



ADMINISTRATIVE POLICIES  
AND PROCEDURES  
State of Tennessee  
Department of Correction


Index #: 513.07 .1

Page 1 of 13

Effective Date: April 15, 2023

Distribution: B

Supersedes: 513.07 (4/1/19)  
PCN 20-18 (6/15/20)

Approved by: 

Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES

- I. AUTHORITY: TCA 4-6-102, TCA 4-3-606, TCA 33-10-407, and TCA 68-24-601, and Title 42, CRF Chapter 2, *Diagnostic and Statistical Manual of Mental Health Disorders-5 (DSM-5)*.
- II. PURPOSE: To identify and provide a continuum of cost-effective intensive residential substance use treatment programs for convicted felons who have or previously have had a history of a substance use disorder.
- III. APPLICATION: All Tennessee Department of Correction (TDOC) inmates, institutional staff, and privately managed facilities.
- IV. DEFINITIONS:
  - A. Addiction Treatment Program Director: A qualified licensed substance use staff member who has direct clinical oversight and administration of addiction treatment programs and recovery services.
  - B. Aftercare: The phase of treatment that begins when a participant has achieved substance use treatment goals and has successfully completed a substance use treatment program.
  - C. Cardinal Rules: Critical rules that govern all substance use treatment programs, and if violated, result in program termination.
  - D. Clinical File: A file that is specifically for substance use treatment programming, with the documentation being maintained by treatment counselors for each participant on their caseload.
  - E. Clinical Need: A medical or behavioral health episode that requires intervention from a medical, behavioral health, or substance use professional.
  - F. Criminogenic Needs: Internal and external attributes of offenders that are directly linked to criminal behavior and subsequent recidivism.
  - G. Facility Treatment Team: A group of institutional personnel that should include but is not limited to the behavioral health administrator, health administrator, addiction treatment program director, unit manager, treatment counselors, drug testing coordinator, inmate jobs coordinator, licensed alcohol, and drug addiction counselor (LADAC), Associate Warden of Treatment (AWT) or Assistant Warden for privately managed facilities, building security supervisor, and chief counselor. This team is responsible for the oversight of the substance use treatment programs at each institution and meet bi-weekly to discuss participant issues and progress.

Effective Date: April 15, 2023	Index # 513.07 .1	Page 2 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- H. Learning Experiences: Actions employed to address less serious negative behaviors that usually include persistent non-compliance with community expectations (Substance Use Treatment Alternative Disciplinary CR-3754).
- I. Phases/Phase Progression: The process by which a participant progresses in a Therapeutic Community treatment program.
- J. Program Rules: All rules, program or facility-based, not considered a cardinal rule violation.
- K. Participant: For the purposes of this policy, any inmate who is actively enrolled in a substance use treatment program.
- L. Qualified Licensed Substance Use Personnel: Correctional staff licensed or certified as alcohol and drug counselors (LADAC I, II, ICRC, NAADAC I, II, or Master level NAADAC certification) or those seeking licensure by reciprocity as a LADAC I or II who meet the qualifications by holding a current license from another state in which the other state's standards for licensure must be comparable to or exceed the requirements for the level of licensure sought in Tennessee (licensed clinical social workers (LCSW), licensed professional counselors (LPC), licensed psychological examiners (LPE), or licensed marriage and family therapists (LMFT) with a minimum of one year documented experience working with substance use disorder treatment programs).
- M. Residential Treatment: A nine-to-twelve-month substance use treatment program held in a Therapeutic Community environment focusing on underlying alcohol and drug use and criminogenic thinking patterns.
- N. Substance Use Behavioral Program Intake and Interpretive Summary (CR-3720): A comprehensive compilation of essential historical and criminogenic needs information designed to determine the extent of behavioral health needs and/or substance use problems and match the inmate with the appropriate treatment service.
- O. Substance Use Initial Treatment Plan [(CR-3752) and Substance Use Disorder Individual Treatment Plan (CR-3753)]: A clinical plan of care that specifies the goals and objectives of substance use treatment, the methods to be used in the treatment process, and a schedule for assessing and updating progress.
- P. Substance Use Treatment Program Alternative Disciplinary (CR-3754): Additional sanctions given to participants for negative behaviors which are punitive in nature and are accompanied by a learning experience. These sanctions are used as a progressive disciplinary sanction at the addiction treatment program director's discretion.
- Q. Substance Use Treatment Transition Accountability Plan, (CR-4153): A strategic plan developed by the participant, with input from the treatment counselors, to identify the offender's needs.
- R. Substance Use Treatment Program: Formal organized behavioral therapies such as individual or group counseling, cognitive skills therapy, or psychotherapy for inmates who have used alcohol and other drugs. These services are designed to address specific physical, mental, or social issues related to the use of mood-altering substances.

Effective Date: April 15, 2023	Index # 513.07 .1	Page 3 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- S. Texas Christian University Drug Screen (TCUDS): A screening assessment based on the most recent *Diagnostic and Statistical Manual of Mental Disorders (DSM)* screening for mild to severe substance use disorders and is particularly useful when determining level of intensity for substance use treatment.
  - T. Therapeutic Community (TC): Treatment method used to serve offenders in in-custody residential treatment programs. The TDOC uses a modified Therapeutic Community model, meaning no shame-based activities, to provide a peer-based support systems for program participants.
  - U. Treatment Counselors: All non-licensed alcohol and drug counselors who are actively pursuing licensure while working in a substance use treatment and recovery services program and who are being clinically supervised by qualified licensed substance use personnel.
- V. POLICY: The TDOC shall provide the opportunity for inmates to receive intensive and individual-based addiction treatment and recovery services programs that impact their entire life structure (values, habits, relationships, cognition, behavior, and attitudes) within the limitations imposed by available resources.
- VI. PROCEDURES:
- A. Mission Statement/Treatment Philosophy: The mission of the TDOC's intensive residential substance use treatment programs is to break the cycle of substance use, criminal behavior, and incarceration, in order to provide a safe and substance-free living and working environment both within state correctional facilities as well as in the local communities to which offenders return. The TDOC intensive residential substance use treatment programs are based on the idea that the participant is ultimately responsible for his/her recovery. Participants work closely with treatment staff to develop individual treatment goals and strategies. The TDOC's intensive residential substance use treatment programs shall blend evidence-based treatment interventions that will focus on the inmate's criminogenic needs. Each program shall develop and maintain a philosophy of treatment and therapeutic goals for their respective programs that is approved by the Director of Addiction Treatment and Recovery Services or designee.
  - B. Intensive Residential Substance Use Treatment Program Services: Shall be offered to inmates (where resources permit) who are parole mandated or have a documented need-based TCU Drug Screen V. Depending on the length of sentence and program availability, inmates shall be provided with the opportunity to participate in addiction treatment and recovery services prior to release from the institution.
  - C. High Intensity Residential Services
    - 1. Therapeutic Communities (TC) - Nine-to-twelve-month residential programs in which participants progress through multiple treatment phases. TC Participants are to be housed separately from general population. Community responsibilities are to be distributed through a structure board and participants are to have responsibility within the community without authority over other inmate participants. Program services will be culturally sensitive and gender specific.
    - 2. Shame based exercise or procedures are strictly prohibited. Ideal score of three or higher on TCU Drug Screen V. All TC programs will be open ended. The TC program will

Effective Date: April 15, 2023	Index # 513.07 .1	Page 4 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

fulfill Board of Parole requirements for Substance Use (TC), Group Therapy (GRTH), Cognitive Behavioral Therapy, Anger Management, and Cognitive Behavior Intervention Programming (CBIP). In addition to substance use treatment, participants shall receive the following:

- a. Motivation Enhancement Therapy
- b. Cognitive Behavioral Therapy
- c. Anger Management
- d. Victim Impact
- e. High School Equivalency (HSE) Education (where resources permit)
- f. Job Readiness/Career Technical Education (where resources permit)
- g. Facility-Based Community Service Work (where resources permit)
- h. Relapse Prevention
- i. Aftercare Planning

D. Admission/Exclusion Criteria

1. Admission Criteria: In order to manage the number of inmates requiring substance use services, consideration shall be given based on clinical need. (See Policy #505.07) Additional admission criteria are as follows:
  - a. Inmates must meet classification level for the program in which they are attempting to enroll.
  - b. The inmate shall receive written notification of the pending placement decision and be afforded an opportunity to accept or deny the placement decision. Inmates who accept placement into a treatment program must sign Substance Use Treatment Program Participant Agreement, CR-3586. All participants have the right to turn down programming before signing CR-3586. Once the CR-3586 is signed, dismissal from the program for any reason other than a non-disciplinary dismissal will be accompanied by a Class A disciplinary as defined by Policies #502.01 and #502.02.
2. Exclusion Criteria:
  - a. Inmates who have received any Class A disciplinary convictions within six months of program start date. An exception can be made if the inmate successfully completes the Intervention Substance Use Recovery Education program in accordance with Policy #513.07.3.
  - b. Inmates who have received a Class B or three Class C disciplinary convictions within three to six months of program start date will be reviewed and admitted as

Effective Date: April 15, 2023	Index # 513.07 .1	Page 5 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

determined by the addiction treatment program director's clinical judgment. An exception can be made based on clinical judgement for general population inmates that have received a disciplinary for a facility drug screen and have not received any prior substance use treatment.

- c. Inmates who decline to sign the Substance Use Treatment Program Participant Agreement, CR-3586. Declining programming shall be documented in the offender management system (OMS). Once participants decline, they will be removed from the Prioritized Register.
- d. Inmates who refuse the initial substance use treatment program drug screen.
- e. Inmates who are assessed as having severe mental or physical disabilities that would prevent the inmate from fully participating in all treatment activities.
- f. Inmates with severe cognitive problems that would prevent full participation in all program curriculum and activities.

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

- 1. Successful Completion Criteria: A participant shall receive credit for successful program completion only after the achievement of the following minimum requirements.
  - a. Completion of program requirements, individual treatment goals and performance objectives as defined by the participant's individual treatment plan.
  - b. Completion of the written Substance Use Treatment Transition Accountability Plan, CR-4153.
  - c. Following initial program placement drug screen, all program random and program discharge drug screens for the participant have been negative for drugs and alcohol and documented on the Drug Screen Consent/Refusal Substance Use Treatment, CR -3992
- 2. Non-Disciplinary Dismissal Criteria: A participant shall receive a non-disciplinary discharge only after the following:
  - a. Treatment team recommends that a participant should be non-disciplinarily discharged due to an inability to complete treatment program through no fault of his/her own.
  - b. If decision is based on medical issue, a recommendation is issued by facility MD.
  - c. A non-disciplinary dismissal should be performed when all other available treatment program options have been exhausted. Once pertinent information has been reviewed and approved by the addiction treatment program director or designee, the non-disciplinary dismissal request shall be forwarded to the Inmate

Effective Date: April 15, 2023	Index # 513.07 .1	Page 6 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

Jobs Coordinator using Request for Program Dismissal, CR-3054, and Notice of Denial of Program Credits, CR-3224, for disposition per Policy #505.07.

3. Disciplinary Dismissal Criteria: The addiction treatment program director and facility treatment team can request that a participant be removed from a treatment program. All disciplinary dismissals are to follow procedures found in Policies #505.07 and #502.01 and will require the issuance of a Class A disciplinary infraction report. The disciplinary infraction report must be reviewed by the addiction treatment program director or their designee before submitting to the on-duty shift commander for approval.
  - a. If the action itself warrants a Class A, the facility treatment team member shall issue a disciplinary infraction report for that particular action. If a participant is dismissed for an accumulation of minor infractions that in themselves do not warrant a specific Class A, the team shall issue a Class A for Refusal to participate based on the participant's signing of Substance Use Disorder Treatment Program Participant Agreement, CR-3586.
  - b. Programs are in no way required to readmit a dismissed participant based on Disciplinary Board outcomes. Even if the facility disciplinary is overturned, dismissed inmates must follow the procedures outlined in Section VI.(D)(1-2) A non-disciplinary dismissal will have to be requested if the disciplinary job drop is not approved; otherwise, the inmate jobs coordinator will keep the inmate assigned.
  - c. The following is a listing of Cardinal Rules that, if violated, result in immediate disciplinary dismissal:
    - (1) Violation of institutional rules considered a Class A offense as outlined in Policy #502.04.
    - (2) Threats or acts of violence.
    - (3) Possession of any type of weapon.
    - (4) Violation of confidentiality laws.
    - (5) Sexual misconduct or solicitation that is assaultive in nature, as defined by Policy #502.05.
    - (6) Failure or refusal to actively participate in program activities (See Policy #505.07).
    - (7) Disrespect to any staff or other program participants in the form of repeated threatening or inciting disturbances that are disruptive to program or institutional operations as determined by the addiction treatment program director and facility treatment team.
    - (8) Possession of drugs or alcohol.
    - (9) Violations against state or federal laws.

Effective Date: April 15, 2023	Index # 513.07 .1	Page 7 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- d. Particularly grievous or repeated program rule violations can also result in disciplinary dismissal.
  - e. All disciplinary dismissals for program rule violations must have proper documentation of the actions that led to the participant's dismissal and will be made available to appropriate TDOC staff should the dismissal be grieved.
4. Program Re-admission: Inmates who are dismissed from the program do not automatically receive eligibility to be re-enrolled for a second time. Inmates must meet all requirements regarding Admission and Exclusion Criteria (See Section VI.(D)(1-2) and be evaluated by the facility treatment team for treatment readiness and appropriateness. Only after meeting all Admission and Exclusion Criteria and receiving approval from the facility Behavioral Health Administrator, will an inmate be eligible for re-enrollment.
- F. Participant Substance Use Treatment Program Intake Procedures, Participation, Progression, and Staff Responsibilities
- 1. Inmates who are selected for participation in a substance use treatment program must complete the admission process outlined in Section VI.(D)(1-2) prior to beginning treatment or the intake assessment process.
    - a. All attached consent forms must be completed before any form of treatment begins.
    - b. At the completion of the interview and assessment process, if the addiction treatment program director determines that program placement is not appropriate based on the inmate's level of substance use treatment need, the addiction treatment program director will contact the following:
      - (1) Chief Correctional Counselor for the purpose of treatment pathway override utilizing the Request for Treatment Override, CR-4157. See Policy #513.09 for form sample
      - (2) Inmate Jobs Coordinator for the purpose of job drop from therapeutic community (TCOM) job position, administratively (non-disciplinary) with closure of the risk needs assessment.
      - (3) Institutional probation/parole specialist (IPPS) for the purposes of parole recommendations/mandates. This communication will also include any other appropriate programming recommendations by the addiction treatment program director, if applicable.
  - 2. Substance use treatment program staff shall complete the Substance Use Behavioral Program Intake and Interpretive Summary, CR-3720, and TCUD within 30 days of admission, which will document the following:
    - a. Addiction Severity as determined by TCUDS V
    - b. Social/Family History

Effective Date: April 15, 2023	Index # 513.07 .1	Page 8 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- c. Medical/Mental Health Severity
  - d. Education Level
  - e. Employment History
  - f. Criminal History
  - g. Inmate's Motivation for Treatment
3. If following the initial program intake assessment, the facility treatment team feels that the potential participant needs a mental health screening, the following procedure will take place:
- a. The addiction treatment program director shall refer inmates who need evaluation of issues that may prevent them from participating in the program to mental health for review. This will be accomplished using the Institutional Health Services Referral, CR-3431.
  - b. The Behavioral Health division's assessment shall include evaluation of any serious mental health issue that will prevent the inmate from fully participating in the program and include any recommendations. A hard copy of these assessments will be provided to the addiction treatment program director to be placed in the participant's clinical file.
  - c. For programs that have work release or community service components, potential participants shall be screened by the Inmate Jobs Coordinator for any impairment that may interfere with the completion of the program activities.
4. All substance use treatment programs shall:
- a. Ensure orientation to any therapeutic community unit occurs within seven days. Each participant shall also sign the Substance Use Treatment Confidentiality Notice and Waiver, CR-3751; Substance Use Treatment Program Participant Rights and Limits of Confidentiality Acknowledgement, CR-3755; and Substance Use Treatment Informed Consent for Treatment Services, CR-3750, at this time.
  - b. Ensure that an Authorization for Release of Substance Use Treatment Information, CR-1974, is completed before any information is shared with an outside source. (See Policy #511.04)
  - c. Provide the Texas Christian University (TCU) pretest within 30 days of admission and posttest within 30 days of successful discharge that will measure inmates in four critical life areas:
    - (1) Criminal Thinking (CTS)
    - (2) Social Desirability (SOC)
    - (3) Psychological Function (PSY)



Effective Date: April 15, 2023	Index # 513.07 .1	Page 9 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

(4) Motivation (MOT), pre-test only

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

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

(1) Participant's name

(2) TDOC ID

(3) Presenting problem/diagnosis

(4) Strengths

(5) Challenges/Obstacles

(6) Severity of disorder

(7) Master Problem List based on criminogenic factors (i.e., Risk Needs Assessment, TCU Scales, and any additional biopsychosocial problems assessed)

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

(9) Staff responsible for providing service

(10) Target dates for completion

(11) Participant's signature

(12) Staff signature(s)

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

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

G. Substance Use Treatment Program Interventions

Effective Date: April 15, 2023	Index # 513.07 .1	Page 10 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

1. Program interventions are to be given at a graduated level and shame-based sanctions are prohibited. Program sanctions should be commensurate with the participant's criminogenic behavior in an effort to move them toward treatment goals. Interventions should always be given in the form of Learning Experiences, while particularly grievous or repeated behaviors may also have punitive sanctions at the addiction treatment program director's discretion.
  2. Program sanctions should be firm, fair, and consistent for all participants. Any actions that do not result in program dismissal but receive Learning Experiences or punitive sanctions should be documented using the Substance Use Treatment Program Alternative Disciplinary, CR-3754.
  3. All learning experiences and program sanctions should also be documented in monthly progress notes using the Substance Use Treatment Program Individual Contact Note, CR-3761.
  4. Particular actions, which affect institutional security but would normally fall under programming confidentiality, will be entered in the OMS/LHSM by the addiction treatment program director so that the information can be accessed on a need-to-know basis by other facilities.
- H. Urinalysis and Alcohol Testing: Drug and alcohol screens will be used primarily for identification of problems and to establish program credibility. Each program participant will be screened initially and on a random basis consistent with Policy #506.21, as well as when reasonable suspicion testing is warranted. All drug and alcohol screens shall be conducted in accordance with Policy #506.21.
1. Each program participant shall be tested within 30 days of admission to the program. Failure of this initial screen will not result in dismissal or any form of disciplinary action.
  2. Any program participant that fails a screen beyond the first 30 days in the program will be subject to serious sanctions, which could result in immediate dismissal and a Class A disciplinary for refusal to participate.
  3. The addiction treatment program director, in collaboration with the facility treatment team, shall evaluate such a failed screen choosing specifically one of the following options:
    - a. The program participant will receive a Class A disciplinary for refusal to participate and be immediately dismissed from the program based on participant's repeated failed drug screens.
    - b. If the participant is in phase 1 of their program, the participant may not receive a disciplinary, and may not be dismissed from the program, but will receive alternative clinically based sanctions as a "Learning Experience", including at least: an extension of program duration of not less than 14 days and not more than 30 days, as well as follow-up with more frequent randomized testing throughout the course of their program.

Effective Date: April 15, 2023	Index # 513.07 .1	Page 11 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- c. If the participant is in phase 2 of their program, the participant may not receive a disciplinary, and may not be dismissed from the program, but will receive alternative clinically based sanctions as a “Learning Experience”, including: a setback to a lower phase of programming immediately preceding the phase he/she occupied upon failing the screen, as well as follow-up with more frequent bi-weekly randomized testing throughout the course of their program.
  - d. If the participant is in phase 3 of their program the participant will receive a setback to a lower phase that is appropriate at minimal three months and the treatment plan will address lapse and relapse triggers. The participant will submit at minimum, a bi-weekly drug screen for duration of the program.
  - e. The addiction treatment program director will document and submit the above clinical recommendation of the facility treatment team to the TDOC Director of Addiction Treatment and Recovery Services or designee requesting review and approval. Once authorized, sanctions and updated individualized treatment plans will be appropriately and adequately documented to the clinical file.
- I. Substance Use Treatment Transition Accountability Plan (CR-4153)/Substance Use Treatment Clinical Discharge Summary (CR-3713): Each program participant shall be responsible for completing a transition accountability plan that will be approved by his/her treatment counselor. The transition accountability plan shall address all ancillary service needs for the participant’s successful re-entry to the community within 30 days of successful discharge. The Substance Use Treatment Clinical Discharge Summary, CR-3713, shall be completed on all participants in substance use treatment programs. The CR-3713 shall document successful program completion, non-disciplinary discharge, disciplinary dismissal, or any other reason within ten days of the participant’s discharge. The substance use treatment program clinical discharge summary shall be completed by the participant’s primary counselor and should be specific to the participant’s release type (i.e., general population, expiration, or parole).
- J. Participant Substance Use Treatment Program Clinical Files
- 1. An individual substance use treatment program clinical file shall be maintained on all participants in a substance use treatment program. The clinical file shall contain a chronological history of the participant’s clinical forms, all substance use related assessments, progress notes, pre and post testing, transition accountability plan, release of information forms, drug screens, treatment interventions, discharge summary, events, and activities.
  - 2. All state-run programs must use forms listed in this policy. Contractor programs may use equivalent forms, as approved by the Director of Addiction Treatment and Recovery Services or designee. All Contractor programs must complete Substance Use Treatment Program Participant Agreement, CR-3586; Authorization for Release of Substance Use Treatment Information, CR-1974; Substance Use Treatment Confidentiality Notice and Waiver, CR-3751, Substance Use Treatment Program Participant Rights and Limits of Confidentiality Acknowledgement, CR-3755; and Substance Use Treatment Informed Consent for Treatment Services, CR-3750.
  - 3. Records of the identity, diagnosis, prognosis, or treatment of any inmate that are maintained in connection with the performance of any program or activity relating to

Effective Date: April 15, 2023	Index # 513.07 .1	Page 12 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

substance use treatment are under the protection of federal law, Title 42, CFR Chapter 2, and shall be considered confidential. Substance use treatment program clinical files shall be stored in a locked cabinet and behind locked doors at all times when unattended.

4. All individual sessions are to be documented on the Substance Use Treatment Individual Contact Note, CR-3761, after every contact with the participant or relevant individuals (i.e., family, support circle, etc.). Progress of participant's program participation, group, and other program related activities shall be updated monthly.
5. Access to substance use treatment program clinical files shall be limited to those employees who have a legitimate need. Substance use treatment program staff shall develop in-house procedures, which are approved by the Warden/Superintendent to ensure that the substance use treatment information is shared between medical, behavioral health, and other institutional staff, as appropriate. No inmate in any position, including but not limited to clerk, mentor, etc., shall have access to any other participant's treatment records.
6. All substance use treatment program clinical files shall be retained at the institution in a secure area and maintained separately from the institutional record for at least three fiscal years following the date of discharge from the program. Retention is required for purposes of federal and state examination and audit.
7. In accordance with federal regulations, at the end of three years, the records shall be forwarded to the designated archive area in each facility and stored for an additional two years, after which time the facility will follow Policy # 512.01 for file retention.
8. A copy of substance use treatment program clinical files or any correspondence pertaining to substance use treatment program participation shall be released only with the written consent of the program participant. Copies of all such documents shall be marked as confidential and maintained in accordance with TDOC state and federal regulations. Exceptions are as follows:
  - a. To medical or behavioral health personnel to the extent necessary to meet a medical/mental health emergency
  - b. To qualified personnel for the purpose of conducting management audits or program evaluation/reviews
  - c. After application showing good cause has been determined by the court of jurisdiction
  - d. To other institutional substance use treatment programs for continued treatment services or aftercare services
  - e. In cases of reported child abuse, disabled or geriatric abuse.
  - f. Threat to self or others
  - g. Threat to institutional security

Effective Date: April 15, 2023	Index # 513.07 .1	Page 13 of 13
Subject: SUBSTANCE USE HIGH INTENSITY RESIDENTIAL SERVICES		

- VII. ACA STANDARDS: 5-ACI-6A-23, 5-ACI-6A-42, 5-ACI-5E-11, 5-ACI-5E-12, 5-ACI-5E-13, 5-ACI-5E-14, and 5-ACI-5E-15.
  
- VIII. APPLICABLE FORMS: CR-1974 (Rev. 12/20), CR-3054 (Rev. 2/21), CR-3224 (Rev. 11/19), CR-3431 (Rev. 09/19), CR-3586 (Rev. 11/19), CR-3713 (Rev. 4/18), CR-3720 (Rev. 08/22), CR-3750 (Rev. 08/22), CR-3751 (Rev. 08/22), CR-3752 (Rev. 8/22), CR-3753 (Rev. 8/22), CR-3754 (Rev. 08/22), CR-3755 (Rev. 8/22), CR-3761 (Rev. 4/18), CR-3992 (Rev. 12/20), CR-4153, and CR-4157 (Rev. 2/22).
  
- IX. EXPIRATION DATE: April 15, 2026



TENNESSEE DEPARTMENT OF CORRECTION
AUTHORIZATION FOR RELEASE OF
SUBSTANCE USE-TREATMENT INFORMATION

INSTITUTION / DRC

Participant's Name \_\_\_\_\_ TDOC ID \_\_\_\_\_ Gender \_\_\_\_\_
Please Print

Last 4-digits of Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, \_\_\_\_\_ authorize \_\_\_\_\_ to
(Participant's Name) (Name of specific program)
disclose \_\_\_\_\_
(Kind and amount of information to be disclosed)

to \_\_\_\_\_
(Name of specific person, program, or organization)

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

Expiration:

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

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

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

Signature of Participant

Signature of Parent/Authorized Representative & Relationship

Witness

Date

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



TENNESSEE DEPARTMENT OF CORRECTION  
REQUEST FOR PROGRAM DISMISSAL

\_\_\_\_\_  
INSTITUTION

DATE: \_\_\_\_\_

TO: \_\_\_\_\_, Inmate Job Coordinator

FROM: \_\_\_\_\_

INMATE NAME \_\_\_\_\_ TDOC ID: \_\_\_\_\_

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

\_\_\_\_\_ because:

Inability to perform the skills of the program as evidenced by: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Change in custody level / medical status

\_\_\_\_\_ Excessive tardiness. Inmate was tardy on the following days: \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

Dismissal is effective: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Approved \_\_\_\_\_ Denied \_\_\_\_\_

Approved \_\_\_\_\_ Denied \_\_\_\_\_

\_\_\_\_\_  
Job Coordinator

\_\_\_\_\_  
Warden/Superintendent/Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date





# TENNESSEE DEPARTMENT OF CORRECTION INSTITUTIONAL HEALTH SERVICES REFERRAL



\_\_\_\_\_ **INSTITUTION** \_\_\_\_\_

- MEDICAL           DENTAL
- BEHAVIORAL HEALTH

INMATE: \_\_\_\_\_ TDOC ID: \_\_\_\_\_  
Last                                  First                                  Middle

PRESENTING PROBLEMS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

REFERRED BY: \_\_\_\_\_  
Signature/Title                                  Date                                  Time

**SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR**

- Behavioral Health
- Medical       Dental

RECEIVED BY: \_\_\_\_\_  
Signature/Professional Title                                  Date                                  Time

REFERRAL DISPOSITION (Course of Action): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

\_\_\_\_\_  
 Signature/Professional Title



**TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT PROGRAM PARTICIPANT AGREEMENT**

\_\_\_\_\_  
INSTITUTION/DRC

Participant Name: \_\_\_\_\_  
*Please Print*

TDOC ID \_\_\_\_\_

**CARDINAL RULES**

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

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

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

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

Check "√" applicable program modality:

- |  |   |
|--|---|
| <input type="checkbox"/> Therapeutic Community | <input type="checkbox"/> Outpatient Group Therapy           |
| <input type="checkbox"/> Family Reunification  | <input type="checkbox"/> Intensive Outpatient Group Therapy |

I **ACCEPT** placement into this program.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Date



TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT CLINICAL DISCHARGE SUMMARY

\_\_\_\_\_  
INSTITUTION/DRC

Participant Name: \_\_\_\_\_ TDOC ID \_\_\_\_\_  
*Please Print*

Date of Birth: \_\_\_\_\_  
Date Format: mm/dd/yyyy

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Discharge Status: \_\_\_\_\_

**Demographics:**

\_\_\_\_\_

**Summary of Treatment Progress (add additional pages as needed)**

\_\_\_\_\_

1) Acute Intoxication and/or Withdrawal Potential: \_\_ Low \_\_ Medium \_\_ High

As Evidenced By/Comments:

\_\_\_\_\_

2) Biomedical Conditions and Complications: \_\_ Low \_\_ Medium \_\_ High

As Evidenced By/Comments:

\_\_\_\_\_

3 Emotional Behavioral & Cognitive Conditions/Complication: \_\_ Low \_\_ Medium \_\_ High

As Evidenced By/Comments:

\_\_\_\_\_

**TCU SCALES**

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

4) **Readiness to Change:** \_\_ Low \_\_ Medium \_\_ High

**As Evidenced By/Comments:**

\_\_\_\_\_

5) **Relapse/Continued Use/Continued Problem Potential:** \_\_ Low \_\_ Medium \_\_ High

**As Evidenced By/Comments:**

\_\_\_\_\_

6) **Recovery and Living Environment:** \_\_ Low \_\_ Medium \_\_ High

**As Evidenced By/Comments:**

\_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> None Recommended                         | <input type="checkbox"/> Level III.1 Clinically Managed, Low Intensity, Residential  |
| <input type="checkbox"/> Level I Outpatient Services              | <input type="checkbox"/> Level III.5 Clinically Managed, High Intensity, Residential |
| <input type="checkbox"/> Level II.1 Intensive Outpatient Services | <input type="checkbox"/> Level III.7 Medically Monitored Intensive Treatment         |
| <input type="checkbox"/> Level II.5 Partial Hospitalization       | <input type="checkbox"/> Level IV Medically Managed Intensive Treatment              |

**Continued Care Recommendations:**

\_\_\_\_\_

\_\_\_\_\_  
Primary Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Addiction Treatment Program Director/DRC Clinical Director  
Signature

\_\_\_\_\_  
Date



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

INSTITUTION/PROBATION PAROLE OFFICE/DRC

\_\_\_\_\_  
 TDOC ID

\_\_\_\_\_  
 Admission Date/Sentencing Date

\_\_\_\_\_  
 Sentence Expiration Date

**SECTION I. PERSONAL DATA**

**GENERAL**

True (Given) Name:

\_\_\_\_\_  
 First

\_\_\_\_\_  
 Middle

\_\_\_\_\_  
 Last

\_\_\_\_\_  
 Pre/Suffix

\_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 FBI No.

Driver License:

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Number

Yes  No  
 Valid?

**GENDER**

- Female
- Male
- Unknown

**RACE**

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern
- Native Hawaiian or Pacific Islander
- Other Race
- Unknown
- White

**HISPANIC**

- Hispanic
- Non-Hispanic
- Unknown

**CITIZENSHIP**

- Illegal Alien
- Legal Alien
- US Citizen
- Unknown

**DEMOGRAPHICS**

**EYE COLOR:**

- Blue
- Green
- Brown
- Hazel
- Other

**HAIR COLOR:**

- Black
- Brown
- Blonde
- Gray
- Red
- White
- None
- Other

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Country/Place of Birth: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

**PERSONAL DATA: GENERAL - COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**SECTION I. PERSONAL DATA *continued***

**SOCIAL**

Do You Own A Vehicle?  Yes  No      If no, do you have sources of transportation?  Yes  No  
 Sources of Transportation  
 (include alternative sources): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Number: \_\_\_\_\_

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

<u>NAME</u>	<u>RELATIONSHIP/ FREQUENCY OF CONTACT</u>	<u>TELEPHONE NUMBER</u>	<u>NOTES QUALITY OF RELATIONSHIP/ RESIDENCE LOCATION</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are your residential plans? (include addresses, if known)

Will you be living with anyone upon release that:

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

**MARITAL HISTORY**

**Current Marital Status:**  Cohabiting  Divorced  Married  Separated  Single  Widowed

<u>NAME</u>	<u>MARITAL STATUS</u>	<u>DATES OF MARRIAGE</u>	<u>NO. OF CHILDREN</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**CHILDREN**

<u>NAME/AGE/GENDER</u>	<u>CHILDREN LIVE WITH WHOM (CAREGIVER)</u>	<u>QUALITY OF RELATIONSHIP BETWEEN PARTICIPANT &amp; CAREGIVER</u>	<u>FREQUENCY OF CONTACT</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**EDUCATION/MILITARY HISTORY**

**EDUCATION LEVEL:**

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

**MILITARY BACKGROUND**

Branch of Service: \_\_\_\_\_  
 Dates from \_\_\_\_\_ to \_\_\_\_\_  
 Discharge Type: \_\_\_\_\_  
 Service Connected:     No     Yes

**DATE EDUCATION OBTAINED/LAST YEAR**

Name of Previous School: \_\_\_\_\_  
 Address/Location of Previous School: \_\_\_\_\_  
 \_\_\_\_\_  
 Highest Grade Completed/ Year: \_\_\_\_\_  
 Certificates/Degrees: \_\_\_\_\_

**LANGUAGE SKILLS**

- English     Spanish  
 French     German  
 Latin     Other \_\_\_\_\_

**Completed and/or Current Prison Curriculum/Programs:** \_\_\_\_\_

**SECTION I. PERSONAL DATA *continued***

**PERSONAL DATA: SOCIAL – COMMENTS AND REMARKS**

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

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





TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
INTAKE AND INTERPRETIVE SUMMARY**

**SECTION II. EMPLOYMENT**

Have You Ever Been Employed?  Y  N

Most Recent Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Start/End Date: \_\_\_\_\_ to \_\_\_\_\_

Occupation: \_\_\_\_\_

Job Title: \_\_\_\_\_

Can You Return: \_\_\_\_\_

If N, Reasons for Unemployment:

Caregiver Treatment  Long-Term

Disabled  Retired

Student  Homemaker

Looking for Work  Other

Work Hours: \_\_\_\_\_

Employer Knowledge of Arrest?  Y  N

**Vocational/Training Skills (Check All That Apply):**

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

**EMPLOYMENT – COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
INTAKE AND INTERPRETIVE SUMMARY**

**SECTION III. FINANCIAL INFORMATION**

**SOURCES OF INCOME BEFORE INCARCERATION OR PRESENT:**

<u>TYPE</u>	<u>MONTHLY</u>
Earnings from Job	_____
Alimony	_____
Child Support	_____
Child Support Hold?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Family Support	_____
Food Stamps	_____
Retirement Pension	_____
Unemployment	_____
Social Security	_____
Other:	_____
_____	_____
_____	_____

**EXPENSES BEFORE INCARCERATION OR PRESENT:**

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

**FINANCIAL INFORMATION – COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**SECTION IV. SUBSTANCE USE HISTORY**

**SUBSTANCE USE:**

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

**SUBSTANCE USE TREATMENT:**

<u>TYPE</u>	<u>CURRENT</u>	<u>HISTORY</u>
Inpatient	_____	_____
Outpatient	_____	_____
Self-Help (AA/NA)	_____	_____
Confined Treatment	_____	_____

<u>NAME OF PROGRAM</u>	<u>LOCATION</u>	<u>DATES</u>	<u>PURPOSE/TREATMENT EXPERIENCE</u>	<u>DISCHARGE TYPE (COMPLETED/NOT)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**SUBSTANCE USE HISTORY – COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
INTAKE AND INTERPRETIVE SUMMARY**

---

**SECTION V. HEALTH**

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

---

**PHYSICAL HEALTH STATUS** (*Check Best Fitting Response*)

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

**NAMES OF MEDICATIONS AND REASON(S) FOR USE:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**MENTAL HEALTH (CHECK ALL THAT APPLY)**

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

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

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



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**SUICIDE ATTEMPT HISTORY**

# of prior attempts \_\_\_\_\_  
 Last attempt? \_\_\_\_\_  
 Method of last attempt \_\_\_\_\_  
 Medical attention needed ever? \_\_\_\_\_  
 Ever while intoxicated? \_\_\_\_\_  
 When incarcerated? \_\_\_\_\_  
 Comments: \_\_\_\_\_

History of self-injury (*non-suicidal intent*)  
 cutting  head-banging  non-cosmetic burning  
 Ever while intoxicated? \_\_\_\_\_  
 When incarcerated? \_\_\_\_\_

**MENTAL HEALTH TREATMENT HISTORY:**  Records available

No history of prescribed psychotropic(s) medication(s)  
 Age (estimated) 1st prescribed psychotropic: \_\_\_\_\_  
 Age (estimated) last prescribed psychotropic medication: \_\_\_\_\_ or  
 Current: \_\_\_\_\_  
 Name of last treatment agency \_\_\_\_\_  
 History of the following prescribed medications: \_\_\_\_\_

Records not available  Records Requested

Medication likely confounded with A/D use  
 Psychotropics primarily when incarcerated only  
 Treatment compliance:  
 always  usually  sometimes  
 infrequently  
 Current psychotropic medication (or within last 2 to 4 weeks): \_\_\_\_\_

Comments: \_\_\_\_\_

No history of Inpatient Psychiatric Treatment  
 Age of 1<sup>st</sup> Psychiatric Hospitalization: \_\_\_\_\_  
 Age of last Psychiatric Hospitalization: \_\_\_\_\_ or Current: \_\_\_\_\_  
 Number of inpatient stays \_\_\_\_\_  
 History of Psychotherapy, psycho-educational groups, classes, or support groups:  Yes  No  
 If yes, please explain: \_\_\_\_\_

Duration of longest stay (est. ok): \_\_\_\_\_  
 Age of longest stay: \_\_\_\_\_  
 History of hospitalization related to suicide threat

**HEALTHCARE/BENEFIT RECONNECTION:**

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

If yes, what kind of coverage? \_\_\_\_\_

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

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

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

**SECTION V. HEALTH continued**

**HEALTH – COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**SECTION VI. SELF REPORTED CRIMINAL HISTORY**

<u>DATE OF ARREST/AGE</u>	<u>AGENCY/LOCATION</u>	<u>OFFENSE CHARGED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

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

Gang Name: \_\_\_\_\_

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

When Did You Get Out? \_\_\_\_\_

**SELF REPORTED CRIMINAL HISTORY – COMMENTS AND REMARKS**



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE BEHAVIORAL PROGRAM  
 INTAKE AND INTERPRETIVE SUMMARY**

**SECTION VII. INITIAL INTAKE ASSESSMENT**

Check the most appropriate response in each category:

<u>PROBLEM AREA</u>	<u>LIMITED/SLIGHT</u>	<u>MODERATE</u>	<u>SEVERE</u>
Employment/Financial Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family/Peer Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leisure/Recreations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal/Criminality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational/Vocational Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MOTIVATORS/BARRIERS:**

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

Motivators (children, family, support, etc.): \_\_\_\_\_

Barriers (race, gender, etc.): \_\_\_\_\_

Staff Completing Intake Summary (*Printed*): \_\_\_\_\_

\_\_\_\_\_  
 Signature Date

DRC Clinical Director/Addiction Treatment Program Director (*Printed*) \_\_\_\_\_

\_\_\_\_\_  
 DRC Clinical Director/Addiction Treatment Program Director Signature Date



**TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT INFORMED CONSENT FOR TREATMENT SERVICES**

\_\_\_\_\_  
INSTITUTION / DRC

Dear Participant:

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

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

**INFORMED CONSENT**

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

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

The informed consent is effective until treatment is terminated.

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

\_\_\_\_\_  
Participant's Name/TDOC ID

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor's Name

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Addiction Treatment Program Director/  
DRC Clinical Director's Name

\_\_\_\_\_  
Addiction Treatment Program Director/  
DRC Clinical Director's Signature

\_\_\_\_\_  
Date





**TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT  
CONFIDENTIALITY NOTICE AND WAIVER**

\_\_\_\_\_  
INSTITUTION/DRC

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

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

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

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

- a. It is earlier revoked by me. (I understand that revoking this waiver before the completion of treatment will prevent the TDOC from informing other facility staff, including Institutional Parole Officers, of necessary information to complete their job. By revoking this waiver, my treatment will end and I will receive the associated consequences of an unsuccessful termination.)
- b. There has been a formal and effective termination or revocation of my sentence, release from confinement, probation, parole, or other completed legal proceeding which removes me from facility control.

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

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
TDOC ID

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Date



**TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE INITIAL TREATMENT PLAN**

\_\_\_\_\_  
INSTITUTION/DRC

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
TDOC ID

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

Modality: \_\_\_\_\_ TC \_\_\_\_\_ Group Therapy \_\_\_\_\_ DRC \_\_\_\_\_ Primary Counselor  
DSM V Diagnostic Impression:

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

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

**OBJECTIVES/INTERVENTIONS**

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

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

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Addiction Treatment Program Director/DRC Clinical Director Signature

\_\_\_\_\_  
Date



TENNESSEE DEPARTMENT OF CORRECTION  
**SUBSTANCE USE DISORDER INDIVIDUAL TREATMENT PLAN**

\_\_\_\_\_  
INSTITUTION / DRC

Participant Name: \_\_\_\_\_ TDOC ID: \_\_\_\_\_

Service Start Date: \_\_\_\_\_ Primary Counselor: \_\_\_\_\_

TC Residential SA \_\_\_\_\_ Group Therapy \_\_\_\_\_ DRC \_\_\_\_\_

**DSM-V- Diagnostic Impression**

**CODE**

**DESCRIPTION**

CODE	DESCRIPTION
_____	_____
_____	_____

**MASTER PROBLEM LIST:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STRENGTHS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OBSTACLES TO TREATMENT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROBLEM DESCRIPTION/#:**

--

**LONG TERM OUTCOMES/GOALS:**

--

**OBJECTIVES:**

	PARTICIPANT AND COUNSELOR INITIALS	OBJECTIVES	TARGET DATE	ACHIEVED DATE/PARTICIPANT AND COUNSELOR INITIALS	CHECK IF GOAL CONTINUED
1.					<input type="checkbox"/>
2.					<input type="checkbox"/>
3.					<input type="checkbox"/>

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

\_\_\_\_\_ Participant Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Primary Counselor Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Addiction Treatment Program Director/DRC Clinical Director Signature

\_\_\_\_\_ Date



TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE DISORDER TREATMENT  
PROGRAM ALTERNATIVE DISCIPLINARY

\_\_\_\_\_  
INSTITUTION

\_\_\_\_\_  
Participant's Name

\_\_\_\_\_  
TDOC ID

\_\_\_\_\_  
Counselor's Name

\_\_\_\_\_  
Date of infraction

**DESCRIPTION OF INFRACTION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LEARNING EXPERIENCE/ SANCTIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

Reviewed by:

\_\_\_\_\_  
Addiction Treatment Program Director's Signature

\_\_\_\_\_  
Date



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

\_\_\_\_\_  
INSTITUTION/DRC

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

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

**PARTICIPANT CONFIDENTIALITY**

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

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

Participant Signature	TDOC ID	Date
-----------------------	---------	------

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

Addiction Treatment Counselor's Signature	Date
---	------

Addiction Treatment Program Director/DRC Clinical Director's Signature	Date
--	------



TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT PROGRAM INDIVIDUAL CONTACT NOTE

\_\_\_\_\_  
INSTITUTION/DRC

Participant Name: \_\_\_\_\_ TDOC ID: \_\_\_\_\_

Phase: \_\_\_\_\_ Contact Date: \_\_\_\_\_ Duration of Contact: \_\_\_\_\_

Context of Contact: \_\_\_\_\_

Problem(s) Addressed: \_\_\_\_\_

Objectives of Contact: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Counselor Name

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Addiction Treatment Program Director/DRC  
Clinical Director (*Print*)

\_\_\_\_\_  
Addiction Treatment Program  
Director/DRC Clinical Director Signature

\_\_\_\_\_  
Date



TENNESSEE DEPARTMENT OF CORRECTION

DRUG SCREEN CONSENT/REFUSAL
SUBSTANCE USE TREATMENT

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

Name: \_\_\_\_\_ TDOC ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Facility: \_\_\_\_\_

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

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

\_\_\_\_\_  
Inmate Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
2nd Witness Signature (Refusal Only)

\_\_\_\_\_  
Date

Table with columns for Positive, Negative, N/A for various substances: AMP, OPI, OXY, THC, BAR, BUP, mAMP, BZO, COC, MTD, PCP, K2, ALC, and Other.

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

TO BE PLACED IN THE INMATE'S TREATMENT FILE





TENNESSEE DEPARTMENT OF CORRECTION  
SUBSTANCE USE TREATMENT  
TRANSITION ACCOUNTABILITY PLAN

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

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

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

---

Participant Signature

---

Counselor Signature/Institution

---

Date of Completion

---

Dates Revised

---

Addiction Treatment Program Director/ DRC Clinical  
Director Signature

---

Date

TRANSITION ACCOUNTABILITY PLAN FOR: \_\_\_\_\_

(your name)

**GOAL**

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

Your goals for the first 3 months out of prison:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Your goals for the first 12 months:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Your goals for the next 5 years:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**LIVING ARRANGEMENTS:**

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

1. (Circle One) Treatment Facility Home Other

2. Address: \_\_\_\_\_  
\_\_\_\_\_

3. Whom will you live with? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Plan A: \_\_\_\_\_ Plan B: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

6. Describe the neighborhood. \_\_\_\_\_  
\_\_\_\_\_

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

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

**EMPLOYMENT:**

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

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

**If yes, answer questions 2-14**

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

2. Where is it? \_\_\_\_\_

\_\_\_\_\_

3. What is the job title? \_\_\_\_\_

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

\_\_\_\_\_

5. How many hours a week will you work? \_\_\_\_\_

6. What days will you work? \_\_\_\_\_

7. How will you be trained? \_\_\_\_\_

8. How will you be supervised? \_\_\_\_\_

9. What will your salary be and what benefits will be included?

Pay: \_\_\_\_\_

Benefits: \_\_\_\_\_

10. Describe the working environment. \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

12. Is the position temporary, seasonal or permanent? \_\_\_\_\_

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

\_\_\_\_\_

14. If you do not have a job lined up, or the job you have falls through, what will you do to find employment?  
\_\_\_\_\_  
\_\_\_\_\_
15. What types of work are you looking for and qualified to do? \_\_\_\_\_  
\_\_\_\_\_
16. How many hours are you planning to work? \_\_\_\_\_
17. Realistically, what would be the starting salary for the work you are qualified to do? \_\_\_\_\_  
\_\_\_\_\_
18. Give all the sources of information and assistance you plan to use. List at least 3 given to you by your counselor that would be beneficial in helping you find employment.
- a. \_\_\_\_\_  
\_\_\_\_\_
- b. \_\_\_\_\_  
\_\_\_\_\_
- c. \_\_\_\_\_  
\_\_\_\_\_

**HEALTHCARE (medical and/or mental health)**

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

1. Do you know what your healthcare needs will be? \_\_\_\_\_  
\_\_\_\_\_
2. List resources given to you in class that can help you obtain healthcare insurance.
- a. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- b. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- c. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. How can you make sure that have healthcare insurance? \_\_\_\_\_  
\_\_\_\_\_
4. How do you know all of the above information? \_\_\_\_\_  
\_\_\_\_\_

# FINANCIAL PLAN

## SOURCES OF INCOME

### Available funds:

Money received upon release	\$ _____
<i>(Includes canteen account, savings account)</i>	
Money available in outside accounts	\$ _____
Gifts	\$ _____
Immediate earnings	\$ _____
<hr/>	
<b>Total Available Money:</b>	<b>\$ _____</b>

### Expenses:

Housing	\$ _____
<i>(rent, program fees, contribution to family expenses)</i>	
Clothing	\$ _____
Food	\$ _____
Transportation	\$ _____
Other Immediate Expenses	\$ _____
<i>(child support, cosmetics, pocket money)</i>	
<hr/>	
<b>Total Immediate Expenses:</b>	<b>\$ _____</b>

### Sources Of Weekly Income

Source _____	Amount	\$ _____
_____		\$ _____
_____		\$ _____
TOTAL WEEKLY INCOME (Before Taxes)		\$ _____
SUBTRACT THE FOLLOWING:		
	Taxes	\$ _____
	Child Support	\$ _____
TOTAL WEEKLY INCOME:		\$ _____

**Expenses:**

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

1. How will you monitor your budget? \_\_\_\_\_  
\_\_\_\_\_
2. What type of banking service will you use? \_\_\_\_\_  
\_\_\_\_\_

**RECOVERY**

1. What recovery meetings, organizations or groups do you plan to participate in? \_\_\_\_\_  
\_\_\_\_\_
2. Where are these meetings being held, be specific? \_\_\_\_\_  
\_\_\_\_\_
3. How many times per week do you plan on going to meetings, organizations, etc.? \_\_\_\_\_  
\_\_\_\_\_
4. How will you get to them? \_\_\_\_\_  
\_\_\_\_\_
5. What other support will you have? Sponsor, clergy, family, etc. \_\_\_\_\_  
\_\_\_\_\_

6. List here at least 3 resources given in class that can assist you in your recovery.
- a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
7. How do you know all of the above information? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**CONTINUING EDUCATION**

1. What are your **specific** educational goals? \_\_\_\_\_
- \_\_\_\_\_
2. What schools or programs are available to help you meet your goals? Include financial assistance.
- \_\_\_\_\_
- \_\_\_\_\_
3. List resources given in class that can assist you in meeting these goals.
- a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
4. How do you know all of the above information? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FAMILY**

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

1. Who do you regard as part of your family and expect to maintain a relationship? **List them**
- \_\_\_\_\_
- \_\_\_\_\_
2. What **specific** responsibilities will you have towards your family? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
3. What plans and agreements do you have for improving your relationships and preventing problems with your family? Remember, there is **always** room for improvement. \_\_\_\_\_



---

---

---

**FRIENDS**

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

1. What are the **types** of people or groups you plan to stay away from as part of your plan? \_\_\_\_\_  
\_\_\_\_\_
2. Which old friends would it be good for you to keep and strengthen relationships with as part of your plan? Why? \_\_\_\_\_  
\_\_\_\_\_
3. Whom are you currently building positive friendships with? \_\_\_\_\_  
\_\_\_\_\_
4. What qualities do you think are important in a friendship? \_\_\_\_\_  
\_\_\_\_\_
5. How are friendships built? \_\_\_\_\_  
\_\_\_\_\_

**RECREATION** (free time/ religious activities)

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

1. What **specific** activities will you participate in? \_\_\_\_\_  
\_\_\_\_\_
2. How much time will you devote to each? (Example: 1 hour, 2x weekly) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Where will you participate in these activities? \_\_\_\_\_  
\_\_\_\_\_
4. Who will join you in these activities? \_\_\_\_\_  
\_\_\_\_\_

- 
5. What are the benefits of participating in these activities? \_\_\_\_\_
- 
6. How do you know all of the above information? \_\_\_\_\_
- 

**SPIRITUAL LIFE**

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

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

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

2. Describe your past participation in spiritual or religious activities and what connections will you make upon your release?
- \_\_\_\_\_
- \_\_\_\_\_
3. What gives your life meaning? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
4. Do you think that participation in spiritual or religious activities would be important to you?

Circle one: Yes    No    Please explain why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COMMUNITY INVOLVEMENT**

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

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

**ACTIVITY SCHEDULE**

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

Day 1

<u>Time:</u>	<u>Activity</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Day 2

Time:

Activity


Day 3

Time:

Activity


Day 4

Time:

Activity


Day 5

Time:

Activity


Day 6

Time:

Activity


Day 7

Time:

Activity


**CRISIS PLANS**

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

1. What are your potentially dangerous situations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. How do you plan to avoid them? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Dangerous situation that you will **not** be able to avoid? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. How will you cope with them in a way that will not risk your coming back to prison? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. What do you think is the most difficult problem that may result in your relapse or recidivism?  
\_\_\_\_\_  
\_\_\_\_\_
6. How will you cope with this problem in a positive way? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Whom will you go to and what else will you do if you need emergency support?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Use this space for additional information if necessary.**

---

---

---

---

---

---

---

---



TENNESSEE DEPARTMENT OF CORRECTION  
REQUEST FOR TREATMENT OVERRIDE

INSTITUTION \_\_\_\_\_

INMATE NAME: \_\_\_\_\_ TDOC ID: \_\_\_\_\_

RED: \_\_\_\_\_ EXP: \_\_\_\_\_ FAD: \_\_\_\_\_

SED: \_\_\_\_\_ LAST PAROLE HEARING: \_\_\_\_\_

PAROLE BOARD ACTION: \_\_\_\_\_

MOST RECENT TCUD: \_\_\_\_\_ MEDICAL CLASS: \_\_\_\_\_ LEVEL OF CARE: \_\_\_\_\_

OVERALL RNA RISK LEVEL: \_\_\_\_\_

CURRENT RNA RECOMMENDATION: \_\_\_\_\_

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

- PAROLE MANDATE
- PAROLE RECOMMENDATION
- OTHER: \_\_\_\_\_
- CLINICAL ASSESSMENT
- CHANGE IN CUSTODY LEVEL
- MEDICAL STATUS
- INSTITUTIONAL NEED

EXPLANATION: \_\_\_\_\_

**OVERRIDE REVIEW COMMITTEE:**

CHIEF COUNSELOR: YES / NO COMMENTS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

BEHAVIOR HEALTH: YES / NO COMMENTS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

MEDICAL STAFF: YES / NO COMMENTS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**WARDEN / SUPERINTENDENT / DESIGNEE APPROVAL:**

APPROVE: \_\_\_\_\_ DENIED: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

WARDEN / SUPERINTENDENT / DESIGNEE: \_\_\_\_\_  
SIGNATURE DATE

**AC REHAB SERVICES / DESIGNEE APPROVAL:**

APPROVE: \_\_\_\_\_ DENIED: \_\_\_\_\_ COMMENTS: \_\_\_\_\_

AC REHAB SERVICES / DESIGNEE: \_\_\_\_\_  
SIGNATURE DATE