**New Hampshire High-Risk Capacity Development Survey for Interested Vendors**

The Community of Practice has developed the attached survey to help increase capacity for serving individuals with histories of high-risk behavior in community settings. The goal of the survey is to develop a better understanding of vendor agencies who are interested in serving this population. The target population includes individuals with intellectual or developmental disabilities that have histories of high risk behaviors, including fire setting, problematic sexual behavior and intentional violence. These treatment programs are intended to be the first step in promoting a fuller continuum of programs capable of serving these challenging individuals. The survey seeks to gather key information and identify the unique operational characteristics of programs that seek to serve individuals with a history of high risk behavior.

The attached survey is intended to gather information about your agency’s current operations. The Community of Practice will follow up with your agency to discuss next steps regarding your interest in providing ITS services, step-down services, or both.

**Statement of purpose:**

It is the purpose of the Community of Practice (CoP) to ensure that the scarce resources of Intensive Treatment Services staffed residential programs are utilized effectively to meet the needs of individuals with developmental disabilities and acquired brain disorders, and who exhibit high risk behavior, defined as dangerous and purposeful aggression towards people and property, problematic sexual behavior, or fire-setting. Within the total population of citizens of the State of New Hampshire, there is a small group of individuals with developmental disabilities and acquired brain disorders who have histories of high risk behaviors. These individuals may require specialized services, supports and treatment in order to assure the safety and well-being of the individual, the community and the people who support the individual. The majority of such individuals can be effectively supported to live safe and fulfilling lives through the process of Person Centered Dynamic Risk Manageability. However, some individuals require a highly specialized combination of intensive treatment, structural supports and intensive supervision beyond that which is available in generic programs offered by typical service providers. In order to assure that these individuals are referred to, served in, and graduated from these intensive services programs in a manner that reflects statewide consistency, sound fiscal management and the best interests of each individual being served, the following process will be followed.

**Statement of Work:**

The CoP accomplishes its purpose through the following:

* Ensuring that all referrals to ITS staffed residential programs are reviewed for appropriateness based on a comprehensive risk assessment and person-centered plan for dynamic risk manageability
* Identifying provider agencies that can provide the appropriate level of support, supervision and safety based on the individual’s unique circumstances as identified in his or her risk assessment
* Reviewing the census of each ITS staffed residential program to identify individuals who may be preparing for transition to less restrictive programs
* Coordination between Area Agencies, provider agencies and the Bureau of Developmental Services to ensure that any barriers to access or transition are appropriately solved

**Applicability:**

 This process is applicable to all individuals with developmental disabilities and acquired brain disorders who have histories of high risk behavior and who are being referred to intensive treatment service programs operated either within or outside of the State of New Hampshire.

**Definitions:**

* **Individuals with histories of high risk behaviors means**: individuals with developmental disabilities and acquired brain disorders who have histories of serious offending behaviors and who exhibit high risk behavior, defined as dangerous and purposeful aggression towards people and property, problematic sexual behavior, and fire-setting. These individuals may also have significant involvement in the criminal justice system.
* **Intensive Treatment Service program means**: a staffed residential program that agrees to serve individuals with histories of high risk behaviors through a combination of intensive treatment, enhanced supervision and environmental modifications. These programs are designed to minimize risk and provide individualized, high quality, state-of-the art treatment to assist individuals in overcoming their high risk behaviors so they can live richer and more fulfilling lives as non-offenders. ITS Programs are those operated under the statewide standards.
* **Responsible Area Agency means**: the Area Agency that is responsible for planning and coordinating services and supports for the individual.
* **Statewide Community of Practice means**: A group consisting of providers of intensive treatment services, a representative from all area agencies, a representative from BDS, and other stakeholders who share a commitment to the provision of high quality services and supports to individuals with histories of high risk behaviors. The Community of Practice was established to promote quality, centralization and uniformity of practice.  The CoP reviews referrals to ensure the clinical, programming and treatment services needed to safely support this population is the least restrictive setting based on the safety, security and treatment needs of the individual. CoP strives to support clinically and fiscally responsible outcomes in the process of response to referrals to intensive treatment service programs.

**PROGRAM SURVEY:**

Please respond to the following questions, and return to the Community of Practice to allow the Committee to review your request.

**ALL QUESTIONS SHOULD BE ANSWERED ABOUT PROGRAMS YOU CURRENTLY OPERATE.**

This survey is not meant to serve as a proposal, only to gather information about the services your agency already offers.

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| *For vendor agencies currently operating in the State of New Hampshire:* |
| Area Agency within whose catchment area program is located: | Click here to enter text. |
| Area agencies that have individuals residing in the program: |
| [ ] 1 | [ ] 2 | [ ] 3 | [ ] 4 | [ ] 5 | [ ] 6 | [ ] 7 | [ ] 8 | [ ] 9 | [ ] 10 |

|  |
| --- |
| *For all interested vendor agencies, in state or out of state:* |
| 1. **Program Name(s):** Click here to enter text.
 |
| 1. **Vendor agency:** Click here to enter text.
 |
| 1. **Program location(s):** Click here to enter text.
 |
| 1. **Total number of individuals served:** Click here to enter text.
 |
| 1. **Age groups served:**
 | Youth [ ]  | Adults [ ]  | Seniors [ ]  |
| 1. **Types of challenging diagnoses/behavior seen in individuals currently supported by your agency:**

[ ]  Traumatic Brain Injury/ABD incurred between age 21-60[ ]  Traumatic Brain Injury/ABD incurred prior to age 21 or in utero[ ]  Traumatic Brain Injury/ABD incurred after age 60[ ]  Intellectual/Developmental Disability [ ]  Persistent Mental Illness[ ]  Personality Disorders (inc. Bipolar D/O, Borderline Personality D/O)[ ]  Schizophrenia[ ]  Dissociative Disorders[ ]  Other: Click here to enter text.[ ]  Sexual Offending [ ]  Problematic Sexual Behavior[ ]  Instrumental Violence [ ]  Fire setting [ ]  Substance or Alcohol Abuse/Addiction[ ]  Elopement[ ]  Self-Harm/Suicidality[ ]  Autism Spectrum Disorders[ ]  Other, please describe: Click here to enter text. |
| 1. **Does your program include residential services, day program services or both?**

[ ]  Residential Program Only [ ]  Day Program Only [ ]  Both Residential & Day If your agency provides day programming, please briefly describe the program (i.e. hours per day spent in community, employment supports, community integration, etc: Click here to enter text. |
| 1. **What is the average length of stay in your current programs?**
 |
| [ ]  Less than 30 days  | [ ]  31 to 90 days  | [ ]  91 to 180 days  |
| [ ]  181 to 365 days  | [ ]  365 to 730 days  | [ ]  More than 730 days |
| 1. **What types of legal statuses apply to current or past program participants?**
 |
| [ ]  Public/Private Guardian  | [ ]  Voluntary Status |
| [ ]  Conditions of Probation/Parole  | [ ]  Civil Commitment (in NH, under RSA 171:B or RSA 135:C) |
| [ ]  Catchment from Court |
| 1. **Are any of the houses associated with the program:**
 |
| Licensed? [ ]   | Certified? [ ]  | Other? [ ]  |
| *If “other”, please describe*: Click here to enter text. |
| 1. **Please briefly describe the general programmatic philosophy of your current program(s):** Click here to enter text.
 |
| 1. **Where do the people in the program come from ? (check all that apply):**
 |
| [ ] Criminal Justice System  | [ ] Designated Receiving Facility | [ ] Family |
| [ ] Human Services Providers within Region | [ ] Human Services Providers outside Region | [ ] DCYF |
| [ ] Bureau of Developmental Services | [ ] Educational System | [ ] Other |
| *If “other”, please describe*: Click here to enter text. |
| 1. **When people leave the program, where do they go (check all that apply):**
 |
| [ ] Criminal Justice System [ ] Designated Receiving Facility or Secure Psychiatric Unit[ ] Family[ ] Human Services Providers within person’s home Region (or Catchment Area)[ ] Human Services Providers outside person’s home Region (or Catchment Area)[ ] Human Services Provider within program’s Region (or Catchment Area)[ ]  State Psychiatric Hospital or Institution[ ]  Community-based residence, independent[ ] Other, please specify: Click here to enter text. |
| 1. **Does the program employ environmental modifications for safety/security?** Yes ☐ No ☐
 |
| [ ]  Locked bedrooms  | [ ]  Alarmed Windows  |
| [ ]  Alarmed bedrooms  | [ ]  Locked/Secured Cabinets  |
| [ ]  Secure/locked perimeter doors  | [ ]  Hardened Interior/Exterior Walls  |
| [ ]  Alarmed perimeter doors  | [ ]  Staff Duress Alarms  |
| [ ]  Fenced/walled perimeter  | [ ]  Lexan/Unbreakable Windows  |
| [ ]  Locked Windows [ ]  Locked Sharps [ ]  Radal Flame Detection | [ ]  Frosted Windows [ ]  Fire suppression system (sprinkler system, etc)[ ]  Delayed Egress |
| [ ]  Other, please specify: Click here to enter text. |
| 1. **Does the program employ rights restrictions?** Yes ☐ No ☐
 |
| [ ]  Access to the Community  | [ ]  Access to personal possessions  |
| [ ]  Room Searches  | [ ]  Visitation restrictions |
| [ ]  Monitored/Restricted Telephone Usage [ ]  Internet restriction | [ ]  Monitored/Restricted Television, Video Viewing[ ]  Mechanical Restraint  |
| [ ] Searches of Person  | [ ]  Mail Monitoring  |
| [ ]  Restricted Privacy  | [ ]  Access to Incendiary Materials  |
| [ ]  Access to Sharps/Utensils  | [ ]  Vehicle searches  |
| [ ]  Other, please specify: Click here to enter text. |
| 1. **If the program employs rights restrictions are they (check all that apply):**
 |
| [ ]  Individualized | [ ]  Included in the Individual’s Behavior Plan |
| [ ]  General or house rules | [ ]  Reviewed/approved by the Human Rights Committee |
| 1. **Who provides clinical treatment in the program?**
 |
| [ ]  In-house clinician | [ ]  Outside/Community-based clinician |
| [ ]  Clinician(s) in agency clinic | [ ]  Other, please specify: Click here to enter text. |
| 1. **What means does the program use to assess treatment progress?**
 |
| [ ]  Treatment progress checklist | [ ]  Daily progress notes |
| [ ]  Individual goal/objective data sheets | [ ]  Behavior plan data sheets |
| [ ]  Other, please specify: Click here to enter text. |
| 1. **Does your program currently offer:**

[ ]  Onsite Medication Management[ ]  Partnership with community Medication Management provider[ ]  Staff nursing[ ]  Contract nursing services[ ]  On-call clinical support[ ]  Partnership between your agency and local inpatient mental health center (including hospitals)[ ]  Access to additional, emergency staff[ ]  Staff behaviorist(s)[ ]  Staff therapists(s), type: Click here to enter text.[ ]  Staff physician(s), type: Click here to enter text.[ ]  Scheduled respite options[ ]  Crisis respite options |
| 1. **What kinds of specific treatment modalities does your program offer, and at what frequency? (I.e skills groups, CBT/DBT, Julie Brown Skills System, Good Lives Model, etc.)**
 |
| Click here to enter text. |
| 1. **Does your agency utilize a standardized referral packet of required information for referrals?**
 |
| [ ]  Yes (If yes, please attach a copy) | [ ]  No |
| 1. **Are there specific types of maladaptive behaviors that preclude individuals from consideration for admission to your agency’s program(s)?**
 |
| [ ]  No |
| [ ]  Yes, please specify: Click here to enter text. |
| 1. **Do your programs currently serve (mark all that apply):**

[ ]  Males only[ ]  Females only[ ]  Co-ed, separate residences[ ]  Co-ed, mixed residences[ ]  Medically complex individuals (including Diabetics, individuals with severe seizure disorders, individuals with neurologic degenerative disorders, etc)[ ]  Physically handicapped individuals [ ]  Individuals requiring personal care[ ]  Individuals diagnosed as deaf or with blindness[ ]  Registered Sexual Offenders |
| 1. **Does your agency require a clinical assessment by their staff as part of the referral process?**
 |
| [ ]  No[ ]  Yes, done at:[ ]  program site [ ]  client residence [ ]  other, please describe: Click here to enter text. |
| 1. **Does your agency collaborate with any other entities (either state operated agencies, other human service agencies, private therapists, medical practitioners, behavioral health agencies, etc) to provide necessary services in your current programs?**

[ ]  No [ ]  Yes, please describe: Click here to enter text. |
| 1. **Does your agency hold any national accreditation (such as CARF, JCAHO, etc.?)**

[ ]  No [ ]  Yes, please state: Click here to enter text. |
| **Survey completed by:**Name: Click here to enter text.Title: Click here to enter text.Agency: Click here to enter text.Date submitted to the Community of Practice: Click here to enter a date. |

**Please be sure to fill out the last page of this survey, pertaining to individual programs your agency already operates that serves high risk individuals. You may copy the last sheet if necessary, as we ask that there be one sheet filled out per program your agency operates.**

**Direct Support, Supervisory, Administrative Staff Information**

**Use one chart per residence.**

***Please copy sheet if necessary, for each ITS or high-risk residence currently in operation.***

|  |  |
| --- | --- |
| **Name of residence:**Click here to enter text. | **No. clients served:**Click here to enter text. |
| **Direct Support Staff, total number:**  | **Supervisors, total number:**  |
| Number on duty, Day: Click here to enter text. | Number on duty, Day: Click here to enter text. |
| Number on duty, Evening: Click here to enter text. | Number on duty, Evening: Click here to enter text. |
| Number on duty, Overnight (awake): Click here to enter text. | Number on duty, Overnight (awake): Click here to enter text. |
| **Administrative staff, total number:**  |
| Number On Duty (Day): Click here to enter text. | Number On Call (Day):Click here to enter text. |
| Number On Duty (Evening): Click here to enter text. | Number On Call (Evening): Click here to enter text. |
| Number On Duty (Overnight): Click here to enter text. | Number On Call (Overnight): Click here to enter text. |
| **How many hours and during what shifts are Clinical Staff:** |
| …on the property? Click here to enter text. | …available on call?Click here to enter text. |
| **Nursing Availability Awake Hours:** [ ]  Available On-Site [ ]  Available on-call [ ]  Not Available |
| **Nursing Availability Overnights:** [ ]  Available On-Site [ ]  Available on-call [ ]  Not Available |
| **Direct Support Staff Training:** |
| 1. Hours of basic training required prior to any contact with individuals: Click here to enter text.
2. Hours of training required via shadowing: Click here to enter text.
3. Total hours of training required before staff can provide full support: Click here to enter text.
4. Hours of specialized, offender specific training required: Click here to enter text.
5. Hours of ongoing specialized training provided: Click here to enter text.
6. Training provided on Risk Management Plans: Click here to enter text.
7. Training provided on Behavioral Support Plans: Click here to enter text.
 |
| **Additional notes:** Click here to enter text. |