TAYLOR COUNTY CSCD

SUBSTANCE ABUSE

TREATMENT FACILITY

1133 South 27th

Abilene, Texas 79602

(325) 691-7407

www.taylorcscd.org

Taylor County CSCD
Substance Abuse Treatment Facility Program Overview

Mission

The Taylor County CSCD Substance Abuse Treatment Facility (SATF) is a 60 bed, all male, Community Correctional Facility (CCF) serving high risk offenders with substance abuse issues for both felony and misdemeanor cases, from any judicial district in the State of Texas. Our mission is to teach recovery, rehabilitation, and relapse awareness to defendants in order to allow them the opportunity to gradually reintegrate into the community as a responsible and sober citizen. Community Correctional Facilities have a financial and moral responsibility to reintegrate defendants into society by providing protection to the community through supervision of the defendant and by providing opportunities for rehabilitation to the defendant by applying the appropriate intervention which allows the defendant to choose to make positive changes to become productive, law-abiding citizens.

The Program

Defendants are ordered by their respective court to participate in and complete the program which is a minimum of nine months, six months of that in treatment and three months in employment. If applicable, this is followed by a twelve-month aftercare component with a transitional housing requirement. The SATF Program addresses responsivity by determining the defendant's risk and needs to create a treatment plan and by providing class instruction or group counseling in order for the defendant to accomplish the interventions of the treatment plan. The program is nine months, with six months being treatment followed by three months of employment. The classes include the substance abuse curriculum of Strategies for Self-Improvement and Change (SSC), cognitive skills, cognitive behavior mapping, life skills which includes family and parenting issues, social skills, anger management, employment skills, financial management, Twelve Step study, Family Education, Fatherhood Effect, Trauma, Kid Connection, Family Day and GED. Defendants are required to attend individual counseling, group counseling, 12 Step groups and participate in all other classes as identified through assessments. The substance abuse curricula, group counseling, individual counseling is administered by and the treatment plan is created by Licensed Chemical Dependency Counselors. In order to advance through the program, defendants must accomplish all interventions of their treatment plan, attend all classes, complete all assignments and CSR.

Resident Responsibilities

During treatment, scrubs will be provided to the defendants. They do not have to pay room, board, transportation or laundry but are responsible for their commissary. If they do not have money, essential commissary items are provided and they will reimburse the facility for those items during employment. During employment, they wear their own clothes, see approved list below. They will pay for room, board, transportation, laundry, and commissary. Beginning January 1, 2019, a $35.00 Program Fee for books and materials will charged to each defendant. The fee will be collected at any point during their stay that they have the funds available.

Referral Process

Any county interested in placing a defendant on the waiting list for the Taylor SATF may do so using the following contact information: **Jennifer Cauthen** at (325) 691-7407 or Email:jcauthen@taylorcscd.org. The referring county will provide the paperwork listed on the Intake Checklist below via email, mail or fax (325) 691-7432 and arrange for a complete medical evaluation and TB screening within 10 days of placement using the CJAD approved forms below. Defendants must be in custody 10 days prior to placement and transported to

the facility. If out of county cases choose to remain in this jurisdiction following completion of the program, court ordered aftercare and transitional housing conditions will be required. **This is a Tobacco Free Program; residents will not be allowed to use or possess any tobacco products during the program.**

Eligibility Requirements

These requirements were developed to insure compliance with CJAD standards and to reduce the number of inappropriate placements into the facility.

Defendants must be deemed physically and mentally capable to participate in treatment and employment.

All defendants must have the approved, completed physical exam form conducted by a qualified health care professional within **10 days** of placement.

Tuberculosis screening must have been administered within the 12 months of placement date.

Defendants who are currently taking prescription medication must bring a **30 supply.** There are limits on approved medications, see list below.

Both felony and misdemeanors defendants are court ordered by their respective judge in lieu of incarceration, not to exceed 24 months. See example court order below.

Offenders who are on probation for Title V offenses are not eligible for the program.

Offenders who have any pending cases are not eligible until the cases are resolved.

Call or email **Jennifer Cauthen** to place a defendant on the waiting list.
Phone (325)-691-7407 Fax (325)-691-7432 Email: jcauthen@taylorcscd.org

TAYLOR COUNTY CSCD SATF

RESIDENT INTAKE CHECKLIST

DEFENDANT'S NAME: _____

_____ Amended Conditions of Probation for Placement

_____ Original Conditions of probation

_____ Copies of all other Modifications to Probation

_____ PSI

_____ Offense Report

_____ Current CH with full rap sheet

_____ Transfer /Transmittal Form, including OID and PID Numbers

_____ CCF Physical Exam Form

_____ Uniform Health Status Updated (Completed only if prior medical history exists)

_____ TB Test Results

_____ TX ID, DL or Certified copy of Birth Certificate and SSC

_____ Proof of Education/Assessment Given

_____ Any discharge summaries from prior treatment or psychological reports

_____ SASSI 3 or SASSI 4 or a comparable substance abuse assessment tool

Example Court Order for Admission to SATF

CAUSE # _____

THE STATE OF TEXAS **IN THE _____TH DISTRICT COURT**

VS. **OF**

_____ **_____ COUNTY, TEXAS**

ORDER AMENDING CONDITIONS OF COMMUNITY SUPERVISION

On this date, the Supervision Officer requested the conditions of Community Supervision in the above numbered Cause be amended. It is the finding of this Court that this request is in the best interest of the public as well as the defendant, and it is the Order of this Court that the original Order Granting Community Supervision dated the _____, under the Community Supervision Law be amended to read as follows:

Condition ( ) amended as follows: Defendant is to self- surrender by Insert Time on Insert Date to Taylor County Adult Detention Center and remain in custody until placed into the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility;

Condition( ) amended as follows, effective Insert Date: As an alternative to incarceration in the Institutional Division, Texas Department of Criminal Justice, you shall serve an alternative Community Supervision sentence of up to twenty four months in the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility. You will:

1. Remain within the confines of the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility at 1133 South 27th Street, Abilene, Texas, unless otherwise authorized by the Center Director or his/her designee.

2. Participate and complete all programs as determined by the Treatment Team.

3. Obey all rules and regulations of the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility.

4. Pay as required, a percentage of your income to the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility for room and board, transportation and laundry.

5. Pay a percentage of your salary, as required, to your dependents for their support while you are in the employment component.

CONTINUED NEXT PAGE

If evaluation indicates that you have made significant progress toward compliance with all Court ordered conditions of Community Supervision, you may be released prior to the completion of the twenty four month sentence from the SATF Program to serve the remainder of your Community Supervision under the remaining Terms and Conditions as imposed by the Court. If the evaluation indicates that you would benefit from continued participation in the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility, the Court may order you to remain therein for a period determined by the Court. Upon release from the SATF, you will be placed in the Taylor-Callahan-Coleman Counties Substance Abuse Treatment Facility Aftercare Program, to include Transitional Housing, followed by being integrated into regular Community Supervision.

In addition to the above conditions, the Defendant will continue to abide by all other conditions of Community Supervision listed on original community supervision order and all subsequent amended orders.

SIGNED THIS ____ DAY OF _____, 2011.

_____

Hon. _____, Judge

_____th District Court

_____ County, Texas

****

Receipt is hereby acknowledged of one copy of the above Order on the below listed date. I have read and understand each additional condition on this Order Amending Conditions of Community Supervision and I have no questions.

_____

Defendant

_____

Supervision Officer

DATE FILED

RESIDENT'S LIST OF APPROVED POSSESSIONS DURING EMPLOYMENT

UNDERGARMENTS

4 each – underwear & socks
1 thermal bottom

SHOES

3 pair – tennis shoes, boots, loafers, work boots/shoes
1 pair – shower shoes

BOTTOMS

6 - any combination – pants, jeans, sweats, shorts

TOPS

6 - any combination - shirts, t-shirts, crew neck pullover sweatshirts

HEADGEAR

1 – do-rag/skull cap for sleeping in room only
1 – ball cap, hats, toboggan

JEWELRY

1–watch 1–wedding ring 1-Religious Jewelry (kept in locker)

JACKETS

1 – jacket/sweatshirt (jackets with zip-out linings not allowed)

ACCESSORIES

1-pair sunglasses 1-pair glasses 2-belts 1-wallet 1–pair weight lifting gloves

COMBS, HAIRBRUSHES, PLASTIC PICK

1 - of each (no pointed or metal combs, picks, etc.)

LETTERS, CORRESPONDENCE, ETC.

All photographs must be stored in the plastic box provided at Intake. Only the extra folder for letters, CSR slips, and misc. paperwork. All papers must be three-hole punched/nothing allowed in folder pockets. No pornographic material, of any kind allowed.

WRITING MATERIALS

Paper, pencils (no pens)

WORK UNIFORMS/CLOTHES

1 - work jacket or coveralls 1 – work hat/visor
Uniforms issued by employer only, number determined by employer

CCF Admission Health Screening Form

Today's Date: _____ Time: _____ am/pm Admission date: _____

Name:_____ ID #: _____

D.O.B._____ Age: _____ Sex: F____ M_____ Race: _____ Bldg./Dorm/Unit:_____

Blood Pressure: _____/_____ Temperature: _____ Pulse: _____ Respirations: _____

Allergies (drugs): _____ Type of reaction: _____

Food Allergies: _____ Type of reaction: _____

Environmental Allergies (cedar, mold, pollen, etc**.): _____ Type of reaction: _____**

Current Weight: _____lbs. Height: _____ft. _____ in.

Recent unplanned weight loss: Yes ____ No ____ Recent unplanned weight gain: Yes ____ No ____

If the answer is yes how much weight in what length of time? _____

TB skin test to be administered and read within 7 calendar days prior to admission or after admission to facility:

Current TB skin test:

Date given: _____ Date read: _____ Results: _____ mm.

If past history of previous positive TB skin test, give date _____ and results _____

TB Symptoms Screening Questionnaire Completed: Yes ___ No____ N/A ____ Date: _____

Symptomatic: Yes ____ No ____ if yes, referred for medical evaluation: _____

Chest x-ray results (only if applicable): Date: _____ Results: _____

Recommendations: _____

Medication History

List prescription drugs and over-the counter drugs currently being taken including herbal preparations, vitamins and other supplements

Name of Medication	Dosage	Frequency/Instructions	Reason for Medication	Last Time Taken

Family Medical History

Does anyone in your family have a history of any of the following?

Health Problem	Yes	No	Who (mother, father, grandparent or sibling)	Health Problem	Yes	No	Who (mother, father, grandparent or sibling)
Alcoholism				Epilepsy / Seizures			
Arthritis				High Blood Pressure			
Cancer				Kidney Disease			
Bleeding Disorder				Mental Illness			
Diabetes				Mental Retardation			
Drug Addiction				Stroke			
Heart Disease				Thyroid Disease			

Past Medical History: (accident, injury, major hospitalizations, surgery): _____

_____

_____

_____

Last tetanus immunization: _____ **Recent fall, head injury or surgery:** _____

Do you now have or have you ever been told that you have any of the following problems?

	Yes	No	Swelling of	Yes	No		Yes	No		Yes	No
Alcoholism			Ankles/Legs			Syphilis			Drug abuse		
Allergies			Gout			Gonorrhea			Seizures		
Anemia			Cancer			Herpes			Stroke		
Asthma			Diabetes						Slurred Speech		
Bronchitis			Thyroid disease			Other STD's			Numbness		
Chronic Cough			Kidney disease			Broken bones			Paralysis		
Frequent colds			Gallbladder			Back problems			Dizziness		
Hay fever			Heartburn			Dentures			Fainting		
Shortness of breath			Gastrointestinal Ulcers			Hearing loss Left / Right Ear			Headaches Frequent/Severe		
Sinusitis			Nausea			Hearing Aid			**Males Only**		
Emphysema			Vomiting			Eye glasses			Prostate problem		
Tuberculosis			Sickle Cell			Contact Lens					
Pneumonia			Hepatitis			Glaucoma			**Females Only**		
Wheezing			Arthritis			Cataracts			Pregnant		
Coughing up Blood			High Cholesterol			High Blood Pressure			Last Menstrual Cycle	Date	
Chest pain			Hernia			Hemorrhoids			Missing periods		
Heart disease			Varicose veins			Constipation			Last Pap Smear		
Heart Murmur			Leg Cramps			Diarrhea			Last Breast Exam		
Pace Maker			Vascular disease			Blood in stool			Postmenopausal		

If you answered yes to any of the questions above, please explain: _____

_____

_____

Are there any other health problems not included in the list above?___

_____

_____

Family physician's information if applicable: _____
_____
_____

Dental Problems: (any current dental problems that require immediate attention):_____
_____
_____

Mental illness current or past history: (any past history of suicide attempts or ideation)_____
Are you currently having any thoughts of harming yourself or others? _____
Have you ever received treatment for mental illness? Yes____ No____ When? _____ Where? _____
Have you ever been diagnosed with any of the following, **please circle one or all that apply:**
Depression Schizophrenia Compulsive disorder Attention deficit disorder Others_____
Anxiety disorder Bipolar disorder Eating disorder Hyperactivity Disorder _____
Panic attacks Sleep disorders Memory Loss Mental Retardation **None: _____**
Are you currently receiving mental health services? _____ Last doctor's visit: _____
Attending Psychiatrist: _____ Telephone #: _____
_____

Do you smoke or use other tobacco products? Yes___ No ___ If the answer is yes, what type? _____
Length of time smoking/using: _____ Amount used daily _____
Have you ever attempted to stop smoking or using tobacco products? Yes ____ No ____ When _____
Comments: _____

Alcohol and Drug Use/Abuse History: Inquire about the use of various types of alcohol (beer, wine, liquor), illicit drugs, inhalants, prescription drugs, over-the counter drugs of abuse, and any other drugs not mentioned.

Types of alcohol and drugs used:	Mode of Use (IV, smoke, oral, etc)	Amounts Used	Frequency of Use	Problems after stopping use	Last date used

General Observations:

1. Behavior which includes state of consciousness, mental status, appearance, conduct, tremors and sweating.

_____

_____

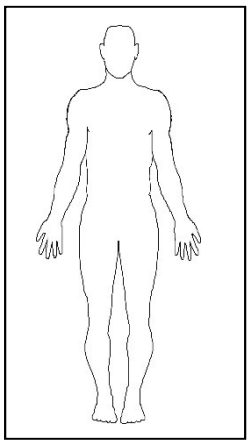
_____

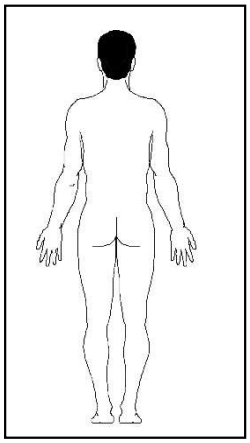
2. Body deformities, ease of movement, limited range of motion, assistive devices required: _____

_____

_____

3. Condition of skin, including trauma markings, bruises, lesions, open sores, jaundice (yellow), skin rashes, infestations of the skin (lice, scabies, etc..) and needle marks or tracks or other indication of drug abuse:





_____

_____

_____

_____

_____

4. Special skin markings (Tattoos, body piercing, etc.) _____

_____

_____

_____

_____

Codes for Body Outline: A - abrasion, B -bruises, C - cut, L - laceration, P - piercing, R - rash, T- tattoo
S - scar, N - needle marks/ tracks, BR - burn, O - open sore, ST – stitches.

Regular Diet: Yes _____ No _____

Special Dietary Needs: _____

_____

Activity Level: Total_____ Limited _____

Lower bed bunk required: Yes _____ No _____

Physical restrictions: _____

Cleared for Kitchen Duty: Yes _____ No _____

_____

Recommendations:

_____

_____

_____

_____	_____	_____
Printed Name and Title **(Physician, PA, NP, RN, LVN, EMT-P)**	**Signature and Title** **(Physician, PA, NP, RN, LVN, EMT-P)**	**Date**

I verify that the information that I have provided regarding my past medical history and current medical problems are correct to the best of my knowledge, and I authorize this information to be released to the residential facility.

_____	_____	_____
Resident's Printed Name	**Resident's Signature**	**Date**

TEXAS UNIFORM HEALTH STATUS UPDATE

NAME_____DOB: ___/___/___ AGE: ____
Last First Mi
STATE ID#_____ RACE:_____ SEX: Male_____ Female_____

COUNTY/TDJC#_____ WT:____ HT:_____

CURRENT/CHRONIC HEALTH PROBLEMS

A. Health Problems

__1. None
__2. Asthma
__3. Cardiovascular/Heart Trouble
__4. Dental Priority
__5. Diabetes
__6. Dialysis
__7. Drug Abuse/Alcoholism
__8. Hypertension
__9. Orthopedic Problems
__10.Pregnacy
__11. Seizures
__12. Mental Retardation
__13. Mental Illness (specify diagnosis) _____
__14. Recent Surgery

NOTE: When screening substance abuse facility clients, please contact the TDCJ-ID Health Services Liaison at (409) 294-2228 for clients with insulin dependent diabetes mellitus(DDM), current mental ill1ness or any chronic disease symptoms deemed unstable.

III. SPECIAL NEEDS (Check all that apply)

A. Housing Restrictions

__1. None
__2. Skilled Nursing Facility
__3. Extended Care Facility
__4. Psychiatric Inpatient Facility
__5. Respiratory Isolation
__6. Other:_____

B. Transportation

__1. Routine
__2. Crutches/Cane
__3. Wheelchair/Wheelchair Van
__4. Prosthesis: _____

C. Pending Specialty Clinic Appointment:
None_____ Type_____

B. Preventive Medicine

__1. Tuberculosis Status
Skin Test: Date Given: __/__/__ Date Read: __/__/__ Results _____mm
X-Ray: Date:__/__/__ Normal__ Abnormal__ Anti-Tuberculosis Treatment? No__ Yes__
__2. Hepatitis: A__ B__ C__ Other:_____
__3. HIV Antibody -Test Date: __/__/__ Results: Negative ___ Positive __ CD4: ___
__4. Syphilis: Date__/__/__ Type: ___ Treatment Completed: __Yes __No

NOTE: If any treatment has been recommended, the X-Ray was abnormal, or skin test indicates infection please attached Tuberculosis record.

Other Health Care problems:_____ V. Allergies ____NKA

CURRENT PRESCRIBED MEDICATIONS ____None

Medication	Dosage	Frequency

Completed By: _____ Facility: _____
_____ Date: __/__/___ Phone Number: _____

Taylor County SATF

Unapproved Medication List

Brand Name	Generic Name
Abilify (includes Maintena)	Aripiprazole
Adderall, Adderall XR	Mixed amphetamine salts
Ambien	Zolpidem
Ativan	Lorazepam
BuSpar	Buspirone
Catapres	Clonidine
Celexa	Citalopram
Clozaril	Clozapine
Cogentin	Benztropine Mesylate
Concerta	Methylphenidate
Cymbalta	Duloxetine
Dalmane	Flurazepam
Dantrium	Dantrolene
Depakene	Valproic Acid
Depakote	Divalproex Sodium
Desyrel	Trazodone
Dilaudid	Hydromorphone
Doral	Quazepam
Effexor	Venlafaxine
Elavil	Amitriptyline
Eskalith/Lithobid/Lithonate	Lithium Carbonate
Etrafon-Triavil	Perphenazine/Amitriptyline
Fanapt	Iloperidone
Fiorinal with Codeine	Butalbital/Codeine
Flexeril	Cyclobenzaprine
Focalin, Focalin XR	Dexmethylphenidate
Geodon	Ziprasidone
Haldol (includes Decanoate injection)	Haloperidol
Halcion	Triazolam
Invega (incl. Sustenna/Trinza)	Paliperidone
Klonopin	Clonazepam
Lamictal	Lamotrigine
Latuda	Lurasidone
Lexapro	Escitalopram Oxalate
Librium	Chlordiazepoxide

Brand Name	Generic Name
Luvox	Fluvoxamine
Maxalt	Rizatripan/Rizatripan Benzoate
Mallari	Thiothixene
Methadose	Methadone
Midrin	Isometheptene/ Dichloralphenzone/ APAP
Navane	Thiothixene
Neurontin	Gabapentin
Noctec	Chloral Hydrate
Nuvigil	Armodafinil
Orap	Pimozide
Oxy-IR, OxyContin	Oxycodone
Pamelor	Nortriptyline
Parafon Forte	Chlorzoxazone
Paxil	Paroxetine
Phenergan	Promethazine
Pristiq	Desvenlafaxine
Prolixin /Decanoate	Fluphenazine
ProSom	Estazolam
Provigil	Modafinil
Prozac	Fluoxetine
Remeron	Mirtazapine
Restoril	Temazepam
ReVia/Depade	Naltrexone
Risperdal /Consta	Risperidone
Ritalin, Ritalin LA	Methylphenidate
Robaxin	Methocarbamol
Rozerem	Ramelteon
Saphris	Asenapine
Serax	Oxazepam
Seroquel	Quetiapine Fumarate
Sinequan	Doxepin
Skelaxin	Metaxalone
Soma	Carisoprodol
Sonata	Zaleplon
Stadol	Butorphanol/Naloxone

Lioresal	Baclofen		Stelazine	Trifluoperazine
Loxitane	Loxapine		Suboxone	Buprenorphine/Naloxone
Luminal	Phenobarbital		Subutex	Buprenorphine
Lunesta	Eszopiclone		Symbyax	Olanzapine/Fluoxetine
Brand Name	**Generic Name**		**Brand Name**	**Generic Name**
Tegretol	Carbamazepine			
Thorazine	Chlorpromazine			
Tranxene-SD	Clorazepate			
Trilafon	Perphenazine			
Trileptal	Oxcarbazepine			
Tylenol w/Codeine	Codeine/Acetaminophen			
Ultram	Tramadol			
Valium	Diazepam			
Vicodin/Lortab/Norco	Hydrocodone			
Viibryd	Vilazodone			
Vistaril	Hydroxyzine Pamoate			
Vyvanse	Lisdexamfetamine			
Wellbutrin	Bupropion			
Xanax/Niravam	Alprazolam			
Zanaflex	Tizanidine			
Zoloft	Sertraline			
Zyprexa / Relprevv	Olanzapine			