requirements for Relapse Prevention. Program services include:

   a. Substance Use Counseling

   b. Relapse Prevention Skills Building

   c. Criminal Thinking Awareness

   d. Recovery Oriented Life Skills

   e. Re-entry Planning

D. Admission/Exclusion Criteria for Substance Use Programs

1. Admission Criteria: In order to manage the number of inmates requiring substance use services, consideration shall be given based on clinical need. (See Policy #505.07) Additional admission criteria are as follows:

   a. Inmates must meet the classification level for the program in which they are attempting to enroll.

   b. The inmate shall receive written notification of the pending placement decision and be afforded an opportunity to accept or deny the placement decision. Inmates who accept placement into a treatment program must sign Substance Use Treatment Program Participant Agreement, CR-3586. All participants have the right to turn down programming before signing CR-3586. Once the CR-3586 is signed, dismissal from the program for any reason other than a non-disciplinary dismissal will be accompanied by a Class A disciplinary as defined by Policies #502.01 and #502.02.

2. Exclusion Criteria

   a. Inmates who have received any Class A disciplinary convictions within six months of program start date. An exception will be made if the inmate completes an intervention substance use education program in accordance with Policy # 513.07.3.

   b. Inmates who have received a Class B or three Class C disciplinary convictions within three to six months of program start date will be reviewed and admitted as determined by the addiction treatment program director's clinical judgment. An exception can be made based on clinical judgement for general population inmates that have received a disciplinary for a facility drug screen and have not received any prior substance use treatment.

c. Inmates who decline to sign the Substance Use Treatment Program Participant Agreement, CR-3586. Declining programming shall be documented in the offender management system (OMS). Once participants decline, they will be removed from the Prioritized Register.

d. Inmates who refuse the initial substance use treatment program drug screen.

e. Inmates who are assessed as having severe mental or physical disabilities that would prevent the inmate from fully participating in all treatment activities.

f. Inmates with severe cognitive problems that would prevent full participation in all program curriculum and activities.

E. Successful Completion/Non-Disciplinary Dismissal/Disciplinary Dismissal/Re-Admission Criteria

1. Successful Completion Criteria: A participant shall receive credit for successful program completion only after the achievement of the following minimum requirements:

a. Completion of program requirements, individual treatment goals, and performance objectives as defined by the participant's individual treatment plan.

b. Completion of the written Substance Use Treatment Transition Accountability Plan, CR-4153.

c. Following the initial program placement drug screen, all program random and program discharge drug screens for the participant have been negative for drugs and alcohol and documented on the Drug Screen Consent/Refusal Substance Use Treatment, CR-3992.

2. Non-Disciplinary Dismissal Criteria: A participant shall receive a non-disciplinary discharge only after the following:

a. Treatment team recommends that a participant should be non-disciplinarily discharged due to an inability to complete the treatment program through no fault of his/her own.

b. If the decision is based on a medical issue, a recommendation is issued by facility MD.

c. A non-disciplinary dismissal should be performed when all other available treatment program options have been exhausted. Once pertinent information has been reviewed and approved by the addiction treatment program director or their designee, the non-disciplinary dismissal request shall be forwarded to the Inmate Jobs Coordinator (IJC) using Request for Program Dismissal, CR-3054, and Notice of Denial of Program Credits, CR-3224, for disposition per Policy #505.07.

3. Disciplinary Dismissal Criteria: The addiction treatment program director and facility treatment team can request that a participant be removed from a treatment program. All disciplinary dismissals are to follow procedures found in Policies #505.07 and #502.01 and will require the issuance of a Class A disciplinary report. The disciplinary infraction report must be reviewed by the addiction treatment program director or designee before submission to the on-duty shift commander for approval.

   a. If the action itself warrants a Class A, the facility treatment team member shall issue a disciplinary infraction report for that particular action. If a participant is dismissed for an accumulation of minor infractions that in themselves do not warrant a specific Class A, the team shall issue a Class A for refusal to participate based on the participant's signing of Substance Use Treatment Program Participant Agreement, CR-3586.

   b. Programs are in no way required to readmit a dismissed participant based on Disciplinary Board outcomes. Even if the facility disciplinary is overturned, dismissed inmates must follow the same procedures outlined in Section VI.(D)(1) of this policy for readmission. A non-disciplinary dismissal will have to be requested if the disciplinary job drop is not approved; otherwise, the IJC will keep the inmate assigned.

   c. The following is a listing of cardinal rules that, if violated, result in immediate disciplinary dismissal:

      (1) Violation of institutional rules considered a Class A offense as outlined in Policy #502.04

      (2) Threats or acts of violence.

      (3) Possession of any type of weapon.

      (4) Violation of confidentiality laws.

      (5) Sexual Misconduct or Solicitation that is assaultive in nature, as defined by Policy #502.05.

      (6) Failure or refusal to actively participate in program activities (See Policy #505.07).

      (7) Disrespect to any staff or other program participants in the form of repeated threatening or inciting disturbances that are disruptive to program or institutional operations as determined by the addiction treatment program director and facility treatment team.

      (8) Possession of drugs or alcohol

      (9) Violations against state or federal laws

   d. Particularly grievous or repeated program rule violations can also result in disciplinary dismissal.

e. All disciplinary dismissals for program rule violations must have proper documentation of the actions that led to the participant's dismissal and will be made available to appropriate TDOC staff should the dismissal be grieved.

4. Program Re-admission: Inmates who are dismissed from the program do not automatically receive eligibility to be re-enrolled for a second time. Inmates must meet all requirements regarding Admission and Exclusion Criteria [See Section VI.(D)(1-2)] and be evaluated by the facility treatment team for treatment readiness and appropriateness. Only after meeting all admission and exclusion criteria and receiving approval from the facility Behavioral Health Administrator, will an inmate be eligible for re-enrollment.

F. <u>Participant Substance Use Treatment Program Intake Procedures, Participation, Progression, and Staff Responsibilities</u>.

1. Inmates who are selected for participation in a substance use treatment program must complete the admission process outlined in Section VI. (D)(1)(b) prior to beginning treatment or the intake assessment process.

   a. All attached consent forms must be completed before any form of treatment begins.

   b. At the completion of the interview and assessment process, if the addiction treatment program director determines that program placement is not appropriate based on the inmate's level of substance use treatment need, the addiction treatment program director will contact the following:

      (1) Chief Correctional Counselor for the purpose of treatment pathway override~~s~~ utilizing the Request for Treatment Override, CR-4157.

      (2) Inmate Jobs Coordinator for the purpose of job drop from therapeutic community (TCOM) job position, administratively (non-disciplinary) with closure of the risk needs assessment.

      (3) Institutional probation/parole specialist for the purposes of parole recommendations/mandates. This communication will also include any other appropriate programming recommendations by the addiction treatment program director, if applicable.

2. Substance use treatment program staff shall complete the Substance Use Behavioral Program Intake and Interpretive Summary, CR-3720, and TCUD within 30 days of admission, which will document the following:

   a. Addiction severity as determined by TCUDS V

   b. Social/Family History

   c. Medical/Mental Health Severity

d. Education Level

e. Employment History

f. Criminal History

g. Inmate's Motivation for Treatment

3. If the facility treatment team feels that the potential participant needs a mental health screening after following the initial program intake assessment, these procedures shall take place:

   a. The addiction treatment program director shall refer inmates who need evaluation of issues that may prevent them from participating in the program to mental health staff by completing the Institutional Health Services Referral, CR-3431.

   b. The Behavioral Health division's assessment shall include evaluation of any serious mental health issue that will prevent the inmate from fully participating in the program and include any recommendations. A hard copy of these assessments will be provided to the addiction treatment program director by behavioral health division staff to be placed in the participant's clinical file.

   c. For programs that have work release or community service components, potential participants shall be screened by the IJC for any impairment that may interfere with the completion of the program activities.

4. <u>All substance use outpatient treatment programs shall</u>**:**

   a. Require each participant to sign the Substance Use Treatment Confidentiality Notice and Waiver, CR-3751; Substance Use Treatment Participant Rights and Limits of Confidentiality Acknowledgement, CR-3755; and Substance Use Treatment Informed Consent for Treatment Services, CR-3750 within seven days of admission.

   b. Ensure that an Authorization for Release of Substance Use Treatment Information, CR-1974, is completed before any information is shared with an outside source. (See Policy #511.04)

   c. Provide the Texas Christian University (TCU) pretest within 30 days of admission and posttest within 30 days of successful discharge that will measure inmates in four critical life areas:

      (1) Criminal Thinking (CTS)

      (2) Social Desirability (SOC)

      (3) Psychological Function (PSY)

      (4) Motivation (MOT), pretest only

5. Inmates participating in any substance use treatment program shall be required to have a Substance Use Initial Treatment Plan, CR-3752, within seven days of entering the program. The Substance Use Individual Treatment Plan, CR-3753, shall be completed within 30 days after participants are accepted into the program. The treatment program director must sign the document.

   a. The Substance Use Individual Treatment Plan, CR-3753, shall include the following information:

      (1) Participant's name

      (2) TDOC ID

      (3) Presenting problem/diagnosis

      (4) Strengths

      (5) Challenges/Obstacles

      (6) Severity of disorder

      (7) Major Problem List will address at minimum three areas based on severity of addiction, criminogenic factors such as Risk Needs Assessment and TCU Scales and lastly any additional biopsychosocial problems assessed.

      (8) Description of goal/objectives, written in measurable terms

      (9) Staff responsible for providing services

      (10) Target dates for completion

      (11) Participant's signature

      (12) Staff signature(s)

   b. The participants shall be afforded the opportunity to participate in the formulation and periodic review of their individual treatment plan to the extent of their ability to do so.

   c. The Substance Use Individual Treatment Plan, CR-3753, at a minimum, shall be reviewed and revised by the treatment counselor and the addiction treatment program director every three months or as often as needed. Revisions shall document dates and signatures by program staff and participants. Phase progression is determined by the observed completion of tasks as defined and outlined by the treatment program and the participant's individual treatment plan.

G. <u>Substance Use Treatment Program Interventions</u>

1. Program interventions are to be given at a graduated level and shame-based sanctions are prohibited. Program sanctions should be commensurate with the participant's criminogenic behavior in an effort to move them toward treatment goals.

Interventions should always be given in the form of Learning Experiences, while particularly grievous or repeated behaviors may also have punitive sanctions at the addiction treatment program director's discretion.

2. Program sanctions should be firm, fair, and consistent for all participants. Any actions that do not result in program dismissal but receive Learning Experiences or punitive sanctions should be documented using the Substance Use Treatment Program Alternative Disciplinary, CR-3754.

3. All learning experiences and program sanctions should also be documented in monthly progress notes using the Substance Use Treatment Program Individual Contact Note, CR-3761.

4. Particular actions, which affect institutional security but would normally fall under programming confidentiality, will be entered in the OMS/LHSM by the addiction treatment program director so that the information can be accessed on a need-to-know basis by other facilities.

H. Urinalysis and Alcohol Testing: Drug and alcohol screens will be used primarily for identification of problems and to establish program credibility. Each program participant will be screened initially and on a random basis consistent with Policy #506.21, as well as when reasonable suspicion testing is warranted. All drug and alcohol screens shall be conducted in accordance with Policy #506.21.

1. Each program participant shall be tested within 30 days of admission to the program. Failure of this initial screen will not result in dismissal or any form of disciplinary action.

2. Any program participant that fails a screen beyond the first 30 days in the program will be subject to serious sanctions, which could result in immediate dismissal and a Class A disciplinary for refusal to participate.

3. The addiction treatment program director, in collaboration with the facility treatment team, shall evaluate such a failed screen choosing specifically one of the following options:

   a. The program participant will receive a Class A disciplinary for refusal to participate and be immediately dismissed from the program based on participant's lack of motivation to change.

   b. The program participant will not receive a disciplinary, and will not be dismissed from the program, but will receive alternative clinically based sanctions as a "Learning Experience", including at least: an extension of program duration of 30 days, as well as follow-up with more frequent randomized bi-weekly testing throughout the course of their program.

   The addiction treatment program director will document and submit the above clinical recommendation of the facility treatment team to the TDOC Director of Addiction, Treatment, and Recovery Services or designee requesting review and approval. Once authorized, sanctions will be appropriately and adequately

documented in the clinical file along with an updated individualized treatment plan.

I. Substance Use Treatment Transition Accountability Plan (CR-4153)/Substance Use Treatment Clinical Discharge Summary (CR-3713): Each program participant shall be responsible for completing a transition accountability plan that will be approved by his or her treatment counselor. The transition accountability plan shall address all ancillary service needs for the participant's successful re-entry to the community within 30 days of successful discharge. The Substance Use Treatment Clinical Discharge Summary, CR-3713, shall be completed on all participants in substance use treatment programs. The substance use treatment program clinical discharge summary shall document successful program completion, non-disciplinary discharge, disciplinary dismissal, or any other reason within ten days of the participant's discharge. The substance use treatment program clinical discharge summary shall be completed by the participant's primary counselor and should be specific to the participant's release type (i.e., General Population, expiration or parole).

J. Participant Substance Use Treatment Program Clinical Files

1. An individual substance use treatment program clinical file shall be maintained on all participants in a substance use treatment program. The clinical file shall contain a chronological history of the participant's clinical forms, all substance use related assessments, progress notes, pre and post testing, transition accountability plan, release of information forms, drug screens, treatment interventions, discharge summary, events, and activities.

2. All state-run programs must use forms listed in this policy. Contractor programs may use equivalent forms, as approved by the Director of Addiction and Substance Use Services or designee. All contractor programs must complete Substance Use Treatment Program Participant Agreement, CR-3586; Authorization for Release of Substance Use Treatment Information, CR-1974; and Substance Use Treatment Confidentiality Notice and Waiver, CR-3751, Substance Use Treatment Program Participant Rights and Limits of Confidentiality Acknowledgement, CR-3755; and Substance Use Treatment Informed Consent for Treatment Services, CR-3750.

3. Records of the identity, diagnosis, prognosis, or treatment of any inmate that are maintained in connection with the performance of any program or activity relating to substance use treatment are under the protection of federal law, Title 42, CFR Chapter 2, and shall be considered confidential. Substance use treatment program clinical files shall be stored in a locked cabinet and behind locked doors at all times when unattended.

4. All individual sessions are to be documented on the Substance Use Treatment Individual Contact Note, CR-3761, after every contact with the participant or relevant individuals (i.e., family, support circle, etc.). Progress of participants' program participation, in group, and other program related activities shall be updated monthly.

5. Access to substance use treatment program clinical files shall be limited to ~~those~~ employees who have a legitimate need. Substance use treatment program staff shall develop in-house procedures, which are approved by the Warden/Superintendent to ensure that the substance use treatment information is shared between medical,

behavioral health, and other institutional staff, as appropriate. No inmate in any position, including but not limited to clerk, mentor, etc., shall have access to any other participant's treatment records.

6. All substance use treatment program clinical files shall be retained at the institution in a secure area and maintained separately from the institutional record for at least three fiscal years following the date of discharge from the program. Retention is required for purposes of federal and state examination and audit.

7. In accordance with federal regulations, at the end of three years, the records shall be forwarded to the designated archive area in each facility and stored for an additional two years, after which time the facility will follow Policy #512.01 for file retention.

8. A copy of substance use treatment program clinical files or any correspondence pertaining to substance use treatment program participation shall be released only with the written consent of the program participant. Copies of all such documents shall be marked as confidential and maintained in accordance with TDOC, state and federal regulations. Exceptions are as follows:

   a. To medical or behavioral health personnel to the extent necessary to meet a medical/mental health emergency

   b. To qualified personnel for the purpose of conducting management audits or program evaluation/reviews

   c. After application showing good cause has been determined by the court of jurisdiction

   d. To other institutional substance use treatment programs for continued treatment services or aftercare services

   e. In cases of reported child abuse, disabled or geriatric abuse

   f. Threat to self or others

   g. Threat to institutional security

VII. <u>ACA STANDARDS</u>: 5-ACI-6A-23, 5-ACI-6A-42, 5-ACI-5E-11, 5-ACI-5E-12, 5-ACI-5E-13, 5-ACI-5E-14, and 5-ACI-5E-15.

VIII. <u>APPLICABLE FORMS</u>: CR-1974 (Rev. 12/20), CR-3054 (Rev. 2/21), CR-3224 (Rev. 11/19), CR-3431 (Rev. 9/19), CR-3586 (Rev. 11/19), CR-3713 (Rev. 4/18), CR-3720 (Rev. 8/22), CR-3750 (Rev. 8/22), CR-3751 (Rev. 8/22), CR-3752 (Rev. 8/22), CR-3753 (Rev. 8/22), CR-3754 (Rev. 8/22), CR-3755 (Rev. 8/22), CR-3761 (Rev. 4/18), CR-3992 (Rev. 12/20), CR-4153, and CR-4157 (Rev. 2/22).

IX. <u>EXPIRATION DATE</u>: April 15, 2026

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
REQUEST FOR PROGRAM DISMISSAL

____
INSTITUTION

DATE: ______________________________

TO: ______________________________ , Inmate Job Coordinator

FROM: ______________________________

INMATE NAME ______________________________ **TDOC ID**: ____________________

I hereby request that the above inmate be dismissed from his/her position as a ____________________

______________________________ because:

Inability to perform the skills of the program as evidenced by: ______________________________

____

____

_______ Change in custody level / medical status

_______ Excessive tardiness. Inmate was tardy on the following days: ____________________

____

_______ Other ______________________________

____

Dismissal is effective: ______________________________

Comments: ______________________________

____

____

Approved _______ Denied _______

Approved _______ Denied _______

____
Job Coordinator

____
Warden/Superintendent/Designee

____
Date

____
Date

TENNESSEE DEPARTMENT OF CORRECTION
NOTICE OF DENIAL OF PROGRAM CREDITS

INSTITUTION: ______________________

INMATE: ____ TDOC ID ___________________

You have received less than the maximum total program credits for the period of: ___________________________

Because: ____

____

____

____

Total Program Credits Awarded for this Period: ____

Supervisor: ______________________________________ Date: _____________________________

If you wish to appeal this decision, sign and forward your copy to the Warden/Superintendent within five (5) days.

______________________	______________	______________
Inmate's Signature	TDOC ID	Date

Briefly state the reason(s) you believe you should have received more program credits: ______________________

____

____

____

Warden's/Superintendent's decision: Affirm ☐ Reversed ☐ Modify ☐

Comments/Reasons: ____

____

____

____

______________________________	______________
Warden's/Superintendent's Signature	Date

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

____
INSTITUTION

☐ MEDICAL ☐ DENTAL
☐ BEHAVIORAL HEALTH

INMATE: ____ TDOC ID: ________________
Last First Middle

PRESENTING PROBLEMS: ____

REFERRED BY: ____________________________ ____________ ____________
Signature/Title Date Time

SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR

☐ Behavioral Health
☐ Medical ☐ Dental

RECEIVED BY: ____________________________ ____________ ____________
Signature/Professional Title Date Time

REFERRAL DISPOSITION (Course of Action): ____

____________________________ DATE: ____________ TIME: ____________

____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION

SUBSTANCE USE TREATMENT PROGRAM PARTICIPANT AGREEMENT

____
INSTITUTION/DRC

Participant Name: ________________________________ TDOC ID ______________________
Please Print

CARDINAL RULES

- No Drugs or Alcohol
- Must Actively Participate in Program Activities as outlined in Policy 505.07
- No Disrespect to Staff or Participants as outlined in Policy 513.07.0 and 513.07.2
- No Violence or Threats of Violence
- No Violating Confidentiality
- No Acting Out Sexually as outlined in Policy 502.05
- No possession of any type of weapon(s)
- No Violations Considered a Class A Offense (institutions only)
- No Violations against state or federal laws

I have read and understand the seven Cardinal Rules of the Program. I agree to abide by these rules and understand that if I violate any Cardinal Rule, I am subject to termination and removal from the program.

I also understand there are other rules I must learn to live by. I further agree to learn these additional rules and work toward learning how to live by them. If I consistently break other rules, this can also result in my termination from the program for Refusal to Participate.

Further, I understand that I must actively participate in the program, put forth the effort necessary to meet program objectives, and make significant progress toward reaching my stated treatment goals. If I do not, I am subject to termination and removal from the program.

Check "√" applicable program modality:

☐ Therapeutic Community ☐ Outpatient Group Therapy
☐ Family Reunification ☐ Intensive Outpatient Group Therapy

I ***ACCEPT*** placement into this program.

____ ______________
Participant Signature Date

I ***DECLINE*** placement into this program; and, I understand that by declining placement, my name will be removed from the Substance Use Treatment Programming register, and I will not be eligible for any further Substance Use Treatment Programs until I notify my case manager that I want to be placed back on the registry.

____ ______________
Participant Signature Date

____ ______________
Staff Witness Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

SUBSTANCE USE TREATMENT CLINICAL DISCHARGE SUMMARY

____
INSTITUTION/DRC

Participant Name: ______________________________ TDOC ID ______________________
Please Print

Date of Birth: ____/____/________
Date Format: mm/dd/yyyy

Admission Date: ____/____/________ Discharge Date: ____/____/________

Discharge Status: ____

Demographics:

_____

Summary of Treatment Progress (add additional pages as needed)

_____

1) **Acute Intoxication and/or Withdrawal Potential: __ Low __ Medium __ High**
As Evidenced By/Comments:

_____

2) **Biomedical Conditions and Complications: __ Low __ Medium __ High**
As Evidenced By/Comments:

_____

3 **Emotional Behavioral & Cognitive Conditions/Complication: __ Low __ Medium __ High**
As Evidenced By/Comments:

_____

TCU SCALES

SCALE	CRITERIA	ADMISSION	DISCHARGE	DIFFERENCE
CRIMINAL THINKING				
	Entitlement			
	Justification			
	Power Orientation			
	Cold Heartedness			
	Criminal Rationalization			
	Personal Responsibility			
PSYCHOLOGICAL				
	Self Esteem			
	Depression			
	Anxiety			
	Decision Making			
	Expectancy			
	Accuracy			
SOCIAL				
	Hostility			
	Risk Taking			
	Social Support			
	Social Desirability			
	Accuracy			

4) Readiness to Change: __ Low __ Medium __ High

As Evidenced By/Comments:

______

5) Relapse/Continued Use/Continued Problem Potential: __ Low __ Medium __ High
As Evidenced By/Comments:

______

6) Recovery and Living Environment: __ Low __ Medium __ High
As Evidenced By/Comments:

______

CONTINUED LEVEL OF SERVICE RECOMMENDATIONS (CHECK "√" THE CLOSEST THAT APPLY)

- ☐ None Recommended
- ☐ Level I Outpatient Services
- ☐ Level II.1 Intensive Outpatient Services
- ☐ Level II.5 Partial Hospitalization
- ☐ Level III.1 Clinically Managed, Low Intensity, Residential
- ☐ Level III.5 Clinically Managed, High Intensity, Residential
- ☐ Level III.7 Medically Monitored Intensive Treatment
- ☐ Level IV Medically Managed Intensive Treatment

Continued Care Recommendations:

______

______________________________ Primary Counselor Signature

______________ Date

______________________________ Addiction Treatment Program Director/DRC Clinical Director Signature

______________ Date

TENNESSEE DEPARTMENT OF CORRECTION

SUBSTANCE USE BEHAVIORAL PROGRAM INTAKE AND INTERPRETIVE SUMMARY

____
INSTITUTION/PROBATION PAROLE OFFICE/DRC

TDOC ID	Admission Date/Sentencing Date	Sentence Expiration Date

SECTION I. PERSONAL DATA

GENERAL

True (Given) Name:

First	Middle	Last	Pre/Suffix

Social Security Number	FBI No.

Driver License: | State | Number | ☐Yes ☐ No Valid? |

GENDER	RACE	HISPANIC	CITIZENSHIP
☐ Female	☐ American Indian or Alaska Native	☐ Hispanic	☐ Illegal Alien
☐ Male	☐ Asian	☐ Non-Hispanic	☐ Legal Alien
☐ Unknown	☐ Black or African American	☐ Unknown	☐ US Citizen
	☐ Middle Eastern		☐ Unknown
	☐ Native Hawaiian or Pacific Islander		
	☐ Other Race		
	☐ Unknown		
	☐ White		

DEMOGRAPHICS

EYE COLOR:	HAIR COLOR:
☐ Blue	☐ Black
☐ Green	☐ Brown
☐ Brown	☐ Blonde
☐ Hazel	☐ Gray
☐ Other	☐ Red
	☐ White
	☐ None
	☐ Other

Height: ____________________

Weight: ____________________

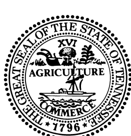
Age: ____________________

Date of Birth: ____________________

Country/Place of Birth: ____________________

Country of Citizenship: ____________________

PERSONAL DATA: GENERAL - COMMENTS AND REMARKS



SECTION I. PERSONAL DATA *continued*

SOCIAL

Do You Own A Vehicle? ☐ Yes ☐ No If no, do you have sources of transportation? ☐ Yes ☐ No

Sources of Transportation (include alternative sources): ______________________________

Emergency Contact: ______________________ Number: ______________

Collateral Contacts (Family, Friends, Other Frequent Contacts, etc.**)**

NAME	RELATIONSHIP/ FREQUENCY OF CONTACT	TELEPHONE NUMBER	NOTES QUALITY OF RELATIONSHIP/ RESIDENCE LOCATION

What are your residential plans? (include addresses, if known)
Will you be living with anyone upon release that:

- ☐ Uses prescribed and/or non-prescription drugs
- ☐ Has a criminal record
- ☐ Has been involved in criminal related activities
- ☐ Has substance use history
- ☐ Has a current alcohol problem

MARITAL HISTORY

Current Marital Status: ☐ Cohabitating ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

NAME	MARITAL STATUS	DATES OF MARRIAGE	NO. OF CHILDREN

CHILDREN

NAME/AGE/GENDER	CHILDREN LIVE WITH WHOM (CAREGIVER)	QUALITY OF RELATIONSHIP BETWEEN PARTICIPANT & CAREGIVER	FREQUENCY OF CONTACT)

EDUCATION/MILITARY HISTORY

EDUCATION LEVEL:

☐ No HS Diploma/GED ☐ Associate's Degree ☐ Some College
☐ Graduate Equivalency ☐ Bachelor's Degree ☐ Unknown
☐ Vocational/Apprentice ☐ Master's Degree

MILITARY BACKGROUND

Branch of Service:
Dates from ________ to ________________
Discharge Type:
Service Connected: ☐ No ☐ Yes

DATE EDUCATION OBTAINED/LAST YEAR

Name of Previous School: ______________________________
Address/Location of Previous School: ______________________________
____
Highest Grade Completed/ Year: ________________
Certificates/Degrees: ______________________________

LANGUAGE SKILLS

☐ English ☐ Spanish
☐ French ☐ German
☐ Latin ☐ Other ________________

Completed and/or Current Prison Curriculums/Programs: ______________________________
____

SECTION I. PERSONAL DATA *continued*

PERSONAL DATA: SOCIAL – COMMENTS AND REMARKS

Family upbringing? Family history of substance use? With whom do you primarily interact with peers, family, etc.)

____

Mood & Affect		Danger to Self/Others	Thought Content	Orientation	Memory	Judgment	General Appearance	Speech	
☐Appropriate ☐Inappropriate ☐Flat ☐Depressed ☐Euphoric	☐Anxious ☐Hostile ☐Labile ☐Suspicious ☐Pleasant	☐Not ☐Present ☐Suicidal ☐Homicidal	☐Appropriate ☐Expansive ☐Pessimistic ☐Loose Assoc. ☐Flight of Ideas	☐Oriented x1,2,3,4 ——— ☐Disoriented ☐Person ☐Time ☐Place ☐Situation	☐Intact ☐Impaired ☐Immediate ☐Recent ☐Remote ☐Confabulations	☐Good ☐Fair Insight ☐Good ☐Fair ☐Poor	☐Neat ☐Unclean ☐Bizarre ☐Disheveled ---------------- Eye Contact ☐Good ☐Fair ☐Poor	☐Appropriate ☐Hesitant ☐Rambling ☐Mute ☐Circumstantial ☐Perseverating	☐Slowed ☐Loud ☐Slurred ☐Tangential ☐Rapid ☐Pressured

SECTION II. EMPLOYMENT

Have You Ever Been Employed? ☐ Y ☐ N

Most Recent Employer: ______________________________

Address: ______________________________

____

Start/End Date: _____ to _____

Occupation: ______________________________

Job Title: ______________________________ Work Hours: ______________________________

Can You Return: ______________________________ Employer Knowledge of Arrest? ☐ Y ☐ N

If N, Reasons for Unemployment:

☐ Caregiver Treatment ☐ Long-Term
☐ Disabled ☐ Retired
☐ Student ☐ Homemaker
☐ Looking for Work ☐ Other

Vocational/Training Skills (Check All That Apply):

☐ Architecture/Engineering ☐ Finance ☐ Military ☐ Food/Lodging Services
☐ Arts, Design, Entertainment and Media ☐ Healthcare ☐ Production ☐ Child/Adult Care
☐ Office/Clerical/Admin Support ☐ Assembly ☐ Sales ☐ Laborer
☐ Janitorial/Cleaning Services ☐ Legal ☐ Management ☐ Landscape/Ground Keeper
☐ Computer and Mathematics ☐ Electrician/Plumber/Mechanic ☐ Tradesman
☐ Cosmetology/Barber ☐ Life, Physical, Social Science ☐ Other
☐ Farming, Fishing, Forestry ☐ Transportation/Materials

EMPLOYMENT – COMMENTS AND REMARKS

SECTION III. FINANCIAL INFORMATION

SOURCES OF INCOME BEFORE INCARCERATION OR PRESENT:

TYPE	MONTHLY
Earnings from Job	
Alimony	
Child Support	
Child Support Hold?	☐ YES ☐ NO
Family Support	
Food Stamps	
Retirement Pension	
Unemployment	
Social Security	
Other:	

EXPENSES BEFORE INCARCERATION OR PRESENT:

TYPE	MONTHLY
Rent	
Gas/Electricity/Water	
Alimony	
Child Support	
Phone/Internet	
Food	
Car Payment	
Transportation (Gas, Bus Fare, etc.)	
Other:	

FINANCIAL INFORMATION – COMMENTS AND REMARKS

SECTION IV. SUBSTANCE USE HISTORY

SUBSTANCE USE:

DRUG TYPE	RANK OF PREFERENCE (1ST, 2ND, 3RD, ETC.)	AGE BEGAN USING	METHOD/DATE LAST USED	FREQUENCY OF USE
Alcohol				
Amphetamines				
Benzodiazepines				
Cannabinoids				
Cocaine				
MDMA (X)				
Hallucinogens				
Heroin				
Meth/AMP				
Opiates				
Suboxone				
Methadone				
Other				

SUBSTANCE USE TREATMENT:

TYPE	CURRENT	HISTORY
Inpatient		
Outpatient		
Self-Help (AA/NA)		
Confined Treatment		

NAME OF PROGRAM	LOCATION	DATES	PURPOSE/TREATMENT EXPERIENCE	DISCHARGE TYPE (COMPLETED/NOT)

SUBSTANCE USE HISTORY – COMMENTS AND REMARKS

SECTION V. HEALTH

PHYSICAL HEALTH (Please Include Allergies):
BRIEF CURRENT STATUS DESCRIPTION

PHYSICAL HEALTH STATUS *(Check Best Fitting Response)*

☐ Minor Medical Problems Only
☐ Significant Medical Disorder (Under control but follow-up care required)
☐ One of More Chronic or Recurrent Medical Problems
☐ Uncontrolled Significant Disorder
☐ Diagnostic Evaluation or Specific Treatment in Progress
☐ None ☐ Unknown

NAMES OF MEDICATIONS AND REASON(S) FOR USE:

1.
2.
3.
4.

MENTAL HEALTH (CHECK ALL THAT APPLY)

☐ No Evidence of a current or past mental health condition
☐ History of mental health condition. No active symptoms.
☐ Mental health condition requiring ongoing treatment.
☐ Has been in psychotherapy or counseling within the last 12 months for a mental health condition.
☐ Currently taking medication for a mental health condition (psychotropic drug).
☐ Has seen a physician within the last 12 months for a mental health condition.
☐ Has been hospitalized within the last 24 months for a mental health condition.

History of being a victim of abuse: ☐ **No history of being a victim of abuse**

☐ No abuse as a child	☐ Physical abuse as child	☐ Sexual abuse as child	☐ Emotional abuse as a child
☐ No abuse as an adult	☐ Physical abuse as adult	☐ Sexual abuse as adult	☐ Emotional abuse as an adult

SUICIDE ATTEMPT HISTORY

# of prior attempts ______

Last attempt? ______

Method of last attempt ______

Medical attention needed ever? ______

Ever while intoxicated? ______

When incarcerated? ______

☐ History of self-injury *(non-suicidal intent)*

☐ cutting ☐ head-banging ☐ non-cosmetic burning

Ever while intoxicated? ______

When incarcerated? ______

Comments: ______

MENTAL HEALTH TREATMENT HISTORY: ☐**Records available** ☐**Records not available** ☐**Records Requested**

☐ No history of prescribed psychotropic(s) medication(s)

Age (estimated) 1st prescribed psychotropic: ____

Age (estimated) last prescribed psychotropic medication: ____or Current: ____

Name of last treatment agency

History of the following prescribed medications:

☐ Medication likely confounded with A/D use

☐ Psychotropics primarily when incarcerated only

Treatment compliance:

☐ always ☐ usually ☐ sometimes ☐ infrequently

Current psychotropic medication (or within last 2 to 4 weeks):

Comments: ______

☐ No history of Inpatient Psychiatric Treatment

Age of 1st Psychiatric Hospitalization: ____

Age of last Psychiatric Hospitalization: ____ or Current: ____

Number of inpatient stays ____

Duration of longest stay (est. ok): ____

Age of longest stay: ____

☐ History of hospitalization related to suicide threat

History of Psychotherapy, psycho-educational groups, classes, or support groups: ☐ Yes ☐ No

If yes, please explain: ______

HEALTHCARE/BENEFIT RECONNECTION:

Do you have healthcare benefits? ☐ Y ☐ N ☐ Unknown

If yes, what kind of coverage? ______

Do you need to be reinstated or need health insurance? ☐ Y ☐ N ☐ Unknown

Were you receiving social security disability or other state provided assistance? ☐ Y ☐ N ☐ Unknown

If yes, what kind and do you need to be reinstated? ______

SECTION V. HEALTH *continued*

HEALTH – COMMENTS AND REMARKS

SECTION VI. SELF REPORTED CRIMINAL HISTORY

Date of Arrest/Age	Agency/Location	Offense Charged

Probation/Parole History? ☐ Y ☐ N **Agency/Location:** **Violations?** ☐ Y ☐ N
Name(s) of Codefendants(s):

Do you continue to have a relationship with codefendant(s)? ☐ **Y** ☐ **N**
If yes, explain:

Are you currently a member of a gang? ☐ Y ☐ N
Have you ever been a member of a gang? ☐ Y ☐ N

Gang Name: ______

Initiation Date: ______

When Did You Get Out? ______

SELF REPORTED CRIMINAL HISTORY – COMMENTS AND REMARKS

SECTION VII. INITIAL INTAKE ASSESSMENT

Check the most appropriate response in each category:

PROBLEM AREA	LIMITED/SLIGHT	MODERATE	SEVERE
Employment/Financial Support	☐	☐	☐
Family/Peer Relationships	☐	☐	☐
Leisure/Recreations	☐	☐	☐
Legal/Criminality	☐	☐	☐
Medical Health	☐	☐	☐
Mental Health	☐	☐	☐
Substance Use	☐	☐	☐
Educational/Vocational Needs	☐	☐	☐

MOTIVATORS/BARRIERS:

	NOT AT ALL	SLIGHTLY	MODERATELY	CONSIDERABLY	EXTREMELY
How serious do you think your drug problems are?					
How important is it for you to get drug treatment now?					

Motivators (children, family, support, etc.): ______________________________

Barriers (race, gender, etc.): ______________________________

Staff Completing Intake Summary (*Printed*): ______________________________

______________________________ Signature ______________ Date

DRC Clinical Director/Addiction Treatment Program Director (*Printed*) ______________________________

______________________________ DRC Clinical Director/Addiction Treatment Program Director Signature ______________ Date

TENNESSEE DEPARTMENT OF CORRECTION

SUBSTANCE USE TREATMENT INFORMED CONSENT FOR TREATMENT SERVICES

____

INSTITUTION / DRC

Dear Participant:

Welcome to the Tennessee Department of Correction (TDOC) Substance Use Treatment Program. We are looking forward to working with you. The following statement will help clarify your responsibility in regard to the development of your program expectations:

I have been fully informed of my rights as a client of this facility, the extent and limits of confidentiality in treatment, and the goals associated with this program. With that knowledge, I request and consent to receive treatment.

INFORMED CONSENT

You have been provided with specific, complete, and accurate information about:

1) The benefits and methods of treatment.
2) Options to proposed treatment.
3) Consequences of not receiving the proposed treatment.
4) The initial treatment plan.
5) The client rights, confidentiality, and grievance procedure.

The informed consent is effective until treatment is terminated.

In signing this form, I understand my rights as a participant in this program and responsibilities for program participation.

Participant's Name/TDOC ID	Participant's Signature	Date
Counselor's Name	Counselor's Signature	Date
Addiction Treatment Program Director/ DRC Clinical Director's Name	Addiction Treatment Program Director/ DRC Clinical Director's Signature	Date

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE TREATMENT
CONFIDENTIALITY NOTICE AND WAIVER

____
INSTITUTION/DRC

I, ______________________________ ______________________________ hereby consent to communication
Participant Name *(Please Print)* TDOC ID

between the Tennessee Department of Correction (TDOC) Addictions Treatment Staff and other facility staff (including Institutional Parole Officers) as needed to complete their job.

The purpose of and need for this disclosure is to inform criminal justice agencies of my attendance and progress in substance use disorder treatment. The extent of information to be disclosed is my assessment, information about my attendance and participation or lack of attendance/participation in treatment sessions, my cooperation with and participation in the treatment program, prognosis, recommendations by the staff, participation in Continuing Care, and compliance with my Re-Entry Plan.

I understand that this consent will remain in effect for 12 months from the date signed unless:

a. It is earlier revoked by me. (I understand that revoking this waiver before the completion of treatment will prevent the TDOC from informing other facility staff, including Institutional Parole Officers, of necessary information to complete their job. By revoking this waiver, my treatment will end and I will receive the associated consequences of an unsuccessful termination.)

b. There has been a formal and effective termination or revocation of my sentence, release from confinement, probation, parole, or other completed legal proceeding which removes me from facility control.

I also understand that any disclosure made is bound by Part 2 of title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records, and that recipients of this information may re-disclose it only in connection with their official duties.

______________________________ ______________________________ ______________________________
Participant Signature TDOC ID Date of Birth

____ ______________________________
Staff Witness Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

SUBSTANCE USE INITIAL TREATMENT PLAN

____
INSTITUTION/DRC

Participant Name	TDOC ID	/ / Date

Modality: ______ **TC** ______ **Group Therapy** ______ **DRC** **Primary Counselor**
DSM V Diagnostic Impression:

Problem: Participant has a need to complete the Substance Use Disorder Treatment Program based on the intake and interpretive summary and/or bio-psycho-social and risk needs assessments outcome.

Long Term Outcome/Goal: Complete all necessary requirements related to the treatment program and attend all scheduled program activities during the next thirty (30) days.

OBJECTIVES/INTERVENTIONS

#	DATE	PARTICIPANT AND COUNSELOR INITIALS	OBJECTIVES	TARGET DATE	ACHIEVED DATE PARTICIPANT AND COUNSELOR INITIALS
1			Client will complete the assessment surveys: CTS, PSY, SOC, MOT.		
2			Client will attend all scheduled program activities.		
3			Client will submit to intake urine drug screen.		
4			Client will show a verbal understanding of all group rules and sign a document (CR-3586) committing to participate by these rules.		
5			Client will attend individual session to develop the master individual treatment plan (CR-3753).		

OBJECTIVE	METHODS/INTERVENTIONS(SERVICES)	FREQUENCY
1.	Counselor will provide all the necessary assessments, score them and place documentation on chart.	One Time
2.	Counselor will monitor program attendance.	On Going
3.	TDOC Staff will administer urine drug screen at intake and the counselor will document results in participant's file.	One Time
4.	Counselor will provide the participant with the group rules and expectations. Will make sure participant understands these requirements by verbal agreement between the counselor and participant as well as a signed document representing this agreement in the clinical file.	One Time
5.	Counselor will provide an individual session to develop the individual treatment plan with the participant.	One Time

____ Participant Signature ______________ Date

____ Primary Counselor Signature ______________ Date

____ Addiction Treatment Program Director/DRC Clinical Director Signature ______________ Date

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE DISORDER INDIVIDUAL TREATMENT PLAN

____
INSTITUTION / DRC

Participant Name: ______________________________ TDOC ID: ____________________

Service Start Date: ____________________ Primary Counselor: ________________________

TC Residential SA _____ Group Therapy _____ DRC ____

DSM-V- Diagnostic Impression

CODE	DESCRIPTION

MASTER PROBLEM LIST:

____

____

____

____

____

STRENGTHS:

____

____

____

OBSTACLES TO TREATMENT:

____

____

____

PROBLEM DESCRIPTION/#:

LONG TERM OUTCOMES/GOALS:

OBJECTIVES:

	PARTICIPANT AND COUNSELOR INITIALS	OBJECTIVES	TARGET DATE	ACHIEVED DATE/PARTICIPANT AND COUNSELOR INITIALS	CHECK IF GOAL CONTINUED
1.					☐
2.					☐
3.					☐

OBJECTIVE	METHODS/INTERVENTIONS (SERVICES)	FREQUENCY	
1.			
2.			
3.			

Participant Signature   Date

Primary Counselor Signature   Date

Addiction Treatment Program Director/DRC Clinical Director Signature   Date

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE DISORDER TREATMENT PROGRAM ALTERNATIVE DISCIPLINARY

____
INSTITUTION

______________________________________ Participant's Name

____________________ TDOC ID

______________________________________ Counselor's Name

____________________ Date of infraction

DESCRIPTION OF INFRACTION:

____
____
____
____
____
____

LEARNING EXPERIENCE/ SANCTIONS:

____
____
____
____
____
____

I have discussed this matter with ____________________________ and have agreed to accept an informal disciplinary sanction rather than have him/her initiate formal disciplinary actions against me. I understand that by signing this form and accepting an informal disciplinary sanction, I am waiving the following rights:

a. The right to be formally charged with the disciplinary infraction(s) listed above once I have successfully completed my Learning Experience/ Sanction.
b. The right to have my guilt and punishment decided by the disciplinary board.
c. The right to have a disciplinary hearing.
d. The right to appeal the decision of my counselors and the Learning Experience/ Sanction imposed.

I further acknowledge that though this report will not result in a formal disciplinary sanction and will not be included in my institutional record, this report will go in my clinical file as documentation of the above mentioned infraction. Repeated violations of program rules and regulations can result in my dismissal from the program.

______________________________________ Participant's Signature

____________________ Date

______________________________________ Counselor's Signature

____________________ Date

Reviewed by:

______________________________________ Addiction Treatment Program Director's Signature

____________________ Date

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE TREATMENT PROGRAM PARTICIPANT RIGHTS AND LIMITS OF CONFIDENTIALITY ACKNOWLEDGEMENT

____
INSTITUTION/DRC

As a participant in our program, you have the right to the following:

1. Be informed of your rights verbally and in writing.
2. Give informed consent acknowledging your permission for us to provide treatment.
3. Be provided a safe environment, free from physical, sexual, and emotional abuse.
4. Receive complete and accurate information about your treatment plan, goals, methods, potential risks and benefits, and progress.
5. Receive information about the professional capabilities and limitations of any clinician(s) involved in your treatment.
6. Be free from audio and/or video recording without informed consent.
7. Have the confidentiality of your treatment and treatment records protected. Information regarding your treatment will not be disclosed to any person or agency without your written permission except under circumstances where the law required such information to be disclosed. You have the right to know the limits of confidentiality and the situations in which your therapist/agency is legally required to disclose information.
8. Have access to information in your treatment records:
    a. With the approval and under the supervision of the addiction treatment program director / clinic director.
    b. To have information forwarded to a new therapist following your treatment at this facility.
    c. To challenge the accuracy, completeness, timeliness, and/or relevance of information in your record, and the right to have factual errors corrected and alternative interpretations added.
9. File a grievance if your rights have been denied or limited. You can initiate a complaint in writing to the grievance chairperson. You have the right to receive information about the grievance procedure in writing.

PARTICIPANT CONFIDENTIALITY

The Tennessee Department of Correction (TDOC) has a commitment to keep information you provide and your clinical record confidential. Beyond our commitment to Ethical Standards, federal, as well as state law, requires it. You can give permission to our program counselors in writing if you wish your information to be shared with specific persons outside our agency. There are exceptions when we can/must release information without your written permission. Your clinical information will be released without your written consent if: (1) it is necessary to protect you or someone else from imminent physical harm; (2) we receive a valid court order that mandates we release your information; or (3) you are reporting abuse of children, the elderly, or persons with disabilities.

This is to acknowledge that I have read, understood, and agreed with the above information.

Participant Signature	TDOC ID	Date

This acknowledges that I have reviewed and answered questions about the client’s rights and confidentiality as well as our services.

Addiction Treatment Counselor’s Signature	Date
Addiction Treatment Program Director/DRC Clinical Director’s Signature	Date

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE TREATMENT PROGRAM INDIVIDUAL CONTACT NOTE

____
INSTITUTION/DRC

Participant Name: ______________________________ TDOC ID: ______________

Phase: __________ Contact Date: ______________ Duration of Contact: __________

Context of Contact: ______________________________

Problem(s) Addressed: ______________________________

Objectives of Contact: ______________________________

Data (self-report observations, interventions, current issues/stressors, functional impairment, group behavior, motivation, progress):

____
____
____
____
____

Assessments (progress, evaluation of intervention(s), obstacles or barriers):

____
____
____
____
____

Plan (tasks to be completed between sessions, objectives for next session, changes, recommendations, sessions remaining, date of next session, plan for termination):

____
____
____
____
____

Counselor Name	Counselor Signature	Date
Addiction Treatment Program Director/DRC Clinical Director *(Print)*	Addiction Treatment Program Director/DRC Clinical Director Signature	Date

TENNESSEE DEPARTMENT OF CORRECTION

DRUG SCREEN CONSENT/REFUSAL
SUBSTANCE USE TREATMENT

*****DO NOT ENTER IN OMS*****

Name: ____________________ **TDOC ID:** ____________

Date of Birth: ____________ **Facility:** ____________________

I ____________________, TDOC ID: ____________, hereby ☐ Consent / or ☐ Refuse to allow a ☐ blood sample, ☐ urine specimen to be drawn/collected for the purpose of alcohol or drug screening.

I understand that this is the only opportunity I will be granted for blood to be drawn or urine to be collected prior to possible disciplinary proceedings. I further understand that, if I refuse, this refusal will be considered in the disciplinary proceedings.

____________________ ____________
Inmate Signature Date

____________________ ____________
Witness Signature Date

____________________ ____________
2nd Witness Signature (Refusal Only) Date

	Positive	Negative	N/A		Positive	Negative	N/A
AMP	☐	☐	☐	BZO	☐	☐	☐
OPI	☐	☐	☐	COC	☐	☐	☐
OXY	☐	☐	☐	MTD	☐	☐	☐
THC	☐	☐	☐	PCP	☐	☐	☐
BAR	☐	☐	☐	K2	☐	☐	☐
BUP	☐	☐	☐	ALC	☐	☐	☐
mAMP	☐	☐	☐	Other: ____________			

Disciplinary Board Ordered ________
Inmate Involved in Altercation ________
Pre-Parole Hearing ________
Program Testing (Non-Substance Abuse) ________
Random List ________
Reasonable Suspicion ________
Within 30-Day Release ________
Other Reason, please specify: ____________
Temperature: ________ Initial ________
Start Time: ________ Random ________
End Time: ________ Exit ________

TO BE PLACED IN THE INMATE'S TREATMENT FILE

TENNESSEE DEPARTMENT OF CORRECTION
SUBSTANCE USE TREATMENT
TRANSITION ACCOUNTABILITY PLAN

The Transition Accountability Plan is intended to promote a successful transition into the community. Therefore, as you work on this plan, keep in mind that your plans should direct you to a productive life that is free from **both** crime and drugs. What is important in making good use of the Transition Accountability Plan information, detailed planning and demonstrated ability? Being able to talk about these issues is only the first step in putting the Transition Accountability Plan into action. The Transition Accountability Plan is designed to bring together many of the ideas and skills you have learned and put them to work for you in the community.

By the end, you will have completed a detailed, realistic Transition Accountability Plan. It is important to understand that your Transition Accountability Plan may change between now and your actual release. You must continue to work on it to enhance your opportunity for a successful transition.

I agree to the terms of the completed Transition Accountability Plan and I will continue to make appropriate revisions that will enhance my successful transition into the community.

Participant Signature	Counselor Signature/Institution
Date of Completion	Dates Revised
Addiction Treatment Program Director/ DRC Clinical Director Signature	Date

TRANSITION ACCOUNTABILITY PLAN FOR: ____
(your name)

GOAL

A goal is something that you work hard to achieve. In order to make a successful transition back into the community, you must know what you want to accomplish and what tools you will need to achieve your goals. Think carefully about the goals you wish to accomplish and BE REALISTIC. Make sure to include your goals for such things as future living arrangements, employment plans, family relations, education and financial issues.

Your goals for the first 3 months out of prison:

1. ____

2. ____

3. ____

4. ____

Your goals for the first 12 months:

1. ____

2. ____

3. ____

4. ____

Your goals for the next 5 years:

1. ____

2. ____

3. ____

4. ____

LIVING ARRANGEMENTS:

As your release date approaches, there are several options for Living Arrangements that you can consider. Where you choose to live is an important factor in increasing your chances of a successful transition back into society. YOU NEED TO THINK CAREFULLY ABOUT WHERE TO LIVE. There are a number of options available to you such as: sober homes, halfway houses, residential recovery programs, transitional homes, shelters, etc.

1. (Circle One) Treatment Facility Home Other

2. Address: ______________________ ______________________

3. Whom will you live with? ______________________

4. How long do you plan to live there? If you do not expect to live there for more than 6 months following your release, go back and answer questions 2-7 for **both** places you thing you might go.

   Plan A: ______________________ Plan B: ______________________

5. What will it cost and how did you come to this agreement? ______________________

6. Describe the neighborhood. ______________________

7. How will you get to this address on the day of your release? ______________________

8. How do you know all of the above information? ______________________

EMPLOYMENT:

Establishing stable, legal employment is necessary in order to be a productive member in society. Finding a job requires enthusiasm, motivation and patience. You may not find your "dream job" right away. Keep an open mind! This is important in creating a realistic plan.

1. Do you have a job set up for when you are released? (Circle One) YES NO

If yes, answer questions 2-14 **If no, answer questions 14-18**

2. Where is it? ______________________________

3. What is the job title? ______________________________

4. Describe the work you will do including **specific** responsibilities. ______________________________

5. How many hours a week will you work? ______________________________

6. What days will you work? ______________________________

7. How will you be trained? ______________________________

8. How will you be supervised? ______________________________

9. What will your salary be and what benefits will be included?
   Pay: ______________________________
   Benefits: ______________________________

10. Describe the working environment. ______________________________

11. How far from home will you be working and how will you get to work? ______________________________

12. Is the position temporary, seasonal or permanent? ______________________________

13. How do you know all of the above information? ______________________________

14. If you do not have a job lined up, or the job you have falls through, what will you do to find employment?

____

____

15. What types of work are you looking for and qualified to do? ______________________________

____

16. How many hours are you planning to work? ______________________________

17. Realistically, what would be the starting salary for the work you are qualified to do? ______________

____

18. Give all the sources of information and assistance you plan to use. List at least 3 given to you by your counselor that would be beneficial in helping you find employment.

   a. ____

   ____

   b. ____

   ____

   c. ____

HEALTHCARE (medical and/or mental health)

Whether you have an emergency or need regular checkups, it is very important that you have health care insurance. Establishing health care insurance requires advanced planning but saves time and money in the end.

1. Do you know what your healthcare needs will be? ______________________________

____

2. List resources given to you in class that can help you obtain healthcare insurance.

   a. ____

   ____

   ____

   b. ____

   ____

   ____

   c. ____

   ____

   ____

3. How can you make sure that have healthcare insurance? ______________________________

____

4. How do you know all of the above information? ______________________________

____

FINANCIAL PLAN

SOURCES OF INCOME

Available funds:

Money received upon release	$_________
(Includes canteen account, savings account)	
Money available in outside accounts	$_________
Gifts	$_________
Immediate earnings	$_________
Total Available Money:	$_________

Expenses:

Housing	$_________
(rent, program fees, *contribution to family expenses)*	
Clothing	$_________
Food	$_________
Transportation	$_________
Other Immediate Expenses	$_________
(child support, cosmetics, pocket money)	
Total Immediate Expenses:	$_________

Sources Of Weekly Income

Source	___________________________________	Amount	$_________
	___________________________________		$_________
	___________________________________		$_________

TOTAL WEEKLY INCOME (Before Taxes)		$_________
SUBTRACT THE FOLLOWING:	Taxes	$_________
	Child Support	$_________
TOTAL WEEKLY INCOME:		$_________

Expenses:

Rent	$_________	Weekly Income	$_________
Utilities	$_________	-Weekly Expenses	$_________
Phone	$_________		
Food	$_________	Balance:	$_________
Medicine/Cosmetics	$_________		
Clothes	$_________		
Gas/Transportation	$_________		
Car Payment/Insurance	$_________		
Entertainment	$_________		
Pocket Money	$_________		
Savings	$_________		
Other	$_________		
Total Expenses	$_________		

1. How will you monitor your budget? ____

____

____

2. What type of banking service will you use? ____

____

____

RECOVERY

1. What recovery meetings, organizations or groups do you plan to participate in? ______________

____

____

2. Where are these meetings being held, be specific? ____

____

____

3. How many times per week do you plan on going to meetings, organizations, etc.? ______________

____

____

4. How will you get to them? ____

____

5. What other support will you have? Sponsor, clergy, family, etc. ______________________________

____

6. List here at least 3 resources given in class that can assist you in your recovery.
   a. ______________________________
   b. ______________________________
   c. ______________________________

7. How do you know all of the above information? ______________________________

____

____

CONTINUING EDUCATION

1. What are your **specific** educational goals? ______________________________

____

2. What schools or programs are available to help you meet your goals? Include financial assistance.

____

____

3. List resources given in class that can assist you in meeting these goals.
   a. ______________________________
   b. ______________________________
   c. ______________________________

4. How do you know all of the above information? ______________________________

____

____

FAMILY

All family members have responsibilities to one another. You will need to demonstrate to your family that you are ready to accept your responsibilities. Rebuilding trust will take time and patience

1. Who do you regard as part of your family and expect to maintain a relationship? **List them**

____

____

2. What **specific** responsibilities will you have towards your family? ______________________________

____

____

3. What plans and agreements do you have for improving your relationships and preventing problems with your family? Remember, there is **always** room for improvement. ______________________________

FRIENDS

We all define "friendship" differently. Will you choose to associate with those living negative, criminal lifestyles or positive, pro-social lifestyles? We tend to associate with those who share common values and are trying to accomplish the same things in life. Keep in mind the direction you want to go.

1. What are the **types** of people or groups you plan to stay away from as part of your plan?

2. Which old friends would it be good for you to keep and strengthen relationships with as part of your plan? Why?

3. Whom are you currently building positive friendships with?

4. What qualities do you think are important in a friendship?

5. How are friendships built?

RECREATION (free time/ religious activities)

Recreation is important in creating life balance. When you are not working or meeting your daily responsibilities, you have free time. It is important to use this time wisely doing pro-social activities to create a balance in your schedule between work and play.

1. What **specific** activities will you participate in?

2. How much time will you devote to each? (Example: 1 hour, 2x weekly)

3. Where will you participate in these activities?

4. Who will join you in these activities?

5. What are the benefits of participating in these activities? ______________________________

6. How do you know all of the above information? ______________________________

SPIRITUAL LIFE

Spiritual Life relates to the values one has, the religion one participates in and the purpose of one's life.

1. Listed below are some values held by different people. Select at least 5 that are important to you and circle them. List other values you hold important in the space allowed.

Accomplishment	Creativity	Family	Integrity	Peace	Trust
Achievement	Decisiveness	Fun	Relationships	Persistence	Wealth
Affection	Discipline	God's Will	Maturity	Recognition	Well-being
Ambition	Duty	Happiness	Laughter	Religious Belief	Wisdom
Appearance	Econ Security	Health	Leadership	Respect	Work
Belonging	Education	Helping Others	Love	Responsibility	Wisdom
Brotherhood	Employment	Honesty	Loyalty	Satisfaction	______
Charity	Enjoyment	Honor	Maturity	Stability	______
Commitments	Eternal Life	Hope	Morality	Success	______
Conservation	Experience	Independence	Order	Survival	______
Corporation	Faith	Industriousness	Patience	Transition	______

2. Describe your past participation in spiritual or religious activities and what connections will you make upon your release?

3. What gives your life meaning? ______________________________

4. Do you think that participation in spiritual or religious activities would be important to you?

Circle one: Yes No Please explain why? ______________________________
____
____

COMMUNITY INVOLVEMENT

By getting involved in the community, you have a chance to establish yourself as a pro-social member. There are a variety of activities within the community to suit your individual style

1. What **specific** groups or organizations will you be involved in? ______________
____
2. What **specific** community activities will you be doing? ______________
____
3. Where will you participate in these activities? ______________
____
4. Who are the contact people for the activities or organizations? ______________
____
5. How do you know all of the above information? ______________
____

ACTIVITY SCHEDULE

Define a daily schedule for your first week in the community (after prison or treatment facility). Be certain that it **includes all major activities** that you have described in detail in all of the above sections of your Transition Accountability Plan. This should be a 24-hour schedule that accounts for **all** of your time.

Day 1

Time:	Activity

Day 2

Time: Activity

Day 3

Time: Activity

Day 4

Time: Activity

Day 5

Time: Activity

Time:	Activity

Day 6

Time:	Activity

Day 7

Time:	Activity

CRISIS PLANS

Being aware of potentially dangerous situations and knowing how to do deal with them can reduce the risk of relapse and/or recidivism. Try to think back to those activities that contributed to your coming to prison and how you can avoid these situations after release.

1. What are your potentially dangerous situations? ______________________________

2. How do you plan to avoid them? ______________________________

3. Dangerous situation that you will **not** be able to avoid? ______________________________

4. How will you cope with them in a way that will not risk your coming back to prison? ______________________________

5. What do you think is the most difficult problem that may result in your relapse or recidivism? ______________________________

6. How will you cope with this problem in a positive way? ______________________________

7. Whom will you go to and what else will you do if you need emergency support? ______________________________

Use this space for additional information if necessary.

TENNESSEE DEPARTMENT OF CORRECTION
REQUEST FOR TREATMENT OVERRIDE

____

INSTITUTION

INMATE NAME: ______________________________ TDOC ID: ________________

RED: ________________ EXP: ________________ FAD: ________________

SED: ________________ LAST PAROLE HEARING: ________________

PAROLE BOARD ACTION: ____

____

MOST RECENT TCUD: ____________ MEDICAL CLASS: ____________ LEVEL OF CARE: ____________

OVERALL RNA RISK LEVEL: __________

CURRENT RNA RECOMMENDATION: ______________________________________

PLEASE SPECIFY THE REASON(S) FOR THE PROGRAM OVERRIDE REQUEST:

☐ PAROLE MANDATE ☐ CLINICAL ASSESSMENT ☐ MEDICAL STATUS

☐ PAROLE RECOMMENDATION ☐ CHANGE IN CUSTODY LEVEL ☐ INSTITUTIONAL NEED

☐ OTHER: ____

EXPLANATION: ____

____

OVERRIDE REVIEW COMMITTEE:

CHIEF COUNSELOR: YES / NO COMMENTS: ______________________________

SIGNTURE: ______________________ DATE: ____________

BEHAVIOR HEALTH: YES / NO COMMENTS: ______________________________

SIGNTURE: ______________________ DATE: ____________

MEDICAL STAFF: YES / NO COMMENTS: ______________________________

SIGNTURE: ______________________ DATE: ____________

WARDEN / SUPERINTENDENT / DESIGNEE APPROVAL:

APPROVE: ______ DENIED: ______ COMMENTS: ______________________________

____

WARDEN / SUPERINTENDENT /DESIGNEE: ______________________________ ____________

SIGNATURE DATE

AC REHAB SERVICES / DESIGNEE APPROVAL:

APPROVE: ______ DENIED: ______ COMMENTS: ______________________________

____

AC REHAB SERVICES / DESIGNEE: ______________________________ ____________

SIGNATURE DATE