Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#1. ADMINISTRATIVE GUIDELINES

Advisory board guidelines (*BAL 53*)
Admission procedure for community living services (*HOM 3)*
Agency information sheet (*BIR 1*)
Appeals process - negative admission decisions for community living services (*HOM 5*)
Applicant admissions packet list/instructions for community living services (*HOM 4*)
Child abuse reporting requirements/acknowledge policy (*HCLA 8*)
Child protection manual (*COL 1*)
Client legal/human rights and grievance procedures (*BIR 7*)
Cold night shelter training booklet (*PCC 1*)
Consumer rights & responsibilities (*CAM 17*)
Cooperative quality improvement program (*NOR 16*)
General admissions criteria for community living services (*HOM 1*)
Guidelines for determining homeless eligibility (*TER 8R/1*)
Homeless screening, certification, and re-certification (*TER 8R/2*)
Notice of confidentiality (*BIR 8*)
Patient grievances (*CAM 4*)
Policy/procedure for ambulatory care (*MER 1*)
Sample safety guidelines (*CLN 1*)
Sexual conduct policy/agreement (*HCLA 9*)

BAL 53

HEALTH CARE FOR THE HOMELESS

HCH CLINIC ADVISORY BOARD

Purpose	To seek consumer input on a regular basis concerning a broad range of program implementation issues including: 1. Services offered 2. Hours of operation 3. General policies and procedures 4. Program development and management
Advisory Board Qualifications	An advisory board member must be a consumer of the HCH clinic.
Length of Term	Advisory board terms are one year in duration. An advisory board member can serve a maximum of two terms.
Number of Members	The advisory board will have a minimum of five members and a maximum of nine members.
Frequency of Meetings	Advisory board meetings will be held every other month.
Selection of Advisory Board Members	Members will be selected by the HCH executive director in consultation with the HCH clinic advisory board and HCH staff members. The director may appoint a committee of advisory board members and HCH staff to review applications.
Officers	A chair and vice-chair will be elected by the HCH clinic advisory board.
Liaison	The HCH clinic director will serve as an ex-officio, non-voting member of the advisory board.
Meeting Place	All advisory board meetings will be held at the HCH clinic.

HOMES, INC.
COMMUNITY LIVING SERVICES
ADMISSION PROCEDURE

1. Referral to the residential program shall occur through the following formal channels:
   a. State or private psychiatric center/hospital; and/or
   b. The County Department of Mental Health and its contract mental health agencies;
   c. Private clinicians;
   d. Private individuals/families.

   A certified clinician shall document the applicant's need for supervised living in the initial stages of the referral process.

2. For initial consideration of a client, the referral source must submit a Community Living Services Applicant Admissions Packet which includes the following:
   a. Referral Form
   b. Applicant Information Summary and Checklist
   c. Consent for Release of Information Form
   d. Psycho-social Assessment
   e. Current Psychiatric and/or Psychological Assessments
   f. Most recent Progress Notes (last 30 days)
   g. Most recent Comprehensive Treatment Plan and Reviews
   h. Applicant Medical Information and Physical Exam Forms
   i. Physician's Authorization for Restorative Services
   j. Living Skills Assessment (Malcom House)
   k. Additional information as requested.

3. After receipt of the above information, an interview with the applicant and family, and/or representative from referral agency will be arranged with Admissions Coordinator and staff.

4. At this point, the Internal Admissions/Discharge Committee, which meets weekly, does the following:
   a. Reviews the referral information in terms of the admission criteria;
   b. Reviews information from staff interviews;
   c. Makes an assessment of the medical, social, psychological and vocational consequences of admission and decides whether or not applicant is appropriate for Community Living Services;
   d. Determines whether or not a service plan is complete (i.e. all referrals for all medical, psychiatric, day programming, case management are made);
   e. Consultation with the Special Review Committee, which is composed of members from the community, may be employed at this time if deemed necessary.

5. If deemed an appropriate candidate, the applicant will be scheduled for visits at a designated site depending on space availability. Applicants may be asked to make visits in addition to, or instead of, those listed below. Applicants will be charged a minimum of $5.00 per over-night visit for food. An appointment with the finance office must be made at this time.
   a. Applicant visits the Admissions/Discharge Committee's recommended site for dinner.

b. Applicant visits the Admissions/Discharge Committee's recommended site for dinner and an overnight stay.
c. Applicant visits the Admissions/Discharge Committee's recommended site for a six/seven day stay. (Up to 30 days for Malcom House.)

6. Staff's recommendation, behavioral observation summaries and the applicant's personal goals are submitted to the Admissions/Discharge Committee in its final deliberation of the suitability of the Community Living Services program for the applicant.

7. Applicants who are not accepted into the Community Living Services program will be notified promptly. A letter will specify reasons for non-acceptance and specific criteria not met. All referral materials will be returned upon request. Reapplication may be made at any time or additional materials may be submitted which indicate that the specified criteria have subsequently been met. This appeal will be processed accordingly (See Appeals Process).

8. The Admissions Coordinator will notify accepted applicants and the referral agency, verbally and in writing. The applicant will then proceed with the following:
a. All case management, day program, contingency plans, psychiatric follow-up arrangements are finalized, and a date for occupancy set.
b. The applicant signs a statement indicating that he/she is making application voluntarily and agrees to active participation in programs.
c. The applicant meets with HOMES Finance Office and signs HOMES Admission & Fee ,Agreement and Payment Procedure Contract.
d. The applicant signs a copy of the Program Guidelines, thus indicating a willingness to cooperate and comply with them.
e. The applicant can score satisfactorily on the Standard Capability of Self-preservation Test.

9. All admission materials are then placed in the program participant's case records by the Admissions Coordinator.

THE ADMISSIONS AND DISCHARGE COMMITTEE CONTINUALLY MONITORS THE APPROPRIATENESS OF ALL PLACEMENTS.

Updated 9-11-90; 5-24-93
DC:aw

BIR 1

BIRMINGHAM HEALTH CARE FOR THE HOMELESS COALITION, INC.

INFORMATION SHEET

Genesis Corner
712 25th Street North
Birmingham, Al 35203
(205) 323-5311

Hours of Operations (medical, case management, and substance abuse services)
Monday - Friday 7:30 a.m.- 4:30 p.m.

Evening Clinics 5:00 p.m. - 7:00 p.m.

Monday	Firehouse Men's Shelter (1501 3rd Avenue North)
Wednesday	Jimmie Hale Mission (2403 3rd Avenue North)
Friday	Salvation Army (2130 11th Avenue North)

Patients will be seen in the following order:

- Emergencies
- Scheduled appointment
- Same day appointment
- Walk in/late for appointment

On-call 24-hour emergency services available by calling 941-4690

Services Provided
Medical (adult & pediatric), Dental, Family Planning, HIV Counseling & Testing, Substance Abuse, Mental Health, Case Management, Employment & Training, and Child Development Center.

Eligibility, Fees & Payment
Eligibility determination is made at the time of intake.

Payment for services is based on a sliding fee scale. No one eligible will be denied services based on ability to pay. We accept Medicaid/Medicare.

Our policy is to protect our client's constitutional, legal, and human rights. Confidentiality of client records are protected by Federal law and regulation. Copies of these policies will be given at time of intake.

For the protection of the patient and the community, universal precautions will be observed by all clinical staff.

HOMES, INC.
COMMUNITY LIVING SERVICES
APPEALS PROCESS - NEGATIVE ADMISSION DECISIONS

POLICY
Applicants to Community Living Services (CLS) of HOMES, Inc. upon receiving a denial of admission into a program site, will have the opportunity to appeal that decision beyond the Admissions/Discharge Committee.

STEP 1: SECOND REVIEW WITH THE ADMISSIONS/DISCHARGE COMMITTEE
At the time that an applicant receives, in writing, a denial of admission to a CLS program, he/she may request a review of the decision by the Admissions/Discharge Committee. This request must be made within five (5) working days after receipt of the written decision.

Along with the request for review, the applicant should include written documentation which support their admission. For example, letters of support from individuals who know the applicant.

STEP 2: PERSONAL INTERVIEW
Should the applicant receive another written denial after the second review, he/she may request a personal interview with the Admissions/Discharge Committee. This request must be made within five (5) working days after receipt of the written decision.

Applicants are invited to bring an individual(s) to act as an advocate on their behalf to this meeting. Within ten (10) days from the date of the personal interview, applicants shall receive the decision of the Admissions/Discharge Committee again, in writing.

STEP 3: REVIEW OF DECISION BY REVIEW COMMITTEE
If, after the personal interview an applicant receives written denial for admission into a Community Living Services program, they, or the referral source, may within 30 days, request a meeting of the Special Review Committee. The Committee is comprised of representatives outside of H.O.M.E.S. along with the Program Director, Program Coordinator and Admissions Coordinator who will meet and review the application and previous reasons for denial.

(continued)

HOMES, INC.
COMMUNITY LIVING SERVICES
APPEALS PROCESS - NEGATIVE ADMISSION DECISIONS
(continued page 2)

STEP 4: REVIEW OF DECISION BY EXECUTIVE COMMITTEE

If, after the personal interview, an applicant receives in writing a denial for admission into a CLS program, the applicant may request a review of that decision, including another personal interview with the Executive Director and the Executive Committee of the Board of Directors of HOMES, Inc. Applicants must request this meeting within five (5) working days after receipt of the second written denial by the Admissions/Discharge Committee. The Executive Director shall convene the Executive Committee for the review meeting as quickly as possible. All written referral/ application information will be reviewed by committee members prior to a final decision being made. Within ten (10) working days from the date of the review meeting, the applicant shall receive the written decision of the Executive Committee in consultation with the Executive Director.

STEP 5: REVIEW OF DECISION BY BOARD OF DIRECTORS OF HOMES,INC

Should the decision of the Executive Committee uphold the denial of admission to a CLS program, an applicant may request a final review of the decision by the full Board of Directors. At this time, the applicant may also request a meeting with the Board accompanied by an advocate(s). The request for a review and meeting must be made within five (5) working days after receipt of the written decision by the Executive Committee. This meeting will be convened by the Executive Director at the earliest convenient time for all parties. This includes written summaries of the Admissions/ Discharge Committee and staff recommendations. A quorum of the Board of Directors shall be necessary for a decision. Within ten (10) working days from the date of this meeting and review, the applicant shall receive the written decision of the Board. This decision shall be considered final by HOMES, Inc.

All applicants must receive a copy of the Appeal Process with the CLS Application. For additional information on the statutory regulations governing the rights of individuals using services certified by the New York State Office of Mental Health, contact the New York State Office of Mental Health, Western Regional Office, Buffalo, New York, 14222 (716) 885-5014.

DC:bc
6-92

HOM 4

H.O.M.E.S., INC.
COMMUNITY LIVING SERVICES
APPLICANT ADMISSIONS PACKET LIST AND INSTRUCTIONS

RETURN TO: Admissions Coordinator
Community Living Services
H.O.M.E.S., Inc.
408 East State Street
Ithaca, NY 14850

Instructions: Before a person can be considered for placement, this packet must be reviewed, completed and then submitted to Community Living Services of H.O.M.E.S., Inc.

A. Reviewed by Client and Referring Person:
1. Program Description
2. Statement of Admissions Criteria
3. Admissions Process
4. Applicant Admission Packet List and Instructions
5. Fee Schedule
6. Housing and Fee for Services Agreement
7. Appeals Process

B. Completed and Returned:
1. Referral Form
2. Applicant's Information Summary and Checklist (completed by applicant)
3. Consent to Share Information Form, signed
4. Psycho-social Assessment For (enclosed for certified clinician)
5. Recent Psychiatric and/or Psychological Assessments (done within three months of application)
6. Applicant Medical Information Form (enclosed for physician)
7. Physical Exam Form (enclosed for physician)
8. Standard Capability of Self-preservation Test (enclosed)
9. Authorization for Restorative Services of Community Residences
10. Additional assessments or documents checked below.

PLEASE ATTACH DOCUMENTS:
[ ] Screening/Admission Note
[ ] Copy of the Office of Vocational Rehabilitation Referral (OVR)
[ ] Summary of Chemotherapy Strategies
[ ] Comprehensive Treatment Plan
[ ] Treatment Plan Reviews
[ ] Other: _____
[ ] Other: _____
[ ] Other: _____

ASSESSMENTS:
[ ] Nutritional
[ ] Vocational
[ ] Activities
[ ] Assessment by psychiatrist of need for medication and/or mental health counseling
[ ] Other: _____

HCLA 8

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
CHILD ABUSE REPORTING REQUIREMENTS/ ACKNOWLEDGE POLICY

The Penal Code of the State of California requires that any person on or after January 1, 1985, as a child care custodian, medical practitioner, or non-medical practitioner, or with a child protective agency shall sign a statement that he or she has knowledge of the child abuse reporting law and will comply with its provisions. This statement must be signed prior to commencing employment and is prerequisite to employment.

Section 11166 of the California Penal Code, requires any child care custodian, medical practitioner, non-medical practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within **36 hours** of receiving the information concerning the incident.

Federal Regulations related to the confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, Part 2, in accordance with the Federal Statute, PL 99-401, the Children's Justice and Assistance Act, enacted on October 1, 1986, provide for the reporting of suspected child abuse and neglect by alcohol and drug treatment programs.

In cases where a client refuses to sign Release of Information forms for Suspected Child Abuse and Neglect, a report may still be filed. It is also possible for a court order to be issued at a later time, for release of client identifying information

EMPLOYEE'S LIABILITY FOR FAILURE TO COMPLY:
Any person who fails to report a case of suspected child abuse as required by this law is guilty of a misdemeanor and is punishable by confinement I the County jail for a term not to exceed six months or by fine of not more than one thousand dollars ($1,000) or both.

I have read and understand the Child Abuse Reporting Policy and I have been informed about the Federal Confidentiality regulations and the California Penal Code requirements on reporting child abuse. I acknowledge this by my signature.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

2330 BEVERLY BLVD., LOS ANGELES, CA 90057 • TEL 213/744-0724 • FAX 213/748-2432

COL 1

Colorado Coalition for the Homeless

2100 Broadway
Denver, Colorado 80205
(303) 293-2217
FAX (303) 293-2309

CHILD PROTECTION MANUAL

DRAFT (June 1997)

. . . Working to eliminate homelessness in Colorado.

CHILD PROTECTION MANUAL
Table of Contents

This is not an official copy of this manual. This DRAFT is being shared with other providers who might use this as a resource to create their own Child Protection Manual.

CHILD PROTECTION MANUAL
Signature Page

I have read and understand the materials presented in this manual. I understand that The Colorado Coalition for the Homeless has specific procedures regarding reports of child abuse and neglect and what my role is within these procedures.

DATE	*EMPLOYEE NAME*	*SIGNATURE*

CHILD PROTECTION MANUAL
Overview

CCH Philosophy on Child Protection

As a professional, dealing with child abuse and neglect can be very challenging. We are all concerned about the well-being of the children we serve and seek to advocate on their behalf the best we can. This manual has been designed as a support to these advocacy efforts, so that we can better serve abused and/or neglected children with accurate documentation and reporting procedures.

Although we are often so familiar with family situations that we wish we could recommend specific follow-up for cases of neglect and abuse, that is not our job. Our job is to maintain a high index of awareness and reporting. It is not to make the Department of Social Services or the police do the right thing. The more accurately we gather histories, document reports, and consult with other professionals regarding cases, the easier it will be for the staff of Child Protective Services to do their job of following up on our reports.

Background on Child Abuse and Neglect

In general, "abuse or neglect" means an act or omission of an act which seriously threatens the health or welfare of a child. Child Protective Services is the division of each county's Department of Social Services that handles reports of child abuse and neglect. Follow-up is dictated, first, geographically: the address of the child dictates which county will handle the case. Secondly, C.P.S. will look at the severity of the case *in comparison to the other reports called in that day*. This is important to understand: although we may define a case as severe, C.P.S. may have received "more severe" reports which will push our report further down their priority list.

In Denver, over 7,000 cases of child abuse and neglect are reported each year. Reports are made by teachers, physicians, social workers, clergy, family, friends, and others. Many professionals are mandated to report (see "Mandated Reporters," Section 3) cases of child abuse and neglect. Our staff are among those who are mandated to report.

Child abuse and neglect encompasses many areas including physical abuse, emotional abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Indicators of abuse can include physical marks on children, unexplained injuries, behavioral extremes, severely poor hygiene, and self-reported incidents. The families we serve are "high risk" for child abuse and neglect. "High risk" can include a history of abuse/neglect for the parent; stressors such as poverty, inadequate housing, or marital discord; geographical or social isolation; and depression. Detailed information of child abuse and neglect is included available through the resources listed in Section 8 of this manual.

Although we are not here to "police" our clients, it is important to be consistently aware of the potential for any of the children we serve to have been abused or neglected. We are legally responsible to report such cases and are professionally responsible to do so in a detailed and respectful manner. This manual will equip CCH staff to do so.

CHILD PROTECTION MANUAL
Mandated Reporters

Considerations for Mandated Reporters

Reporting child abuse and neglect is a difficult part of our jobs. The reporter will naturally be concerned about the impact of the report on the family and child. But **the focus must remain on the safety and well-being of the child.** The importance of protecting children is so great that Colorado law mandates the following professionals who work with children and families to report suspected abuse or neglect:

- Physicians or surgeons, including physicians in training
- Child health associates
- Medical examiners or coroners
- Dentists
- Osteopaths
- Optometrists
- Chiropractors
- Chiropodists or podiatrists
- Registered nurses or licensed practical nurses
- Hospital personnel engaged in the admission, care, or treatment of patients
- Christian Science practitioners
- Public or private school officials or employees
- Social workers or workers in family care homes, employer-sponsored on-site child care centers, or child care centers
- Mental health professionals
- Dental hygienists
- Psychologists
- Physical therapists
- Veterinarians
- Peace officers
- Pharmacists
- Commercial film and photographic print processors who observe or have knowledge of films, photographs, slides, or negatives depicting a child engaged in an act of sexual conduct
- Fire fighters
- Victims' advocates

How to Make a Report

A Pre-Reporting Form (Section 6) has been designed for use in all cases which might be called into Child Protective Services by CCH staff.

When considering whether to report a particular incident, the reporter must remain focused on whether or not there is a threat to the health or welfare of a child. The reporter should use her/his own best judgment and present information which causes her/him to think that a child has been harmed or may be in danger as a result of a parent's or caretaker's actions or failure to act. Don't delay because of information that is incomplete, however. Report the information available to the **County Department of Social Services.**

The American Humane Association recommends preparing to make a report by writing down or outlining observations about the situation and the information about the child you want to convey. Information about a child may be gleaned from: 1. what you see, 2. what you hear, 3. what you are told by other people who are in contact with or concerned about the child.

The Department will ask for the following basic identifying information:

- child's name
- child's address
- telephone number
- date of birth
- parent(s) address
- work phone number(s)
- child's location
- a clear description of what has been seen, heard, and reported about the child
- concerns about the child's safety and any immediate dangers to the child or ongoing risks to the child
- reporter's name, address, phone number (required for mandated reporters)

The same information should be reported for the child's siblings and any other children residing in the household.

Additional information that is also helpful to report includes:

- your relationship to the family
- other potential witnesses to your concerns
- collateral agencies and individuals known to be working with the family such as schools, medical personnel, or law enforcement.

Gathering information about circumstances potentially indicating abuse or neglect may be an ongoing process. **But you should report immediately, with the information that you have at hand, if you believe that a child is in immediate danger.** As the reporter, you are not responsible for interviewing and conducting an investigation, and should not attempt to do so. That is the job of your local County Department of Social Services and law enforcement.

Refer to CCH's Pre-Reporting Form (Section 6) for more information on reporting child abuse and neglect.

Response of the Department to the Reporter

When a report or referral is made to the County Department of Social Services, it is reasonable for the reporter to expect a response. County departmental personnel are permitted to tell the reporter whether or not an investigation will be made as a result of the referral. If the Department determines that it will not investigate, staff will, if appropriate, inform the reporter of the reasons for that decision and provide the reporter with the referral information for other community services. If you are told that an investigation will not be completed, but new information or concerns have surfaced, you should report again.

Child Protective Services will not disclose the source of the report to the client. Often, due to the specifics involved with the case, clients might be able to identify the reporting party on their own.

Adapted from materials by the American Humane Association

CHILD PROTECTION MANUAL
CCH Safety Guidelines

On-Site

Staff meeting with clients on-site should adhere to the guidelines for safety which are presented in the CCH Safety Manual. Staff safety is our top priority at all times. Notify security if, at any time, you are concerned about your personal safety. Always alert the security staff if a Child Protective Services worker or the police are coming on site.

Off-Site

Staff conducting off-site visits should refer to the CCH Safety Manual for guidelines in violence prevention and de-escalation techniques. In going off-site, all staff should consider the safety of the neighborhoods entered and the need for cellular phones, having a colleague join for the visit, etc.

Staff are advised to use discretion when calling Child Protective Services while in a client's home. Be aware of your own safety and that of the child at all times. Staff conducting home visits should familiarize themselves with indicators of severely injurious conditions for the rare instances when one needs to call the police to a home. However, it is advised that staff, as a general rule, assess the situation and call C.P.S. from outside the clients' homes.

CHILD PROTECTION MANUAL
CCH Procedures

Reporting Suspected Child Abuse

Whenever there is any suspicion of child abuse and/or neglect, the provider should complete the following steps:

1. **Fill out the Pre-Reporting Form (Section 6).**
2. **Consult with other staff members / colleagues as necessary (see below).**
3. **Notify Child Protective Services, if reporting is deemed necessary.**
   In Denver County, the phone number is 727-3000.

Please be certain that the Pre-Reporting Form is filled out in its entirety. This will ease the process of reporting and assure that all necessary information is gathered. It will also become a part of the child's and/or family's record which is to be kept at CCH. A sample copy of the Pre-Reporting Form follows (Section 7). If you have any questions regarding the form, speak to your department Child Protection Committee contact person or your immediate supervisor.

After reporting, notify other staff as indicated below.

Consults

If there are questions whether to report an incident, CCH staff members may consult someone on the Child Protection Committee for further advice. Please see that list for a C.P.C. member within your department (Section 9).

If there are medical questions surrounding the incident, or an exam is being considered, please consult the physician or a mid-level provider with pediatrics experience.

Another resource for consultation is the Family Crisis Center. The contact there is Paulette Obrigewitch, 572-4609.

Calling Child Protective Services (C.P.S.)

The most important consideration when calling C.P.S. is maintaining the safety and well-being of the child. There are circumstances when the child is not in immediate danger and calling C.P.S. is the most appropriate step. In these cases, separation of the child from the family is not necessary at that time.

However, there are more serious situations, when the child must be separated from the family, caretakers, or potential abuser, and the child needs to remain on CCH premises until s/he can be taken to safety. In these cases, the Denver Police Department is required to be involved. The police should only be called on site when immediate separation is warranted. Before calling the police, consult and get prior approval from either C.P.S. or a Child Protection Committee Member.

continued ...

... continued

Before calling C.P.S., you will need to determine whether to tell the parents about your call. When making this decision, keep in mind the CCH Safety Guidelines (Section 4) outlined in this manual.

Only a single report should be made to C.P.S. for each individual incident, unless there is new information on the case. Multiple reports of the same incident are defined by C.P.S. as harassment.

Staff You Need to Notify

It is important that we, as a staff, communicate about the incidence of child abuse and neglect, as well as the reporting of it. Depending on the nature of your job, your role within your department, and the imminent danger of a situation, you will need to rely on your own judgment as to who "needs to know." The Child Protection Committee recommends that you notify:

1. Your department Child Protection Committee contact person

and/or

2. your immediate supervisor

and (if applicable)

3. other staff and/or departments involved with the child/family.

Documentation You Need to Complete

In order to track the reporting of child abuse and neglect, all staff are being asked to do the following record-keeping when reports have been called in to Child Protective Services:

1. **Fill in your department's log**. It is located in the back of this manual (Section 10).

2. **Forward the original report to the main Child Protection file**, which is located in the office of the Child Protection Committee Chair (Section 9).

Remember, all copies of child abuse and/or neglect reports MUST be kept in confidential locations.

CHILD PROTECTION PRE-REPORTING FORM

Date of Referral: _____

Reported to CPS? ___ yes ___ no
(If yes, remember to forward this original to the Child Protection Committee Chair listed in Section 9.)

INFORMATION ON CHILD:

Name: _____ D.O.B.: _____ Sex: _____

Current Location: _____ Other Address: _____

_____ _____

S.S.# _____ Race: _____

FAMILY COMPOSITION:

Name of parent(s) or guardian(s): _____

Address: _____

_____

Phone: (h)_____ (w)_____

Siblings:

Name	Age	S.S. #
_____	____	_____
_____	____	_____
_____	____	_____

NATURE OF COMPLAINT:

___ lack of adult supervision
___ inadequate clothing
___ poor body hygiene
___ lack of proper medical attention
___ lack of adequate diet
___ exploitation of child
___ physical abuse
___ emotional abuse
___ sexual abuse
___ injurious environment

DESCRIBE THE CONCERN OR INCIDENT:

_____

_____

_____

_____

_____

PAST CONCERNS OF CHILD OR SIBLINGS? ___ yes ___ no

If yes, please describe: _____

_____

PERSON(S) RESPONSIBLE FOR SUSPECTED ABUSE OR NEGLECT (IF KNOWN):

Name: _____ Relationship to child: _____

Address: _____

_____

Phone: (h)_____ (w)_____

PERSON MAKING REFERRAL:

Name: _____

Address: _____

_____

Phone: _____

Position: _____

Signature: _____

OTHERS CONSULTED:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Position: _____ Position: _____

Signature: _____ Signature: _____

ACTION TAKEN:

_____

_____

CPS Called? _____ County: _____ Phone # Called: _____

Name of Person Receiving Call: _____ Time Called: _____

ANY FOLLOW UP?

_____

_____

_____

BODY CHART ATTACHED? ___ yes ___ no

MISCELLANEOUS INFORMATION:

_____

_____

Denver's C.P.S. Hotline: 727-3000

**** Remember to file this original with ****
**** the Child Protection Committee Chair. ****

See Child Protection Manual for more information.

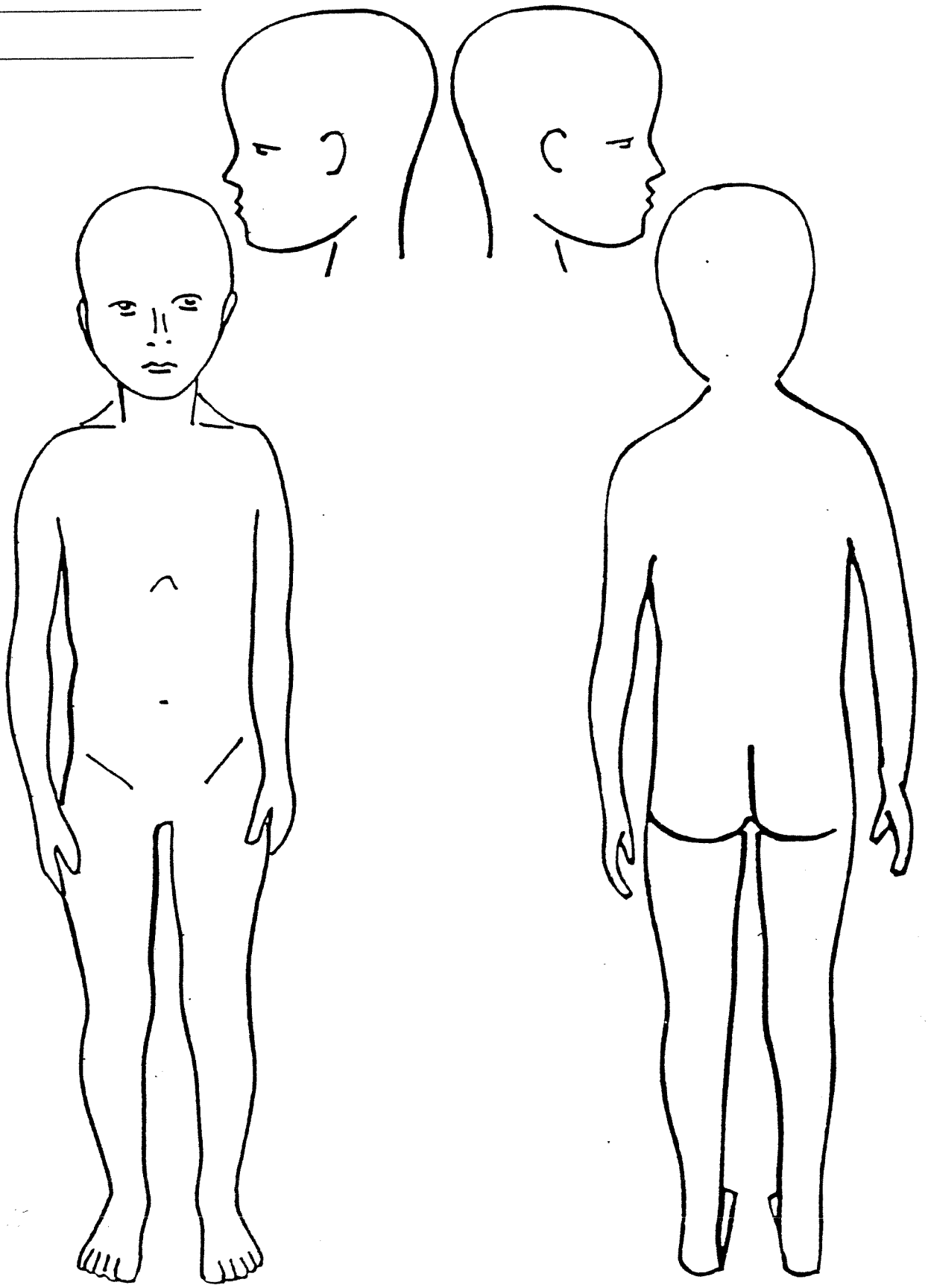
DRAFT (June 1997)

NAME: _____

D.O.B.: _____

S.S.#: _____

DATE: _____



CHILD PROTECTION MANUAL
Guide to Using the Pre-Reporting Form

The following pages outline how to use the Pre-Reporting Form and Body Chart. The Child Protection Committee recommends that staff who have regular contact with children keep copies of these two documents on hand for quick reference. Appendix B of this manual holds originals which you may duplicate and keep filed at your desk for easy access.

CHILD PROTECTION MANUAL
Guide to Using the Pre-Reporting Form

- Page A -

INFORMATION ON CHILD:

Current Location: Indicate where the child is at the time of the report.

Other Address: Child's residential address (street address, shelter, motel, etc.).

FAMILY COMPOSITION:

Siblings: List any other siblings / children residing in the same environment as the child who is being reported.

NATURE OF COMPLAINT:

Lack of adult supervision: Children under the age of 12 left unattended (especially in dangerous situations or for long periods of time). Children presenting injuries which appear to be related to poor supervision.

Inadequate clothing: Clothing completely inadequate to protect from the elements.

Poor body hygiene: Appearance suggests severe lack of self care or hygiene. Medical problems which have been contributed to by poor hygiene.

Lack of proper medical attention: Untreated medical conditions including failure to thrive, developmental delays, mental health concerns, serious physical injuries, or illness.

Lack of adequate diet: Poor weight gain, failure to thrive, health issues related to malnutrition, consistent hunger, or meals being unprovided.

Exploitation of child: Any sexual exploitation of a child for the purposes of prostitution or use in pornography.

Physical abuse: Bruises, welts, burns, fractures, lacerations, abrasions, unexplained injuries, signs of shaken or tossed infant or small child.

Emotional abuse: Failure to provide the physical or mental stimulation that a child needs to grow. Exposure to domestic violence or corruption such as drug abuse / criminal activity. Direct and dramatic threats to child's daily sense of security. Restriction of emotional interaction or access.

Sexual abuse: Inability or unwillingness to support or protect the child. Interaction with the child that is marked by over-stimulating, sexualized behavior. Any forcing, coercing, or threatening of a child to have any form of sexual contact or engage in any type of sexual activity.

Injurious environment: Safety and health hazards in a dwelling such as dangerous substance or objects accessible, human and/or animal waste, no heat in freezing weather, or rodents / bugs. Jeopardizing or refusing to seek adequate shelter.

** For more descriptions of child abuse and neglect, refer to the resource materials listed in Section 8 of this manual.*

DESCRIBE THE CONCERN OR INCIDENT:

Indicate the time the incident was made known to you. Provide as much detail as possible. Use language that is non-judgmental, such as "appears," "seems to," "claims," etc. Describe indicators of abuse, other parties witnessing complaint, previous reports of abuse, where abuse took place, emotional state of involved parties, etc. Quote involved individuals where appropriate. Include a body chart as needed to describe the abuse.

PAST CONCERNS OF CHILD OR SIBLINGS:

Make note of previous reports or previous documentation of suspected abuse or neglect.

SAMPLE

CHILD PROTECTION PRE-REPORTING FORM

SAMPLE

Date of Referral: 10/21/96

Reported to CPS? X yes ___ no
If yes, remember to forward this original to the Child Protection Committee Chair

INFORMATION ON CHILD:

Name: JANE MARTIAN D.O.B.: 6/12/92 Sex: F

Current Location: F.C.C. Other Address: SAMARITAN HOUSE

S.S.# 123-45-6789 Race: CAUCASIAN

FAMILY COMPOSITION:

Name of parent(s) or guardian(s): MARTHA MARTIAN

Address: SAMARITAN HOUSE

Phone: 294-0241

Siblings:

Name	Age	S.S. #
JOHN MARTIAN	18mos.	123-45-6788
BETH MARTIAN	2½	123-45-6781

NATURE OF COMPLAINT:

___ lack of adult supervision
___ inadequate clothing
___ poor body hygiene
___ lack of proper medical attention
___ lack of adequate diet
___ exploitation of child
X physical abuse
___ emotional abuse
___ sexual abuse
___ injurious environment
___ other

DESCRIBE THE CONCERN OR INCIDENT:

AT 9:30AM CHILD COMPLAINED TO CLASSROOM TEACHER THAT HER "BOTTOM HURT." TEACHER ASKED "WHERE?" JANE TOUCHED HER BUTTOCKS AND SAID "HERE." TEACHER ASKED "DID YOU GET HURT?" JANE REPLIED "MY MOMMY WHOOPED ME WITH A BELT." CLASSROOM TEACHER ASKED ANOTHER TEACHER TO BE PRESENT WHILE EXAMINING AREA OF COMPLAINT. (SEE BODY CHART.) CHILD TAKEN TO P.N.P. FOR FURTHER EXAM.

PAST CONCERNS OF CHILD OR SIBLINGS? X yes ___ no

If yes, please describe: MOM HAS STATED IN THE PAST THAT SHE USES PHYSICAL DISCIPLINE.

CHILD PROTECTION MANUAL
Guide to Using the Pre-Reporting Form

- Page B -

PERSON(S) RESPONSIBLE FOR SUSPECTED ABUSE OR NEGLECT:

Provide information on suspected abuser(s) as accurately as possible.

PERSON MAKING REFERRAL:

Document your position at CCH and your direct phone number.

OTHERS CONSULTED:

Indicate with whom you have consulted (in-house staff and/or outside resources) as needed. If appropriate, have those you have consulted sign the form.

ACTION TAKEN:

Document the decision to call or not to call C.P.S. If C.P.S. was called, note the number dialed, the person spoken to, and the time of the call. Describe any medical attention given or any staff consultation with the child/parent regarding the suspected abuse or neglect.

ANY FOLLOW UP?

Describe any medical or mental health appointments related to the incident, any paperwork completed (e.g. "incident noted in medical chart"), any phone calls or contacts, etc.

BODY CHART ATTACHED?

Indicate if you have completed a body chart.

MISCELLANEOUS INFORMATION:

Use this space for pertinent information which is not covered elsewhere on the form.

A COPY OF EVERY PRE-REPORTING FORM FOR WHICH C.P.S. WAS CALLED MUST BE FILED IN THE CHILD PROTECTION MAIN FILE WHICH IS MAINTAINED BY THE CHILD PROTECTION COMMITTEE CHAIR LISTED ON SECTION 9 OF THIS MANUAL.

SAMPLE

PERSON(S) RESPONSIBLE FOR SUSPECTED ABUSE OR NEGLECT (IF KNOWN):

Name: MARTHA MARTIAN Relationship to child: MOTHER

Address: SAMARITAN HOUSE

Phone: 294-0241

PERSON MAKING REFERRAL:

Name: BARBIE DOHLE

Address: 2100 BROADWAY
DENVER CO 80205

Phone: 293-2217 x555

Position: E.C.E. TEACHER

Signature: Barbie Dohle

OTHERS CONSULTED:

Name: DIANA PRINCE

Address: 2100 BROADWAY
DENVER CO 80205

Phone: 293-2217 x554

Position: INFANT TEACHER

Signature: Diana Prince

Name: KELLY GARRETT

Address: 2100 BROADWAY
DENVER CO 80205

Phone: 293-2220

Position: P.N.P.

Signature: Kelly Garrett

ACTION TAKEN:

INCIDENT REPORTED TO C.P.S. PARENT + CHILD REMAINED ON SITE UNTIL A WORKER ARRIVED TO DISCUSS INCIDENT.

CPS Called? YES County: DENVER Phone # Called: 727-3000

Name of Person Receiving Call: JANE DOE Time Called: 10:50AM

ANY FOLLOW UP?

INCIDENT DOCUMENTED IN FCC + SSC CHARTS. CPS WORKER WILL UPDATE CCH STAFF AS NEEDED. ASSIGNED WORKER IS CLARK KENT, 727-9999.

BODY CHART ATTACHED? X yes ___ no

MISCELLANEOUS INFORMATION:

BECAUSE OF PRIOR C.P.S. REPORTS ON MARTHA, CPS DISPATCHED A WORKER IMMEDIATELY AND ASKED US TO KEEP HER HERE.

Denver's C.P.S. Hotline: 727-3000

**** Remember to file this original with ****
**** the Child Protection Committee Chair. ****

See Child Protection Manual for more information.

CHILD PROTECTION MANUAL
Guide to Using the Pre-Reporting Form

- Page C -

BODY CHART

Label and describe each mark, using specifics (i.e. type, color, size, shape, etc.). Illustrate marking(s) on body chart in approximate scale. Include any relevant quotes from the child or involved parties regarding the source of marks and/or injuries.

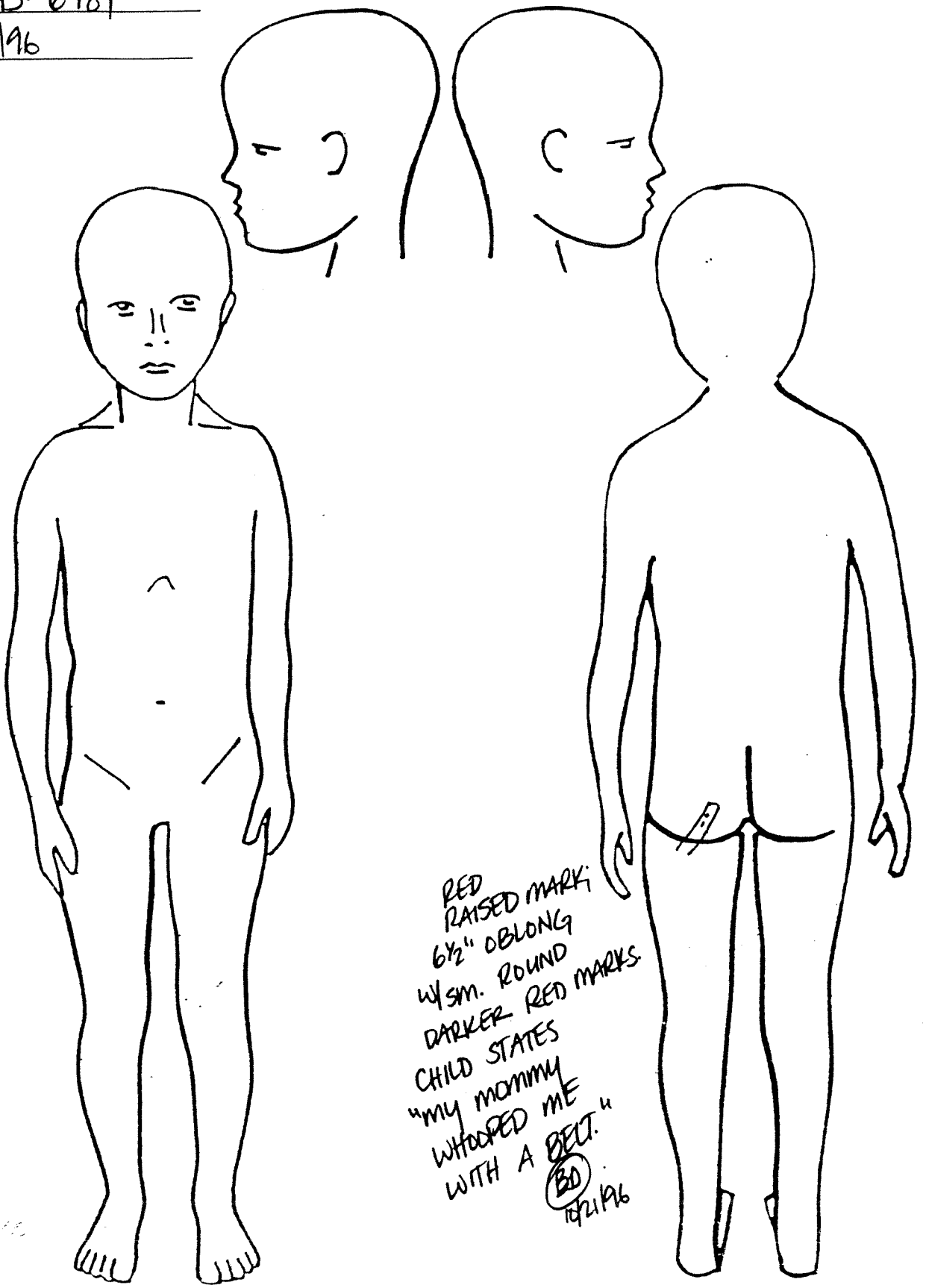
NAME: JANE MARTIAN

D.O.B.: 6/12/92

S.S.#: 123-45-6789

DATE: 10/21/96

SAMPLE



CHILD PROTECTION MANUAL
Resource List

Child Protective Sevices (County Listing)

COUNTY	PHONE #	OFFICE HOURS	AFTER HOURS #	HOURS
Adams County	412-8121 (ask for C.P.S.)	8:00am - 4:30pm M - F	412-5212	after 4:30pm / weekends
Arapahoe County	795-4825	8:00am - 4:30pm M - F	none needed	4:30pm - 10pm M - F Noon - 10pm Sa / Su
Boulder County	441-1240 or 441-1000	8:00am - 4:30pm M- F	none needed	24-hour on-call intake
Denver County	727-3000	8:00am - 5:00pm M - F	none needed	24-hour on-call intake
Douglas County	688-4825 (ask for C.P.S.)	8:30am - 4:30 pm M - F	660-7500 (Sherriff's Dept.)	after 4:30pm / weekends
Jefferson County	271-4131 (ask for C.P.S.)	8:00am - 5:00pm M - F	none needed	24-hour on call intake

In emergent situations, you may need to ask for a supervisor when reporting. When calling, please note that, if a family has an open welfare case in a specific county, the report should go to that county's CPS office, even if the family is temporarily sheltered in a different county.

Denver County Agencies

Children's Hospital Child Advocate and Protection Team
Contact: Andy Sirotnak, MD
Phone: 861-6919

Crisis Intervention Program
Contact: Connie Clifton
Phone: 292-3060 ext. 205; after hours #: 296-5131

Denver Dept. of Social Services
Contact: any supervisor
Phone: 727-3000

Family And Community Education & Support (FACES)
Contact: Ann DeForest Afton, MA
Phone: 782-9337

Family Crisis Center
Contact: Paulette Obridgewitch, NP
Phone: 572-4609

Mental Health Corp. of Denver
Contact: Barb Schaffer, Family Preservation Program
Phone: 757-7227

continued ...

... continued

Resource Materials

A resource binder with many articles related to Child Protection is located in the office of the Child Protection Committee Chair (see Section 9) for staff use.

In addition, the following reading lists are good sources of information on child protection issues.

Child Abuse and Child Sexual Abuse Reference Textbooks

American Academy of Pediatrics. A Guide to References and Resources in Child Abuse and Neglect. 1994 - due for revision.

Briere J, Berliner L, Bukley JA, Jenny C, Reid T. The APSAC Handbook on Child Maltreatment. SAGE Publications, Thousand Oaks CA, 1996

Chadwick DL, Berkowitz CD, Kerns D, Mc Cann J et al. Color Atlas of Child Sexual Abuse. Mosby Yearbook, St. Louis 1989.

Giardino AP, Finkel MA, Giardino ER, Seidl T, Ludwig S. A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child. SAGE Publications. Newbury Park, CA 1989.

Heger A, Emans SJ. Evaluation of the Sexually Abused Child: A Medical Textbook and Photographic Atlas. Oxford University Press,New York, 1992.

Kleinman PK. Diagnostic Imaging of Child Abuse. Williams & Wilkins, Baltimore 1987.

Ludwig S, Kornberg AE. Child Abuse: A Medical Reference. Churchill Livingstone, New York. 1992.

Monteleone JA, Brodeur.Child Maltreatment: A Clinical Guide and Reference. GW Medical Publishing, St. Louis, 1994.

Reece RM. Child Abuse: Medical Diagnosis and Management. Lea & Febiger, Philadelphia, 1994.

CHILD ABUSE

BOOKS FOR ADULTS

THE BATTERED CHILD. 3rd ed. C. Henry Kempe and Ray E. Helfer. University of Chicago Press, 1980. Classic book on understanding the causes and contexts of child abuse, assessment, intervention and treatment, and prevention.

BY SILENCE BETRAYED: SEXUAL ABUSE OF CHILDREN IN AMERICA. John Crewdson. Little, Brown, 1988. Objective, yet compassionate report and analysis of child sexual abuse and the people involved from the victims and abusers to advocates, law enforcement officials and lawyers.

CHILD ABUSE: AN AMERICAN EPIDEMIC. Elaine Landau. Rev. ed. Messner, 1990. Discusses the many forms child abuse can take, its causes and what can be done to prevent it.

EMOTIONAL CHILD ABUSE: THE FAMILY CURSE. Joel Covitz. Sigo Press, 1986. Examines the causes and effects of dysfunctional parenting from its subtle to more blatant forms.

HELPING ABUSED CHILDREN: A BOOK FOR THOSE WHO WORK WITH SEXUALLY ABUSED CHILDREN. Patricia Kehoe. Parenting Press, 1988. Provides an overview of sexual abuse, signs and symptoms, suggested activities, books and games to encourage recovery, how to encourage prevention in families and an overview of treatment and aftermath.

MALTREATMENT AND THE SCHOOL-AGE CHILD: DEVELOPMENTAL OUTCOMES AND SYSTEM ISSUES. Phyllis T. Howing. Haworth Press, 1993. Assessment of the long-term effect of physical abuse and neglect on school-age children and suggestions on how to improve existing efforts to prevent and respond to child maltreatment.

NO MORE SECRETS: PROTECTING YOUR CHILD FROM SEXUAL ASSAULT. Caren Adams and Jennifer Fay. Impact Publishers, 1981. Practical answers to questions parents ask about sexual assault prevention, talking with children and what to do if it happens.

OUTGROWING THE PAIN: A BOOK FOR AND ABOUT ADULTS ABUSED AS CHILDREN. Eliana Gil. Dell, 1983. Easy-to-read book to help adults try to make sense of the issues of abuse in the past and how to seek help.

PROTECT YOUR CHILD: A PARENT'S SAFEGUARD AGAINST CHILD ABDUCTION AND SEXUAL ABUSE. Laura M. Huchton. Prentice-Hall, 1985. Safety training for parents on protecting their children from abduction and abuse. Topics such as stranger awareness, safety away from home and in public places are covered.

THE SAFE CHILD BOOK. Sherryll Kerns Kraizer. Dell, 1985. For parents about sexual abuse and victimization. Emphasizes safety techniques for teaching children ages 3-12 personal safety rules.

SEXUAL ABUSE--LET'S TALK ABOUT IT. Margaret O. Hyde. Westminster Press, 1987. Discusses the sexual abuse of children, how they can protect themselves, where to seek help and kinds of help available and how to increase public awareness of abuse. Suggested ages teenage to adult.

The Children's Hospital
1056 East 19th Avenue Denver, Colorado 80218
Affiliated with
University of Colorado Health Sciences Center

All books listed are available in the Family Resource Center

(over)

SOMEWHERE A CHILD IS CRYING: MALTREATMENT--CAUSES AND PREVENTION. Vincent J. Fontana. New American Library, 1983. Case histories that reveal the extent and nature of child maltreatment, the failure of society to come to grips with it, and the changes that are needed to save future victims.

WHAT ONLY A MOTHER CAN TELL YOU ABOUT CHILD SEXUAL ABUSE. Karen Schaefer. Child Welfare League of America, 1993. First-person account of the emotional, social, legal and financial costs of sexual abuse on the child, family and society.

YOUR CHILDREN SHOULD KNOW: PERSONAL-SAFETY STRATEGIES FOR PARENTS TO TEACH THEIR CHILDREN. Flora Colao and Tamar Hosansky. Perennial Library, 1987. Discusses warning signs that may indicate to parents that abuse has already taken place, safety rules for prevention, the medical and legal process if abuse occurs and the emotional consequences of abuse.

ORGANIZATIONS

AMERICAN HUMANE ASSOCIATION / CHILDREN'S DIVISION
Operates the: NATIONAL RESOURCE CENTER ON CHILD ABUSE/NEGLECT.
63 Inverness Drive East, Englewood, CO 80112-5117. 303-792-9900. 800-227-5242.

C. HENRY KEMPE CENTER FOR THE PREVENTION AND TREATMENT OF CHILD ABUSE.
1205 Oneida Street, Denver,CO 80220. 303-321-3963.

CHILD FIND OF AMERICA, INC., NY. Hotline: 800-426-5678. Mediation: 800-292-9688.

CHILD WELFARE LEAGUE OF AMERICA. Washington, DC. 202-638-2952.

NATIONAL CENTER ON CHILD ABUSE & NEGLECT. Wash., DC. 800-FYI-3366. 202-205-8586.

NATIONAL CENTER FOR MISSING/EXPLOITED CHILDREN. Arlington, VA. 800-843-5678.

NATIONAL CHILD ABUSE HOTLINE. CA. 800-422-4453.

NATIONAL CLEARINGHOUSE ON CHILD ABUSE/NEGLECT INFORMATION. Wash., DC.
800-394-3366. 703-385-7565.

NATIONAL COMMITTEE TO PREVENT CHILD ABUSE. Chicago. 800-835-2671. 312-663-3520.

NATIONAL RESOURCE CENTER ON CHILD SEXUAL ABUSE. Huntsville, AL. 800-543-7006.

PARENTS ANONYMOUS. Los Angeles, CA. 800-421-0353.

ELECTRONIC RESOURCES

Health Reference Center
Pediatric Advisor (book list only)

Colorado Coalition for the Homeless

2100 Broadway
Denver, Colorado 80205
(303) 293-2217
FAX (303) 293-2309

If you have a client who is ineligible for services due to lack of legal custody of a child who is not hers/his biologically, but the client has a well-documented and arguable case, and would like to seek legal guardianship, s/he can **petition for legal guardianship at the Probate Court** on the 2nd floor of the City and County Building (on the Colfax end of the building). There is a small fee for this service.

The individual will petition for Temporary Guardianship / Custody pending a hearing and be given verification of a hearing date. It is recommended that s/he bring any proof that s/he has been providing for the child in question. The court will seek out the biological parents for the hearing date. At the hearing, if there is no contest to the arrangement, guardianship is likely to be awarded to the applicant on a long-term temporary basis.

The individual would only need legal assistance if the petition for guardianship was contested by the biological parent or someone else.

This information was obtained from the Child Protective Services division of Denver Dept. of Social Services.

sn 4/97

CHILD PROTECTION MANUAL
Committee Members / In-House References

Child Protection Committee Members

Ed Farrell	ext. 126	Stout St. Clinic	(beeper: 855-4668)
Kathy Gansemer	ext. 183	Homeless Families Project	
Ali Hesson	ext. 182	Family Community Center	
Rachel Hutson	ext. 169	Stout St. Clinic / F.C.C.	(beeper: 855-5236)
* Shari Nacson	ext. 160	Homeless Families Project	
Dave Ursone	ext. 154	Homeless Families Project	

* Child Protection Committee Chair

Medical Staff with Pediatrics Training

Ed Farrell, M.D.
Rachel Hutson, P.N.P.
Kay Kinzie, F.N.P.
Frank Scalise, P.A.

The medical staff should be consulted if there is a need for medical evaluation or other input from a health care provider.

On-Going Plan for the Child Protection Committee

Child Abuse Prevention Month

Increase agency awareness regarding Child Abuse Prevention Month (April).

Printed Information

The Child Protection Committee will circulate relevant information regarding child protection via our employee newsletter and other distribution mechanisms.

As an outreach effort, the Child Protection Committee will make available copies of this manual to other homeless providers. If CCH a staff-member should receive an inquiry from a provider who would like a copy, s/he should direct the inquirer to the Child Protection Committee Chair listed above.

Staff In-Services

Staff in-services on child protection will be held agency-wide at least once every 6 months.

Child Protection Committee Meetings

The C.P.C. will meet regularly, at least 4 times per year.

CHILD PROTECTION MANUAL
Departmental Log of C.P.S. Reports

Date of Incident	*Child's Name*	*Date of Birth*	*Social Security Number*	*Staff Initials*

1.2. Children's Code

Title 19 of Colorado Revised Statutes is known as the Colorado Children's Code. C.R.S. §19-1-101. The purposes of the Code are to:

(a) Secure care and guidance for each child subject to the code, preferably in his own home, as will best serve his welfare and the interests of society;

(b) Preserve and strengthen family ties wherever possible, including improvement of the home environment;

(c) Remove a child from the custody of his parents only when his welfare and safety or the protection of the public would be endangered and, in either instance, for the courts to proceed with all possible speed to a legal determination that will serve the best interests of the child; and

(d) Secure the necessary care, guidance, and discipline for any child removed from the custody of his parents to assist him in becoming a responsible and productive member of society.

In addition, the courts and the media are to refrain from causing undue hardship, discomfort, and distress to any child victims of sexual assault, child abuse, incest, sexual exploitation, procurement, trafficking or child prostitution (see §1.4) by not disseminating or publishing their names. C.R.S. §19-1-102(1.7).

The Colorado Children's Code provides for the following guarantees for children who have been removed from home:

(I) To be placed in a secure and stable environment;

(II) To not be indiscriminately moved from foster home to foster home; and

(III) To have assurance of long-term permanency planning.

C.R.S. §19-1-102(1.5)(a). The court has a duty to enforce these rights. Even when parental rights are at stake, the primary and controlling issue is what will best serve the interests and welfare of the child. *People in the Interest of M.M.*, 520 P.2d 128 (Colo. 1974), *appeal after remand*, 533 P.2d 913 (Colo. 1975).

To carry out these purposes, the general assembly states that the Code should be liberally construed to serve the welfare of children and the best interests of society. C.R.S. §19-1-102(2). According to the Supreme Court of Colorado, the Code is to be construed *in pari materia*—the various portions of the statute should be read together with all the other statutes relating to the same subject or having the same general purpose so that the legislature's intent may be ascertained. *R.E.N. v. City of Colorado Springs*, 823 P.2d 1359 (Colo. 1992).

Practice Commentary

In Colorado, the purpose of the Children's Code in dependency and neglect proceedings is to "provide the jurisdictional basis for child(ren) in establishing a relationship and home environment that will preserve the family unit." *Interest of A.M.D.*, 648 P.2d 628, 640 (Colo. 1982).

Ramirez

1.2.1. Court

Under the Children's Code, the "juvenile court" or "court" means the Juvenile Court of Denver or, outside of Denver, the juvenile division of the district court. C.R.S. §19-1-103(17). It does not include municipal courts. *R.E.N. v. City of Colorado Springs*, 823 P.2d 1359 (Colo. 1992).

Practice Commentary

In 1987, Denver enacted a city ordinance establishing a municipal juvenile court. Revised Municipal Code of the City and County of Denver, Colorado, section 34. Therefore, at the present time two juvenile courts exist in Denver. The municipal court has jurisdiction over juveniles 10 to 18 years of age who violate the municipal code, i.e., by violating curfew, shoplifting, trespassing, etc. The penalities for convictions include fines of for convictions include fines of up to $999, imposition of court costs and/or for useful public service and probation. The municipal courts do not have the authority to impose a jail sentence under the Children's Code, absent a finding of contempt of court. In that situation, the maximum confinement which may be imposed is 48 hours.

Ramirez

1.2.2. Adult, Juvenile and Child

An "adult" under the Children's Code is any person age 18 or older. C.R.S. §19-1-103(3).

A person over 18 may be considered a "juvenile" under the Code if he is:

- under the continuing jurisdiction of the court;
- before the court for an alleged delinquent act committed before his 18th birthday; or
- subject to an adoption petition filed other than under the Children's Code.

C.R.S. §19-1-103(3).

A "child" is a person under 18 years of age. C.R.S. §19-1-103(4). In practice, the term "child" is used in dependency and neglect proceedings and "juvenile" in delinquency proceedings.

1.2.3. Parent, Guardian, and Custodian

Under the Children's Code, a "parent" means either a natural parent of the child or a parent by adoption. C.R.S. §19-1-103(21). A parent can only lose legal custody of a child by court action. "Legal custody" is the right to the care, custody and control of a child and the duty to provide food, clothing, shelter, ordinary medical care, education, and discipline for a child. It also includes the right, in an emergency, to authorize surgery or other extraordinary care. C.R.S. §19-1-103(18).

If legal custody or guardianship of the child has been vested in another person, institution or agency, the parent still retains "residual parental rights and responsibilities." These rights include but are not necessarily limited to:

- the responsibility for support;
- the right to consent to adoption;
- the right to reasonable parenting time unless restricted by the court; and
- the right to determine the child's religious affiliation.

C.R.S. §19-3-101(2). If the parent-child legal relationship is terminated by the court, all parental rights and duties, including these residual parental rights, are permanently eliminated (see § 5.1). C.R.S. §19-3-101(5). See C.R.S. § 19-3-608 for a more comprehensive delineation of the effect of the court's order.

A "guardianship of the person" means the court vests another person with the duty and authority to make major decisions affecting a child, including but not limited to:

(a) the authority to consent to marriage, enlistment in the armed forces, and medical or surgical treatment;

(b) the authority to represent the child in legal actions and to make other decisions of legal significance concerning the child;

(c) the authority to consent to adoption of the child after termination of the parent-child legal relationship; and

(d) the rights and responsibilities of legal custody when legal custody has not been vested with another person, agency or institution.

C.R.S. §19-1-103(15). A "guardian" is not the same as a "guardian ad litem" who is appointed to represent the best interests of the child in court (see §1.1.6).

A "custodian" means a person who has been providing shelter, food, clothing, and other care for a child in the same fashion as a parent would, whether or not by court order. C.R.S. §19-1-103(8).

For dependency and neglect proceedings (see Chapter 3), a "responsible person" is a child's parent, legal guardian or custodian, or any other person responsible for the child's health and welfare. C.R.S. §19-3-103(7).

1.2.4. Stepparent, Spousal Equivalent, and Grandparent

Under the Children's Code, a "stepparent" is person married to a parent of a child, but who has not adopted the child. C.R.S. §19-1-103(26).

A "spousal equivalent" is a person who is in a family-type living arrangement with a parent and who would be a stepparent if married to that parent. C.R.S. §19-1-103(25).

A "grandparent" is a parent of the child's father or mother, who is related to the child by blood (in whole or in half), adoption, or marriage. C.R.S. §19-1-103(12.5).

1.2.5. Child, Family and Group Care Facilities

A "child care center" under the Children's Code is a licensed and approved facility that provides care for five or more children for the whole or part of a day. C.R.S. §19-1-103(5). They include day care centers, day nurseries, nursery schools, kindergartens (separate from elementary schools), preschools, play groups, day camps, summer camps, centers for developmentally disabled children, and facilities that give 24-hour care to dependent and neglected children. C.R.S. §26-6-102(1)(a). Out-of-state child care centers must be licensed or approved in that state and DSS must certify that no appropriate available space exists in Colorado. C.R.S. §19-1-103(5).

A "family care home," commonly known as a foster care home, is a licensed and approved residence of a family or a person who provides family care and training for an unrelated child under 16 years of age. C.R.S. §§19-1-103(12) & 26-6-102(4). Out-of-state family care homes must be licensed or approved in that state and DSS must certify that no appropriate available space exists in Colorado. C.R.S. §19-1-103(12).

"Group care facilities and homes" are licensed placements other than foster family homes providing care for small groups of children, including institutions meeting the requirements for caring for the developmentally disabled. C.R.S. §§19-1-103(13); 26-6-102 & 27-10.5-109.

1.2.6. Protective Supervision and Out-of-Home Placement

"Protective supervision" under the Children's Code is a legal status created by court order under which the child is permitted to remain at home or with a relative or other suitable person (see §3.8.3) and the court, DSS or another agency designated by the court provides supervision and assistance. C.R.S. §19-1-103(23).

"Placement out of the home" means placement for 24-hour residential care in any facility or center licensed or operated by DSS or the Department of Institutions (see §1.2.5). It does not include any placement which is paid for totally by private moneys or any placement in a home under an adoption decree of a foreign country (see §6.3.6). C.R.S. §§ 19-1-103(22) &19-5-205. According to *Heim v. District Court*, 575 P.2d 850 (Colo. 1978), the juvenile court has the authority to place minors in the custody of private facilities and direct payment by the appropriate department of social services.

1.2.7. Shelter and Detention

Under the Children's Code, "shelter" is defined as the temporary care of child in physically unrestricted facilities pending court disposition or execution of a court order for placement. C.R.S. §19-1-103(24).

"Detention" means the temporary care of a child who requires secure custody in physically restricting facilities pending court disposition or an execution of a court order for placement or commitment. C.R.S. §19-1-103(10). If it is determined that a child taken into temporary custody requires a staff-secure or physically secure setting before a detention hearing is held, she must be placed in a temporary holding facility. A "temporary holding facility" must be separated by sight and sound from any area which houses adult offenders. C.R.S. §19-1-103(27).

CHILD PROTECTION MANUAL
Signature Page

I have read and understand the materials presented in this manual. I understand that The Colorado Coalition for the Homeless has specific procedures regarding reports of child abuse and neglect and what my role is within these procedures.

DATE	*EMPLOYEE NAME*	*SIGNATURE*

CHILD PROTECTION PRE-REPORTING FORM

Date of Referral: _____

Reported to CPS? ___ yes ___ no
(If yes, remember to forward this original to the Child Protection Committee Chair listed in Section 9.)

INFORMATION ON CHILD:

Name: _____ D.O.B.: _____ Sex: _____

Current Location: _____ Other Address: _____

_____ _____

S.S.# _____ Race: _____

FAMILY COMPOSITION:

Name of parent(s) or guardian(s): _____

Address: _____

_____

Phone: (h)_____ (w)_____

Siblings:

Name	Age	S.S. #
_____	____	_____
_____	____	_____
_____	____	_____

NATURE OF COMPLAINT:

___ lack of adult supervision
___ inadequate clothing
___ poor body hygiene
___ lack of proper medical attention
___ lack of adequate diet
___ exploitation of child
___ physical abuse
___ emotional abuse
___ sexual abuse
___ injurious environment

DESCRIBE THE CONCERN OR INCIDENT:

_____

_____

_____

_____

_____

PAST CONCERNS OF CHILD OR SIBLINGS? ___ yes ___ no

If yes, please describe: _____

_____

PERSON(S) RESPONSIBLE FOR SUSPECTED ABUSE OR NEGLECT (IF KNOWN):

Name: _____ Relationship to child: _____

Address: _____

_____

Phone: (h)_____ (w)_____

PERSON MAKING REFERRAL:

Name: _____

Address: _____

_____

Phone: _____

Position: _____

Signature: _____

OTHERS CONSULTED:

Name: _____

Address: _____

_____

Phone: _____

Position: _____

Signature: _____

Name: _____

Address: _____

_____

Phone: _____

Position: _____

Signature: _____

ACTION TAKEN:

_____

_____

CPS Called? _____ County: _____ Phone # Called: _____

Name of Person Receiving Call: _____ Time Called: _____

ANY FOLLOW UP?

_____

_____

_____

BODY CHART ATTACHED? ___ yes ___ no

MISCELLANEOUS INFORMATION:

_____

_____

Denver's C.P.S. Hotline: 727-3000

**** Remember to file this original with ****
**** the Child Protection Committee Chair. ****

See Child Protection Manual for more information.

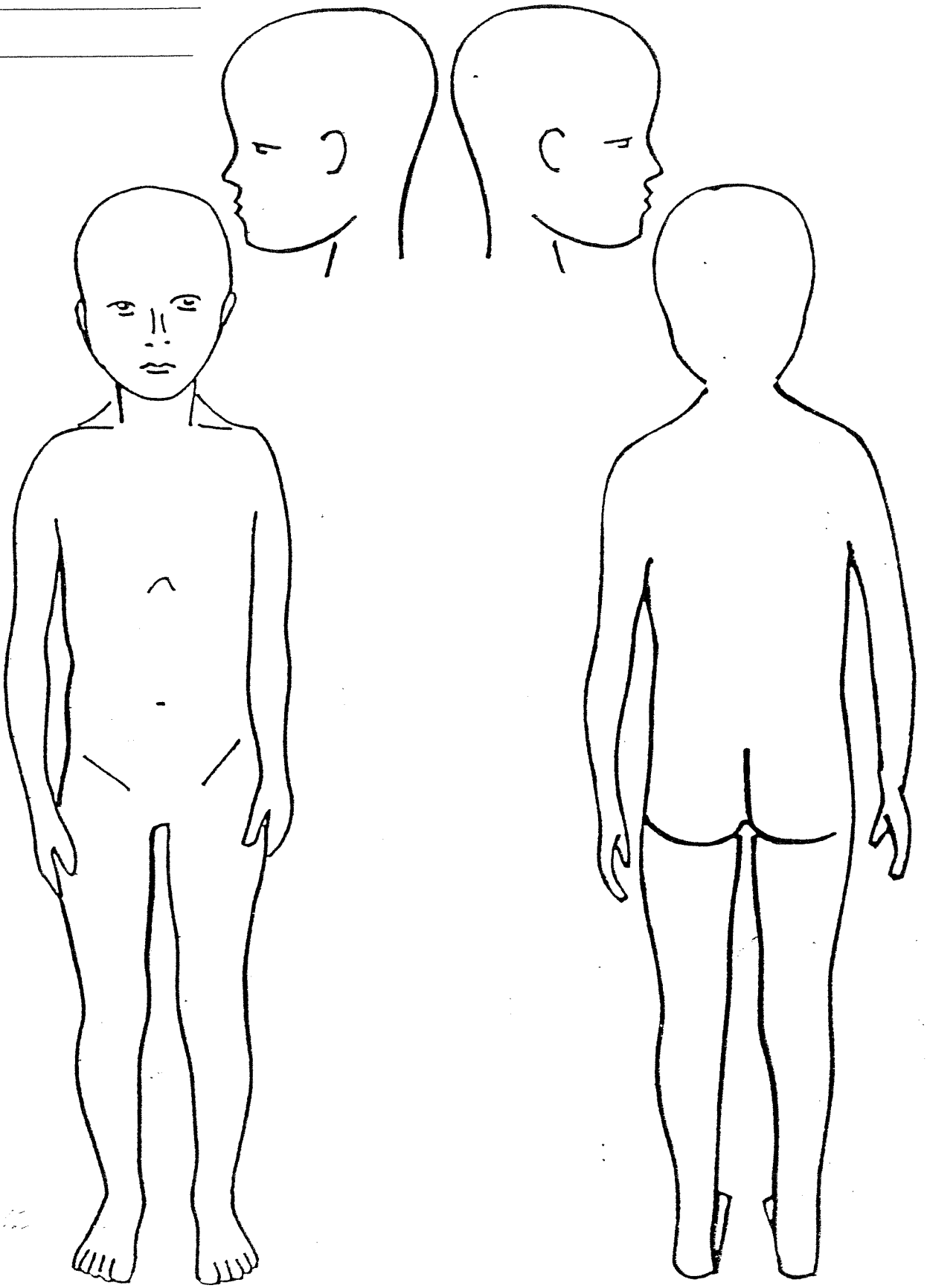
DRAFT (June 1997)

NAME: _____

D.O.B.: _____

S.S.#: _____

DATE: _____



CHILD PROTECTION MANUAL
Departmental Log of C.P.S. Reports

Date of Incident	*Child's Name*	*Date of Birth*	*Social Security Number*	*Staff Initials*

BIR 7

Birmingham Health Care for the Homeless Coalition, Inc.

P.O. Box 11523, Birmingham, Alabama 35202

CLIENT LEGAL AND HUMAN RIGHTS AND GRIEVANCE PROCEDURES WHILE RECEIVING TREATMENT THROUGH BHCHC OUTPATIENT PROGRAMS

Our policy is to continue to protect our client's constitutional, legal and human rights. The procedures used to protect these rights are defined below:

No Client will be discriminated against by BHCHC or by any staff member on the bases of race, religion, sex, ethnicity, age, handicap, creed, national origin, social status, diagnostic category, sexual preference or length of residence in the service area.

Clients have the right to privacy and confidentiality concerning their presence in treatment, as well as the right to personal privacy, space, personal communications, and protection from visitors entering the facility. These rights are to be respected by everyone. Visitors will not be allowed to "sit in" during therapy sessions. This policy does not prevent interns from attending or cofacilitating therapy groups.

Clients have a right of access to their own medical records. This agency shall have the client sign an authorization form, releasing information to the client, before such information will be released. The agency will inform the client of the full nature of any request of client information and the client will be made fully aware of any sensitive information which may be released before the client authorizes the release of such information.

Every client shall have the right to file a complaint and/or grievance either against the personnel staff or the program operation. A complaint or grievance may be made either orally or in writing to the Director of Clinical Services who shall take necessary action to investigate such complaints immediately.

Specific consent shall be obtained from the client before the use of any special surveillance equipment, such as two-way mirrors, cameras, etc., for observation of drug screen testing.

The client shall: be allowed to actively participate in treatment, including discharge planning, if appropriate; be protected from harm including any form of abuse, neglect or mistreatment; receive treatment and care in a safe and humane environment; receive the least restrictive treatment appropriate and available; be informed of the nature of possible significant adverse effects of the recommended treatment, including any appropriate and available alternative treatments, services and types of providers, including substance abuse services if applicable.

A copy of this statement will be prominently and permanently displayed at all BHCHC treatment facilities. In addition, each client will be furnished a personal copy of this statement at the time of admission into a BHCHC program.

Patient: _____
(Please Print Patient Name)

Signature: _____
(Patient, Parent, Legal Guardian)

Witness: _____

Date: _____

PCC 1

Pinellas County Coalition For The Homeless

2000 - 2001

COLD NIGHT SHELTER

TRAINING BOOKLET

DECEMBER 2000

Post Office Box 11195 • St. Petersburg, Florida 33733 • Phone (727)328-7759 • Fax (727)328-7860

In Appreciation

This booklet (2000 update) represents a tribute to those churches, community agencies and volunteers who have demonstrated the dedication necessary to address, and to a great degree, to positively affect the potential for resolution of a community problem. The fact that many of them have been involved since the first year of operation (1986), gives testimony to the sense of personal satisfaction of being part of a job well done and of serving one's fellow man.

The Pinellas County Coalition For The Homeless
sincerely thanks each of them.

FORWARD

The training booklet has been prepared by the Cold Night Shelter Subcommittee of the Pinellas County Coalition for the Homeless. It is intended to prepare you for the task you have undertaken: to provide cold night shelter for those people who lack a warm, safe place to spend the night.

We do not claim to have all of the answers to the questions or situations that will arise. We do feel that we have the basic guidelines to stimulate your thinking and to give you an overview of what needs to be done.

Each shelter will differ as a result of facilities and the personalities and resources of those involved. The common service to be provided is simply a safe, warm place to spend the night.

The service we provide through the Cold Night Shelters will be personally rewarding, enriching the lives of those who are helped, as well as those who help. Our community churches seem to be the single best means of addressing a community tragedy.

COLD NIGHT SHELTER TRAINING GUIDE FOR VOLUNTEERS

1. Overview of Shelter Personnel
2. Duties of the Shelter Coordinator
   - A. Select a Committee
     - (1) Shelter Manager
     - (2) Assistant Shelter Manager
     - (3) Sleeping Space Manager
     - (4) Serving/Food Manager
     - (5) Cleanup Manager
   - B. Meet With Committee
     - (1) Plan Training
       - a. Safety Regulations
       - b. Health Regulations
       - c. Record Keeping
       - d. Maintenance
     - (2) Allocate Space
       - a. Eating/Sleeping Area
       - b. Sleeping Area
       - c. Office Space
       - d. Recreational Activities
     - (3) Notification of Shelter Staff (see attachment)
     - (4) Prepare Instruction Sheet for Shelterees
3. Duties of the Shelter Manager
   - A. Planning
     - (1) Procurement of Supplies
     - (2) Storage
   - B. Opening the Shelter
     - (1) Assemble Shelterees
       - a. Define Rules

b. Introduce Shelter Staff

c. Announce Eating Times/Places

d. Announce Recreational Activities

(2) Overnight Monitoring

a. Ensure Shelterees Are Settled

b. Check Room Temperature

c. Check Operation of Restrooms

d. Establish the Routine

(3) Registration

a. Complete Registration Sheet

b. Submit to Coalition Office

(4) Safety Monitoring

a. Ensure Fire Regulations are Followed

1) Open Flame

2) Loitering

b. Check Shelter Exits

c. Check Perimeter of Building

1) Fires

2) Loitering

C. Notification of Second Shift

4. Duties of the Food Coordinator

A. Have Food Available

(1) Evening Meal

(2) Morning Meal

B. Utensils and Cleaning Equipment

C. Clean Kitchen and Eating Area

5. Duties of the Sleeping Space Manager

A. Have Bedding Available

B. Issue Bedding

C. Laundering Bedding

6. Duties of the Cleanup Manager
    A. Monitor Cleanliness (6:00 p.m. to 6:30 a.m.)
    B. Handle Sanitation Problems
    C. Assist in Cleaning Kitchen
    D. Clean Building Each Morning

CONCLUSION

1. Problems in the Shelter and Attitude Toward Guests
2. Be Familiar With Your Shelter
3. Select Your Shelter Team
    A. Have Adequate Assistants
    B. Have Adequate Backup
4. Develop a Cascade-Calling Plan
    A. Test It
    B. Use it for Notification
5. Open Shelter Only After Proper Approval

GUIDELINES FOR COLD NIGHT SHELTERS

1. **General Information**:

   A. The Cold Night Shelter Program will operate between December 1, 2000 and March 15, 2001, on nights the temperature is expected to fall to 40 degrees or lower.

   B. The Cold Night Shelter Committee of the Pinellas County Coalition for the Homeless will work with the Pinellas County churches and agencies which have participated in some aspect of the program in the past. Additional shelter sites will be selected on the basis of their commitment to a successful program, their location in areas of need, willingness to coordinate the necessary volunteers, financial support of their individual shelter, available space, bathrooms, etc. It is expected that few shelters will be selected, compared to the number of congregations that will want to provide volunteers, supplies, food, money, etc., to maintain those which are selected. In this way, the Cold Night Shelter Program is expected to continue to be a county-wide ecumenical effort to alleviate the misery of those not fortunate enough to have shelter during those nights of inclement weather.

2. **Specific Shelter Responsibilities:**

   A. Making a commitment to participate in the Cold Night Shelter Program for the 2000-2001 winter season by providing space, volunteers, supplies, etc., opening when the Coalition activates the program. Although the coalition has no source of income to assume costs of the program, monies have been donated by public-minded citizens in the past. These monies will continue to be shared amongst the participating shelters.

   B. Designating a shelter coordinator and assistant shelter coordinator. These may be the same individuals who actually manage the shelter.

C. Assuring appropriate access to the site facilities by the shelter coordinator and/or the assistant shelter coordinator, so that activation of the shelter plan can be accomplished with ease when a shelter alert is declared.

D. Assuring that shelter staff are familiar with the building, fire extinguishers, exits, etc.

E. Reviewing their insurance plans to clarify whether or not current policies sufficiently cover activities such as overnight use of the facility as an emergency shelter.

F. Assuring access to a telephone, heating controls, bathrooms.

G. Assuring that volunteers maintain a nonjudgmental attitude towards guests housed for the night.

H. Participating in Coalition data gathering activities to determine the extent of homelessness in the county. Data gathering will be held to a minimum.

3. **Specific Coalition Responsibilities:**

A. Making a commitment to participate in the Cold Night Shelter for the 2000-20001 winter season by providing leadership in developing the program, guidance in establishing the emergency shelter, training in shelter management and activating the program on any given night. An effort will be made to adhere to the agreed upon trigger-temperature; however, since weather reporting carries a degree of error, the program may be activated at times when the temperature fails to drop as predicted. Pinellas County, as a result of its location on the water and its urban population, tends to have a very variable temperature within its geographical area.

B. Developing and maintaining a system to activate the Cold Night Shelter Program.

C. Serving as a channel for public donations for shelter services to the

extent that donations are available.

D. Assuring that the Cold Night Shelter Program maintains a nonjudgmental approach to providing emergency overnight housing for the homeless.

E. Assuring an opportunity for evaluation of the program from year to year.

F. Assuring continuity of the program.

G. Conducting a public education/relations component on behalf of the homeless and available cold night shelters.

H. Gathering relevant data regarding the needs of homeless persons residing within the county.

4. **Responsibilities of the Shelter Coordinator:** *(It is important that this person be able to take charge, develop a program and assume responsibility.)* Developing a shelter plan and assuring that the plan will be activated as appropriate. This will include developing a plan to identify volunteers for each assignment necessary to operate a shelter; a plan to feed guests; store supplies and equipment; check guests in; assign sleeping space, etc. The shelter must be empty of all guests and cleaned by 6:30 - 7:00 a.m.

5. **Staff Needed to Operate a Shelter and Responsibilities of Each:**

A. Shelter Manager: May be the same person as the Shelter Coordinator. The Shelter Manager must be available to activate the shelter plan, including the following:

(1) Arriving at the building by 6:00 p.m. to prepare the shelter for operation by moving furniture, if necessary; set up the food equipment; make coffee, tea, etc.; check availability of blankets; set up the sign-in sheet; post signs, if necessary, etc. Assign a staff volunteer to remain in the guest room at all times. Store of move items which may have resale value on

the street, etc.

(2) Checking on corps of volunteers for the first shift, *i.e.,* 6:00 p.m. to midnight. Make assignments necessary to complete duties included in (1) above.

(3) Assuring that volunteers, including homeless guests who may volunteer, understand their assignment and are appropriate.

(4) Opening the shelter and begin checking guests in by 6:30 p.m.

(5) Checking on corps of volunteers for second shift, *i.e.,* 11:00 p.m. to 6:30 a.m.

(6) Assuring that data is gathering during the registration process and turned over to the Coalition. (See registration sheet attached to Guidelines.)

(7) Assuring the safety of volunteers and guests. Each guest should be routinely asked to turn in any weapons, alcoholic beverages, drugs, etc. These items will be identified by the owner's name, stored in a paper bag marked with the guest's name, and placed in a safe are (such as a locked drawer), and must be returned to the owner the following morning.

(8) Assuring shelter is locked and returning keys to site officials by 6:30 a.m., when the shelter is closed.

B. Assistant Site Manager: Backup person for the Shelter Manager in the event he/she is not available to assume his/her responsibilities. He/she may also assume responsibility for managing the program during the second shift.

C. Food Coordinating/Serving Manager: Responsible for assuring availability of food and drinks, the equipment necessary to eat and clean up food processing equipment. Two meals must be planned -- evening and breakfast. Food should be simple, such as sandwiches,

fruit, drinks, etc. Participating sites may prepare, package, and freeze sandwiches and bring them to the shelter as their contribution to the shelter program. They may also provide the financial support necessary to simply secure fast foods from McDonald's, etc. Food should not be placed out for guests to help themselves since hoarding tends to be a problem. Seconds are appropriate. Coffee, tea, etc. should be available throughout the night, especially in those shelters which do not permit smoking.

D. Blanket/Sleeping-Space Manager: Responsibility for assuring that blankets are available and assigned; space is cleared for sleeping men, women and children; and blankets laundered at the end of each period of activation. Participating sites may pick up and take blankets to a laundromat or absorb costs of washing and drying them. Blankets should not be stored dirty. Mats may be available through the Coalition. However, it is the responsibility of the Blanket/Sleeping-Space Manager to assure their cleanliness and safety so they can be used for several years.

E. Cleanup Manager: Responsibility for assuring the shelter is clean by 6:30 a.m. and in a condition ready to be used for other site purposes during the day. The cleanup manager will work closely with the food and blanket managers to assure eating areas have been cleaned and blankets washed. Emergency cleanup supplies and/or equipment should be available for "accidents". Access to a change of clothing might prove to be beneficial.

COLD NIGHT SHELTER ACTIVATION SYSTEM

1. **Introduction**: The activation System for the Cold Night Shelter Program, although simple in concept, is vitally important to the success of the overall program. Each individual must fulfill designated responsibilities in a conscientious, timely manner. Failure of any one person to make the necessary calls or activate will result in failure of all or part of the segments of the program. Volunteers must be carefully selected and trained.

2. **Staff Needed and Responsibilities of Each:**

   A. Weatherman: Dick Fletcher or an alternate weatherperson at Channel 10 will provide the technical weather predictions upon which activation of the cold night shelters will be based.

   B. Volunteer Weather Watcher: An official weather watcher designated by Cold Night Shelter Committee, the official Volunteer Weather Watchers will watch Channel 10 to monitor weather reports likely to result in 40-degree-or-below temperatures for Pinellas County. The weather watcher will call Dick Fletcher or designee at Channel 10 to confirm conditions and then coordinate with the assigned on-call person to contact the assigned subcommittee person to make a decision on whether or not to open cold night shelters. WHEN A DECISION IS MADE TO OPEN, THE WEATHER WATCHER WILL INITIATE THE CALL-DOWN SYSTEM ON PAGE 16 OF THIS HANDBOOK.

   C. Shelter Coordinators: Designated Coordinators or their backups will initiate calls to their volunteers, as appropriate, to activate cold night shelters by 6:30 p.m. Volunteers should arrive by 6:00 p.m. to prepare facilities for occupancy.

D. On-Call: The designated Coalition member will make the decision regarding activation of the Cold Night Shelters based on information from the Official Volunteer Weather Watcher. All cold night shelter operators have committed to activation of their shelters when a decision to open has been made by the on-call coalition member.

ON-CALL ASSIGNMENTS

DATE	ON CALL	BACKUP
December 1 - December 15, 2000	Joan Malone	Cliff Smith
December 16 - December 31, 2000	Mary Lou Guthart	Joan Malone
January 1 - January 15, 2001	Bob Valentine	Barbara Green
January 16 - January 31, 2001	Jim Leiby	Harry Ferguson
February 1 - February 15, 2001	Bonnie Collins	James Holland
February 16 - February 28, 2001	Cliff Smith	Bob Valentine
March 1 - March 15, 2001	Lonia DeSanto	Jan Bryant

COLD NIGHT SHELTER COMMITTEE MEMBERS/TELEPHONE NUMBERS

NAME	HOME NUMBER	WORK NUMBER/CELL NUMBER

Call-Down Chart

WEATHER WATCHER

(Molly Stephenson)

Will call appropriate Coalition members on On-Call List. (See top of page 15.)	Will Call HELPLINE (See page 18.)	Will Call Channel 10 Weatherman Dick Fletcher work:

Will call Shelters and Shelter Coordinators (See page 17.)	Will call Law Enforcement Coordinator	Will call News Media Coordinator (See page 19.)

2000-2001 COLD NIGHT SHELTERS

FIRST UNITED METHODIST CHURCH OF TARPON SPRINGS
501 E. TARPON AVENUE, TARPON SPRINGS, FL 34689
PHONE: 937-3271
COORDINATOR: JAN BRYANT-PHONE:

PEACE MEMORIAL PRESBYTERIAN CHURCH
110 S. FT. HARRISON AVENUE, CLEARWATER, FL 33756
PHONE: 446-3001
COORDINATOR: BOB VALENTINE-PHONE:

NORTHWEST PRESBYTERIAN CHURCH
6330 54TH AVENUE NORTH, ST. PETERSBURG, FL 33713
PHONE: 544-4551
COORDINATOR: JIM LEIBY-PHONE:

THE TURNING POINT
1801 5TH AVENUE NORTH, ST. PETERSBURG, FL 33713
PHONE: 823-7811
COORDINATORS: BONNIE COLLINS-PHONE:
LONIA DESANTO-PHONE:

THE BEACON HOUSE
2151 CENTRAL AVENUE, ST. PETERSBURG, FL 33713
PHONE: 823-5780
COORDINATOR: EDDIE BRODIE-PHONE:

2000-2001 COLD NIGHT SHELTER GUIDE

CALLING LIST ACTIVATION

CALLS TO BE MADE BY HELPLINE - 344-5555

Agency/Company	Telephone Number
Advocates for Shelter Action Policy (ASAP)	823-5665
American Red Cross - St. Petersburg	898-3111
American Red Cross - Clearwater	446-2358
Bus Station - St. Petersburg	894-4128
Bus Station - Clearwater	796-7315
CHIP (Clearwater Homeless Intervention Project)	466-6612
Community Service Foundation	461-0618
Day Star Life Center	825-0442
Directions for Mental Health - Homeless Program	547-4566
Everybody's Tabernacle	442-9041
H.R.S. Community Affairs	588-7091
HOST (Suncoast Center for Community Mental Health)	894-3533
Mid Pinellas Homeless Outreach	521-1577
St. Petersburg Mission (Beacon House)	823-5780
Quest Inn	443-2067
R.C.S. Emergency Housing - Grace House	446-5964
Salvation Army - St. Petersburg	821-9123
Salvation Army - Clearwater	446-4177
St. Petersburg Free Clinic - We Help	823-3471
St. Petersburg Free Clinic - Women's Shelter	821-3894
St. Vincent De Paul Food Center - St. Petersburg	821-3446 or 823-2516
St. Vincent De Paul Food Center - Clearwater	441-3950
Shepherd Center - Tarpon Springs	937-9535
Suncoast Haven of Rest Rescue Mission	545-8282
YWCA Virginia Lazarra Emergency Shelter	823-2859

MEDIA TELEPHONE CONTACT LISTING

2000-2001 COLD NIGHT SHELTERS

PINELLAS COUNTY DEPARTMENT OF SOCIAL SERVICES WILL BE RESPONSIBLE FOR MEDIA NOTIFICATION.

PHONE:

TV Stations	Telephone Number	FAX
WFLA TV Channel 8 News Desk	461-5835	225-2770
WTSP TV Channel 10 News Desk	577-8450	576-6924
WTVT Channel 13 News Desk	876-1313	871-3135
WTOG TV Channel 44	576-4444	570-4458
WFTS TV Channel 28	354-2828	870-2828
Bay 9 News	437-2001	437-2034
Radio Stations	**Telephone Number**	**FAX**
WFLA WMTX 100.7 FM WFLZ 93.3 FM	839-9393 or 446-9352	831-6397
WWRM FM WFJO FM WDUV FM	576-1073	576-8098
Newspapers	**Telephone Number**	**FAX**
St. Petersburg Times City Desk	893-8215	893-8675
Tampa Tribune	799-7413	791-6826

NOTE: All media will be contacted via FAX.

THINGS TO CONSIDER FOR YOUR SHELTER

POSTED EMERGENCY NUMBERS

Shelter Coordinator:

Shelter Manager:

Backup Shelter Manager (Assistant):

Food Coordinator/Serving Manager:

Backup Food Coordinator/Serving Manager:

Blanket/Sleeping-Space Manager:

Backup Blanket/Sleeping-Space Manager:

Cleanup Manager:

Backup Cleanup Manager:

Police:

Emergency Medical:

Church Housekeeper:

Other:

NOTES:

GUIDELINES FOR COLD NIGHT SHELTER RULES

1. Drinking of alcoholic beverages NOT PERMITTED. Bottles must be given to the Shelter Manager who will return them when you leave.
2. Smoking permitted in designated areas only.
3. Abusive language or behavior NOT PERMITTED.
4. Wandering about the building NOT PERMITTED.
5. Readmission NOT PERMITTED if guest chooses to leave before morning. Guest will be escorted to the door to be sure they leave the building.
6. Use of the telephone is permitted only if an emergency arises. The Shelter Manager will make calls, as necessary.
7. Volunteers DO NOT accept money or hold money for guests.
8. Volunteers DO NOT bring their children to the shelters.
9. Media (TV, newspaper) representatives are admitted only with prior approval of the Shelter Coordinator.
10. Media representatives are permitted to interview or photograph a guest only with his or her approval.
11. Interviews are to be given by volunteers only with the approval of the Shelter Coordinator.
12. Police will be admitted only with an invitation from the Shelter Manager or a search warrant.
13. Children must be under supervision of their parents AT ALL TIMES.

GUIDELINES FOR COLD NIGHT SHELTER CLEANUP PROCEDURES

(As determined appropriate by each individual site)

Selected guests will be encouraged to help. The Shelter Cleanup Manager will supervise activities. Four or five cleanup persons will be needed to:

1. Turn on ventilator system and open designated windows.
2. Fold blankets.
3. Sweep and wet mop the entire shelter area, including halls and restrooms, using disinfectant.
4. Empty all wastebaskets (wastebaskets should be lined with plastic bags to minimize cleanup). Put bags in appropriate trash/garbage containers.
5. Clean sinks, toilets, urinals.
6. Rinse and dry coffeepots and/or other beverage equipment and put them away.
7. Replace any furniture that was moved in preparation of the shelter.
8. Pick up any trash left outside the building.
9. Close and lock windows. Shut off ventilation system.
10. Make sure everyone is out of the building.
11. Collect log sheets and mail to the Coalition.
12. Lock doors and return key to Shelter Coordinator.
13. Launder blankets as necessary in preparation for evening when shelter is again activated.

PINELLAS COUNTY COALITION FOR THE HOMELESS

Cold Night Shelter

2000 - 2001

SIGN IN SHEET

Please FAX sign in sheets after each open night to Pinellas County Social Services, ATTN: Carolyn Cobb; FAX # (727-464-8454)

Name of Shelter:_____ **Date Open:** _____ **Page** _____ **of** _____

Name	Age	Gender (M/F)	Veteran (Y/N)	Employed? Full Time = F Day Labor = D None = N	How long have you been on the streets?	Where did you sleep last night?

CAM 17

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RESPONSIBILITIES

- **You have the responsibility to be considerate and courteous** to other clients and Camillus staff.

- **You have the responsibility and the right to participate in decisions** related to your care.

- **You are responsible to be open and honest with us** about instructions you receive concerning your health. Let us know immediately if you do not understand them, or if you feel you cannot follow them.

- **You are responsible to bring with you information about past illnesses**, hospitalizations, medications, and other matters related to your health and/or social history.

- **You are responsible to be on time for scheduled appointments**, or to contact us if you cannot make the appointment.

- **You are responsible to know and follow** the Camillus Code of Conduct (see posting in waiting room).

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RIGHTS

- **You have the right to receive the best care indicated for your problem** regardless of your gender, race, color, religion, national origin, age, economic status, disability, sexual orientation, or lifestyle.

- **You have the right to be treated respectfully by others** and to be addressed by your proper name without undue familiarity.

- **You have the right to confidentiality of all records and communications.** However, there are limitations to maintaining confidentiality; for example, under the law we are mandated to report the abuse of children, elderly, and disabled. If you have any questions, please ask us.

- **You have the right to review your medical record,** to request amendments, and to request copies of the your medical record.

- **You have the right to know all services available** at Camillus Health Concern, Inc. (CHC)

- **You have the right to know that when the clinic is closed** you can contact your health care provider by calling (305) 577-4840.

- **You have the right to know that all CHC health care providers** are licensed professionals and experienced in the provision of health care.

- **You have the right to seek and receive easily understood information necessary** for you to make informed decisions about your health, social, or psychological situation, including an explanation of all procedures and treatments, and including information about your health care plan, if applicable.

- **You have the right and responsibility to participate in decisions** related to your care.

- **You have the right to appropriate emergency services by** contacting 911, or going directly to the nearest emergency room, or, if necessary, by referral from a CHC health care provider.

- **You have the right to refuse care** by any health care provider and to request a different health care provider if one is available.

- **You have the right to refuse treatment to the extent** permitted by law and be informed of the consequences of that action.

- **You have the right to know when students** are to perform specific examinations or treatment that pertain to your care.

- **You have the right to refuse participation in any research** study or project.

GRIEVANCES

- If you feel you are not bring treated fairly or properly, you have the right to formally address your complaint or problem by filing a grievance; however, we encourage you to first speak with a supervisor so that the problem can be immediately resolved.
- We have a grievance process, which allows for you to discuss your concerns with Camillus Management.
- To register a grievance:
  You may request a grievance form at the Reception Desk.

  Or

  You may write a letter to:
  Director of Operations
  Camillus Health Concern, Inc.
  336 N.W. 5th Street
  Miami, FL 33128

NOR 16-1

NORTHEAST VALLEY HEALTH CORPORATION

Manual: Corporate
Section: Improving Organizational Performance
Subject: Cooperative HCH QI Program

Number: CA 8-000013
Date Implemented: 1/1/02
Date Revised:

Policy:

1. The NEVHC Cooperative HCH Network shall seek to continuously improve the quality of service delivery to homeless individuals in Los Angeles County.
2. All contracted Homeless Programs will participate in NEVHC's Quality Management Program.

Procedure:

1. Each contracted Homeless Provider shall maintain an individual Quality Management Plan, developed and approved by the organization's administrative staff. A copy of this plan shall be submitted to NEVHC. Each program shall have a Quality Management Committee consisting of key staff directly related to the delivery of homeless services. Committee members shall implement the key QI Indicators developed and approved by the Cooperative HCH Program. They are:

-- Diabetes Management	Prevention & Education
-- Pediatric Asthma	-- Pediatric Lifecycle
-- Tuberculosis	-- Domestic Violence
-- Screening/Referrals	-- Alcohol/Substance Abuse
-- STD/Family Planning/Cancer	-- Case Mgmt Srvcs - Level 1, 2, 3

2. Committee members will identify/prioritize indicators (above) relevant to population served. Performance will be measured against program's individual set threshold. Committee will plan and implement corrective actions, reassess at designated intervals and report progress through quarterly QI reports to Cooperative Homeless Director.

3. Each identified indicator will be assessed/measured once per calendar year, and reassessed/re-measured based on the programs corrective action plan if not at desired threshold.

4. The QM Committee shall meet once per quarter. This may consist of a staff meeting with QI as a separate agenda item. The findings and results of QI audit for that quarter shall be discussed at that time and be reflected in your minutes. A sign-in sheet shall be maintained for record of attendance.

5. The QM Committee will maintain minutes of its meetings. Minutes, reports, outcomes and corrective action plans will be forwarded to Homeless Administration at on a quarterly basis.

6. A report of network QI activities/results will be made quarterly to the Corporate QI Committee.

7. Overall QI meetings will be held by the NEVHC Cooperative Homeless Director on a quarterly basis. All contracted Homeless Providers are required to participate in the quarterly Network QI meetings. Minutes will be maintained and submitted at subsequent meetings for approval.

8. Annually, the Quality Improvement Indicators will be reviewed and revised if necessary.

9. Additional indicators may be developed at the recommendation of the Homeless Network.

Compliance Monitor: (attach review form, cite reports, policy review data, etc.)

-- Administrative Policy	-- Compliance Monitor
-- Operational Procedure	-- Each Section Paginated, Policy numbered/section. TOC by
-- Implementation	subject/page number

NOR 16-2

NORTHEAST VALLEY HEALTH CORPORATION
HEALTH CARE FOR THE HOMELESS

QUARTERLY QUALITY IMPROVEMENT ACTIVITIES CALENDAR

2002	AUDIT	DUE DATE
QUARTER ONE (JAN-MAR)	Pediatric Lifecycle Pediatric Asthma	April 26, 2002
QUARTER TWO (APRIL-JUNE)	Diabetes Management Alcohol/Substance Abuse	July 26, 2002
QUARTER THREE (JULY-SEPT)	STD/Family Planning/ Cancer Prevention & Education Domestic Violence	October 25, 2002
QUARTER FOUR (OCT-DEC)	Tuberculosis Screening Case Management Services-Levels I, II and III	January 31, 2003

HOMES Inc.

Housing Opportunities Management and Essential Services, Inc.

408 East State Street • Ithaca, New York 14850 (607) 272-1741

H.O.M.E.S., Inc.
Community Living Services
General Admissions Criteria

Applicants who are residents of Tompkins County will be given priority. Consideration for admission to Community Living Services will based on the following criteria and be made without regard to sex, sexual orientation, race, color, creed, or national origin. Candidates for admission shall be:

1. Individuals who need support in making the transition from a State Psychiatric Center or private hospital to community living, as well as persons presently residing in an inappropriate community setting whose primary diagnosis is psychiatric.

2. Individuals whose primary diagnosis is psychiatric and not alcohol or drug abuse or dependence. *(For Malcom House, individuals who have a secondary diagnosis of mental retardation or borderline intellectual functioning IQ 60-85. Exceptions will be made on an individual basis.)

3. Persons 18 years of age and over. * (Malcom House - 18-35 years of age.)

4. Persons who are capable of caring for basic personal hygiene and perform daily maintenance requirements.

5. Individuals who agree to participate in programming for at least 20 hours a week (e.g. work at a job in the community, either paid or volunteer, or attending school.

6. Persons must be capable of self-preservation (independently exits building in 2 1/2 minutes or less in response to emergency).

7. Persons who agree to and are capable of assuming, with staff assistance, the responsibilities of cooperative homemaking, including shopping, housecleaning and cooking.

8. Persons who have the potential to participate in a curriculum for self-administration of medication.

9. Persons who are stabilized on their medication(s) with no major dosage or medication adjustment <u>for at least one month prior to trial pre-placement visit.</u>

(continued)

H.O.M.E.S., Inc.
Community Living Services
General Admissions Criteria
(continued)

10. Persons who have sufficient insight to recognize the need, when recommended, for appropriate psychiatric services, and the motivation to accept these services if deemed necessary.

11. Individuals who are interested and motivated, and who agree to develop new strategies to cope more effectively with the stresses of community living.

12. Individuals who have been clinically assessed not to be a danger to self or others.

13. Persons who are basically ambulatory and mobile, and who are medically stable.

14. Individuals who are assessed as having the ability to comprehend and adhere to the expectations of the residence and make application voluntarily.

15. Persons with no history of arson, pyromania, or fire setting.

16. Individuals whose placement plan is complete.

The applications of those with histories of violence to themselves or others will be assessed rigorously.

7/92

TER 8R-1

BOISE CLINIC
TERRY REILLY HEALTH SERVICES
POLICY AND PROCEDURES MANUAL

TOPIC: GUIDELINES DETERMINING HOMELESS ELIGIBILITY

POLICY: Persons who might be homeless will be screened at intake to the clinic. Those who are eligible will be certified for a year. At the end of twelve months, they must be recertified to continue to receive services funded through the HCH grant. Recertification may last for 12 months or less.

I. Homeless categories - These categories refer to those on the registration form and are analyzed for the yearly UDS federal report.
   A. Shelter: This generally includes persons who live at shelters like Community House, the Mission, the WCA, or Salvation Army - Booth.
      1. Exceptions:
         a) Clients who live on the third floor of Community House pay rent and are only served by the homeless grant if they are still on their "transition time." (See below.)
         b) Shelter staff who live at a shelter are not homeless, unless they were previously homeless and are on "transition time."
   B. Transitional housing: This category should only be used if approved by the HCH Director, Clinic Manager, or Social Worker.
      1. Institutions that provide temporary residence for individuals intended to be institutionalized.
      2. Transitional housing for the mentally ill.
      3. Currently there is no housing that meets this definition in Boise.
      4. Exceptions: Clients who come from mental health unit at intake.
   C. Doubling up: This includes people who cannot afford to pay rent elsewhere and thus temporarily live doubled up with friends or family.
      1. Persons qualifying under this category do not pay rent, nor do they contribute in-kind services in place of rent.
      2. There is a 12 month time limit for homeless services under this criteria within any two year time period.
      3. There is no transition time allowed under this category.
         a) Example: A woman is accepted as homeless as she moved back to her parents after being beat up by her husband. She will be certified for 12 months. If she is still living with her parents 12 months after intake, she will be moved to the low income program, as she is no longer in a temporary living situation.
         b) Example: The same woman is living doubled up at recertification at another person's home. She would be re-classified as low income.
         c) Example: A 28 yr. male moved in with friends when he lost his job and apartment. He is certified as homeless. After 8 months, he gets a new job and rents his own place. When he comes in to recertify,

he is reclassified as low-income, with no transition time on the HCH grant.

4. Those who do not qualify under this category
   a) Persons who contributed financially or with inkind services.
   b) Children or other dependents under age 24 living with parents in a house owned or rented by those parents.
   c) Couples living together (of either sex) who regard themselves as spouses, lovers, or "significant others."

D. Street
   1. Those who are camping permanently, i.e. do not have a home.
   2. Those who state they live on the street or in their cars
   3. Those inhabiting abandoned buildings or other structures not meant for human habitation.

E. Other
   1. Persons who currently live in a drug treatment center but who met our homeless criteria immediately prior to treatment
   2. Persons who live in substandard housing which lacks running water and a source of heat.
      a) Those who live in trailers or garages with access to running water and/or plumbing at a nearby house may be closer to a doubled up situation. Coverage at recertification needs to staffed with either the HCH Director or Boise Clinic Manager.
      b) The same is true for those living in cabins with outside plumbing and water.
   3. Use this category at recertification for those who entered the HCH program under another homeless category above, but who have since gotten permanent housing, i.e. are in the transition phase. See below.

II. Transition time

A. Definition: A description of the status of a client at recertification who was originally certified as "homeless" under one of the above categories (A-E2) but who obtains permanent housing during his first 12 months on the HCH grant.
   1. We allow up to 12 months of transition time on the HCH grant.
   2. Transition time begins when the client obtains permanent housing, not when he or she is recertified.
   3. Persons who qualify for HCH services under the "doubling up" criteria above, are not allowed transition time at the end of those original 12 months if they still at doubled up at the same address.
   4. Example: A family of four is living at Community House at intake. At recertification 12 months later, they are in their own apartment, where they have been living for the past 9 months. They would be allowed 3 months of transition time on the HCH grant. At the end of those three months, they would be moved to the low income program.

B. Questions
   1. When in doubt about any of these programs, consult either the HCH Director, Clinic Manager, or Social Worker.

2. There is often considerable gray area.

III. Minimum history of homelessness

A. Time: Clients must qualify under one of the above categories for a minimum of the past 7 days.

B. Exceptions:

1. Clients living at Community House and seen at Community House.
2. Other exceptions may be approved by either the HCH Director, Clinic Manager, or Social Worker.

IV. Appeals

A. Process:

1. Any patient whose status has changed from homeless to low income under these guidelines may appeal that decision in writing to the HCH Director. (See attached form.)
2. A committee comprised of a clinician, social worker and the HCH Director shall have final say and will communicate a decision on the appeal within 10 working days of receipt of that appeal.

V. Suspected fraud

A. If a client is suspected of fraudulent statements about living or income status, clinic staff may investigate the validity of information provided.

B. If after investigation, the patient does not qualify for homeless status, TRHS will communicate this decision to the patient in writing, to be effective from the date such fraudulent information was provided.

REVIEW/REVISION FREQUENCY REQUIREMENTS: Annually

PERSONS RESPONSIBLE FOR REVIEW/REVISION: Boise Clinic Social Worker, Clinic Manager, HCH Director, Front Desk Supervisor

APPROVALS:

S. Ellen FNP — 4-2-97

Boise Clinic Manager — Date

Ann Sanders — 4-2-99

Healthcare Care for the Homeless Director — Date

ppdefhom.doc

APPEALS FORM
HEALTH CARE FOR THE HOMELESS - BOISE CLINIC

Patient Name: _____ **Date:** _____

Address: _____

_____

Home telephone: _____ **Message or work phone:** _____

I am appealing the decision to remove me/my family from the Health Care for the Homeless Program for the following reasons:

Signed: _____

Please leave with the Boise Clinic receptionist or mail form to the following address :

Health Care for the Homeless Director
Boise Clinic
848 La Cassia
Boise, ID 83705

TER 8R-2

BOISE CLINIC
TERRY REILLY HEALTH SERVICES
POLICY AND PROCEDURES MANUAL

TOPIC: HOMELESS SCREENING, CERTIFICATION, AND RECERTIFICATION

POLICY: To make primary health care and related services available to homeless persons seen through the Boise Clinic. New homeless patients must be screened prior to receiving medical services, except in an emergency situation. Established homeless patients must be re-certified yearly to continue to receive Health care for the Homeless supported services.

I. Intake certification
  A. Screening
    1. Definition: Screening is the process whereby the Front Desk determines if the person they are interacting with is a new or existing patient and if he or she might be homeless.
    2. Telephone screening
      a) Determine if the caller is a person who is calling for an appointment or calling for another reason.
      b) Ask why needs to be seen.
      c) Determine if new or existing patient.
      d) If new, screen as to whether potentially homeless or not.
        (1) Do not ask," Are you homeless?"
        (2) Ask, "What is your living situation?"
        (3) Be sensitive to the need to screen quickly without giving offense.
      e) If existing patient, ask whether have a Boise Clinic pharmacy card, and if so, when it expires.
        (1) The color of the card will tell you if the patient is currently on the homeless grant.
        (2) The expiration date gives information about how long to either their re-cert or the end of the fiscal year (March 31.)
      f) Make appointment with appropriate mid-level provider, either first available, if new patient, or with the provider of choice if existing patient.
      g) Advise that need to bring proof of income and Medicaid or other third party payment card, if appropriate.
    3. Face to face
      a) Ask how you can help the person at the window.
      b) Proceed as above. For existing patients, ask to see the pharmacy card, if the patient has one.
  B. New patient certification at initial in-clinic registration .

1. Definition: the process by which the Front Desk or Social Worker determines if a patient and/or family is eligible for Health Care for the Homeless Services. Demographic data is also collected at the same time to meet Federal and local reporting requirements.
2. Ask the patient to complete the TRHS registration form.
3. Scan the form for completeness, requesting omitted information or clarification.
4. Using the living situation information on Page 2 determine if homeless or not. Refer to P/P Guidelines Determining Homeless Eligibility, 1997, for definitions.
    a) If homeless, transfer the housing information to the bottom of Page 2 and proceed as described below.
    b) If not homeless, determine sliding fee and third party codes, and mark chart and registration form accordingly.
5. Code homeless charts with yellow sticky. (Low income charts receive a pink sticky.)
6. Determine the correct income code, based on family size and income, or third party coverage, if applicable.
    a) Write code on Registration form, and send copy of registration form with the batch to Nampa; registration form original goes in patient's Boise Clinic chart and a copy in the Front Office files.
    b) Write income code on yellow sticker, or add third party stickers as appropriate.
7. Fill in date of certification on front of chart under "Initial Certification" and initial.
8. Determine date for re-certification and write under "Recertification Due."
    a) Generally, this is one year from the date the certification was done.
    b) Exceptions: When the patient received medical care under the homeless program prior to having the certification completed. Then the re-cert should be back-dated to one year from the original date of medical care.
9. Give Pharmacy card, writing expiration date under Rx stamp to coincide either with end of fiscal year or re-certification date, whichever is first.

C. Certifications if there are questions
1. If the Front Desk staff is unsure whether the patient is homeless, refer to Social Work.
    a) If a walk-in slot with the Social Worker is available, the determination may be made as part of the initial medical visit.

(1) The Social Worker will review the information contained on the registration form, making any changes needed.

(2) If determined homeless, the social worker will transfer the housing information to bottom of Page 2 ("for office use only") and complete the information on the front of the chart.

(3) If not homeless, appropriate information will be noted on the registration form and in a progress note and the Front Desk notified.

b) If the patient needs to make an appointment with the Social Worker, the Front Desk may issue a temporary eligibility, based on their initial determination. Generally, this will be for two weeks or less, depending when a social work appointment is available.

(1) The chart and other paper work will be processed as normal, with the exception that the certification date will be left blank on the front of the chart.

(2) The Pharmacy card will be issued using the same date as the social work appointment.

(3) The Social Worker will make a determination based on an interview at the appointment.

(a) If homeless, he/she will add the certification date(date of social work appointment) and the recertification date, which will be 12 months from the original medical appointment.

(b) The Social Worker will issue a new Pharmacy card with expiration date, as per Pharmacy P/P guidelines and fill in Rx date on front of chart, as above (I.A.9.)

D. Emergencies

1. When the Front Desk suspects that a new patient might be in an emergency situation, they will refer the patient to nursing for triage.
2. The registration form may then be completed after the patient has been treated, as well as other new patient forms.

E. New patients from an already certified family

1. Definitions: Often a child, but could be a parent, from a family where one of the parents or another child has already been certified as homeless within the last 12 months.
2. If one family member (the "index person") has been seen as a new patient at the clinic prior to other family members, all members of the family are deemed to be homeless from that first date.
3. The Front Desk will treat a new patient from an already certified family the same as any other new patient with regards to the chart.

a) A new registration form needs to be filled out for the patient, using the housing status of the new patient that day, not that at the index person's registration.
b) If no longer homeless, but still within the first 12 months of eligibility, code as "Other."

4. Use the certification date of the "index person."
5. If index person is unknown, use 12 months from the new patient's date of service. Use this option sparingly!
6. Set up chart otherwise as above under "B."

F. Community House certifications

1. The Social Worker or Volunteer Registrar will assist new patients in filling out the registration form, as well as the consent form and verified lack of income form.
2. Scan the form for completeness, requesting omitted information or clarification.
3. Using the living situation information on Page 2, determine if homeless or not. Refer to P/P: Guidelines Determining Homeless Eligibility, 1997, for definitions.
   a) Main areas of concern are whether living on the 3rd floor or not. All new clients living on floors 1-2 are homeless, H-1 until determined otherwise.
   b) All new clients from the 3rd floor are "Low income" and will be expected to pay according to the sliding fee scale. Their income needs to be determined at the time of registration.
4. If homeless, transfer the housing information to the area below the line labeled "for office use only." Check "shelter."
5. If homeless, give Pharmacy card, filling out appropriate expiration date.
6. BC staff will return registration forms and charting notes the next morning to the BC Front Desk, which will complete a new chart, note the certification and recertification date due on front of chart.

G. Other off-site certifications

1. New Boise Clinic patients may also be seen through outreach in the community by the Social Worker.
2. If the Social Worker encounters homeless persons who have medical problems which need attention, she may do certifications in the field.
   a) Complete registration form as usual, as well as verified lack of income and release forms.
   b) Patient's name and other information is entered on the Social Work encounter log.
   c) The Social Worker will assess for bio-psycho-social needs and develop a plan.

d) Upon returning to clinic, the Social Worker will give the registration and other forms, plus progress notes to the Front Desk which will make up a new chart.

II. Recertifications

A. Definitions

1. The process by which homeless patients are certified as still eligible for HCH services.
2. Interview done by Social Worker either in the clinic or in the community and documented in chart.
3. Due when 12 months or more have elapsed since the last intake date stamped on front of chart OR
4. When the date of the current medical visit is past the due date stamped on the front of the chart for re-certification OR
5. When no date at all is found on the front of a homeless (yellow sticky) chart OR
6. When requested by Boise clinic staff, which is generally because staff suspects original information might not have been accurate..

B. Procedures

1. Front Desk will scan all charts of patients to be seen that day to see if recertification is due.
2. If it is time for recertification, Front Desk will screen:
   a) If currently homeless, make appointment with social worker ASAP.
      (1) Issue a Pharmacy card good until that Social Work appointment and note on medical chart.
      (2) Inform patient that must keep Social Work appointment or will not receive further pharmacy or other HCH services.
   b) If not currently homeless, ask if were homeless any time within the last 12 months.
      (1) If "yes," refer to Social work for re-certification.
         (a) Social Work will code as "Other" and place on "transition time."
         (b) Social Worker will educate patient on definition of "transition time" and the date the patient can expect to be transferred to the low income program.
         (c) Expiration of "Transition Time" will be clearly noted on the front of the chart, with notation, "Transfer to Low Income Program" next to "Recert. Due."
      (2) If "no," initiate change form to Low Income program.

3. Social Work will initial front of chart after recertifying a patient, next to the current Recert Due Date and will then note the next Recert Due Date.
4. An updated Pharmacy Card will be issued by the Social Worker, per Pharmacy P/P.

REVIEW/REVISION FREQUENCY REQUIREMENT: Yearly.

PERSONS RESPONSIBLE FOR REVIEW/REVISION: HCH Director, Boise Clinic Manager, Boise Clinic Social Worker, Front Desk Supervisor.

APPROVALS:

HCH Director — Date: 8-21-97.

Boise Clinic Manager — Date: 8/21/97

8/21/97

BIR 8

Birmingham Health Care for the Homeless Coalition, Inc.

P.O. Box 11523, Birmingham, Alabama 35202

NOTICE OF CONFIDENTIALITY

The confidentiality client records maintained by this agency is protected by Federal law and regulations. Generally, the agency may not say to a person outside the agency that a client attends any agency program unless:

1) The client consents in writing; or
2) The disclosure is allowed by a court order; or
3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the agency or against any person who works for the agency or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local authorities.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations pertaining to clients who are in a substance abuse treatment program.

Client Name _____
(Please Print)

I have read and received a copy of this notice.

Signature _____
(Client, Parent, Legal Guardian)

Witness _____

Date _____

CAMILLUS HEALTH CONCERN, INC
PATIENT GRIEVANCES

POLICY NUMBER: MP-07 **REVISION DATE: 03/26/02**

I. POLICY

Camillus Health Concern, Inc (CHC) is committed to provide quality care to all its consumers. As we strive for "Excellence in Care", we recognize that at times there may be occasions when consumers find themselves involved in circumstances or conditions believed to be unjust, and thus that they have grounds for a grievance. Therefore, it is the policy of CHC to acknowledge consumer rights and provide an impartial and confidential forum for the resolution of any grievance that may be brought to the attention of staff at CHC.

II. Grievance Committee Membership

A. The Grievance Committee (thereinafter "Committee") will be a Standing Committee consisting of three (3) persons, who will meet on an ad hoc basis. That is, the Committee will meet, if and when a grievance is filed.

B. Representing a cross section of disciplines and backgrounds, the membership of the Committee will be comprised of:

- One (1) Brother representative from the Brothers of the Good Shepherd, who is staffed at Camillus
- One (1) CHC Management staff representative
- One (1) CHC Patient Services staff representative
- If necessary, the consumer's health care provider and/or case manager will be invited to attend the Grievance Committee meeting.

C. Membership length will be approximately one (1) year and will be staggered to allow for continuity within the Committee. The Committee Chair, who will be elected by the Committee, will provide oversight to ensure that there is continuity and that the Committee is fully staffed. As needed, the Chair will make recommendations for new members to the Executive Director.

III. PROCEDURES

A. Every effort will be made to amicably resolve a complaint before it becomes a formal grievance; however, if the consumer declines to speak with a CHC staff member in order to resolve the compliant, he or she has the right to file a formal grievance.

B. A consumer who verbalizes his or her dissatisfaction with, for example, a service, procedure, employee, or physical appearance of the facility, will be encouraged to resolve the issue by dialogue with the appropriate staff member (the immediate supervisor of the area or discipline covering the grievance). The consumer will do this by verbalizing in private to that supervisor his or her dissatisfaction.

C. If the complaint is against the immediate supervisor of the area or discipline, than the supervisor will consult with his or her supervisor as to who should address the complaint.

D. Immediately upon being informed of the dissatisfaction, the supervisor will inform the consumer of the method he or she will use to attempt to resolve the issue. If the supervisor cannot immediately resolve the issue to the satisfaction of the party involved, he or she will follow-up with the consumer within 24 hours, with additional steps in order to resolve the issue.

E. In the event that the issue cannot be resolved, the consumer may file a formal grievance with the supervisor who has been assisting him or her. As needed, the supervisor will assist the consumer in completing the form and ensure that the form has been completed accurately. See attachment 1 for the Camillus Health Concern, Inc. Grievance Form.

F. The supervisor will provide a copy of the Grievance Form to the consumer, and the original is then forwarded to the Chair of the Committee.

G. The Chair then sends a copy of the Grievance Form to the Camillus House Chief Executive Officer and CHC's Executive Director so that they may become aware of possible safety, legal, or other issues. However, the grievance continues to be processed by the Chair of the Committee.

H. Within five (5) working days, the consumer will be notified, in writing, of the receipt of the grievance and the scheduled date for review by the Committee.

I. Prior to the meeting, the Chair will forward a copy of the Grievance Form to all Committee members.

J. Also, prior to the meeting, the Chair may use his or her discretion to initiate a preliminary investigation of the grievance. For example, in order to facilitate the Committee's first meeting, the Chair may decide to conduct some interviews prior to the meeting.

K. The Chair will maintain all grievance materials and documents, for example, the Grievance Policy and Procedures and meeting minutes, in the Camillus Health Concern Grievance Documents binder.

III. Grievance Review Process

A. The Committee will make a good faith effort to convene within two (2) weeks of when a grievance is filed and schedule additional meetings, at least every two (2) weeks, until recommendations for the resolution of the grievance are finalized.

B. The Committee will determine if additional persons need to be interviewed as part of its impartial investigation.

C. Additional interviews and/or investigation by Committee Members must be written and submitted to the entire Committee for its review at a scheduled meeting.

D. The Committee's recommendations for action, including timelines, will be prepared and presented by the Chair of the Committee to the Executive Director, who will then either approve the recommendations as presented, or modify them, and then, finally, approve the recommendations. See Attachment 2, Camillus Health Concern, Inc. Grievance Committee Recommendations for Action.

E. After the Executive Director approves the recommendations, the consumer will be so notified in writing within ten (10) working days.

F. If the grievance is not resolved at the Committee level, the Committee Chair will confer with an Ad Hoc Committee of the Board of Directors, chosen by the Chairperson of the Board. The Ad Hoc Committee of the Board will review the grievance and recommend to the Board to uphold or to refute the resolution.

G. The consumer will thereafter be so advised of the final resolution of the grievance.

V. Quality Improvement

A. The Chair of the Committee will submit summaries of grievances to CHC's Quality Improvement Committee (QIC) for trending and monitoring of the grievances.

B. The QIC will ensure that all Committee recommendations are implemented, and kept confidential.

CAM 5

DATE: _____ **CHC WOMEN'S HEALTH CLINIC** CHC# _____

NAME: _____ AGE: _____ DOB: _____ ALLERGIES: _____

FDLMP_____ X _____ Days

MENOPAUSE/AGE _____ ERT: NO ___ RES: ____yrs.

G _____ PARA: F ____ P____ A____ L____ SEXUALLY ACTIVE NO YES

Birth Control: None OCP Diaphragm IUD Condoms Other_____

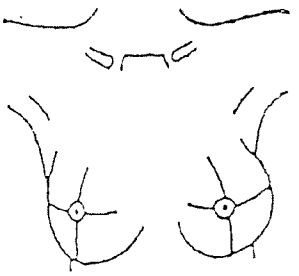
Last PAP: _____ Last MAMMOG _____

F.H. BREAST CA: NO YES: MOTHER SIB AUNT MSBE: NO YES

PMH/STD: MEDS: ETOH: NO / YES
TOB: NO / YES
IVDU: NO / YES
HOMELESS: NO / YES

BS: BP _____ HR_____ R _____ T _____ HT _____ WT _____

BREAST:



PELVIC: EXT.
Vaginal
Cervix

BIMANUAL: CMT: NEG / POS
Adnexa:
Uterus:

KOH
Wet Mount
GM Stain
UCG - +

ASSESSMENT / PLAN:

MERCY HOSPITAL

AMBULATORY CARE DEPARTMENT

POLICY & PROCEDURE

Subject: Standards of Health Care for the Homeless Nursing Practice

Code: Health Care for the Homeless

POLICY

The scope of Health Care for the Homeless nursing practice encompasses activities which are directed toward health problems of various levels of complexity.

Professional nurses of Health Care for the Homeless bear primary responsibility and accountability for the nursing care patients receive. Standards of Nursing Practice are implemented at Mercy Hospital to assure optimal achievable quality of nursing care. Nursing care given to patients by the professional Health Care for the Homeless nurse shall be measured in accordance with these standards.

I. PRACTICE

A. Comprehensive Standard I - Knowledge & Skills - Health Care for the Homeless nurses shall possess current comprehensive knowledge and skills in community health care.

1. Health Care for the Homeless nurses succesfully complete 12 contact hours per year of continuing education, 50% of which is related to the specialty of Health Care for the Homeless or community nursing.

2. Health Care for the Homeless nurses renew their BLS certification annually.

3. Health Care for the Homeless nurses disseminate information derived from regular review of professional literature and attendance at conferences that are pertinent to their practice setting.

B. Comprehensive Standard II - Assessment - Health Care for the Homeless nurses shall assess physical and psychosocial problems of patients.

1. Assessment: Assessment shall include systematic and pertinent collection of data about the health status of the patient

2. Data collection: Data shall be collected and recorded as appropriate to the nature and severity of illness or injury.

C Comprehensive Standard III - Analysis - Health Care for the Homeless nurses shall analyze data to formulate a nursing diagnosis/assessment or problem statement.

1. Data base formulation: Health Care for the Homeless nurses shall formulate a nursing assessment for patients for whom they care.

2. Data organization: Health Care for the Homeless nurses shall organize data in a systematic manner to coordinate activities of themselves and other team members. The S.O.A.P. format shall be used as a guideline for this data recording.

D. Comprehensive Standard IV - Planning - Health Care for the Homeless nurses shall formulate a comprehensive nursing care plan for the patients and collaborate in the formulation of the overall patient care plan.

1. Priority setting: Health Care for the Homeless nurses shall assure that all patients entering the system are evaluated according to the health care needs of the patient, the spatial and/or temporal needs of the patient and the system, and the administrative needs of the system.

2. Supplies and equipment: Health Care for the Homeless nurses shall ensure that supplies and equipment necessary for the care of the patient are readily available within the resources of the system.

3. Safety: Health Care for the Homeless nurses shall assure the safety of co-workers, patients, significant others, and themselves whenever possible within their practice setting.

E. Comprehensive Standard V - Intervention - Health Care for the Homeless nurses shall implement a plan of care based on assessment data as well as a sound knowledge base.

1. Independent function: Health Care for the Homeless nurses shall function independently within parameters established in their job description.

2. Comfort: Health Care for the Homeless nurses shall identify and manage factors that influence comfort.

3. Coping: Health Care for the Homeless nurses shall assist the patient and significant others to cope with crises and stress within individual physiological and psychosocial capabilities.

4. Aftercare and referral: Health Care for the Homeless nurses shall give verbal and/or written instructions regarding aftercare and a source of referral for follow-up care as needed.

F. Comprehensive Standard VI - Evaluation - Health Care for the Homeless nurses shall evaluate and modify the plan of care based on observable responses of patients and attainment of patient goals.

Quality assurance: A comprehensive plan for quality assurance of Health Care for the Homeless nursing practice shall be developed and implemented by nursing management.

* G. Comprehensive Standard VII - Human Worth - Health Care for the Homeless nurses shall provide care based on philosophical and ethical concepts, such as a reverence for life and a respect for the inherent dignity, worth, autonomy, and individuality of each human being, and on a resolution to act dynamically in relation to people's beliefs.

1. Legal responsibilities: Health Care for the Homeless nurses shall demonstrate an awareness of current state and local laws governing the delivery of care to the homeless and/or indigent patient.

2. Ethics: Health Care for the Homeless nurses shall provide care that demonstrates ethical beliefs and respect for patient's rights.

H. Comprehensive Standard VIII - Communication - Health Care for the Homeless nurses shall assure open and timely communication with patients, their significant others, and team members.

1. Patient and family liaison: Health Care for the Homeless nurses shall provide sufficient information to allow patients and significant others to participate in patients' care and prevention of illness

2. Community liaison: Health Care for the Homeless nurses shall participate in formal and informal education and information endeavors related to the practice care setting and the community.

3. Documentation. Health Care for the Homeless nurses shall accurately document pertinent patient data, nursing interventions, and patient responses

III EDUCATION

A. Comprehensive Standard I - Provision of Information - Health Care for the Homeless nurses shall assist the patient and significant others to obtain knowledge about illness and injury prevention and treatment.

1. Patient and significant other teaching: Teaching shall be an ongoing process that includes provision of information about the patient's condition, patient and significant other responsibilities and options, and recommendations for appropriate follow-up.

2. Prevention: Epidemiological trends shall serve as a basis for identification of individuals at risk of illness or injury.

3. Public education: Public education regarding homeless health care issues and health care for the homeless shall be a responsibility of Health Care for the Homeless nurses.

B. Comprehensive Standard II - Education of Self and Peers - Health Care for the Homeless nurses shall recognize their own learning needs and those of peers and assist in meeting those needs to maximize professional development and optimal nursing practice.

D Comprehensive Standard III - Communication - Health Care for the Homeless nurses shall actively communicate with team members.

Interactions: Health Care for the Homeless nurses shall interact as team members, respecting the limits, capabilities and responsibilities of other team members. This is including, but not limited to the covering physician.

Vice President, Medical Affairs

Vice President, Nursing Affairs

Director, Health Care for the Homeless

Date: April 16, 1992

1. Continuing self-education: Health Care for the Homeless nurses shall obtain ongoing education consistent with their level and areas of practice.

2. Nursing education: Health Care for the Homeless nurses shall facilitate formal and informal learning experiences for professional peers and nursing students.

III PROFESSIONALISM

Comprehensive Standard I - Qualifications - Health Care for the Homeless nurses shall be competent and current, adhering to established standards of practice.

1. Entry level: Entry level Health Care for the Homeless nurses shall meet specified qualifications for employment as professional nurses.

2. Competency: Health Care for the Homeless nurses shall demonstrate integration of knowledge and technical skills through application of the nursing process and ongoing professional growth.

C. Comprehensive Standard II - Administration - Health Care for the Homeless Director shall function in collegial relationships with other administrators.

1. Job description: Health Care for the Homeless nurses shall have a job description that reflects current standards of professional practice and lists specific responsibilities.

2. Performance review: Health Care for the Homeless nurses performance shall be reviewed by Health Care for the Homeless Director, based on identified roles and responsibilities.

3. Staffing: The Health Care for the Homeless department head shall take measures to ensure provision of adequate staffing of qualified professional nurses to provide for safe care.

Compiled by the

HCH Clinicians' Network

with support from the

U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration
Center for Mental Health Services, Homeless Programs Branch

and the

U.S. Department of Health & Human Services
Health Resources & Services Administration
Bureau of Primary Health Care
Division of Programs for Special Populations

March 1996

SAMPLE SAFETY GUIDELINES

In Homeless Health Services Programs

Table of Contents

Sample Safety Guidelines
In Homeless Health Services Programs

Purpose
Developed by agencies to help prevent and reduce violent incidents, these safety guidelines were compiled by the Health Care for the Homeless Clinicians' Network. The Network is making these sample guidelines available as a reference for others who are developing policies and protocols specific to their unique practice setting and model of care.

Nonviolent Crisis Intervention Techniques for Clinicians
In June 1995, the HCH Clinicians' Network identified a need for nonviolent crisis intervention training among clinicians working with homeless people. A planning committee was organized with the task of coordinating and implementing a training session on nonviolent crisis intervention techniques. In addition to hosting the training in March 1996, the Network produced this Sample Safety Guidelines manual and purchased a two-volume videotape series on nonviolent crisis intervention.

This manual and the videotape series are available to Network members and other clinicians working in federally funded Health Care for the Homeless projects as well as programs receiving funding from Projects for Assistance in Transition from Homelessness (PATH) and Access to Community Care & Effective Services & Supports (ACCESS). For further information on these and other resources, contact the Network at 615/226-2292.

About the HCH Clinicians' Network
The Health Care for the Homeless Clinicians' Network is a national peer support organization for clinicians who work with homeless people. Network members are from a variety of practice settings including Health Care for the Homeless projects, hospitals, health departments, managed care organizations, universities, and PATH/ACCESS projects.

These contents are solely the responsibility of the authors and do not necessarily represent the official views of the U. S. Department of Health & Human Services, Substance Abuse & Mental Health Services Administration, Center for Mental Health Services; the U. S. Department of Health & Human Services, Health Resources & Services Administration, Bureau of Primary Health Care; the National Health Care for the Homeless Council, Inc.; the HCH Clinicians' Network or the National Crisis Prevention Institute, Inc. This publication was made possible by purchase order # 95MF23466701D from the Center for Mental Health Services.

March 1996

Big City Mental Health Center
Violence Policy & Procedures

INTRODUCTION

These policy and procedures were written for a medium-sized mental health agency in a downtown urban area. The agency consists of an outpatient clinic and several types of client residences. The guidelines give specific responses for the different agency settings, and were developed for use by both clinical and support staff.

The guidelines are valuable because they clearly state in writing the agency response to escalating and violent incidents. This increases the confidence and security of staff and clients, thereby decreasing the number of potentially dangerous incidents.

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Nonviolent Crisis Intervention Techniques for Clinicians
Planning Committee

Big City Mental Health Center
Violence Policy & Procedures

I. **Definition.** Violence is defined as any act or attempted act of physical aggression intended to hurt or harm oneself, another person or property. Physical aggression includes assaultive physical contact such as slaps, kicks, punches, tripping, pushing, and shoving as well as throwing objects or destroying property. The Big City Mental Health Center does not tolerate violence in the office, in homes, or in apartments operated by the agency.

II. **Assessment.** Assessment of violent incidents must include the following considerations:

A. Assessment of the type, intent and result of an act of violence.

1. The **type** of violence includes the actual act or threat.

2. The **intent** of the violence includes the amount of control the person had over his/her behavior. For example, was the client influenced by drugs or alcohol? Is the individual psychotic? Was the aggression intentional or premeditated?

3. The **results** of the violence include the consequences of the threat or action.

B. Assessment of the milieu of the act or threat of violence.

1. Assess the involvement of other clients and/or staff. Was there provocation?

2. Assess the perceptions of clients and/or staff who were present. What did the clients and/or staff see and hear?

C. Using information gained from the assessment, staff then uses his or her clinical judgment to address the situation.

III. **Policies for facilities and programs.** Each program, because of its circumstances and parameters, responds differently to perceived threats or incidences of violence.

A. **Main offices.** A Crisis Resolution Team consisting of four clinicians is assigned to each week day. Each Team is responsible for covering client crisis situations at the agency during its assigned day. All members of the Crisis Resolution Team are volunteers so that only staff members who feel that they can handle crisis situations are called on to do so. Each team member is aware of his or her assignment and who is to be Team Leader for that day. In the event that more than four clinicians are needed to handle a crisis, the Team Leader can call for more staff support. An act or attempted act of overt physical aggression initiates the following staff response:

1. The identifying staff person calls the Crisis Resolution Team into action by making a system-wide telephone page stating, *"We have a code strong,"* and giving the location. The Team Leader directs the intervention. The identifying staff person should not intervene alone.

2. The Crisis Resolution Team directs other clients to clear the area. The Team then attempts to contain or remove persons from the room through verbal interventions. Physical contact should not be attempted unless it is necessary to protect self, other clients or the violent client.

3. If verbal interventions are ineffective or if a physical intervention is necessary, the Team Leader will instruct a staff person to call for police assistance by dialing 911. The Team Leader may also ask that a second Code Strong be called to alert general staff that assistance is needed.

4. Staff should always obtain appropriate back-up support. It is important to know who is available to help and what the group's limitations are regarding controlling an individual.

5. Once the violent client is contained, the Crisis Resolution Team and other staff on the scene need to process the

incident. The client's case manager is informed so that appropriate follow-up interventions may be planned.

6. After the violent episode is resolved, the building coverage clinician or the Crisis Resolution Team Leader should take charge in the absence of the case manager or the case manager's supervisor. The clinician in charge should:

   a. Provide follow-up attention to other clients and staff after resolution of the incident.
   b. Notify absent case managers and supervisors whose clients were affected by the incident.
   c. Obtain and/or provide supervision and support by appropriate personnel—supervisors, senior staff—for all staff immediately affected.
   d. If both the clinician and building coverage person are available, they should work together to attend to both the individual and the milieu.

B. **Supervised group residences**. A violent act results in an immediate call to the police. House staff should notify the clinical coordinator and the client's case manager or on-call clinician. If before 5 P.M., a threat of violence will be evaluated by the clinical coordinator and case manager and a course of action will be determined.

C. **Crisis Residences.** The Crisis Team initially screens incoming residents for potentially violent behavior. Any client who acts out violently is removed immediately.

D. **Apartment Program.** The Apartment Program has a policy of no violence. Each incident is separately evaluated and a plan of action is determined by the clinical case manager in consultation with the residential team.

E. **Case Management.** If a person becomes violent or appears to be at risk for violence, the case manager and supervisor develop a plan of action including options such as hospitalization, counseling, time out, or contracts. This plan should be clearly communicated to appropriate agency staff. Unless the violent act is imminent, individualized treatment plans prevail.

Wasatch Homeless Health Care Program
Safety Protocol

INTRODUCTION

These safety and violence guidelines were developed for use by staff and volunteers within a clinical setting. They emerged after episodes of violence had occurred in waiting rooms as well as after patients had left the clinic or dental office. The guidelines are intended for use by all persons on staff with no differentiation due to profession or job duties.

These guidelines have been in place at our facility for two years, giving staff and volunteers guidance and explanations focusing on violence reduction and prevention. In addition, they provide a clear means to evaluate our response to violent episodes. We have found them easy to read and to put into action, and they seem to impact positively our patient interactions.

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Wasatch Homeless Health Care Program
Safety Protocol

Goals & Priorities

The primary goal of the Wasatch Homeless Health Care Program is to interact with patients in such a manner that prevents the escalation of negative actions and potentially violent situations. The secondary goal is to persuade patients who act out to leave the premises willingly and quietly.

In order to achieve these goals, we must establish behavior guidelines that enable us to identify problem behaviors and deal with them effectively and appropriately before they escalate into a crisis situation. In order of priority, these are the personnel who will be involved with problem clients:

1. Front desk personnel and dental personnel who receive patients and make appointments are usually first to encounter possible difficulties.

2. Medical assistants and dental assistants are second in this role.

3. Medical and dental providers, other staff and volunteers are usually last in this interaction process.

Regardless of our role, however, when serving patients we are equally responsible for our own behavior and for protecting the security of coworkers.

Guidelines

Here are guidelines to follow in our everyday interactions with patients. In order to promote workable relationships, we must address our patients with respect and kindness. It is imperative that we do not react to verbal abuse with anger or disrespect. Instead, we should remain calm and in control. Occasionally patients use aggressive and intimidating tactics to get what they want. It is important that we be aware of this type of behavior and learn to respond without being manipulated.

- Answer patients' questions assertively and assure them that they will be seen as soon as possible or according to their respective appointments.

- Do not offer lengthy explanations or excuses. Responding in this manner may increase the patient's frustration level.

- Simply state the facts and repeat them if necessary. If appropriate, refer the patient to other possible resources.

If a patient becomes verbally abusive or physically threatening, appropriate staff—the medical receptionist and the care coordinator [males]—should be alerted to assist in a supportive capacity. Staff members should be present on a standby basis and be prepared to intervene if required. For example, if the designated staff person becomes ineffective with the patient, another staff person should take over giving the same message.

People whose behavior escalates beyond communications will be asked to leave and be informed that it is not our policy to serve belligerent people. If they can remain calm and discuss the problem, however, we will attempt to serve them and work out a solution. If necessary, the medical receptionist and the care coordinator will escort them off the premises.

In extreme situations, the police will be called to intervene and staff will stop further involvement unless it becomes necessary to restrain a patient for his or her own safety or for the safety of the staff. In this situation, only designated, trained staff will perform the task of restraint. It is our goal to prevent escalation of a possible confrontation and to serve our patients.

In the event of a traumatic encounter, all staff members involved will meet to support each other through the debriefing process. They will document the encounter, file notations in the patient's chart, and determine if our services will be offered to the patient in the future. If the patient is denied further services, a letter stating this will be handed to him or her at the final encounter.

Wasatch Homeless Health Care Program
Safety Manual

Purpose

The purpose of this manual is to outline proper procedures for handling situations with aggressive patients which have the potential to further escalate into violence. Staff safety is our top priority at all times. It is also important to respond to aggressive or violent situations in a professional and sensitive manner. Our patients are individuals who deal with grave physical and emotional difficulties daily, and they should not be subjected to unnecessary suffering from interacting with clinic staff or volunteers.

Patient Stress and Special Extenuating Circumstances

When serving our patients, it is important to keep in mind the extremely adverse living conditions and backgrounds patients come from. Stressful living situations break down morale and social behaviors such as courtesy and patience. Under these circumstances, it can be challenging to deal with such a person. If the patient is involved with drugs or alcohol, suffers from a mental illness, or has a serious antisocial background such as a history of criminal activity or prison, they can be especially difficult.

Another factor exacerbating a patient's frustration is the fact that many of them frequently interact with a multitude of private and public agencies to get basic needs met. Consequently, during the process of waiting, answering personal questions and applying for various types of assistance, their frustration level often becomes elevated. By the time that they visit our clinic, they may be—understandably—in the mood to react negatively towards our requests or instructions.

Although a patient's negative behavior may appear unwarranted, this behavior may be a learned survival technique. Through hard living, some patients have found that an aggressive, demanding behavior will get their needs met no matter how inappropriate.

In addition, there are individuals who blame the system for everything that has happened to them. These patients give up very easily using passive-aggressive

behaviors—such as walking out—to express frustration. It is important to remember not to take a patient's negative or aggressive behavior personally. There are reasons for this behavior, and most likely you are not the reason.

Regardless of the patient's actions, it is imperative that staff reactions not encourage further negative behaviors or responses. Instead, we can employ simple intervention strategies when a patient begins to act inappropriately within the clinic environment.

Guidelines for Addressing Aggressive Patients
Strategies for dealing with aggressive individuals are best formulated around the principle of least restrictive measure. This means starting with the least invasive tactic for subduing the aggressor and not advancing to the next level of restriction unless absolutely necessary. The three levels of intervention are:

Level 1: Prevention;
Level 2: De-escalation of tension; and
Level 3: Action aimed toward safety for all individuals involved.

Our goal of preventing violent behavior can be achieved by effectively employing these four basic steps:

- Observing,
- Skilled Listening,
- Talking, and
- Actions.

LEVEL 1: PREVENTION
The first and best method for managing physically or emotionally assaultive behavior is to anticipate and prevent. Management can be achieved by early assessment of the patient. For example, what are his or her needs? Can we meet these needs? If not, what options can we offer the patient, e.g., *"Would you like to speak to a supervisor?"* Consider whether there is another facility that can assist the patient and ask, *"Can we make a referral for you?"* or *"Would another time be more appropriate?"*

Observation. As you work, pay attention to the following warning signals that may hint of escalating tensions:

- Defiant attitude
- Excessive swearing
- Aggressive motions
- Unusual demands
- Increase or decrease in voice volume
- Challenging demeanor
- Tightening of jaws
- Deep sighs
- Fidgety movements
- Rapid pacing
- Clenched fists
- Advance or retreat actions

LEVEL 2: DE-ESCALATION OF TENSION

Listening. The listening and attending skills of therapeutic communication are the most effective tools of averting violent behavior. Even though you may be having a busy, stressful day, remember to clear your mind and pay attention to what the other person is trying to tell you. Don't rehearse your response. Don't defend yourself verbally.

Practice reflective listening. This involves finding out information about what a person is thinking and feeling, and what may be done about a problem. Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer. Listen carefully to what is said. Spending two or three minutes interacting with the patient may prevent an altercation. The more information you have, the better you will be able to work out a solution.

Steps for Effective Listening

- Tune in to your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
- Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say *"You seem very upset," "I know how you must feel,"* or *"I'm concerned that you might hurt yourself or others here."*
- Try to elicit the real issue and determine what is behind the anger.
- Demonstrate appropriate affect. Be sincere and assertive.
- Convey calmness, control and a willingness to help.

Talking. Being able to talk down an angry, agitated patient is a valuable skill for anyone providing patient care services. It is a skill dependent upon having and demonstrating a positive regard and respect for others. While talking, be aware of your voice. The tone of your voice will have an immediate affect upon the patient. It is imperative that your voice remain calm and soft yet firm. If you become angry or aggressive like the patient, you will be giving away your control of the situation. Simply state the facts and if necessary, repeat them. Avoid using your title or authority. Do not offer lengthy explanations or excuses.

The Don'ts and Do's of Therapeutic, Effective Talking

The Don'ts — Verbal

- Don't threaten the patient or demand obedience.
- Don't argue with the patient about the facts of the situation. Both of you may be right, but this does not help ease the situation.
- Don't tell the patient that she or he has no reason to be angry.
- Don't become defensive and insist that you are right.
- Don't offer placating responses such as *"Everything will be OK"* or *"You're not the only one."*
- Don't make promises you can't keep.
- Never challenge the patient or call his or her bluff.
- Never criticize the patient.
- Never laugh at the patient.

The Do's — Verbal

- Do ask, *"What can I do to help?"*
- Do use simple, direct statements.
- Do ask opinions: *"In what way do you feel we may be of service to you?"* or *"How would you like to see the situation resolved?"*
- Do offer choices and alternatives: *"If our services are not appropriate, may we assist in referring you to another facility?"* or *"May we make another appointment for you at a more convenient time?"* Try to leave the patient with options.
- Do encourage verbalization of anger rather that acting out. Express your limitation with this verbalization, however,such as expressions or language that is too offensive and not necessary.
- Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner.
- Do assume that the patient has a real concern and that she or he is understandably upset.
- Do recognize and acknowledge the patient's right to her or his feelings.

LEVEL 3: ACTION

Taking Action. Everything that we have learned so far about interacting with difficult patients becomes part of the process and culminates when we take action. A key concept in violence prevention is to try to decrease the person's sense of powerlessness or helplessness in order to minimize his or her frustrations. Communicate verbally and behaviorally that the person is responsible for his or her own actions. The following steps promote successful interactions:

The Don'ts and Do's of Successful Interactions

The Don'ts — Actions

- Don't ignore the patient.
- Don't come too close to the patient or hover over him or her. Keep a comfortable, nonthreatening distance between you and the patient that still allows you to hear and be heard.
- Don't make threatening physical gestures.
- Don't analyze or interpret the patient's motivation.
- Don't personalize the patient's anger.

The Do's — Actions

- Follow instinct and intuition. Use common sense.
- Detect danger signals.
- Keep everyone feeling safe:
  - ❑ Open the door to the room;
  - ❑ Identify an escape route convenient to you and the patient;
  - ❑ Position yourself closest to the room exit;
  - ❑ Keep furniture positioned with safety in mind; and
  - ❑ Assess the environment for potential weapons.
- Identify a code word that will alert the need for additional help. For example, clinic staff and volunteers are to say *Code Red* through the telephone intercom and identify the area where they are. At that point, designated staff are to respond.
- Protect others in nearby surroundings.
- Ask the patient to sit down.
- Establish and maintain eye contact.
- Observe social distance. Don't touch the patient.

- Decrease environmental stimuli by:
  - Minimizing the presence of staff and other patients,
  - Turning down any loud music, and
  - Minimizing distractions.
- Promote privacy.
- Attempt to meet as many of the patient's reasonable requests or demands as possible.
- Follow through with promises. Do not make promises that you can't keep.
- Remember who you are and practice professional behavior.

Summary

These principles, guidelines and procedures are basic suggestions to assist in averting abusive and violent behavior. They are for the express purpose of effectively serving our patients as well as protecting staff from dangerous and abusive behavior. When put into practice, these steps of observing, listening, talking and action can help achieve our goal of preventing violent behavior. Using common sense while practicing courtesy, concern and compassion will greatly enhance everyone's experience at our clinic.

Always keep in mind the adverse living conditions that our homeless patients deal with day and night. If we can be empathetic, and treat them as we would like to be treated, then we have not only provided good health care, but perhaps we have empowered them in their attempt to take control of their lives.

Good Health Medical Center
Crisis Prevention & Intervention

INTRODUCTION

These guidelines were developed by a small hospital for use in its mental health department. In addition to the regular training and review of these written policies, staff are encouraged to attend a workshop on managing people, Crisis Prevention & Intervention, The Mandt System. While these policies are very specific in nature, the concepts described can be translated into a more general approach for use in an ambulatory setting.

The guidelines are clear and brief, and we have found that they work because staff take them seriously. Our facility is in the process of updating these guidelines. Their weakness is that they need to be expanded to help staff recognize when violence might be directed towards others including violence towards children, the elderly, spouses, etc. In addition, the revised guidelines will be modified to include Critical Occurrence Follow-up so that the debriefing following a violent incident is required, not optional.

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Planning Committee

Good Health Medical Center
Crisis Prevention & Intervention

The Mandt System: *A workshop on managing people*

This workshop is available to all hospital personnel to provide them with options that will help them manage an individual's behavior, the individual's family and visitors' behavior, as well as that of his or her coworkers. The workshop is offered to all Good Health Medical Center employees including but not limited to: RNs, psych techs, social workers, security guards, CNAs, residential staff workers, emergency department techs, therapists, psychologists, psychiatrists, MDs, DOs, and administrators.

Program Purpose

To present a person-centered, value-based process developed to encourage positive interaction with others. Concepts presented promote respect and dignity for all persons. The Mandt System is a systematic training program designed to help you de-escalate yourself and other people when you or they have lost control. To accommodate different training needs, we are offering the option of either the Basic or the Intermediate Workshop:

- The Basic Workshop is designed for staff who work on a daily basis with people who are for the most part cooperative.

- The Intermediate Workshop is designed for staff who work on a daily basis with people who are uncooperative and who may become aggressive. *The Basic Workshop is a prerequisite to the Intermediate Workshop.*

Basic Workshop Objectives

1. List a graded system of alternatives in managing people and the advantages using a team approach.

2. Identify and match the stages and responses in the crisis cycle.

3. Identify how physical presence and body stance can de-escalate or escalate a situation.

4. Recognize the importance of nonverbal communication.

5. Complete the final exams at the end of each module with a score of 100 percent. Must attend 100 percent of workshop.

6. Demonstrate the proper body stances with no errors.

Intermediate Workshop Objectives

1. Explain the difference between support and restraint, including why pain compliance and hyperextension of joints is abuse.

2. Identify when you may need to restrain a person.

3. Explain how supporting and restraining are similar and how they are different.

4. Complete the final exams at the end of each module with a score of 100 percent. Must attend 100 percent of workshop.

5. Demonstrate the proper physical techniques with no errors.

Mental Health Departmental Protocol
Violence Towards Others

INITIATED
Date_____
Time_____
RN _____

DISCONTINUED
Date_____
Time_____
RN _____

Title: Potential for Violence Toward Others

Purpose: To outline the management of patients exhibiting potential for violence toward others.

Level: Independent

Indications: Implement protocol for patients who are violent or are assessed as a high risk to be potentially violent toward others.

Patient Outcomes:

1) The patient will be able to verbalize that violent behavior is impending and ask for help.

2) The patient is able to identify alternatives for expression of anger, rather than striking out.

3) The patient will be able to accept the limits of his or her environment.

4) Prior to discharge, patient is able to demonstrate use of alternatives to striking out.

KEY WORDS	NURSING MANAGEMENT CONTENT

Assessment:

1) Complete admission assessment to determine past history of violent behavior or assault.
2) Assess past history of assault in a treatment setting.
3) Assess past history of disorders that may indicate that the patient has a predisposition to violence such as:
   - ❑ oppositional disorder
   - ❑ conduct disorder
   - ❑ delusional (paranoid) disorder
   - ❑ organic personality disorder
   - ❑ borderline personality
   - ❑ antisocial personality
   - ❑ history of substance abuse
   - ❑ psychotic conditions
   - ❑ post-traumatic stress disorder
4) Assess precipitating events to prior violent episodes.
5) Observe continuously for behavioral cues predicting violence such as:
   - ❑ anxiety
   - ❑ breathlessness
   - ❑ rigid posture
   - ❑ pacing
   - ❑ verbal outbursts or profanity
   - ❑ increase in voice volume
   - ❑ threatening stances

KEY WORDS	NURSING MANAGEMENT CONTENT, *continued*
Psychosocial Support:	6) If patient is assessed as being on the verge of losing control, attempt to isolate the patient from the rest of the patient group or the stimulating situation. Recognize that the patient on the verge of violent behavior is usually experiencing a panic level of anxiety. 7) Speak to the patient softly, slowly and with assurance. Do not use a confrontational approach. Give concise, clear directions. 8) Assist the patient to verbalize feelings. This may require the staff member to point out to the patient body language and other behaviors that indicate that the patient is angry. 9) If patient refuses to talk about feelings, ask patient what may be helpful to assist the patient in staying in control such as physical activity, being alone, listening to music, etc. Provide these activities if possible. Be aware that although some patients respond well to physical activity, this needs to be used with care, since it may also precipitate loss of control. 10) Inform patient of acceptable limits for behavior and clarify the patient's responsibility for own behavior. Define consequences for acting out. 11) Be supportive of the patient and if he or she acts out, protect patient's self-esteem by keeping other patients out of area. 12) If patient does become violent, obtain order and institute seclusion or restraint and follow protocol for care of the patient in seclusion or restraint.

KEY WORDS	NURSING MANAGEMENT CONTENT, *continued*
Educational Needs:	13) Explore with patient reasons for acting out and help identify alternative behaviors. 14) Assist the patient to recognize and label anger. 15) Communicate that angry feelings are normal. Anger is not inherently good or bad and expression of anger is not always positive or negative. 16) Teach patient that effectively dealing with anger implies that the person can accept his right to be angry and the reciprocal right of others to be angry. 17) When the patient has an experience of expressing anger, assist the patient in analyzing the event. The following questions can be used as a guideline: ❑ What precipitated the anger? ❑ What did you attempt to do to control your anger? ❑ How did the other person behave in response to your anger? ❑ What would you change in the future? ❑ How would you do this? 18) Medication teaching on any medication ordered.
Medication:	19) Administer medication(s) ordered. These may be anti-anxiety or anti-psychotic medication. 20) Document effectiveness of medication. Observe for side effects, especially with anti-psychotic medication. Syntonic reaction and/or acathisia will increase the level of anxiety.

KEY WORDS	NURSING MANAGEMENT CONTENT, *continued*
Discharge Planning:	21) Review education teaching with patient and significant other. 22) If referral is made, encourage patient to use outpatient services. Provide patient with appointment card. 23) Provide written instructions on any prescribed medication.
Documentation:	24) Complete flow sheet every shift per guidelines. 25) When indicated, complete seclusion or restraint flow sheets per guidelines. 26) Document teaching on teaching record or focus notes.

Homeless Health Care Los Angeles
Safety Guidelines for Outreach

INTRODUCTION

These guidelines were developed for use by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street, and they do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach worker who has a very different work environment than staff who are agency-based. The guidelines are intended as only one piece of an agency's overall safety policies and procedures. Staff have found them useful for addressing this particular safety need.

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Nonviolence Crisis Intervention Techniques for Clinicians
Planning Committee

Homeless Health Care Los Angeles
Safety Guidelines for Outreach

1. Your supervisor needs to know where you will be at all times.

2. Learn as much as possible about the situation before setting out to do outreach.

3. Do not plan outreach for areas in which you have good reason to believe are inherently dangerous.

4. Be aware of gang areas and their colors. To be safe, do not wear red, blue or purple while conducting outreach.

5. Always carry business cards and California identification with you.

6. Inform collaborating agencies of your presence.

7. Introduce yourself and inform people of what you are doing and why.

8. Do not stand and argue with someone who does not agree with what you are doing.

9. Preferably, outreach is conducted in two-person teams. No team member shall conduct outreach activities alone unless receiving prior approval from their supervisor.

10. Never approach those who are giving "signs" that they do not want to be bothered.

11. Do not be critical of your partner in public while conducting outreach. Always present yourselves as a team.

12. Wear comfortable clothes and shoes. Do not overdress.

13. Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, etc. If carrying incentives, make arrangements to hold these in a secure place.

14. Do not remain in a spot where you are privy to a drug deal in process or being set up to "go down." Leave area immediately without drawing attention to yourself or others.

15. Do not linger with a person who you know is holding illicit drugs.

16. Do not interrupt the sale of sex or drugs for money. Leave area immediately without drawing attention to yourself or others.

17. Do not counsel or play the role of a social worker on the streets.

18. Maintain confidentiality of all clients you meet.

19. Do not accept gifts, food or buy any merchandise from clients.

20. Do not give or lend money to clients.

21. Do not accept or hold any type of controlled substance.

22. Never enter any clients' cars, homes or any enclosed area.

23. Tell clients approximately when you will be back and where you can be reached. Provide clients with a business card.

24. Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor.

25. Keep your supervisor informed of any unusual developments.

26. In case of an emergency, call or have another person call 911. Do not separate from your partner unless you feel that staying would increase your danger.

Employee Statement:

I acknowledge that I have received a copy of the safety guidelines for performing outreach. I certify that I have read and understand these guidelines, and I agree to comply with agency guidelines related to this issue to the best of my ability.

Print Name: _____

Signed: _____ *Date:* _____

Supervisor Signature: _____ *Date:* _____

Street Outreach Safety
Thoughts from Street Outreach Workers

INTRODUCTION

These are comments gathered from several outreach workers based on their own personal experiences in the field. Thanks to workers from the following Seattle programs: the Mental Health Chaplaincy, Health Care for the Homeless Network, ACCESS, and the Harborview Medical Center/Pioneer Square Clinic.

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Street Outreach Safety
Thoughts from Street Outreach Workers

- Explore the territory with folks who are knowledgeable about the area such as local residents, someone who is or has been homeless, agency staff, shopkeepers, clergy, etc.

- Develop a route or routes that regularly take you to shelters, drop-in sites, survival service, parks, etc. Have eventual destinations, be on the way, but always be available, ready to stop and reach out.

- Avoid being isolated; stay in public areas.

- Get to know the neighborhood. Be a neighbor, get to know the whole fabric of the community. Foster others' capacity to share in the outreach effort. Help the neighborhood—business people, street vendors, apartment managers, community service officers, church secretaries—to become skilled outreach partners with you. Help the community to be able to identify needs and concerns early on, rather than waiting for situations to become critical

- Always *observe* first. Consider how an individual is reacting and interacting with others and the environment. Tune your approach to what each person can tolerate. A glance, a smile, a hello? What is the response?

- Monitor how you affect the other person as you approach and begin to converse. Is the person able to handle someone coming closer? Is the exchange causing him or her to become agitated? Is she or he trying to create more space for themselves?

- Pay constant attention to your basic feelings and instincts. Ask yourself, *Am I feeling uncomfortable? Uneasy? Unsafe? Frightened?* Trust is a two-way street. Take time, don't push. Be prepared to back off and come back later. The issues and concerns will still be there.

- Pair up whenever going to more dangerous-feeling places and situations. Don't hesitate to ask for accompaniment. We are not looking for martyrs. Ask a colleague, apartment managers, security guards, police, agency staff, etc.

- Tell someone at your agency or clinic how long you expect to be gone and your planned route when doing outreach.

Thoughts from Street Outreach Workers

- Carry a cellular phone. It's handy for many purposes including personal safety.
- Keep a whistle in your pocket.
- Use good judgment with personal safety being the foremost consideration. Follow your instincts and intuitions.
- Consider meeting certain individuals in public spots or sites where others are around for safety support. Confidentiality becomes a possible trade-off.
- Keep in mind that with individuals who are experiencing a thought disorder, the brain's alarm system is highly and continuously active. A person in the midst of a manic episode, for instance, may already be easily irritated. Go as a bearer of peace, calm, safety, non-aggression, respect, warmth, genuine regard, openness, and patience. Treat people with dignity. Ask permission, say thanks. Be prepared to dust off your sandals and move on.
- The bottom line is *leave* if you feel unsafe or if someone is acting inappropriately.
- Be prepared to do what you need to do to protect yourself. Learn nonviolent physical defense and escape techniques.
- Think in advance of potential dangers that may exist. Operate in a cautious, defensive mode and attempt to predict what could happen.
- Beware of being too comfortable and overly confident in any situation; for example, *"I've been doing this a long time," "I can take care of myself on the streets,"* or *"I know what street life is about."*
- When visiting someone in an apartment, always ask permission first; *"May I come in?"* In addition to being a polite gesture, this request can help avoid being accused of illegal entry should something occur requiring legal action.
- When visiting an apartment, position yourself closest to the door. Always have an escape route in mind.
- Outreach is not crisis intervention. If someone is hostile, belligerent, violent, abusive, out of control or dangerous, it is work for the appropriate crisis intervention teams, involuntary treatment or police. The community doesn't need a "hero." We need you to be there tomorrow and again the day thereafter.

Street Outreach Project
Safety Protocols & Guidelines

INTRODUCTION

These guidelines were developed for use by a mental health facility that specializes in providing outreach and housing placements to homeless individuals with psychiatric disabilities. They have been developed for use by clinicians, outreach teams and support staff.

These guidelines provide a foundation for understanding possible causes of violent and aggressive behavior, how to predict it, what signals or clues to look for when someone is about to act-out, as well as possible responses to de-escalate the behavior before clients or staff are injured. These guidelines have been especially useful in a classroom setting with discussion and role playing.

The chief weakness of the guidelines, however, is that they are incomplete. We need to add interventions and procedures for the specific situations where staff work with clients, such as in the clinic, in a client's residence, in shelters and on the streets. In addition, we need to develop skills and protocols that do not require physical restraints.

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Street Outreach Project
Safety Protocols & Guidelines

I. THE ENVIRONMENT

The environment you create around your client can greatly effect the safety for you, your client and others in the clinical setting. A client will feel less stressed, less nervous and less confused in a situation where care and concern are constant and well organized.

II. GUIDELINES FOR PROVIDING A SAFER ENVIRONMENT

- Make change very slowly. Prepare clients for any physical, emotional, personnel or geographic change.
- Maintain a routine. It is important to create a dependable world and a structured existence and environment for your clients.
- Maintain communication through every channel. Provide social stimulation without overload.
- Assist your clients in avoiding crowds or large spaces without boundaries. Be sure that the environment is designed to avoid sensory overload.
- Keep instructions short and concrete. Clients may not have tolerance for complex activities or conversations.
- Maintain positive input such as reinforcement for any worthy act. This helps maintain the client's self-esteem and encourages participation in healthy activities.

III. THE CRISIS CYCLE

A. Crisis. A crisis is a turning point; it is the decisive or crucial time, stage or event. It may be the actual event of aggression or assault. It is a situation that:

- ❑ causes a sudden alteration in the individual's expectations of himself and/or his environment;

- ❑ cannot be handled by the individual with the usual patterns of coping; and
- ❑ is an emergency or an "emerging situation."

B. **Catastrophic reaction.** This is an over reaction to minor stressors. Catastrophic reactions may occur out of distress when the person becomes overwhelmed by high expectations and demands. People with brain impairment often become excessively upset and may experience rapidly changing moods. It is precipitated by fear or misinterpretation of a person or a situation. The person may weep, blush, or become agitated, angry or stubborn, or may strike out at those trying to help them.

C. **Trigger.** When a person exceeds his tolerance for stress, he or she is said to have begun the crisis cycle. He/she has been triggered.

D. **Escalation.** Once a person has been triggered, he or she begins to escalate. Escalation is manifest by increasing levels of agitation and/or activity. This phase can take minutes to days to years and is generally longer than the crisis itself.

E. **Continued escalation.** When escalation continues as evidenced by exaggerated behaviors and louder, more specific verbal threats such as *"I can't take it any more, I'm going to hit someone,"* move to the following interventions:

- ■ Bear in mind that attention is reinforcing. At whatever point you begin to attend to a client, you are giving reinforcement to that behavior.
- ■ Talking does little good at this point. Verbal interaction should be matter-of-fact and directed in short sentences.
- ■ Contract with the person—I'll do something for you, and you do something for me, *"I'll get you some coffee and you come outside and sit down."*
- ■ Keep the person talking—this will help distract them from assaultive thoughts; conversation is not usually compatible with assault.

- Set limits.

- Use *"please."* Please is a powerful word and gives the person control through providing an option.

- Help the person save face. Make it look more attractive not to assault than to assault.

F. **De-escalation.** Characterized by decreasing levels of physical activity. Behaviors in this phase can look the same as those presented during escalation. Care must be taken to determine which phase it is.

IV. MANAGING THE DIFFICULT TO MANAGE CLIENT

- Be aware of the Karpman Triangle and counter transference which can be dysfunctional. Tips for recognizing and avoiding triangulation:
  - *Triangulation typically involves parties assuming the classical roles of victim, rescuer and persecutor.*
  - *When caught in triangulation, interactions tend to go round and round with no resolution and may lead to a power struggle.*
  - *Triangulation can also happen with only two parties.*
  - *Keep interactions simple and visual.*
  - *Be aware of staff being manipulated by the client.*

- To avoid triangulation, provide a lot of structure in order to maintain focus. Ways to provide structure to your interactions with clients:
  - *Contracting.*
  - *The treatment plan, which is a type of contract, provides structure and focus.*
  - *Contract for this session/encounter; make the contract clear and concrete; include time, goals and session content.*
  - *Anti-harm contract.*

- It is important to engage difficult clients in treatment—especially clients who are mandated and non-voluntary. Engagement can be accomplished by getting agreement, contracting in small increments, and reducing goals and expectations to the smallest, acceptable steps.

- Make use of very specific steps, especially when the task is difficult for the client.

- Do not accept passive agreements.

- Clearly identify your bottom line when negotiating agreements. Be up front and clear about what is nonnegotiable.

V. AGITATED AND AGGRESSIVE BEHAVIOR

A. Behaviors indicative of potential physical aggression:
   - Loud or increased tone of voice; yelling
   - Verbal threats
   - Frowning
   - Trembling
   - Psychomotor restlessness (i.e., pacing, wringing hands, picking at skin, twisting hair, etc.)

B. Overt physical aggression:
   - Hitting
   - Kicking
   - Biting
   - Pushing
   - Throwing things
   - Pinching
   - Head banging
   - Scratching

   Verbal agitation and aggression can lead to violent and destructive physical behavior. Verbal aggression frequently occurs prior to or concomitant to physical violence.

C. Potential etiologies of agitated and aggressive behavior:
   - Infection and fever
   - Polymedicine, drug interaction, drug side effect, drug toxicity, or abrupt drug discontinuance
   - Chronic psychosis
   - Paranoid psychosis often presents as agitation
   - Depression
   - Bipolar disorder; manic phase
   - Anxiety
   - Chronic pain

- Acute discomfort or pain related to unmet physical needs
- Lack of sufficient coping skills needed to handle life and environmental changes
- Fear of misinterpretation
- Trauma, especially head injury
- Malnutrition
- Anemia
- Dehydration.
- Seizures—during or following a seizure
- Tumor—may present as confusion and/or agitation or aggression
- Cerebrovascular disease
- Hypothermia
- Hypothyroidism—known to be associated with psychological changes
- Hyperthyroidism—presenting as apathy, depression or a confused state
- Liver disease or failure
- Decreased cardiac output, secondary to congestive heart failure or pulmonary embolism
- Acute heart attack—may present mainly as confusion
- Respiratory disorders—pneumonias, hypoxia, chronic lung disease with hypoxemia and hypercapnia, pulmonary emboli
- Renal insufficiency (kidney)
- Azotemia (presence of excessive amounts of nitrogenous substances in the blood)—secondary to obstructive uropathy or over zealous dieresis
- Hypoglycemia (low blood sugar)—associated with hypoglycemic agents or over zealous attempts to control blood sugar with insulin
- Hyperglycemia (high blood sugar)—associated with ketoacidosis, lactic acidosis or hyperosmolar states
- Electrolyte imbalance
- Substance abuse or withdrawal

D. Behaviors indicating agitation or aggression:

- Tears
- Eyes may widen
- Increased volume to voice
- Rate of speech may quicken
- Increased psychomotor behavior (pacing, grabbing, picking).
- Frowning
- Shaking or trembling.

- Catastrophic reaction; over reaction to a minor stress. May exhibit some escalating behaviors or lose control explosively.

E. Environmental conditions contributing to agitation or aggression:
- Increased noise from the television, radio, or voices
- Crowded room
- Increased lighting
- Increased heat

VI. ASSESSING DISRUPTIVE AND AGGRESSIVE PATIENTS

Any behavior that presents a danger to the patient or others or that delays or prevents appropriate care is disruptive and may lead to a crisis situation.

A. Assessing the situation
- Describe what information you have; what happened
- Assess the environment—emotional, social, and physical; does it seem dangerous to you or others?
- Does the patient seem agitated, elated, depressed, or restless?
- Has he/she already demonstrated violent or aggressive behavior?
- Does he/she talk loudly and in a sarcastic way?
- Is he/she easily provoked to anger?
- Does he/she have a limited attention span?
- Does the patient seem to be out of control or disoriented?
- Does he/she seem to be afraid or panicky?
- Does he/she have a weapon?
- Is there evidence of alcohol or drug use?
- Is a domestic disturbance involved?
- Has criminal activity occurred?

If you answer *yes* to three or more of the above questions, use extreme caution. If possible, try not to control or suppress the patient's behavior. Instead, allow him or her to express these feelings. The most effective way to deal with a patient who exhibits aggressive and/or violent behavior is to reduce the crisis and prevent further disruptive behavior. Probably the safest thing to do in these situations is to call the police.

B. Clinical assessment of agitation:
- Thorough assessment of behaviors and circumstances is needed before intervention
- Is the onset acute or chronic? Was there a precipitating event?

- Define specific behaviors being assessed
- Describe the physical changes being observed
- Assess environmental or recent life changes
- Complete a physical exam; include a mental stress exam
- Complete lab tests and review results
- Review medication

C. Guidelines for clinicians

- After checking to be sure that the patient is not injured, helping the patient feel safe and secure should be the focus of the intervention, not the agitated behavior itself. You may say, *"This is a safe place. You are safe here. There is no need to act that way here. I won't let anyone hurt you."*
- The goal is to help the patient regain control.
- The clinician should not show fear or agitation.

VII. INTERVENTION STRATEGIES

A. Behavioral strategies to reduce agitation:

- Speak in a soft, quiet voice
- Use a calm, even tone of voice and calm manner
- Repeatedly call the patient by name
- Maintain appropriate eye contact
- Do not point
- Avoid folding arms or taking a "John Wayne" stance
- Ask in a calm manner what he/she needs. Allow time and space for a response. The goal is to help the patient regain control of his/her situation.
- Turn down the brightness of the lighting
- Turn down the volume of the television or radio
- Relocate to a less crowded or noisy area
- Try playing soft music
- Encourage the patient to sit down by sitting down yourself

B. Safety strategies with assaultive or potentially assaultive persons:

- Look for a door or an escape route
- Look for other people
- Scan the room for potential weapons
- Scan the area for obstacles

- Stand sideways
- Maintain appropriate eye contact; call the person by name
- Consider territory
- Change place, position
- Keep the person talking
- Help the person save face. Make it look more attractive not to be assaultive than it is to assault.
- Do not mistake anger for aggression
- Use *"please"*
- Know methods of talking "to and through" the individual to let other staff know your plan
- Be aware of the usual progression of aggression:
  - Stance;
  - Looks at you;
  - Looks away; and
  - Hits you.
- If the person grabs you:
  - Say *"Please let go"*
  - Make a fist; this will facilitate a release
  - Get out of their grip
  - If you can't get out of the grip, get in.
- If you are hit at:
  - Don't let the blows land.
  - Dodge toward the side of the attack and turn your back to person.
  - If hit, use the momentum to push yourself off in a different direction.

C. Medical management—start low, go slow

- Try to use only one drug at a time.
- Target specific symptoms to treat.
- Consider half doses for younger persons.
- Use multiple doses instead of one big dose.
- Change dose in small increments.
- Make changes slowly:
  - Consider drug half-life;
  - Wait for a steady state; and
  - More aggressive dose changes may be indicated for violent or assaultive behavior.
- Monitor risk for side effects, toxicities and interactions.

- It is sometimes helpful to increase the dose, and sometimes better to lower it.
- Sometimes the best thing to do is to discontinue all medications, i.e., a drug vacation.
- PRN medications should be given during the escalation phase and before the crisis when behavioral interventions are ineffective to help the person regain control.

VIII. DOCUMENTATION

The recording of incidents involving agitation and/or aggression must be specific and thorough. Essential elements include:

- **Biography**: Briefly describe who the person is, and his/her history with the agency. Add relevant details about why the patient is here today.

- **Behavior**: (Problem) State what the patient is doing that is a problem. Be specific with behavior descriptions. The note should include the first sign or signs of the trigger, escalation and a step-by-step progression of events. Descriptive, direct quotations from clients are helpful. Include the specific time the incident began or occurred as well as the incident's location. A description of the environment is also important. Note the problem on the Problem List.

- **Intervention**: (Method) Describe what you are doing to solve the problem and why you are doing it. The note should reflect step-by-step interventions in cases where the first intervention or interventions are ineffective. It should be noted as a "method" on the Treatment Plan.

- **Outcome**: (Response) Describe the patient's response to the intervention and what the patient does when you intervene (i.e., is the plan working?). The outcome should relate to the goal on the Treatment Plan. Outcome charting involves the patient's immediate response to an intervention as well as a longer-term response (e.g., follow-up notes indicating effectiveness or lack thereof from PRN medication, time-out, diversional activity, etc.). In addition, the note should contain recommendations regarding further treatment (i.e., are current interventions helpful or not; has a new method been discovered which should be added to the treatment plan; etc.).

IX. POST-CRISIS DEPRESSION

A. Behaviors

- May be sleepy.
- May attempt to harm self.
- May refuse to care for self—eat, groom, etc.

B. Intervention strategies

- One-to-one to provide support. Ask *"Can I do anything to help you feel better?"* or *"I'll sit with you."*
- Watch closely.
- Reassuring touch.
- Attempt to elicit information regarding the nature of the trigger. Generally patients have a lowered resistance and are receptive one-to-one.
- Allow the person to rest. Failure to allow the body time to rest may serve as another stressor.

X. OTHER PROBLEMATIC BEHAVIORS

A. Sun-downing: increased confusion and/or agitation in the evening or at night. Interventions include:

- Plan the day so that fewer things are expected in the evening.
- Reduce the number of things going on around the person.
- Plan a walk or a car ride in the late evening.
- See that he/she has gone to the bathroom before going to bed.
- A night light may help.
- Check room temperature for comfort.
- Is the bed comfortable?
- Sit with the person or allow them to sit with you; offer quiet reassurance.
- If they get up, allow them to stay up; provide a safe environment and a chair to nap in.
- Consider medications and be alert to side effects.

B. Paranoia

- Do not argue or confront.
- Give the person as much control as possible; for example, in decision making.
- Provide calm, consistent support.

GLOSSARY OF MENTAL HEALTH TERMS

Abusive language: Use of language that is not acceptable to you. In fact, it is not acceptable to most people.

Acting out behavior: Behavior that is not tolerated in your facility; for example, yelling, swearing, hitting or throwing things.

Affect: An immediate expressed emotion (i.e. euphoria, anger, sadness). Terms frequently used to describe affect include blunted, flat, inappropriate, and labile.

Anxiety: Nervous, may be shaky, may walk a lot, complains of being restless, seems to be anticipating danger.

Attention span: The length of time that a client has the ability to sustain focus on one task or activity.

Blocking: Interruption of a train of speech before a thought or idea has been presented.

Confabulation: Fabrication of facts or events in response to a question about situations or events that are not recalled due to memory impairment.

Confused: A client does not know the time, place, his or her own name, or location; may show all or part of these symptoms.

Delusion: May have one or more thoughts or fears with no external reality, but the person continues to have the thought, belief, or fear.

Depression: Not talking, looking sad, showing no interest in anything, not taking care of self (personal hygiene, grooming, etc.), eating and/or sleeping poorly.

Disorientation: Confusion about date, time of day, place, and person.

Empathy: A current understanding of an individual's feelings gained by "borrowing" that person's feelings in order to understand them, sensing their world as if it were your own, while never losing the "as if."

Feeling: Affect—the immediate expression of feeling inferred from appearance, behavior and comments; and mood—the predominant and pervasive general feeling such as anger, fear, elation, anxiety, depression, and apathy.

Hallucination: A client may hear something that others do not hear—auditory hallucinations—or may see something that others do not see—visual hallucinations.

Illusion: A misperception of a real external stimulus, i.e., seeing a tray cart in the room as a load of wood.

Labile: A rapid change of moods for no apparent reason, i.e., the client may cry and then start laughing when there has been no change in the conversation. A client may look very sad and then suddenly start laughing or be laughing and suddenly start crying.

Orientation: Awareness of where one is in relation to time, place and person.

Paranoia: A tendency on the part of an individual or group toward excessive or irrational suspiciousness or distrustfulness of others.

Psychosocial: Involving both psychological and social aspects—the non-medical aspects of the total patient.

Sympathy: Helper "takes on" the feelings of the patient as if he or she were in other's place and stays there. The helper loses the "as if" aspect and shares the patient's feelings.

Withdrawn: A patient may stay in his or her own room, may not talk to others, may not take part in usual activities, or may not want to leave their residence for outside activities.

U. S. Public Health Service, Region III
Template for Emergency Policies
Addressing Violence in the Clinic

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1. It is recommended that there be policies forbidding any form of violent action among staff, as well as violent, abusive, intimidating, or disrespectful language.

2. There should be protocol for management of violent incidents in the clinic addressing the following points:

   - Designate *"where the buck stops."* Most clinic personnel should not have to deal with—and are not trained to deal with—violent persons. This duty goes to leadership personnel with training in the management of violent persons and incidents.

   - Remove immediately the violent person from any public area where staff and bystanders can be injured or where the violent person can "act out" for an audience. Staff should refer the violent person to a designated manager in a calm and helpful manner, e.g., *"I see what you mean; let me take you to Mr(s). X who can help you."*

   - Establish a code to alert staff that a violent or potentially violent person is on the premises, e.g., *"Mrs. McGee, I am bringing Z back to Mr(s). S."* There is no Mrs. McGee; that is the code word for a violence emergency.

   - Identify a back-up source of control for physical violence; for example, a security guard or the police. Share the clinic's violence protocol with them. Establish the best way to notify them that there is a volatile situation. In response to the emergency code words, while Mr. Z is on his way to Mr(s). X, a designated person should be responsible for calling in the back-up in the event that they are needed.

   - Establish a closing protocol. The last person out of the clinic at night is the one most vulnerable to attack. It is best for the last staff members to leave the building together.

HCLA 9

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
SEXUAL CONDUCT POLICY

Sexual contact shall be prohibited between clients and al program staff, including members of the Board of Directors. Homeless Health Care Los Angeles (HHCL) shall include a statement in each employee's personnel file noting that the employee has read and understands the sexual contact prohibition policy.

Drug Abuse Homeless Day Care Services case managers counselors shall include the policy prohibition as part of an overall client's rights statement given to the client at admission. The policy shall remain in effect for six months after a client is discharged.

I have read the above policy related to sexual conduct and I agree to abide by the above statement. I acknowledge this by my signature.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HHCLA: 1990, REVISED 10/01

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