

## HOW TO USE THIS DOCUMENT

These support documents are intended to help you to document your HHSC facility licensure mandated face to face, in person and/or agency specific processes. We have provided a general outline of information that you should cover, some student handout material you can provide and general “in-house” certificates you can use to place in the employee file.

In addition, we have provided you with a sample of an annual in-service training schedule. We encourage you to create an organization training plan with content outlines. This will help you to better meet your training requirements.

You will find an initial and annually training checklist to help you organize the training section of your personnel file. And three “competency” checklists have been included to complement your in-person training. These are intended to document verification of training and competency of specific agency procedures and tasks. While HHSC rules do not explicitly require this, TAC 448 wording is “demonstrated competency.” HHSC has begun asking for documentation of demonstrated competency. If you are accredited this documentation will help you as well.

These are not intended as advice, but guides to help you achieve compliance with your facility training requirements. Feel free to modify as you see fit for your organization and customize your internal certificate.

**Let us know if we can help.**

A handwritten signature in blue ink, consisting of a large, stylized initial 'R' followed by a horizontal line extending to the right.

# Facility New Employee Orientation In-Service

Date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

1. Agency administrative policies and procedures related to standards of conduct
2. Agency personnel policies and procedures- Review of employee handbook
3. Agency client care policies and procedures- Review of client handbook
4. Agency emergency procedures- Review of drills and evacuation
5. Discussion of HHSC Standards of Care
6. Review of Confidentiality

This training was conducted live and in-person. This in-service is intended to meet the TAC §448.603 (C)- Prior to performing their duties and responsibilities, the facility shall provide orientation to staff, volunteers, and students. This orientation included information about HHSC rules; facility policies and procedures; client rights; client grievance procedures; confidentiality of client-identifying information (42 C.F.R. pt. 2; HIPAA); standards of conduct; and emergency and evacuation procedures.

## Attendance

Name	Position	Signature

**CERTIFICATE OF COMPLETION**

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*NEW EMPLOYEE ORIENTATION FOR NEW HIRES*

**THESE ORIENTATION REQUIREMENTS  
WERE FULFILLED ON**

**To the best of my knowledge, I certify that this employee has meet the requirements of new employee orientation TAC §448.603 (C).**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

**THIS INCLUDES THE COMPLETION OF ALL ONLINE TRAINING MODULES, ALL IN-SERVICES, AND COMPLETION OF ALL READING ASSIGNMENTS.**

**Preventing Abuse, Neglect and Exploitation In-Service**

Date: \_\_\_\_\_

Start/End Time: \_\_\_\_\_

In Person Facilitator: \_\_\_\_\_

1. Review of laws and regulations regarding abuse, neglect and exploitation.

2. Regulatory definition of abuse, neglect and exploitation.
3. Agency policies and procedures regarding defining abuse, neglect & exploitation
4. Agency policies and procedures regarding reporting (legal obligations, forms to be completed, reporting actions and chain of command)
5. Intervention techniques when observing client abuse, neglect & exploitation
6. Case/scenario discussion.

This training was conducted live and in-person. This in-service is intended to meet the TAC §448.603 (D) (1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training. Outpatient program personnel with any direct client contact shall receive two hours of abuse, neglect and exploitation training.

### Attendance

Name	Position	Signature

# CERTIFICATE OF COMPLETION

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*PREVENTING ABUSE, NEGLECT & EXPLOITATION*

**THESE TRAINING REQUIREMENTS WERE  
FULFILLED ON**

**To the best of my knowledge, I certify that this employee has met the requirements for the prevention of abuse, neglect & exploitation as stated in TAC §448.603 (D)(1).**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

This training was conducted live and in-person

**Abuse, Neglect and Exploitation**

The Texas Health and Human Services (HHSC) requires that all staff who works in licensed substance abuse treatment programs receive annual training on the topic of “abuse, neglect, and unprofessional or unethical conduct in health care facilities.” In 1993, the 73<sup>rd</sup> Legislature, required the Texas Department of Mental health and Mental Retardation, Texas Health and Human Services to ensure all healthcare facilities under their oversight ensure that all employees receive in-service training on this subject. The agencies came together in 1994 to develop an interagency agreement defining the content of the required training. The three agencies agreed on the following minimum standards, which will be addressed in this training module:

1. Applicable laws and regulations governing client abuse and neglect
2. Policies and procedures adopted by various governing boards of differing agencies regarding client abuse and neglect
3. Applicable laws and regulations governing illegal, unprofessional, and unethical conduct
4. Policies and procedures adopted by various governing boards of differing agencies regarding illegal, unprofessional, and unethical conduct
5. Applicable laws and regulations governing client rights
6. Policies and procedures adopted by various governing boards of differing agencies regarding client rights
7. Specific types of client abuse and neglect
8. How to identify when abuse or neglect is occurring or has occurred
9. Specific types of illegal, unprofessional, and unethical conduct
10. How to identify when illegal, unprofessional, and unethical conduct is occurring or has occurred
11. Requirements and procedures for reporting an incident of client abuse and neglect, together with the applicable penalties for non-reporting
12. Requirements and procedures for reporting illegal, unprofessional, and unethical conduct, together with the applicable penalties for non-reporting
13. Protections afforded to employees and associated health care professionals who report client abuse and neglect and illegal, unprofessional, and unethical conduct
14. Techniques for improving client care

### ***Applicable laws and regulations governing client abuse and neglect***

The state of Texas has two basic bodies of law that define abuse, neglect & exploitation, the Texas Family Code and the Texas Administrative Code.

The Texas Family Code specifically defines abuse and neglect as it applies to children, the Texas Administrative Code address abuse, neglect & exploitation for all ages, for those people under the care of another person.

Both codes require that the “abuse and/or neglect” cause a physical, developmental, and/or emotional injury. Furthermore, the injury must be observable and material. **Materiality (e.g. significance, relevance, pertinent)** is determined by the person investigating the allegations. Materiality tends to be a subjective measure based on that person’s individual beliefs and experiences. This explains why some investigators will validate a finding and a different investigator will invalidate a similar incident.

Another important distinction between the Texas Family Code and the Texas Administrative Code is the acknowledgement of exploitation. Exploitation is not addressed in the Texas Family Code, primarily because children are still considered property of parent. It is a long held belief that property is not exploitable and as such there are no law protecting children from financial or personal exploitation. Contrary to that belief many children are financially exploited by parents, disabled children who receive financial assistance are at greatest risk.

### **Texas Administrative Code: Abuse, Neglect & Exploitation Defined**

#### **Abuse**

- (1) The intentional, knowing, reckless, or negligent infliction of injury or intimidation with resulting physical or emotional harm or pain or mental anguish, or sexual abuse, including an unnecessary or excessive use of force or the inappropriate use of restraints or seclusion. **This addresses all of the areas in the Texas Family Code and goes further to identify what is not considered abuse, especially related to**

restraint and seclusion. Many facilities have “no touch” policies to avoid situations that could be construed as abuse.

(2) Abuse does not include:

- the proper use of restraints or seclusion in accordance with federal or state laws or regulations, agency policies, or court order;
- other actions taken in accordance with federal or state laws or regulations, agency policies, or court order;
- actions an employee may reasonably believe to be immediately necessary to avoid imminent harm to self, patients or clients, or other individuals if such actions are limited only to those actions reasonably believed to be necessary under the existing circumstances; or **This means, what you must do to get yourself, clients or staff away from the dangerous acting out client. It does not include retaliation or any direct attack on the client. This may include, pushing a client away who is attacking you or another person.**
- complaints related to the daily administrative operations of a facility (e.g., staffing ratios).

### **Neglect**

(1) The failure by the caretaker to provide the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain.

### **Exploitation**

(1) The illegal or improper act or process of a caretaker who has an ongoing relationship with the person using the resources of the person for monetary or personal benefit, profit, or gain.

## TAC 40, PART 3 §448.703

HHSC defines Abuse and Neglect as follows:

**Abuse**- An intentional, knowing, or reckless act or omission by provider personnel, a counselor, applicant for counselor licensure, or counselor intern that causes or may cause death, emotional harm or physical injury to a participant or client. Abuse includes without limitation the following:

- any sexual activity between provider personnel, a counselor, applicant for counselor licensure, or counselor intern and a participant or client;
- corporal punishment;
- nutritional deprivation or sleep deprivation;
- efforts to cause fear;
- the use of any form of communication to threaten, curse, shame, or degrade a participant or client;
- restraint that does not conform with chapter 148 of this title (relating to Standard of Care);
- coercive or restrictive actions taken in response to a participant or client's request for discharge or refusal of medication or treatment that are illegal or not justified by the participant or client's condition; and
- any other act or omission classified as abuse by Texas law, including but not limited to, TEX. FAMILY CODE ANN. §261.001 (Vernon 1996) and TEX. HUM. RES. CODE ANN. §48.002 (Vernon Supp. 2004).

**Neglect**- A negligent act or omission by provider personnel, a staff member, volunteer, or other individual working under the auspices of a provider, or by a counselor, applicant for counselor licensure, or counselor intern that causes or may cause death, physical injury, or substantial emotional harm to a participant or client. Examples of neglect include, but are not limited to:

- failure to provide adequate nutrition, clothing, or health care;
- failure to provide a safe environment free from abuse;
- failure to maintain adequate numbers of appropriately trained staff;
- failure to establish or carry out an appropriate individualized treatment plan; and
- any other act or omission classified as neglect by the Texas law including, but not limited to, TEX. FAM. CODE §261.001 (Vernon 1996) and TEX. HUM. RES. CODE §48.002 (Vernon Supp. 2004).

**Exploitation**- The illegal or improper use of a client or participant, or their resources, for monetary or personal benefit, profit, or gain by provider personnel, a staff member, volunteer, or other individual working under the auspices of a provider or by a counselor, counselor intern or applicant for counselor licensure or any other act or omission classified as exploitation by Texas law including, but not limited to, TEX. FAM. CODE §261.001 (Vernon 1996) and TEX. HUM. RES. CODE § 48.002 (Vernon Supp. 2004).

**Sexual Exploitation**- A pattern, practice, or scheme of conduct by provider personnel or other individual working under the auspices of a provider, or by a counselor, intern, or applicant that involves a client or participant and can reasonably be construed as being for the purpose of sexual arousal or gratification or sexual abuse. It may include sexual contact, a request for sexual contact, or a representation that sexual contact or exploitation is consistent with, a part of or, a condition of receiving services. It is not a defense to sexual exploitation of a client, or participant if it occurs:

- with consent of the client or participant;
- outside of the delivery of services; or
- off of the premises used for the delivery of substance abuse services; or
- after the client or participant is no longer receiving services, unless it occurred two years after the client or participant stopped receiving services.

**Child Abuse and Neglect**- Any act or omission that constitutes abuse or neglect of a child under the age of 18 by a person responsible for a child's care, custody, or welfare as defined in the TEX. FAM. CODE ANN. § 261.001 (Vernon 1996).



**In addition staff must be able to recognize signs and symptoms of abuse, neglect and exploitation. The following are common signs:**

You might recognize some or all of the signs listed below, and there might be other signs we haven't listed. Not all of the signs need to be present for your situation -- or for your child's situation -- to be dangerous. Besides the physical danger, your children might be learning either to accept abuse, or perhaps to be abusive themselves. **So if several of these warning signs are familiar to you, or if your situation makes you at all uncomfortable, please seek help immediately.** We wish we could guarantee your safety; alas, we cannot. But the professionals will do everything in their power to keep you and your children safe.

**And if you know of someone who's in need of intervention,** please either encourage that person to get help from a trained professional -- or if the person is a child, call the police or your state's protective services. You can do this anonymously (and you should know that, by U.S. law, anyone who suspects that a child is being abused must report it). Remember, it's hard for an abused person to leave, or sometimes to even recognize that help is needed. **Please don't turn your back.**

### **Physical indicators of physical abuse:**

- Baby or child suffers physical symptoms of Shaken Baby Syndrome **If you see these signs, call 911. The child needs help immediately.**
- Facial injuries (black eyes, broken jaw, bloody or broken nose, bloody or swollen lips), with implausible, inconsistent or nonexistent explanations)
- Bruises, welts, bite marks, burns (water, cigarettes, ropes, or with specific marking, such as with an iron or heater)
- Subdural hematomas, fractures or lacerations, perhaps in various stages of healing
- Bruises on the back, stomach, back of the thighs (not typically present in normal child play)
- Suspicious patterns of bruises (parallel or circular bruises, in shape of human fingers, or several bruises in different stages of healing)
- Swelling, pain during movement, or unusually restricted movement
- Child wears torn, stained or bloody clothing
- Baby is born with drugs in his/her system

### **Physical indicators of neglect:**

- Non-organic failure to thrive
- Signs of malnutrition (child is chronically hungry, too thin, weak, lethargic, and fainting -- and perhaps with a bloated stomach, sunken cheeks, and skin that's dry and flaking)
- Developmental delays in speech and/or motor skills. Height and/or weight is substantially below the norm
- Inappropriately dressed for weather - either overdressed or underdressed, missing important articles of clothing
- Dirty, unkempt, smells bad, squints, poor oral hygiene. Might have lice, scabies, severe or untreated diaper rash
- Left alone and/or unattended in inappropriate and/or harmful ways
- Lacks proper immunizations
- Unattended medical conditions (illnesses, sunburns, ear infections, infected burns, bites or scrapes, broken bones). **Note:** If withdrawal or refusal of necessary medical care is considered to be for "religious" reasons, it might nevertheless constitute a crime or a situation requiring intervention by the state.
- Drug and/or alcohol abuse in the home; unhealthy, unsafe, and/or inadequate living conditions
- Presence in the home of an abuser and/or child molester.

## Physical indicators of sexual abuse:

- Family member, friend, or acquaintance seems unusually interested in child -- taking child away for trips or activities and/or giving child gifts. Child might exhibit unusual behavior around this person, and/or begin having conflicts with parental authority.
- Sudden acquisition of money, new clothes or gifts with no reasonable explanation
- Trauma to the genital area, or complaints of pain around the genitals
- Presence of venereal disease, gonococcus, spermatozoa in children
- Pregnancy in children
- Bruises, bleeding, swelling or other discharge from penis, vagina or anus
- Consistent complaint of unexplainable abdominal pain, headaches, sore throats or other physical problems
- Painful urination, bowel disturbances, enuresis (involuntary discharge of urine), or fecal soiling
- Difficulty in walking or sitting
- Child wears torn, stained or bloody clothing
- Presence of pornographic material involving child (pictures, videos, drawings, etc.)
- Presence in the home of an abuser and/or child molester

## Behavioral Indicators of Emotional, Physical or Sexual Abuse:

- Baby lies unusually still while being examined or played with -- or while surveying surroundings.
- Baby or child suffers behavioral symptoms of Shaken Baby Syndrome (see the [Signs of Shaken Baby Syndrome](#) page). **If you see these signs, call 911. The child needs help immediately.**
- Child (or adult victim) makes a report about abuse or harmful activity either directly -- or perhaps indirectly ("I have a friend..." "What would you say/do if..." "I heard something about somebody...") to a friend, classmate, teacher, friend's parent, or other trusted adult.
- Aggressive play and behavior, destructive tendencies, victimizing others, inappropriate expressions of anger, hostility and rage (often repressed), ignoring others' boundaries
- Provocative tendencies (i.e. deliberately elicits punishment).
- Inhibited or depressed behavior, withdrawal, despair, hopelessness, sense of impotence, excessive feeling of vulnerability, crying without provocation, pessimistic or callous outlook on life, overly compliant behavior
- Regressive behavior (bedwetting, refusal to speak, thumb sucking, separation anxiety, baby talk, whining, clinging, rocking, head banging, biting).
- Behavioral extremes - from aggressive to inhibited
- Pseudo-mature behavior and appearance -- sexual or otherwise.
- Child assumes adult responsibilities and/or reports no caregiver at home.
- Sexualized or seductive response toward others (including molestation of younger or more immature children), confusion or excessive concern about sexual norms, compulsive sexual behavior (possibly with toys or objects), demeaning or hurtful sexual activities or habits, viewing sex in persistently negative light (as dangerous, hurtful, controlling, bad, inappropriate), promiscuous behavior, prostitution, sexual preoccupation (excessive curiosity), despair regarding inability to control sexual urges
- Self-consciousness or self-awareness of body and sexual behavior beyond that appropriate for age group (expressed through play, drawings, or stories)
- Confusion with identity and sense of self
- Hurtful to animals, small children or other vulnerable members of society and/or takes pleasure in being hurt.
- Sleep disorders (insomnia, fearful about falling asleep, excessive sleeping, sleep-walking, nightmares, restless sleep)
- Speech disorders or nervous disorders such as stammering, stuttering, facial tics, rashes, hives, muteness, developmental delays, height or weight substantially below the norm

- Complaints of unexplained pains and aches (and/or unbelievable or inconsistent explanations for injuries).
- Begging for leftover food and/or collects leftover food
- Difficulty in walking or sitting
- Eating disorders (excessive or insufficient food intake)
- Drug and/or alcohol abuse
- Suicide gestures or attempts, or homicidal ideation
- Poor self-image, self-hatred, feelings of shame and guilt, aversion to own body, self-destructive forms of behavior (alcohol/drug abuse, self-mutilation/cutting, excessive risk taking), withholding of necessities to self, poor self-care
- Poor hygiene or excessive bathing. Fear of undressing and/or wearing of excessive and perhaps unflattering clothing.
- Fear of showers, restroom, or other particular place
- Extraordinary fear of particular gender, person
- Various phobias, generalized fear and anxiety, depression, disturbances in memory, multiple personality disorder
- Social difficulties (inability to trust, teasing or getting teased, bullying or getting bullied, inability to make and/or keep friends, trouble communicating with peers), difficulty in forming positive, nonabusive relationships, increased affection-seeking from adults
- Lack of participation in sports and social activities
- School problems: frequent absences, learning difficulties, difficulty concentrating, significant change in grades and/or attitude, cognitive/neurological/verbal delays, fear of dressing for physical education classes
- Fearful of home life -- demonstrated perhaps by arriving at school early and leaving late, running away, early marriage
- Delinquent behavior (such as stealing, vandalism, fire setting, etc.)
- Unusual behavior around family member, friend, or acquaintance who seems unusually interested in child -- taking child away for trips or activities and/or giving child gifts. Child might begin having conflicts with parental authority.

## **Sex Between Therapist and Patient is NEVER Acceptable**

Most counselors and psychotherapists are responsible, ethical professionals who work for the benefit of their clients. However, sometimes therapists have problems of their own which can result in impaired judgement and may lead them to become sexually involved with their patients.

**EVERY MENTAL HEALTH PROFESSION'S CODE OF ETHICS CONTAINS A SPECIFIC PROHIBITION AGAINST THERAPIST-PATIENT SEXUAL INVOLVEMENT.**

### **WHY IS SEX BETWEEN THERAPIST AND CLIENT EXPLOITATION?**

By its nature, the therapeutic relationship is unequal. Clients make themselves vulnerable by sharing intimate details of their lives with their therapists. Patients invest trust and authority in therapists, relying on the therapist's judgement for help. Often, clients view their therapists as powerful, parental figures, and patients may interact with the counselor in a child-like way. Many clients idealize, admire, and experience sexual attraction or romantic feelings toward their therapists.

Competent, ethical therapists recognize that these client responses are normal, but they also realize that *the power imbalance between therapist and patient negates the possibility of an equal, consenting relationship*. Therapists who encourage clients to act on these feelings abuse their position of trust. They misuse the relationship to gratify their own needs, failing to fulfill their responsibility to help the patient. Such manipulation is a violation of the client's trust and a form of sexual abuse, even if the client appears to consent or to initiate the sexual contact.

Many people believe that the power dynamics in the therapeutic relationship so closely resemble those in the parent-child dyad that sex between therapist and patient is psychologically equivalent to incest. For this and for other reasons, several states have criminalized sexual exploitation of patients as a form of statutory rape.

## **HOW COMMON IS THERAPIST-PATIENT SEXUAL EXPLOITATION?**

Members of the major mental health professions have conducted research on the prevalence of psychotherapist-patient sexual exploitation. These studies show that approximately 7% to 15% of professionals, in confidential self-reports, admitted to sexual involvement with a client. However, some researchers believe that the actual incidence may be higher.

## **WHO EXPLOITS, WHO IS EXPLOITED?**

Although the most common pattern involves a male therapist and a female client, abuse can occur between a therapist and patient of the same gender, or between a female therapist and a male client. According to one researcher, 80% of offenders exploit more than one patient.

## **WHAT EFFECT DOES THIS EXPLOITATION HAVE ON VICTIMS?**

Although each person will have a unique response, common reactions include:

- Isolation
- Confusion about the abuse, about the perpetrator, and about one's role in the abusive relationship
- Loss or lessening of ability to trust
- Feelings of guilt and shame
- Anger or rage
- Anxiety and panic
- Mood swings
- Depression
- Suicidal feelings
- Sexual problems
- Cognitive problems, such as difficulty concentrating and intrusive thoughts about the abuse
- Worsening of the problems for which client originally sought treatment
- Reluctance to seek help from another professional

## **DANGER SIGNALS!**

The following behaviors are often indicators that a sexual boundary violation may be occurring:

- Increased or inappropriate therapist self-disclosure
- Longer appointments or appointment at end of day
- Change of location from a professional setting to a social setting (e.g., meeting at a restaurant or bar)
- Introduction of alcohol or misuse of drugs in treatment
- Suggestive or seductive statements, "dirty jokes," or other verbally demeaning behavior
- Bartering for services
- Therapist intruding into client's personal life (phone calls at home, social engagements)
- Excessive or intrusive focus on sexuality
- Request for secrecy
- Inappropriate physical contact
- Nudity
- Erotic/sexual contact

## **WHAT CAN VICTIMS/SURVIVORS DO IF THEY ARE SEXUALLY EXPLOITED?**

- Get out of the therapy
- Recognize that you are not at fault
- Tell someone you trust what has happened
- Share experiences with other survivors of therapist-client sexual exploitation and/or other types of sexual abuse; join a support group
- Report offender to agency where treatment was provided

- Report offender to professional ethics and/or licensing board. (Boards may discipline offender, may suspend or revoke license to practice.)
- File a civil (malpractice) suit. (You can sue for monetary compensation for injury; however, litigation can be retraumatizing and collecting award may be difficult because of insurance policy coverage exclusions and economic "caps")
- File a criminal complaint. (Depending on the state in which the offense occurred and the specific details, you may be able to bring criminal charges.)
- Become politically active concerning therapist-client sexual exploitation and clients' rights

### **WHAT CAN PROFESSIONALS DO?**

- Articulate strict prohibitions against therapist-client sexual involvement.
- Report offending colleagues to appropriate boards, and advocate for appropriately strict discipline for offenders
- Support efforts to regulate unlicensed therapists
- Receive education on therapist-client sexual exploitation and advocate for including such training in academic and continuing education programs.
- Become politically active concerning therapist-client sexual exploitation and clients' rights
- Work with other professionals, consumer-advocates, and survivors to reduce the degree of retraumatization to survivors who report or litigate

***Requirements and procedures for reporting an incident of client abuse and neglect, together with the applicable penalties for non-reporting***

**Persons Required to Report; Time to Report**

(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report.

(b) If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has cause to believe that the child has been abused, the professional shall make a report not later than the **48th hour after the hour** the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

(c) The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, and an employee of a clinic or health care facility that provides reproductive services.

(d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

**Matters to be Reported**

A report should reflect the reporter's belief that a child has been or may be abused or neglected or has died of abuse or neglect.

**Report Made to Appropriate Agency**

(a) A report shall be made to:

(1) any local or state law enforcement agency;

(2) the department if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child;

(3) the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or

(4) the agency designated by the court to be responsible for the protection of children.

(b) A report may be made to the Texas Youth Commission instead of the entities listed under Subsection (a) if the report is based on information provided by a child while under the supervision of the commission concerning the child's alleged abuse of another child.

**Contents of Report**

The person making a report shall identify, if known:

- (1) the name and address of the child;
- (2) the name and address of the person responsible for the care, custody, or welfare of the child; and
- (3) any other pertinent information concerning the alleged or suspected abuse or neglect.

### **Immunities**

(a) A person acting in good faith who reports or assists in the investigation of a report of alleged child abuse or neglect or who testifies or otherwise participates in a judicial proceeding arising from a report, petition, or investigation of alleged child abuse or neglect is immune from civil or criminal liability that might otherwise be incurred or imposed.

(b) Immunity from civil and criminal liability extends to an authorized volunteer of the department or a law enforcement officer who participates at the request of the department in an investigation of alleged or suspected abuse or neglect or in an action arising from an investigation if the person was acting in good faith and in the scope of the person's responsibilities.

(c) A person who reports the person's own abuse or neglect of a child or who acts in bad faith or with malicious purpose in reporting alleged child abuse or neglect is not immune from civil or criminal liability.

### **False Reporting Penalty**

(a) A person commits an offense if the person knowingly or intentionally makes a report as provided in this chapter that the person knows is false or lacks factual foundation. An offense under this section is a Class A misdemeanor unless it is shown on the trial of the offense that the person has previously been convicted under this section, in which case the offense is a state jail felony.

(b) A finding by a court in a suit affecting the parent-child relationship that a report made under this chapter before or during the suit was false or lacking factual foundation may be grounds for the court to modify an order providing for possession of or access to the child who was the subject of the report by restricting further access to the child by the person who made the report.

(c) The appropriate county prosecuting attorney shall be responsible for the prosecution of an offense under this section.

### **Failure to Report Penalty**

(a) A person commits an offense if the person has cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect and knowingly fails to report as provided in this chapter.

(b) An offense under this section is a Class B misdemeanor.

### **Employer Retaliation Prohibited**

(a) An employer may not suspend or terminate the employment of, or otherwise discriminate against, a person who is a professional and who in good faith:

(1) reports child abuse or neglect to:

(A) the person's supervisor;

(B) an administrator of the facility where the person is employed;

(C) a state regulatory agency; or

(D) a law enforcement agency; or

(2) initiates or cooperates with an investigation or proceeding by a governmental entity relating to an allegation of child abuse or neglect.

(c) A person whose employment is suspended or terminated or who is otherwise discriminated against in violation of this section may sue for injunctive relief, damages, or both.

(d) A plaintiff who prevails in a suit under this section may recover:

(1) actual damages, including damages for mental anguish even if an injury other than mental anguish is not shown;

(2) exemplary damages under Chapter 41, Civil Practice and Remedies Code, if the employer is a private employer;

(3) court costs; and

(4) reasonable attorney's fees.

(e) In addition to amounts recovered under Subsection (d), a plaintiff who prevails in a suit under this section is entitled to:

(1) reinstatement to the person's former position or a position that is comparable in terms of compensation, benefits, and other conditions of employment;

(2) reinstatement of any fringe benefits and seniority rights lost because of the suspension, termination, or discrimination; and

(3) compensation for wages lost during the period of suspension or termination.

(f) A public employee who alleges a violation of this section may sue the employing state or local governmental entity for the relief provided for by this section. Sovereign immunity is waived and abolished to the extent of liability created by this section. A person having a claim under this section may sue a governmental unit for damages allowed by this section.

(g) In a suit under this section against an employing state or local governmental entity, a plaintiff may not recover compensatory damages for future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other nonpecuniary losses in an amount that exceeds:

(1) \$50,000, if the employing state or local governmental entity has fewer than 101 employees in each of 20 or more calendar weeks in the calendar year in which the suit is filed or in the preceding year;

(2) \$100,000, if the employing state or local governmental entity has more than 100 and fewer than 201 employees in each of 20 or more calendar weeks in the calendar year in which the suit is filed or in the preceding year;

(3) \$200,000, if the employing state or local governmental entity has more than 200 and fewer than 501 employees in each of 20 or more calendar weeks in the calendar year in which the suit is filed or in the preceding year; and



(4) \$250,000, if the employing state or local governmental entity has more than 500 employees in each of 20 or more calendar weeks in the calendar year in which the suit is filed or in the preceding year.

(h) If more than one subdivision of Subsection (g) applies to an employing state or local governmental entity, the amount of monetary damages that may be recovered from the entity in a suit brought under this section is governed by the applicable provision that provides the highest damage award.

(i) A plaintiff suing under this section has the burden of proof, except that there is a rebuttable presumption that the plaintiff's employment was suspended or terminated or that the plaintiff was otherwise discriminated against for reporting abuse or neglect if the suspension, termination, or discrimination occurs before the 61st day after the date on which the person made a report in good faith.

(j) A suit under this section may be brought in a district or county court of the county in which:

(1) the plaintiff was employed by the defendant; or

(2) the defendant conducts business.

(k) It is an affirmative defense to a suit under Subsection (b) that an employer would have taken the action against the employee that forms the basis of the suit based solely on information, observation, or evidence that is not related to the fact that the employee reported child abuse or neglect or initiated or cooperated with an investigation or proceeding relating to an allegation of child abuse or neglect.

(l) A public employee who has a cause of action under Chapter 554, Government Code, based on conduct described by Subsection (b) may not bring an action based on that conduct under this section.

(m) This section does not apply to a person who reports the person's own abuse or neglect of a child or who initiates or cooperates with an investigation or proceeding by a governmental entity relating to an allegation of the person's own abuse or neglect of a child.

## **CLIENT ABUSE & NEGLECT REPORTING OF ABUSE OR NEGLECT**

When a provider or its personnel have knowledge of unethical conduct or practice on the part of a person or provider, they have a responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public. Any provider or provider personnel who receive an allegation or have reason to suspect that an individual has been, is, or will be subject to abuse, neglect or exploitation by any provider shall immediately inform HHSC's investigations division. The provider shall also take immediate action to prevent or stop the abuse, neglect, or exploitation and provide appropriate care and treatment. The provider shall report allegations of child abuse or neglect to the Texas Department of Protective and Regulatory Services. The provider shall report allegations of abuse, neglect or exploitation of elderly or disabled individuals to the Texas Department of Protective and Regulatory Services. If the allegation involves sexual exploitation, the service provider shall comply with reporting requirements listed in the TEX. CIV. PRAC. & REM. CODE ANN. §81.006 (Vernon 1997 & Supp. 2004).

All staff shall report to HHSC's investigations division, all allegations of client abuse, neglect, and exploitation. The report shall be made no later than 24 hours after the incident occurred. HHSC shall be informed both verbally and in writing.

The staff shall complete an internal incident report for all client incidents, including:

- a violation of a client rights, including but not limited to, allegations of abuse, neglect and exploitation;
- accidents and injuries;
- medical emergencies;
- psychiatric emergencies;
- medication errors;
- illegal or violent behavior;
- loss of a client record;
- personal or mechanical restraint or seclusion;
- release of confidential information without client consent;
- fire;
- death of an active outpatient or residential client (on or off the program site);
- clients absent without permission from a residential program;
- suicide attempt by an active client (on or off the program site);
- medical and psychiatric emergencies that result in admission to an inpatient unit of a medical or psychiatric facility; and
- any other significant disruptions.

The incident report shall be completed within 24 hours of the occurrence of an incident on-site, or within 24 hours of when the staff became aware of, or reasonably should have known of an incident that occurred off-site. The incident report shall provide a detailed description of the event, including the date, time, location, individuals involved, and action taken.

The individual writing the report shall sign it and record the date and time it was completed.

The Program Director is responsible for reviewing incident reports.

## **Filing a Complaint with Texas Department of State Health Services**

Licensed chemical dependency counselors have an obligation to maintain a high standard of conduct toward their clients and others. Additionally, licensed chemical dependency treatment facilities and HHSC-funded programs have the responsibility to see that chemically dependent individuals receive adequate and appropriate treatment services. To uphold these standards, HHSC investigates and prosecutes allegations of abuse, neglect, exploitation, and professional misconduct against licensed chemical dependency counselors, licensed facilities, and HHSC-funded programs. HHSC also investigates violations of facility licensure standards against licensed chemical dependency treatment facilities in Texas.

Any person who reasonably believes that a violation has occurred may file a complaint with the Texas Department of State Health Services against a licensed chemical dependency counselor, licensed chemical dependency treatment facility, or HHSC-funded program.

### ***How do I file a complaint?***

Complaints against licensed chemical dependency treatment facilities and HHSC-funded programs can be received by phone or in writing via mail, fax, and e-mail. However, state law requires that counselor complaints must be in writing and sworn to by the complainant. Counselor complaint forms are available by calling the HHSC directly or on the agency's Internet site.

### ***What kind of information should I include in a complaint?***

For all complaints, you will need to provide dates, witnesses, and specific details of any incident. Once your complaint is received, the Investigations Division will acknowledge the receipt of your complaint. If accepted, an investigator will be assigned for review. If additional information is needed from you, you will be contacted by the investigator.

### ***Can I file a complaint anonymously?***

From time to time the HHSC receives anonymous complaints. However, very few of these cases can be successfully pursued unless the person making the complaint is willing to come forward. A violation requires evidence, and the testimony of the person making the complaint is almost always important evidence.

### ***Can HHSC guarantee anonymity?***

No. Complaints are subject to open records requests.

### ***How long do I have to file a complaint?***

Complaints should be filed as soon as possible after the alleged violation. The older the complaint, the more difficult it is to investigate. If the incident is old and the possibility of a realistic investigation is severely diminished as a result, the HHSC may choose not to pursue the matter.

### ***What happens during the investigation?***

The investigator will determine whether or not the complaint provides sufficient information to be investigated and if the matter is within HHSC's jurisdiction. If the complaint does not contain sufficient information or does not fall within the agency's jurisdiction, you will be notified in writing. If the complaint is not within the jurisdiction of HHSC, it may be referred to another agency. The facility, HHSC-funded program, or licensed counselor against whom the complaint was filed also may be contacted in the course of the investigation and is required to cooperate.

### ***How long does the investigation take?***

The time it takes to investigate a complaint varies because each case and the amount and quality of the evidence is different. However, it is the policy of the HHSC Investigations Division to conclude all investigations within 90 days. Complainants will be advised of the investigation status every 90 days until a determination is made.

***What does the investigator do?***

Allegations contained in the complaint are thoroughly investigated by trained professionals. Investigators may gather evidence by correspondence, interviews, site visits, and review of documentation of past investigations. If sufficient evidence suggests a violation has occurred, as determined by the investigative staff, the case will be forwarded to the Legal Division for disciplinary action.

***What if my complaint can't be proven?***

It is important to remember that even though misconduct or rule violations may have occurred, in certain circumstances there may not be sufficient evidence to prove the allegations legally. Therefore, these cases will be closed as unsubstantiated.

***What happens after the case is referred to the Legal Division?***

Legal staff reviews the facts of the matter in question and determine the next steps.

***What type of action can be imposed on the counselor or facility?***

The forms of sanctions that may be imposed include reprimand, suspension of a license and/or funding, monetary fine, or a revocation of license. The complainant will be notified in writing of the final action taken by the HHSC.

***What is a contested hearing?***

If HHSC and the licensee cannot agree to a resolution of the complaint, the licensee may request a contested hearing. A contested hearing is similar to a trial, except that an Administrative Law Judge hears the evidence. The complainant may be called to give testimony. Following the hearing the Administrative Law Judge recommends a resolution of the complaint to HHSC's board.

***What rules govern licensed chemical dependency counselors?***

The rules are found within 40 TAC, Chapter 450.

***What rules govern all licensed chemical dependency treatment facilities?***

TAC 40, Chapter 148, lists the rules that licensed chemical dependency treatment facilities must follow.

**To ensure high ethical standards and protect the public health, HHSC licenses chemical dependency counselors and chemical dependency treatment facilities across the state.**

**How to reach HHSC staff:**

For additional information on the investigation process, contact the Investigations Division by dialing toll-free (800) 832-9623, ext. 6749 or (512) 349-6749. You also may reach the division via fax at (512) 821-4452 or e-mail at [complaints@HHSC.state.tx.us](mailto:complaints@HHSC.state.tx.us)

**Reporting Contacts**

Texas Health and Human Service Commission

800-832-9623

Texas State Board of Medical Examiners

512-305-7010

Texas Department of Family and Protective Services

800-252-5400

**Filing a Complaint with Texas Health and Human Services-Process****Purpose**

Form 6108 is used to notify Texas Health and Human Services Commission (HHSC) of an incident and the actions taken by the facility.

### **Procedure**

Submit each form within two business days of the incident. Submit each form separately and do not submit multiple incidents in one document. Explain how the facility will improve care as a result of the incident. Complete the entire form with all requested attachments so that HHSC may review the incident without requiring additional information or documents.

### **Transmittal**

Submit each completed form by ONE of the following (email, fax or mail):

Email: [cii.sa@hhsc.state.tx.us](mailto:cii.sa@hhsc.state.tx.us)

Fax: 1-833-709-5735 or 512-206-3985

Mail: Texas Health and Human Services Commission

Complaint and Incident Intake

P.O. Box 149030, Mail Code E-249

Austin, TX 78714-9030

### **Detailed Instructions**

Print or type the information and provide as much information as possible. Use the facility name and license number as listed on your license.

Reportable Incident – Check box.

Date of Report – Enter the report date.

Date of Incident – Enter the date of the incident.

Time of Incident – Enter the time of the incident and check A.M. or P.M.

Facility License No. – Enter the facility license number.

Facility Name – Enter the name of the facility.

Address – Enter the street address, city, state, ZIP code.

Telephone – Enter the area code and telephone number.

Reporter Name and Title – Enter the contact person and title that the surveyor will ask for should a follow-up telephone call be needed.

Primary Phone No. and Secondary Phone No. – Enter the area code and telephone numbers.

Email – Enter the email address.

Client Name – If the incident involves a client, enter the first, middle and last name.

Date of Birth – Enter the client's date of birth.

Date of Admission – Enter the date the client was admitted.

Date of Discharge – Enter the date the client was discharged.

Diagnoses (all) – Enter the diagnoses.

Discharge Disposition – Check the box for home, hospital or other. If other, enter the other disposition.

Facility Name and City – Enter the name of the facility and city.

Perpetrator Name and Title – Enter the perpetrator's name and title.

Perpetrator License No. – Enter the perpetrator's license number.

Social Security No. – Enter the perpetrator's Social Security number.

Telephone – Enter the perpetrator's area code and phone number.

Address – Enter the perpetrator's street address, city, state and ZIP code.

#### **Summary**

When did you first learn of the incident? – Enter the date and time.

On what shift did the incident occur? – Check the box for day, evening or night.

Provide a brief summary – Enter what happened, who was involved (e.g., RN, LVN, PCT, MD, other), and the action taken at the time of the incident.

Did the client receive any treatment? – Check Yes or No. If yes, explain.

Was this reported to law enforcement? – Check Yes or No.

Was this reported to another organization? – Check Yes or No. If yes, provide the name of the organization.

Provide a narrative report of the investigation – Explain how you handled the incident and what actions you will take to reduce the potential for similar incidents in the future.

Actions to be taken as a result of this incident – Check all boxes that apply.

Signature, Printed Name and Date – The supervising authority signs, prints his/her name and enters the date. Then, email, fax or mail the completed incident form to the number or address provided above under Transmittal.

***Policies and procedures adopted by various governing boards of differing agencies regarding illegal, unprofessional, and unethical conduct***

Although on Licensed counselor and counselor interns have a specific set of ethical standards they are held too, all staff that work in HHSC licensed facilities and funded programs are required to follow Standards of Conduct identified in the Standards of Care §448.218. Standards of Conduct are in place to protect the rights of clients and to provide adequate and appropriate treatment.

HHSC Licensed Treatment Program and all its agents shall protect the health, safety, rights, and welfare of its clients. All programs shall provide adequate services as described in respective program descriptions. All programs shall comply with all applicable laws, regulations, policies and procedures. HHSC Licensed Treatment Program shall maintain required licenses, permits, and credentials. HHSC Licensed Treatment Program and all its programs shall comply with professional or ethical codes of conduct. Staff, volunteers or any agent of the agency shall report violations of laws, rules and standards that govern substance abuse services to HHSC, when such violations pose a significant threat to the health, safety, well being or rights of impaired participants.

The successful business operation and reputation of HHSC Licensed Treatment Program is built upon the principles of fair dealing and ethical conduct of our employees. Our reputation for integrity and excellence requires careful observance of the spirit and letter of all applicable laws and regulations, as well as a scrupulous regard for the highest standards of conduct and personal integrity.

The continued success of HHSC Licensed Treatment Program is dependent upon our community's trust and we are dedicated to preserving that trust. Employees owe a duty to HHSC Licensed Treatment Program and its clients to act in a way that will merit the continued trust and confidence of the public.

Neither HHSC Licensed Treatment Program nor any of its personnel shall:

- Provide services while under the influence of alcohol or illegal drugs;
- Commit an illegal, unprofessional or unethical act (including client-abuse, neglect, or exploitation);
- Assist or knowingly allow another person to commit an illegal, unprofessional or unethical act;
- Knowingly provide false or misleading information;
- Falsify, alter, destroy or omit significant information from required reports and records or interfere with their preservation;
- Retaliate against anyone who reports a violation or cooperates during a review, inspection, investigation, hearing, or other related activity; or
- Interfere with HHSC reviews, inspections, investigations, hearings, or related activities. This includes taking action to discourage or prevent someone else from cooperating with the activity.
- Abuse, neglect, or exploit clients;
- Commit an illegal, unprofessional, or unethical act.

Any person associated with HHSC Licensed Treatment Program who receives an allegation or has reason to suspect that a person associated with HHSC Licensed Treatment Program has been, is, or will be engaged in illegal, unethical, or unprofessional conduct shall immediately inform HHSC investigations division.

Neither HHSC Licensed Treatment Program nor any of its personnel shall enter into a personal or business relationship with a person who receives services from HHSC Licensed Treatment Program until at least two years after the service recipient's discharge.

HHSC Licensed Treatment Program and its personnel shall comply with Chapter 164 of the Texas Health and Safety Code (relating to Treatment Facilities Marketing and Admission Practices).

Violations of laws, rules, and professional and ethical codes of conduct are to be reported to HHSC in writing within 72 hours of learning of the infraction. An employee who learns of such an infraction must inform his/her supervisor, unless his/her supervisor is involved in the infraction.

In general, the use of good judgment, based on high ethical principles, will serve as guide with respect to lines of acceptable conduct. If a situation arises where it is difficult to determine the proper course of action, the matter should be discussed openly with the immediate supervisor and, if necessary, with the Chief Executive Officer and/or the governing body for advice and consultation.

The following acts are specifically prohibited:

HHSC Licensed Treatment Program shall not provide services, interact with individuals receiving services, or perform any job duties while under the influence or impaired by the use of alcohol, or mood altering substances, including prescription medications not used in accordance with a physician's order.

HHSC Licensed Treatment Program shall not commit an illegal, unprofessional or unethical act (including acts constituting abuse, neglect, or exploitation).

HHSC Licensed Treatment Program shall not assist or knowingly allow another person to commit an illegal, unprofessional, or unethical act.

HHSC Licensed Treatment Program shall not falsify, alter, destroy or omit significant information from required reports and records or interfere with their preservation.

HHSC Licensed Treatment Program shall not retaliate against anyone who reports a violation of these rules or cooperates during a review, inspection, investigation, hearing, or other related activity.

HHSC Licensed Treatment Program shall not interfere with HHSC reviews, inspections, investigations, hearings, or related activities. This includes taking action to discourage or prevent someone else from cooperating with the activity.

HHSC Licensed Treatment Program shall not enter into a personal or business relationship of any type with individuals receiving services until at least two years after the last date an individual receives services from the provider.

HHSC Licensed Treatment Program shall not discourage, intimidate, harass, or retaliate against individuals who try to exercise their rights or file a grievance.

HHSC Licensed Treatment Program shall not restrict, discourage, or interfere with any communication with law enforcement, an attorney, or with HHSC for the purposes of filing a grievance.

HHSC Licensed Treatment Program shall not allow unqualified persons or entities to provide services.

HHSC Licensed Treatment Program shall not hire or utilize known sex offenders in adolescent programs or programs that house children.

HHSC Licensed Treatment Program shall prohibit adolescent clients and participants from using tobacco products on the program site. Staff and other adults (volunteers, clients, participants and visitors) shall not use tobacco products in the presence of adolescent clients or participants.



## ***Policies and procedures adopted by various governing boards of differing agencies regarding client rights***

HHSC Standards of Care §448.701 indicate that client have the following rights and that facilities and their staff must protect and ensure that each client rights are not violated:

- (1) You have the right to accept or refuse treatment after receiving this explanation.
- (2) If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
- (3) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
- (4) You have the right to be free from abuse, neglect, and exploitation.
- (5) You have the right to be treated with dignity and respect.
- (6) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
- (7) You have the right to be told about the program's rules and regulations before you are admitted.
- (8) You have the right to be told before admission:
  - (A) the condition to be treated;
  - (B) the proposed treatment;
  - (C) the risks, benefits, and side effects of all proposed treatment and medication;
  - (D) the probable health and mental health consequences of refusing treatment;
  - (E) other treatments that are available and which ones, if any, might be appropriate for you; and
  - (F) the expected length of stay.
- (9) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
- (10) You have the right to meet with staff to review and update the plan on a regular basis.
- (11) You have the right to refuse to take part in research without affecting your regular care.
- (12) You have the right not to receive unnecessary or excessive medication.
- (13) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
- (14) You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.
- (15) You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
- (16) You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
- (17) You have the right to complain directly to the Texas Health and Human Services at any reasonable time.
- (18) You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Health and Human Services.
- (19) You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

For residential sites, the Client Bill of Rights shall also include:

- (1) You have the right not to be restrained or placed in a locked room by yourself unless you are a danger to yourself or others.
  - (2) You have the right to communicate with people outside the facility. This includes the right to have visitors, to make telephone calls, and to send and receive sealed mail. This right may be restricted on an individual basis by your physician or the person in charge of the program if it is necessary for your treatment or for security, but even then you may contact an attorney or the Texas Health and Human Services at any reasonable time.
  - (3) If you consented to treatment, you have the right to leave the facility within four hours of requesting release unless a physician determines that you pose a threat of harm to yourself and others.
- (c) If a client's right to free communication is restricted, the physician or program director shall document the clinical reasons for the restriction and the duration of the restriction in the client record. The physician or program

director shall also inform the client, and, if appropriate, the client's consenter of the clinical reasons for the restriction and the duration of the restriction.

## *Techniques for improving client care*

Treatment, because it is a deeply intimate kind of learning, demands staff who is willing to risk shedding stereotyped roles and being a real person in a relationship. It is in the context of a person-to-person relationship that a client experiences growth. If we hide behind our role as “staff” then our clients will keep themselves hidden from us as well. It is through our own realness and our aliveness that we can significantly touch our clients. If we make life-oriented choices, radiate a zest for life, are real in our relationship with our clients, and let ourselves be known to them, we can inspire and teach them. This doesn’t mean that we have no problems, it simply means that we believe in hope and that change is worth the risk, it is this hope that we can hold out to our clients, that they have the capacity to change and become the person they wish to be. We are models, if we model incongruent behavior, low-risk activity, and deceit by remaining hidden and vague, we can expect our client to imitate our behavior. If we model realness by engaging in appropriate self-disclosure, clients will begin to integrate this characteristic in themselves. The degree of aliveness and psychological health of the staff is the crucial variable in determining client outcomes.

There are three types of self-disclosure:

**No disclosure-** counselors are unwilling to discuss the reactions they are having towards the clients or what has been going on with them during the session. Lots of questioning, lots of probing, but no honest dialogue.

**Over disclosure-** counselor who blur the role between helper and one who is helped. Sharing own past, problems as a means of working on their own needs.

**Appropriate self disclosure-** facilitative disclosure generally entails revealing reactions that stem from the relationship with the clients, not disclosing some unrelated experience out of the therapist pasts. It is relevant and timely. Reactions in the here and now.

When talking about yourself with clients, be mindful of the following:

- Disclosing my persistent feelings that are directly related to the present transaction
- Not every fleeting feeling or fantasy.
- Timing, relevant to here and now.
- Distinguish between disclosure and history telling. Disclosure is unrehearsed expression of current experiences.
- Ask yourself why you are revealing and is it appropriate.

Below is a short list of professional characteristic for staff working with drug and alcohol clients:

- Avoid perfectionism
- Be honest with clients
- Understand Silence
- Learning to deal with demanding clients
- Learn your limits
- Don’t lose yourself in your clients
- Develop a sense of humor
- Decline to give advice
- Develop your own counseling style



# **CERTIFICATE OF COMPLETION**

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*NON-VIOLENT CRISIS INTERVENTION TECHNIQUES*

**THESE TRAINING REQUIREMENTS WERE  
FULFILLED ON**

**To the best of my knowledge, I certify that this employee has met the requirements of non-violent crisis intervention as stated in TAC §448.603 (D)(4).**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

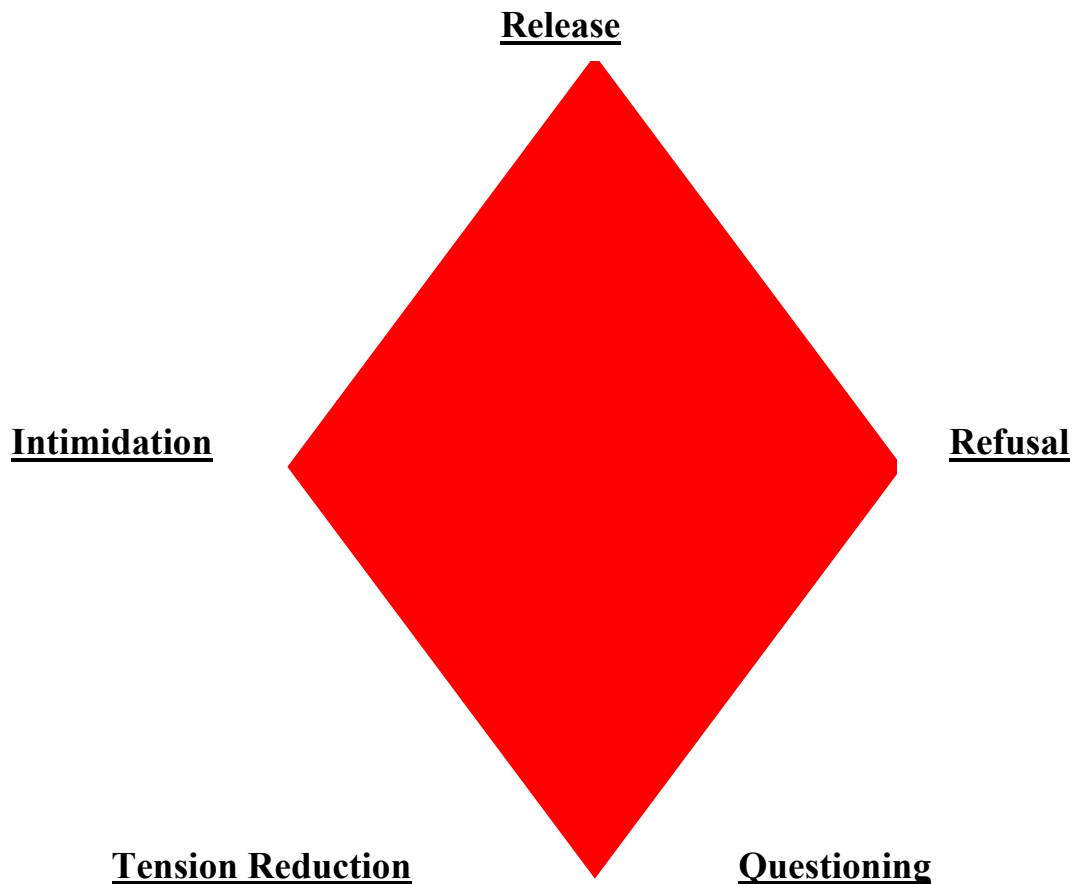
This training was conducted live and in-person

## **CPI Crisis Development Model**

The CPI Crisis Development Model is a way of understanding how a crisis situation evolves through a series of stages and how our response to each stage has an effect on the outcome.

<b><u>Crisis Development</u></b>	<b><u>Staff Response</u></b>
<b><u>1. Anxiety</u></b>	<b><u>1. Supportive</u></b>
<b><u>2. Defensive</u></b>	<b><u>2. Directive</u></b>
<b><u>3. Acting-Out Person</u></b>	<b><u>3. Nonviolent Physical Crisis Intervention</u></b>
<b><u>4. Tension Reduction</u></b>	<b><u>4. Therapeutic Rapport</u></b>

## **Verbal Escalation Continuum**



## **The Anxiety Level: Early Warning Signs**

Recognizing anxious behavior early in the crisis development process and responding in a supportive manner is the best way to defuse a potentially explosive situation. Most people would agree that early intervention, while the person is still rational, is more effective than intervening later, when the individual becomes irrational and possibly assaultive.

Human service professionals often receive training in techniques designed to provide support to an anxious person. This formal training many include listening skills, interviewing methods, and counseling techniques. Each of these intervention strategies revolves around the exchange of words. Yet the skills which are often most effective in dealing with an anxious person involved a type of training that is frequently absent from the human service professional's repertoire: understanding and utilizing effective nonverbal communication.

### Role of Nonverbal Behavior

Despite our highly developed language skills, as much as 80% of our communication is estimated to be nonverbal. In the context of intervening with a person experiencing anxiety, an acute awareness of nonverbal messages becomes essential.

### Proxemics

Imagine being alone in an elevator. The doors of the elevator open and a person you've never met step inside. Instead of retreating to the traditional "opposite corner," the stranger stands about a foot away from you. In addition, he doesn't cast his eyes up toward the numbers above the door, but pleasantly looks at you. This unusual behavior would be highly unsettling to most people. At a minimum, you would probably feel uncomfortable, and you might even be fearful that your safety may be threatened. What is at work here is much more than simply rude or inappropriate social behavior. Few of us were taught by our parents to seek out the opposite corner of an elevator and stare at the numbers. In fact, we probably instinctively kept our distance in elevators before we had the language skills to comprehend a parental lesson in elevator etiquette.

When a person stands too close to us in an elevator, or when we approach too closely a person experiencing anxiety, a very powerful dynamic involving proxemics is triggered. Proxemics, or personal space as it is mostly commonly called, refers to the area around our bodies that we perceive as an extension of ourselves. Any encroachment on or invasion of that space tends to heighten anxiety. Generally, the distance we feel comfortable maintaining is two to three feet.

This distance varies from person to person, as it does for the same person, depending on who is approaching and the context of the situation. For instance, if someone you knew and trusted approached you in a nonthreatening environment, your personal space would be much different than it would be if a stranger approached you on a city street late at night. We allow very few people to get much closer to us than 2-3 feet.

This dynamic becomes critical in a potential crisis situation. When approaching a person displaying anxiety behavior, keep in mind that he may not be as comfortable as you are with the situation. Pay close attention to the intensity of the anxiety behavior. If the anxiety increases, you may need to back off a few steps. Maintaining a distance of two to three feet is good rule of thumb; however, you should take your cues from the person you are approaching. Some people may need five to ten feet or more in order to feel comfortable in certain situations.

Being aware of an individual's need for personal space is one of the most critical keys to defusing a crisis, especially in the early stages of anxiety. Unfortunately, many crisis situations that could have been de-escalated are not, because of a staff member's invading a person's space. Often the staff member has good intentions. He may even want to give a supportive touch to the shoulder, thinking the anxious person need reassuring gesture. Such a gesture, however, not only might heighten anxiety, but also, in extreme cases, might be perceived as a threat and escalated the person to the point at which he becomes assaultive. Supportive touch can be an excellent therapeutic technique, but be sure you are taking cues from the anxious person. Giving a person "space" can be just as therapeutic.

## Kinesics

Narrowly defined, kinesics is the way we move and position our bodies. A broader application of the definition is more useful when intervening with a potentially disruptive individual- otherwise known as body language. The way we move and position our body in relation to another person has a direct impact on the message we deliver. Even subtle gestures add meaning to our words. When we approach an anxious person, much of her anxiety is displayed by kinetic behavior. The very words we use to describe an anxious person reflect the fact that we are constantly reading body language. Phrases such as “uptight,” “wound up,” and “on edge” create visual image of pacing, fidgeting, or wringing their hands. By “tuning in” to people’s body language, we get some important cues about their levels of anxiety.

It is equally important when intervening in a crisis situation that we be aware of the message our body language is sending. Contrasting supportive words with negative body language can send mixed messages to the individual we are trying to calm. If, for example, a staff member approaches an anxious person head on, face to face, shoulder to shoulder, hands on hips while sighing and rolling her eyes, it will not make much difference what she says to the person. Her verbal message will be overridden by her inappropriate kinesic behavior.

We “read” people’s bodies just as much as, if not more than, we listen to the words they speak. It is important to remember that a person in the early stages of crisis development may be even more acutely aware of our body language. If the intent to present a supportive approach to the individual, we must be sure it is a consistent message, one that is supported by our non-verbal behavior as well as by our words.

## Supportive Stance

Since our nonverbal behavior plays such a major role in keeping anxiety to a minimum, we need to devise an approach that is nonthreatening or neutral in nature. For several reasons, the following stance is recommended for approaching a person displaying anxiety behavior. First, by maintaining 2-3 feet of distance between yourself and the anxious person, you communicate a certain degree of respect by the fact that you are honoring the individual’s personal space. Remember, 2-3 feet is a guideline, take your cues from the person. The second benefit of this stance is that by standing off to the side of the individual, you are presenting a nonthreatening, nonchallenging posture. When two people want to challenge each other, they generally “square off.” This is true in almost all cases. It would be difficult to imagine an altercation in which this kinesic dynamic did not occur. It is highly unusual to see two people in a heated dispute in which one or both parties are maintaining a supportive stance.

Finally, a supportive stance affords you much greater personal safety should the individual you are approaching become physically aggressive. The first safety factor built in to this stance is that you are providing a margin of at least one leg length of distance between you and the other individual. If the person tries to physically attack you, she must telegraph her assault by taking a step towards you. Also, by not squaring off with the individual, you are protecting the vulnerable areas of your body, such as your face, groin, knees and shins. It is important that you keep your hands in a neutral position and plainly in view. Keeping your hands in front of you puts them in position to be used as shields, should the person strike out at you. Placing your hands behind your back is a good way to increase the other person’s anxiety. Keep in mind that the person you are approaching may not be totally rational and could very well imagine you have something behind your back that could harm him. This supportive stance is recommended posture for approaching a person who displaying a significant amount of anxiety. It is also a sound way to position your body, regardless of where the individual is in the crisis development process. The fundamental dynamics that make it effective in defusing anxiety also apply to those individuals in the more volatile Defensive Level. And, as previously mentioned, you are physically safer in this position should the individual escalate to the level of physically acting out.

## Paraverbal Communication

Paraverbal communication is simply “how we say what we say.” It is the manner in which we alter our tone, volume, and rate of speech affects the way our message is interpreted. The foregoing example illustrates the impact of paraverbal communication. How does this dynamic apply to intervening with potentially disruptive



and assaultive individuals? People in crisis situations, even in the early stages, begin to lose rationality. When this occurs, they respond to more basic levels of communication.

Recall for a moment a time when you became extremely upset. It is likely you will remember most vividly not the words that were exchanged, but the “flavor” of the exchange.

The tone, volume, and cadence of our speech provide a backdrop for our words. Take the simple phrase “calm down.” By slightly altering the tone and volume of our voice we can substantially change our meaning. If we whine a little and stretch the phrase out until it has three or four syllables instead of only two, we can deliver a message that implies, “what are you so upset about? Your problems are trivial.” Shorten our speech pattern and increase the volume, we could give a totally different message that says, “I’m in charge, and I’m ordering you to calm down... or else!”

When intervening, be aware of the message your paraverbal communication sends. Coupled with nonverbal communication, paraverbal “package” your verbal intervention. Pay special attention to the tone of your voice. Although rate and volume are important, your tone tends to give your message a great deal of its meaning. If your intent is to provide support, make sure your tone is supportive. On the other hand, if you want to be directive, adjust your paraverbals accordingly. Try to keep your verbal, nonverbal, and paraverbal communication in sync with one another to avoid giving the person a mixed message.

## **Defensive Level: Hostility and Noncompliance**

If all crisis situations could be defused at the anxiety level, life would be much simpler. Some crisis situations, however, escalate past the anxiety level into more volatile defensive level. When individuals become defensive, they lose rationality and often become difficult to handle. Many people find it extremely challenging to manage defensive behavior. A person in the defensive level begins to lose control. Often this loss of control is accompanied by belligerence, hostility, and noncompliance. The person who was nervous and edgy during the anxiety level now becomes extremely volatile and is not so easily approached. Often the defensive person will challenge you or your authority.

Typically, this behavior is characterized by verbal outbursts. In some cases, however, the person may become passively noncompliant and refused to accommodate even the simplest request. Supportive responses that work well with people who are anxious lose much of their effectiveness with the defensive person. This can lead to frustration on the part of staff. A directive approach, which provides structure and choices, is generally much more effective with a person in the defensive level. With a directive approach, unlike the supportive approach, you set limits for the individual and clearly establish consequences for the defensive behavior.

Although defensive behavior seems chaotic and unpredictable, often with no apparent pattern. However, there are certain behaviors commonly observed when individuals become defensive.

### Questioning

Generally, questioning is one of the behaviors you see in a person who is escalating in the defensive level. Questioning can take one of two forms. The first is information-seeking in nature. These are productive questions and usually are asked to clarify information. When a question appears to be informational, give the person the benefit of the doubt and answer the question. In many cases, explanation and clarification are all that is necessary. Once the person receives more information, he will comply with your directive.

The second type of questioning, however, is not so straight-forward. At times questions may be disguised as information seeking, but they have little to do with gaining information. This type of question does not seek information. Instead, it attempts to challenge you and your authority. By trying to answer a challenge question, you may end up defending yourself and, as a result, losing credibility.

Another common pitfall in trying to answer challenge questions as if they were information-seeking is that your interaction strays from the original directive. The best response to a challenge question is to refocus the

attention back to the issue at hand. The more focus you can maintain on the specific directive, the better chance you have of gaining compliance.

### Refusal

The refusal stage of the continuum is characterized by outright noncompliance. The individual with whom you are being directive simply refuses to do what you ask her to do.

It is easy to become frustrated at this point. In some cases you may feel that if you cannot convince the person to comply, you have failed in your intervention. The reality is that you cannot make anyone do anything she has made up her mind not to do. Refusal is often the point at which the classic power struggle develops; unfortunately this is a no-win situation.

The appropriate response to the refusal is to set limits with the individual. Setting limits involves clearly pointing out to the person that she has choices to make. Also clearly pointing out that those choices have consequences. You must let the individual know that the choices are hers to make, not yours. The basic key to setting limits are to be sure your limits are clear, simple, reasonable, and enforceable.

### Release

The third stage of the continuum is verbal release and is simply an outpouring of verbal energy. At this point, the individual might be screaming at the top of his lungs. During verbal release you may hear profanity, insults, and verbal irrationality.

During the release stage, keep in mind that if you respond verbally, the individual probably will not hear your words. At best, he will only partially process your verbal intervention. Unfortunately, this can cause a staff member to raise the volume of his voice to match the volume of the defensive person. This accomplishes little other than escalating the situation.

A person who is verbally releasing does not have an infinite amount of energy to expand. Sooner or later he will run out of steam and experience an “energy hole”. If possible, allow the person to expand and vent some energy. Since he will not hear most of what you’re saying during the peak of energy output, you have few alternatives.

As the energy drops in intensity, attempt to restate your directive. Obviously, you cannot allow a person to go on indefinitely screaming at an earsplitting decibel level. You’ll find, however, that most people will not be able to keep up a maximum energy output for very long. Most of individuals will ultimately calm down, giving you an opportunity to interact with them at a more rational level.

### Intimidation

Intimidation is the next stage in the continuum intimidation and is the point at which an individual threatens you in some manner. This could be in the form of a verbal or nonverbal threat to your safety. Although many threats are not acted upon, you should take the threat seriously. Treat the threat as if it could be carried out. Assess the nature of the threat. If it is not a threat to your personal safety, you may choose to continue your intervention and inform the individual of the consequences should she carry out the threat. For example, a person may threaten to tell your supervisor that you are treating her unfairly. This obviously is not a threat to your personal safety and would be treated differently than a threat to your life.

If you are alone and feel the threat is a potential danger to your personal safety, you are wise to consider removing yourself from the situation. And these instances it is best to call in some assistance to handle the situation.

### Tension reduction

Many verbally escalating situations conclude with tension reduction. Tension reduction is the point at which the individual begins to regain rationality. The reduction in tension is both physical and emotional. This level is

often characterized by embarrassment and remorse. Tension reduction provides an excellent opportunity for communication to occur.

Once the individual has regained rationality, it becomes much easier to talk to the person and, hopefully, affect some positive resolution to the incident. Communication with a person in the tension reduction stage is often called therapeutic rapport.

The verbal escalation continuum is a working model of the behaviors you will frequently observe in a defensive person. Although the stages are numbered from one to five, the model does not mean that the person progress and sequence from one to another. Human behavior is not so predictable. A person may begin with questioning, proceed directly to the release stage, go back to refusal, and return again to questioning. The value of the model does not lie in its ability to predict behavior in a sequential pattern. Instead, it provides a framework for you to design specific intervention strategies, depending on where the person is in the verbal escalation process. These responses are designed to maximize the chances of effecting tension reduction at any stage on the continuum.

## **Setting Limits**

Setting limits is the functional cornerstone of maintaining a directive approach. Stated simply, limit setting is the process by which you inform an individual of the choices he has regarding compliance with the directive you have issued. The second step of the process involves informing the individual of the consequences that will occur depending on his choice.

Setting limits is probably one of the single most difficult tasks in a human service professionals daily responsibilities. Whether you are a teacher, a nurse, a childcare worker, a counselor, a supervisor, or a parent, setting limits can be tough. Certain individuals seem to carry an aura of confidence and have very little problem being directive, but many of us struggle.

Not everyone can master the art of setting limits. Most people, however, can improve their limit setting abilities through an on-the-job experience. The individuals who are highly effective in limit setting have unique styles of managing behavior; however, they use certain underlying principles when setting limits.

Set limits that are clear. If you are not specific when you establish a limit, you have less chance of the individual complying. For example, suppose a person is using vulgar language and you need to inform her that that language is inappropriate. You have a much greater chance of beating gaining compliance if you are specific in your direct if. Avoid using general phrases such as your behavior is inappropriate. Which behavior is inappropriate? Don't assume the person knows; be specific. Say: your language is offensive and violates the rules of this facility.

Set limits that are simple. Complex limits do not work very well. Keep in mind that the individual with whom we are working may not be rational. Giving a person for five different choices when he is in a crisis may only confuse and escalate the situation. Generally, the simpler the limit, the more effective.

Set limits that are reasonable. Setting a limit that is unreasonable or unenforceable is a sure way to escalate the situation. Most people in your care know what you can and cannot do. If, for example, you impose stricter limits than your facility or organization allows, the individual may challenge you on the basis of your not been able to enforce the consequences. Reasonable limits go hand in hand with reasonable policies and procedures. Be sure the limit you impose our parallel to your organization's policies.

Set limits you will enforce. Before setting any limit, take a moment to ask yourself: will I be able to enforce the consequences of this limit? Is it human nature to test the limits? You must be prepared to enforce the consequences, or your limit is meaningless. The individuals who are most effective in setting limits are those who follow through with consequences.

## Five step approach to setting limits

Setting limits with a noncompliant individual is anything but a science. There are many variables to take into account, including the type of person who is being noncompliant, the specific behavior for which you are setting limits, your skills and abilities and enforcing consequences, and the context of the situation. Although each situation is different, several steps should be followed in virtually every situation requiring limit setting. The following five steps can be used as a guideline to follow.

**Explain exactly which behavior is inappropriate.** Be specific. Don't assume the individual knows which behavior is inappropriate. If, for example, a person is playing his radio too loudly, try to get avoid generalizing, as in, "it's too noisy and here." Instead, focus on precisely what you want the person to do. In this example, a response such as, "Your radio is too loud. Can you please turn the volume down?" is much more direct. The more specific you can be, the less chance there is of misinterpretation.

**Explain why the behavior is inappropriate.** Do not assume that the individual knows why the behavior you are limiting is inappropriate. In the radio example, this may mean informing the individual that the loud music is disturbing others in the area. Most rules have some rationale behind them. Often those asked to abide by rules are not aware of why a rule is in place.

**Give reasonable choices and consequences.** Let the individual know he has choices. Try to emphasize the positive choice so it does not sound like an ultimatum. Using a radio example, you might want to let the person know that if he turns the radio down he can continued to play it. Try to emphasize the fact that the choice and their consequences are the individual's responsibility. People like to have options. Make sure the individual fully understands that he can determine the outcome of the situation.

**Allow time to choose.** Keep in mind that a verbally escalating person is probably somewhat irrational; the person may need a little time to sort out the choices and make a decision allow a reasonable amount of time for the person to make that decision. By allowing the person a little time, you are reinforcing the fact that it is his choice, not an ultimatum that you are imposing.

**Enforce consequences.** None of your limits will be effective unless you are prepared to them for sure consequences. Often, the individual will be waiting to see if you're going to follow through.

## **Empathic listening**

At least 50% of our task when verbally intervening is listening. Unfortunately, we often pay more attention to what we are going to say than to actively listening to the other person is saying. In many cases our minds drift and lose focus. We've become distracted by external stimuli. In other words, our thought process interferes with our efforts to listen empathically. Often we are simply too preoccupied, preparing our response to what the other person is saying.

To verbally defuse a person's hostility we have to first and foremost listen with empathy. We have to try to understand what the other person is saying and how she is feeling about what she says. Good listeners have a profound calming effect on people. This is true regardless of whether the person is a trained cycle analyst or a bartender.

Empathic listening is an active process requiring intense concentration and effort. Hearing is different from listening. When we hear someone say something, a series of sound wave strikes our eardrums causing nerves to send electrochemical impulses to our brain. When we listen, on the other hand, we involve a multitude of additional steps to process the information we receive. For example, if we listen empathically, we probably are doing as much listening with our eyes as we are with our ears. In order to empathize with what another person is feeling, we must listen to the "holistic expression" of their message, not merely their words. Empathic listening involves listening, as much as possible, for the other person's point of view.

## Five Keys to empathic listening

**Avoid being judgmental.** To listen with empathy, you must listen, not advise. This is not the time to give advice, offer counsel, determine who is right or wrong, or determine how serious the issue is. Empathy and criticism are opposite extremes. Empathy attempts to unconditionally understand another's point of view. Criticism, on the other hand, evaluates the validity of another's point of view. If it is your responsibility to make a judgment, bide your time and withhold judgment and consequences for behavior until a more opportune moment to render a decision presents itself. Remember, you want to defuse a potentially hostile person. Trying to understand how he feels is a wise or prescriptive approach at this time, not passing judgment.

**Give your undivided attention.** Most people, even young children, can tell when we are not paying attention to them. Focusing intently on what is being said not only allows you better opportunity to feel what is being said, but also has a calming effect on the person with whom you are intervening. The quickest method known to enrage another person is to ignore him. Listening empathically takes intense concentration and is ineffective if the person listening is distracted by an internal or external interference.

**Focus on feelings.** When listening empathically, listen for meaning. This requires paying close attention to feelings as well as fact. Try to listen for subtle underlying messages. Often, they are disguised by surface issues. The underlying messages are often conveyed through nonverbal and paraverbal signals. Try to listen to the tone of voice, which is often a much clearer indicator of affect than words are.

**Use silence.** Silence is probably the most viable technique used in empathic listening. Unfortunately, we are socialized to approach conversations as if they were tennis matches. When someone speaks to me, it is expected that I respond immediately after he has spoken. This volleying effect may be suitable for everyday conversations when both people are rational. However, in situations involving a person who is escalating in a crisis, verbally responding to every statement can be a mistake. Silence, on the other hand, can be used to allow the person time to vent emotions, clarify meaning, and regain rationality.

**Use restatement.** Restatement, or reflective questioning, is an extremely valuable way to assist the person and you in understanding the real meaning behind the words he is using. Often, during a crisis, an individual emotes feelings in the form of statements, not even realizing what is being said. Reinstating his phrases can help the individual clarify and organize his thoughts. In addition, restatement assists you in verifying that you have not misunderstood what the individual is really saying.

## **Summary**

The second level of the CPI crisis development behavior level model is the defensive level, characterized by the beginning stages of loss of rationality. Defensive individuals often become belligerent and hostile, and challenge you and your authority. A directive approach is the most effective staff response at this level and involves setting clear, reasonable, and enforceable limits.

One of the most important elements critical to successful verbal intervention is empathic listening. Listening with empathy is an active process and involves avoiding being judgmental, giving undivided attention, focusing on feelings as well as facts, and using silence and restatement.

## **The Acting Out Person: When Hostility Turns to Violence**

Thus far we have examined the crisis development behavior levels through anxiety and defensive levels. And both of these stages, the person escalating still maintains a degree of control over his behavior.

Although an individual at the defensive level may be extremely irrational, he still maintains enough rationality to avoid physically acting out his verbal aggression. In some cases, however, the energy builds and becomes so intense that the person does lose control and becomes physically aggressive. This is the point at which verbal defensiveness explodes into physical hostility, and the individual attempts to physically assault others or

possibly harm himself. Supportive and direct verbal intervention is no longer adequate to calm down the situation, and other measures have to be taken before verbal intervention can resume its effectiveness.

### **Nonviolent physical crisis intervention**

When a person totally loses control and is physically acting out, have we failed in our efforts to diffuse the crisis? Some would say yes, pointing to the fact that therapeutic verbal diffusing efforts have failed. It is said that when a person gets to the point at which he is physically out of control, he should be restrained, medicated, and secluded until he is calmed down. Only then can therapeutic processes be resumed. There are two flaws in this thinking. First, the shame that you have failed if a person escalates to the point of physical aggression is a fallacy. Though most situations can be diffused prior to that point, some individuals will escalate regardless of your intervention strategies. Second, if a person acts out physically, to think that you have failed and that their process excludes physical acting out as part of the crisis process. Flailing, punching, kicking, and choking are the epitomes of a crisis. Why should the therapeutic process be abandoned at the apex of crisis development?

Nonviolent physical crisis intervention is a continuation of the therapeutic process that may have begun as early as the anxiety level. Physically taking control of another person's body and keeping her safe while not hurting her is possibly the most therapeutic act one can imagine.

### **When should nonviolent physical crisis intervention be used?**

Often, staff members who encounter physical acting out behaviors ask the question, "Should one use physical restraint?" "In some cases, the question they really want answered is, "When shouldn't we use physical restraint?" Due to the litigious nature of our society, liability is always a major concern when the issue of physical restraint is addressed.

Asking a question such as "When should we restrain a person?" is like asking, "Should I brake or accelerate when approaching a traffic light when it turns yellow?" Ask ten people and you'll get ten different answers. The question is not a black-and-white issue; it involves many variables, including the training and skill of the individuals involved, the specific situation, and a great deal of professional judgment. As a general policy guideline, the following serves well: Nonviolent physical crisis intervention should be used only as a last resort after all other verbal interventions have been exhausted, and only when the individual presents a danger to himself or others. This definition provides structure and guidelines for staff, as well as sufficient flexibility for professional judgment to be applied to each situation.

### **The dangers of the hands off policy**

Physically restraining a person is dangerous. It can lead to serious injury and, in extreme cases, death. It is no wonder that administrators are hesitant to train staff in how to physically restrain another person.

This fear of injury, death, and subsequent litigation leads many facilities to adopt a "hands off policy". Such a policy usually means that the person should become physically assaultive, the staff are to remove themselves from the immediate situation and call for assistance, such as law enforcement.

This policy sounds reasonable. In many cases removing yourself from the situation is the best alternative for everyone involved. Law enforcement officers have more training to handle violent situations, they usually respond in teams, and they carry weapons, if necessary.

However, there are some dangers inherent in the hands-off policy. To start with, a hands-off policy implies conditional care during a crisis. It says to the staff and potentially acting out persons, we will intervene in your crisis to ensure your care up to a certain point. If you move past that point and your behavior becomes too disorderly, we will no longer provide for your care, welfare, safety and security. Although this may be the best course of action when the person enters the front doors of the school threatening to use a shotgun it is not the most appropriate policy in other situations, such as when two adolescents are fighting. The problem arises

when the policy is absolute. Facilities that adopt an absolute hands-off policy are telling staff it is policy to walk away from many situations. This presents an ethical concern as to where a professional's obligation starts and ends, as well as a legal concern involving potential negligence. The more practical problem with the hands-off policy is that it does not address situations in which an acting-out person assaults a staff member. Hands off policy usually results in staff that are not properly trained in the safe management of assaultive behavior. Without specific training, what should a staff member do if assaulted?

Some facilities are hesitant to put staff through such training because of the concern that physical techniques will be misused. This is dangerous logic.

If people are not trained, they usually have very little confidence. When the staff are fearful of being physically assaulted that can lead to overreaction. Without training, a normal human reaction, if one is assaulted, is to defend oneself. Using self defense equates to doing whatever is necessary to avoid being injured, and this often results in harm to the other party, as well as oneself.

An absolute hands-off policy can lead to injury and litigation. It is analogous to not teaching a person how to use a fire hose lest she flee the building while putting out a fire. On the other hand, a modified hands-off policy, tempered by staff training and good contingency planning can be quite effective.

### **Action to take if your agency has a hand-off policy**

Remove yourself and the other clients from the area, you may do what is reasonably necessary to ensure your safety and the safety of others. Have someone call 911 for police assistance or call 911 yourself. Continue to verbally intervene, if safe, until the police arrive. Make sure your supervisor knows what is occurring or what has occurred and complete

an incident report.

### **What is considered reasonably necessary?**

An investigator reviews a situation in which a client was restrained or secluded, and in the absence of policy allowing restraint, will look at the documented information as to what was occurring, what action the staff took to attempt to defuse the situation and reasons why the staff took the course of action they did. Documentation of every detail is very important in these situations. The basic rule is: Were your actions necessary for your safety or the safety of others?

### **The appropriate use of nonviolent physical intervention**

Physical intervention should be implemented to achieve only one goal: keeping the acting out person and others in the area, including staff, safe. It must be stressed when training staff that physical intervention has a singular purpose, to temporarily take control of another person until she can regain control of her own physically acting-out behavior. This may take five seconds, a minute or ten minutes, depending the individual.

Physical restraint should never be used as a punitive measure. In addition to the legal and ethical problems, punishing a person by restraining her does not curb future acting out behavior.

Take, for example, techniques that are often pain inflicting. There are whole series of techniques borrowed from the martial arts that inflict pain without causing injury. The practical dilemma of using a pain infliction technique is that it actually promotes more acting out behavior in the future.

When a person loses control and physically acts out, he often does not remember what happened during the loss of control. Often he regains his memory in the middle of a restraining procedure. If the person does not remember going out of control, the first sensation he has when he regains control is pain; he will likely feel as if the staff has taken advantage of him. It is important to remember that when a person physically loses control,

he is in a very emotionally vulnerable state. If you take care of his physical well-being during this vulnerable time, you will have a much greater chance of developing rapport once he is calmed down. If pain is inflicted, on the other hand, he will most likely view you as an adversary, at best, and as a target for future aggression in a worst-case scenario.

Physical restraint used as punishment or administered in a painful manner may temporarily put a stop to physical acting out behavior. It will be extremely difficult, however, to establish any post-intervention therapeutic rapport with the individual because the therapeutic process was abandoned in the middle of the crisis at the time the individual was most vulnerable.

### **When should non-violent physical crisis intervention end?**

How long should a person be physically restrained? How do you know when it is safe to stop? Physical restraint should last only as long as the physical acting out behavior itself. There are no guidelines or averages to follow. Most people who physically act out do so for a brief period of time. The more securely they are restrained, the more likely they are calm down quickly. Generally, a personal struggle and rest, struggle and rest, with the intensity of the patient's struggling diminishing as time goes on.

It is important to continue verbal intervention efforts throughout the restraining process. Because staff cannot be sure when the individual regains her rationality, staff should continually attempt to reestablish communication by talking with the person while restraining her. Reassure the individual. Let her know she is all right and that she is not going to be hurt. Keep in mind that the person being restrained may not remember what is happening just prior to being restrained and is probably very frightened.

When the individual's energy level begins to subside, the staff doing the restraining begins to feel an actual reduction of tension in the person's body. The struggling becomes less intense, and the muscles began to relax. Keep talking to the person. As the energy subsides, an emotional tension reduction paralleling the physical tension reduction will be observed. Rage and cursing may transform into statements of remorse accompanied by sobbing.

Have the individual take some deep breaths. This serves two functions. First, breathing facilitates the process of calming down. Also, by directing the individual to take deep breaths, you are testing her rationality. If she complies, she is probably regaining much of a rational thought process. Tell the individual exactly what is going to happen now. Remember that she is frightened. If staff is going to show restraint, and negotiate an agreement, this will be done only if the client remains calm. If staff is going to walk with the client to another area to talk, let the client know where you are going and what you intend to do when you get there.

Be prepared for another physical outburst. Often when a restraint technique is released, the individual begins to physically act out again. If this happens, resume the restraint and repeat the negotiating process once the individual appears calm.

### **Summary**

Nonviolent physical crisis intervention involves safe restraint and is the appropriate response to an event in which an individual is physically acting out. It is part of the therapeutic process and is used only as a last resort when the physically acting out individual presents a danger to himself or others. Physical intervention is used only long enough for the individual to regain control of his behavior, never as a punitive measure. As control is regained, the individual moves to the final crisis development behavioral level: tension reduction.





# **CERTIFICATE OF COMPLETION**

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*Medication Self Administration*

**THESE TRAINING REQUIREMENTS WERE  
FULFILLED ON**

**To the best of my knowledge, I certify that this employee has met the requirements of Medication Self Administration as stated in TAC §448.603 (D)(7).**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

This training was conducted live and in-person by a licensed health professional



# CERTIFICATE OF COMPLETION

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*Intake, Screening and Admission Authorization*

**THESE TRAINING REQUIREMENTS WERE  
FULFILLED ON**

**To the best of my knowledge, I certify that this employee has been trained in the Intake, Screening and Admission Authorization process as stated in TAC §448.603 (D)(6).**

---

**Name**

---

**Signature**

---

**Title**

---

**Date**

**THIS INCLUDES THE COMPLETION OF ALL ONLINE TRAINING MODULES, ALL IN-SERVICES, AND COMPLETION OF ALL READING ASSIGNMENTS.**

**Clinical Process and Documentation In-Service**

Date: \_\_\_\_\_



# **CERTIFICATE OF COMPLETION**

**THIS ORGANIZATION CERTIFIES THAT**

**HAS COMPLETED**

*Clinical Processes, Documentation and Health/Medical Records*

**THIS TRAINING WAS COMPLETED ON**

---

**Name**

---

**Signature**

---

**Title**

---

**Date**

## Clinical Processes

Modify your clinical process to expand on these, this is the minimum process per the HHSC facility licensure rules. Incorporate the documentation process and requirements including the electronic record that the facility uses.

- Create Electronic Record
  - Profile
  - SUD Screening
  - Financial/Insurance Information
  - Admission Consents and Permissions
  - Billing and Privacy Notices
  - SUD Assessment
  - Admission Authorization
  - Treatment Plan
  - Discharge Plan
  - Treatment Plan Review
  - Referrals
  - Consent to Release Information
  - Individual and Group Therapy Progress Notes
  - Psychoeducational Group Notes
  - Administrative/Utilization Management Notes
  - Discharge Summary
  - Discharge Follow-Up
  - Collateral Information for Other Sources
  
- Admission/Intake Day
  - While waiting to see admission staff
    - ✓ Give client intake information sheet/questionnaire to complete.
    - ✓ Give a client handbook to review
  - Meet with admissions staff
    - ✓ Complete profile, screening, gather insurance and resource information, verify benefits, complete general admissions assessment.
    - ✓ Complete facility intake packet- consents, notices, information
    - ✓ QCC authorize admission and add admit note
    - ✓ Assigned primary counselor and inform client of name and credentials.
    - ✓ Get Consent Forms signed to talk to other agencies if needed (ongoing)
    - ✓ Introduce to primary counselor
  
- Service Day 1
  - Complete orientation to the program
  - Client to sign orientation document
  - Make any referrals for MAT as appropriate
  - Schedule or begin process of setting up mental health assessment
  - Referral for HIV, TB, HEP and STI testing and counseling.
  - Overdose prevention education

- Service Day 3 (72hrs)
  - Counselor meets with client for individual session to complete assessment and start the treatment plan.
  - Follow up on any referral made to date
- Service Day 5
  - Meet with client to finalize the treatment plan and initial discharge plan and have them sign. Treatment plan should include estimated length of stay.
  - Review and discuss any referrals or linkages that have been started and where in the process.
  - Set up a schedule for individual sessions on a weekly basis and discuss with them the expectation of attending all services.
  - Discuss any initial behavioral issues that may be problematic and ensure that they understand you schedule and process for dealing with needs outside of sessions and groups.
- Subsequent Service Days
  - Provide services as outlined in Treatment Plan- review service plan at least every 14 days for updates and revisions.
  - Provide ongoing assessment of client needs and link with support services.
  - Conduct psychoeducation curriculum groups and activities as scheduled
  - Conduct individual counseling session no later than every 7 days from admission
  - Provide service coordination activities to address discharge planning and ongoing psychosocial needs.
  - Address Barriers to independence
  - Develop and monitor safety plans
  - Assist with obtaining basic needs
  - Document all activities and services
- Termination Process
  - Within a week before scheduled discharge meet with client and finalize discharge plan. Make sure client has a written relapse prevention plan that goes with them at discharge. Provide any overdose prevention education.
  - Make all necessary referrals for supportive services.
  - Refer and link with recovery support services or other recovery programs.
  - Complete discharge process
  - Complete a discharge Progress Note
  - Complete the discharge summary
- Follow Up Process
  - 60 days after discharge contact client for follow up



## **Sample Month Inservice Agenda (For Meeting HHSC Training Mandates)**

1. Introductions (5 minutes)
  - a. New Staff Introduction
2. Facility Issues (10 minutes)
  - a. Client Issues
  - b. Physical Plant Issues
  - c. Schedule and Other Milieu Issues
3. Preventing Abuse Neglect & Exploitation (45 minutes) (8/2 months a year)
  - a. Specific instances this month
4. Non-Violent Crisis Intervention Techniques (45 minutes) (2 months a year)
  - a. Specific Client Examples this month
5. Intake, Screening and Admission Procedures (45 minutes) (1 month a year)
  - a. Review of Forms
6. Medication Self Administration Process (45 minutes) (1 month a year)
  - a. Review of Process and Documentation

\*Keep minutes/notes about the training and what was talked about. You can write directly on the agenda or have someone keep formal minutes. If you are accredited by Joint Commission or CARF you should keep formal minutes and attach them to this agenda.

\*Pick one topic of items 3-6). If you are a residential treatment provider, you need to have 8 hours total of the abuse and neglect at the end of the year, which is 8 sessions. You need 2 hours total of NVCI which is 2 sessions. You have to cover the facility internal processes for intake, screening and admission and medication self-administration. Make sure to complete the online courses.

### **Example of In-service Topic Schedule:**

January- Preventing Abuse Neglect & Exploitation: Texas Administrative Code

February- Non-Violent Crisis Intervention Techniques: Managing Daily Change Crisis using basic crisis intervention

March- Preventing Abuse Neglect & Exploitation: Texas Family Code: Abuse and Neglect

April- Preventing Abuse Neglect & Exploitation: Signs of Abuse/Neglect

May- Preventing Abuse Neglect & Exploitation: What is consider exploitation

June- Non-Violent Crisis Intervention Techniques: Managing Daily Change Crisis using basic crisis intervention

July- Preventing Abuse Neglect & Exploitation: Reporting abuse, neglect and exploitation

August- Preventing Abuse Neglect & Exploitation: What happens when there is a compliant

September- Preventing Abuse Neglect & Exploitation: Client rights/Grievance

October- Medication Self Administration

November- Preventing Abuse Neglect & Exploitation: Professional Boundaries/What about sexual exploitation and staff/client relationships

December- Intake, Screening, Admission procedures

**HHSC FACILITY LICENSURE TRAINING**

TAC 448 requires employees to have the following training **PRIOR** to starting in their position. This can be done in a combination for online training module and/or face to face in-service. It must be documented in their personnel file.

TRAINING	COMPLETION DATE
HHSC TAC 448 Standards of Care	
Agency policies and procedures (provide employee with copy)	
Client rights	
Client grievance procedures	
Program rules and client expectations (provide employee with copy of client handbook)	
Confidentiality of client-identifying information 42 CFR and HIPAA	
Client abuse, neglect, and exploitation	
Requirements for reporting abuse, neglect, and other serious incidents	
Employee standards of conduct	
Emergency and evacuation procedures	

TAC 448 requires employees to have the following training within 90 days of the hire date. This can be done in a combination for online training module and/or face to face in-service. Please review the attached training mandates for explanation of what must be completed with live, instructor-led training. It must be documented in their personnel file.

TRAINING	COMPLETION DATE
Abuse, Neglect and Exploitation (2hrs Outpatient, 8hrs Residential)	
HIV, STD, TB, and Hepatitis C (3hrs)	
Non-Violent Crisis Intervention (4hrs)	
Screening and Assessment- including DSM-V (8hrs)	
Medication Self Administration (2hrs- direct care staff who supervise medication self-administration in residential programs)	
Detoxification Practices (Detox only)	
CPR and First Aid (Residential Only)	

TAC 448 requires employees to have the following training annually. This can be done in a combination for online training module and/or face to face in-service. Please review the attached training mandates for explanation of what must be completed with live, instructor-led training. It must be documented in their personnel file.

TRAINING	COMPLETION DATE
Abuse, Neglect and Exploitation (2hrs Outpatient, 8hrs Residential)	
HIV, STD, TB, and Hepatitis C (3hrs)	
Non-Violent Crisis Intervention (2hrs)	
Screening and Assessment- including DSM-V (8hrs)	

**GENERAL ACCREDITATION-JOINT COMMISSION/CARF**

CARF and Joint Commission requires employees to have training that is relevant and specific to their job description and service delivery.

RECOMMENDED TRAINING	COMPLETION
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	DATE
Health and Safety Practices-Emergency Procedures (At Hire and Annually)	
Critical Incident Reporting (At Hire and Annually)	
Infection Control Procedures-Including COVID (At Hire and Annually)	
Customer Service Training-Including confidentiality and privacy (At Hire and Annually)	
Person Centered Practice-Including CLASS (At Hire and Annually)	
Cultural Competency and Diversity (At Hire and Annually)	
Clinical Service Delivery and Documentation (At Hire and Annually)	

## HHSC GRANT

HHSC grant statement of work requires employees to have the following training within 90 days of hire. Some are required only one time, and some are required annually. Review your Statement of Works for any training specific to your grant type. The frequency will be noted next to the training topic.

TRAINING	COMPLETION DATE
Overdose Prevention Training (One Time)	
Child Welfare Training (One Time)	
Abuse, Neglect and Exploitation (One Time)	
Reproductive Health Education (One Time)	
Motivational Interviewing Techniques (At Hire and Annually)	
Cultural Sensitivity and Competency (At Hire and Annually)	
Risk and Harm Reduction Strategies (At Hire and Annually)	
Alcohol, Tobacco, and Other Drugs and effects on the Fetus (At Hire and Annually)	
Trauma Informed Care (At Hire and Annually)	
Suicide Prevention and Intervention (At Hire and Annually)	
Health Insurance Portability and Accountability Act (HIPAA) (At Hire and Annually)	
42 CFR Part 2 (At Hire and Annually)	

## MEDICATION SELF ADMINISTRATION COMPETENCY EVALUATION

Competency Area	
Employee understands the law and agency policy related to medication self-administration	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the location of emergency contact numbers	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee knows when to call poison control	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee knows when to call 911 for medication related issues	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can demonstrate medication self-administration agency procedure	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can document agency medication self-administration	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee demonstrates ability to read, understand and follow directions on medication labels	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understand medical abbreviation related to medication	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understands routes of administration	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee knows location of and how to use medication reference manual	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize and demonstrate the storage, maintenance, handling, and destruction of medication	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the procedures for medication errors, adverse reactions, and side effects.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING

Employee was observed supervising and documenting medication self-administration and was competent in all areas required by TAC 448.603(d)(7). This employee is APPROVED NOT APPROVED by the supervising nurse to supervise patient/client medication self-administration.

\_\_\_\_\_  
Supervising Nurse

\_\_\_\_\_  
Date

## INTAKE, SCREENING & ADMISSION COMPETENCY EVALUATION

Competency Area	
Employee understands the law and agency policy related to screening, intake and admission of patients/clients to the program.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the HHSC priority populations.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the Texas Department of Insurance (TDI) and American Society of Addiction Medicine (ASAM) patient placement/admission criteria.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the Diagnostic and Statistical Manual V (DSM-V) criteria for substance use disorder.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the agency admission criteria.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the process for documenting and verifying financial resources to pay for treatment.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understands that a qualified credentialed counselor must review the screening and intake information and authorize the admission.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understands that to admit a person to a DETOX level of care, a physician or a health provider under the supervision of the physician (Physician Assistant/Nurse Practitioner) must review the screening and intake information and authorize the admission.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the difference between acute and sub-acute withdrawal symptoms and understand what symptoms may make a person's ineligible for admission.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can demonstrate screening, intake and admission agency procedures.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can document agency screening, intake and admission process.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understands and knows how to access information to make referrals for infectious disease testing and medication for opioid use disorder.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee understands agency procedure related to admitting pregnant women.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize how to utilize and monitor the agency waitlist. Including notification to the OSAR is required.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize how to document the circumstance by which a person is determined to be ineligible for treatment.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING

Employee was observed conducting and documenting screening, intake and admission and was competent in all areas required by TAC 448.603(d)(6). This employee is APPROVED NOT APPROVED by the program director to conduct patient/client screening, intake and admission.

\_\_\_\_\_  
Program Director

\_\_\_\_\_  
Date

# DETOXIFICATION PATIENT SUPERVISION COMPETENCY EVALUATION

Competency Area	
Employee has reviewed and understands the agency approved detoxification process and standards.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
If the employee is responsible for medical monitoring of the patient, the employee can verbalize the acute withdrawal symptom for each major classification of substance.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Monitoring employees can verbalize the difference between acute and subacute withdrawal symptoms.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize the location of emergency contact numbers for nursing and physician.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee knows when to call 911 for medical complication related to related to the detoxification process.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
If admit pregnant women, employee can verbalize potential pregnancy related complication during the detoxification process and necessary course of action for each potential complication.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can demonstrate patient observation and monitoring procedures.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize and demonstrate appropriate clinical intervention for patients in detoxification level of care.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can document observation and monitoring data that supports admission, continuing stay, and discharge/transfer to/from detoxification level of care.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING
Employee can verbalize medications used for detoxification, expected outcomes, and potential side effects.	<input type="checkbox"/> FULL COMPETENCY <input type="checkbox"/> NEED FURTHER TRAINING

Employee was observed supervising and documenting persons in detoxification level of care and was competent in all areas required by TAC 448.902(f). This employee is APPROVED NOT APPROVED by the supervising detoxification nurse to observe and monitor persons admitted to detoxification level of care.

\_\_\_\_\_  
Supervising Nurse

\_\_\_\_\_  
Date