COMMUNITY TREATMENT SERVICES (CTS)

2022 STATEMENT OF WORK (SOW)

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CHAPTER ONE: INTRODUCTION

1.1 **PURPOSE.** The purpose of this Community Treatment Services (CTS) Statement of Work (SOW) is to outline the government's technical requirements for Contractors who provide substance use disorder (SUD), to include medication-assisted treatment (MAT), mental health (MH), and/or sex offender treatment (SOT) services to offenders in the custody of the Bureau of Prisons (Bureau), residing in a Residential Reentry Center (RRC), on Home Confinement (HC), or on Federal Location Monitoring (FLM).

1.1.1 **Scope.** The scope includes community SUD, MAT, MH, psychiatric, and SOT services for Bureau offenders in the United States and territories.

1.1.2 All services and programs will comply with the SOW; the U.S. Constitution; all applicable federal, state, and local laws and regulations; applicable Presidential Executive Orders (E.O.); all applicable case law; and court orders. Should a conflict exist between any of the aforementioned standards, the most stringent will apply. When a conflict exists, and a conclusion cannot be made as to which standard is more stringent, the Bureau will determine the appropriate standard. The Bureau reserves the right to issue interim guidance that supersedes policy and/or aforementioned standards. The Contractor will comply with and implement any applicable changes to Bureau policy, Department of Justice (DOJ) regulation, Congressional mandate, federal law, or Presidential Executive Orders.

1.1.3 The Bureau reserves the right to enter into negotiations with the Contractor to change the conditions or procedures in this SOW and the contract.

1.1.4 The Bureau reserves the right to conduct announced and unannounced inspections of any part of the Contractor’s operation at any time and method deemed reasonable by the Bureau to assess contract performance and compliance. The Bureau, or other appropriate agency, may investigate any incident pertaining to the performance of this contract. The Contractor must comply and cooperate with the Bureau, or other appropriate agency, on all investigations, inspections, and inquiries.

1.1.5 The Contractor will submit any request for contract modifications through the Federal Acquisition Certification Contracting Officer’s Representative (FAC COR) for evaluation. Only the Bureau’s Contracting Officer (CO) may approve contract modifications. Contract modifications must be in the best interest of the government.

CHAPTER TWO: BUREAU INFORMATION

2.1 **THE BUREAU’S COMMITMENT.** The Bureau is committed to providing high-quality, evidence-based programs to all offenders in need of services. Bureau Psychology Treatment Programs (PTPs) are based on the most recent research and evidence-based practices, ensuring effective treatment programs. These evidence-based treatment practices lead to:

- **reduction** of misconduct;
- **reduction** of mental illness symptoms and behavioral disorders;
- **reduction** of substance use, relapse, and recidivism;
- **reduction** of future sexual offending;
- **increase** in the level of the individual's stake in societal norms; and
- **increase** in the likelihood of treatment success and the public's health and safety.

2.2 **COGNITIVE BEHAVIORAL THERAPY (CBT).** The Bureau uses CBT as its theoretical model because of its proven effectiveness in the criminal justice setting. Empirical support for CBT's effectiveness is noted in the treatment of substance use disorders, mental illness, and criminal thinking patterns. CBT emphasizes the learning and practice of skills associated with improved mental health and adaptive, pro-social, behavior. Therefore, offenders who participate in CBT and related interventions are better able to achieve goals the Bureau has for offenders, including developing personal responsibility, self-awareness, and self-sufficiency.

According to the CBT model, a person's feelings and behaviors are influenced by their perceptions and core beliefs. By helping offenders perceive events objectively and challenging irrational beliefs, they may become more successful in achieving pro-social goals.

CBT combines different treatment targets and specific conforming behaviors, focusing on an offender's:

- core beliefs;
- intermediate beliefs;
- current situation;
- automatic thoughts; and
- the effects these thoughts and beliefs have on one's emotional, behavioral, and psychological wellbeing.

2.2.1 **CBT Treatment Protocols.** While CBT is the primary treatment modality, other treatment protocols may be used in addition to CBT. These program additions must be CBT-based or compatible with CBT and meet the goals of the treatment program. These compatible treatment programs include Motivational Interviewing, Rational Emotive Behavior Therapy, Mindfulness Based Cognitive Therapy, Dialectical Behavior Therapy, and the Good Lives Model (GLM).

2.2.2 **Self-Help Programs.** Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Rational Recovery (RR) are often powerful and important interventions in an offender's recovery, but they are not substitutes for CTS. Self-help programs cannot be conducted during treatment. The Contractor shall not require attendance at self-help groups, and shall not utilize as a treatment concept, mandate as treatment goal activities, or include as part of the treatment plan.

2.3 **INSTITUTION SUBSTANCE USE DISORDER (SUD) SERVICES.** The Bureau operates a structured, multi-component SUD treatment protocol to identify individuals in

need of treatment upon entry and throughout their incarceration. The primary substance use disorder programs are the residential and non-residential drug abuse programs.

2.3.1 **Residential Drug Abuse Program (RDAP).** RDAP operates as a Modified Therapeutic Community (MTC). The community is the catalyst for change and focuses on the offender as a whole person with overall lifestyle change needs, not simply abstinence from drug use. RDAP encourages participants to examine their personal behavior to help them become more pro-social and to engage in a lifestyle based on honesty, responsibility, hard work, and willingness to learn. As participants progress through the phases of the program, they assume greater personal and social responsibilities in the community. It is expected that program participants take on leadership and mentoring roles within the MTC. Progress in treatment is based on the offender's ability to demonstrate comprehension and internalization of treatment concepts by behaviorally observable actions to change his or her maladaptive and unhealthy behaviors.

2.3.2 **Non-Residential Drug Abuse Program (NR-DAP).** The NR-DAP is a flexible non-unit based, psychoeducational-therapeutic group designed for treatment of offenders in general population with self-reported substance use disorders. NR-DAP is presented through scheduled and time-limited therapeutic group sessions. The journal-based program is designed to meet the specific, individualized treatment needs of the offenders. In general, this program challenges an offender's core beliefs, their most fundamental (negative and unhelpful) ideas about themselves and others, and/or their world views within the backdrop of their individual substance use. The focus of NR-DAP treatment is to improve an offender's current functioning and alleviate symptoms that may significantly interfere with their post-release functioning.

2.3.3 **CTS Substance Use Disorder Referrals**: RDAP offenders are required to participate in CTS as their final phase of treatment. Offenders who have not completed RDAP may be referred for treatment if they meet one or more of the following criteria:

- completed the NR-DAP;
- completed a Psychology Treatment Program (PTP);
- volunteered for treatment; or
- self-reported or tested positive for using drugs/alcohol while in the RRC and/or HC, or FLM.

2.4 **INSTITUTION MENTAL HEALTH (MH) SERVICES.** Mental health recovery refers to the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability, while for others, recovery implies the reduction or complete remission of symptoms.

The components of mental health recovery are: self-direction, individualized and person-centered care, empowerment, holistic treatment, non-linear progression, strengths-based focus, peer support, respect, responsibility, and hope.

2.4.1 **Mental Health Treatment Programs**. Mental Health Treatment Programs are a series of programs dedicated to the management and treatment of the Bureau's seriously mentally ill and behaviorally disordered offenders. Current Mental Health Treatment Programs include:

- **The Resolve Program.** The Resolve Program is a non-residential trauma treatment program for male and female offenders. Originally developed for the large number of female offenders who had experienced traumatic life events, it is now offered to male offenders as well.

- **The Skills Program.** The Skills Program is a unit-based residential treatment program designed for male offenders who have intellectual and social impairments which create adaptive problems in prison and in the community.

- **The STAGES Program.** The Steps Toward Awareness, Growth, and Emotional Strength (STAGES) Program is a unit-based residential program which provides treatment to male offenders who require enhanced care for their mental illness and have a diagnosis of borderline personality disorder

- **Transitional Care Unit.** The Transitional Care Unit addresses the needs of mentally ill male offenders who have spent extended periods of time in secure treatment programs or restrictive housing settings. Mental health treatment is provided along with participation in work and leisure activities.

- **Step Down Programs.** Step Down Programs offer an intermediate level of care for male offenders with serious mental illness who do not require inpatient treatment, but lack the skills to function in a general population prison. Evidence based treatment is offered to maximize their ability to function and to minimize relapse and the need for inpatient hospitalization.

2.4.2 **Bureau of Prisons Special Programs.** The Bureau utilizes Evidenced Based Practices and interventions for diverse populations to include transgender offender care, offenders with disabilities, female offenders, and veteran services.

2.4.3 **Mental Health Care Levels.** Mental health care is generally guided by the level of need assigned to the offender following a clinical assessment.

- **CARE1-MH: No Significant Mental Health Care.** The offender shows no significant level of functional impairment associated with a mental illness and demonstrates no need for regular mental health interventions by psychologists. No history of serious functional impairment due to mental illness or, if a history of mental illness is present, the offender has consistently demonstrated appropriate help-seeking behaviors in response to any reemergence of symptoms.

- **CARE2-MH: Routine Outpatient Mental Health Care or Crisis-Oriented Mental Health Care.** The offender has a mental illness requiring routine outpatient mental

health care on an ongoing basis (monthly); and/or brief, crisis-oriented mental health care of significant intensity (e.g., placement on suicide watch or behavioral observation status).

- **CARE3-MH: Enhanced Outpatient Mental Health Care or Residential Mental Health Care.** The offender has a mental illness requiring enhanced outpatient mental health care (i.e., weekly mental health interventions); or residential mental health care (i.e., placement in a residential Psychology Treatment Program).

- **CARE4-MH: Inpatient Psychiatric Care.** The offender requires acute care in a psychiatric hospital due to significant disability. The offender cannot function in the general population in a CARE3-MH environment.

2.4.4 **CTS Mental Health Referrals.** CTS staff review offenders for mental health services prior to community placement. All offenders assessed to have psychiatric or psychological needs are referred for community assessment and treatment. If an offender has not been referred for treatment, the Residential Reentry Management Branch (RRMB) or the local Residential Reentry Center (RRC), can request services in writing to the local CTS office.

2.5 **INSTITUTION SEX OFFENDER TREATMENT (SOT) SERVICES.** The Bureau offers treatment, management, and psycho-educational opportunities for offenders with a history of sexual offenses. This is done through a stratified treatment model where volunteers are referred to one of the following programs. Programs are designed to match the delivery of treatment services to the unique characteristics of the offender (learning style, intelligence level, etc.).

2.5.1 **Sex Offender Management Program (SOMP).** SOMP is a multi-component program that includes treatment (SOTP-R or SOTP-NR), risk assessment services, and specialized correctional management.

Offenders who engage in conduct relevant to their history of sexual offending while incarcerated (e.g., offenders who collect pictures of children), may be referred to a SOMP where a Correctional Management Plan (CMP) is implemented. Sex offender treatment through CTS is the final component of SOMP. This allows offenders to build on the treatment received in the institution and to incorporate those philosophies into daily living in the community.

2.5.2 **Sex Offender Treatment Program-Residential (SOTP-R).** SOTP-R is a high-intensity program designed for high-risk sexual offenders. It is a unit-based program with a cognitive-behavioral emphasis. The co-housing of SOTP-R participants permits the implementation of a modified therapeutic community. This model has been proven effective in reducing offender recidivism. A modified therapeutic community in a prison setting emphasizes pro-social values and behaviors that are needed in the outside community.

2.5.3 **Sex Offender Treatment Program-Non-Residential (SOTP-NR).** SOTP-NR is a moderate intensity program designed for low-to-moderate risk sexual offenders. It shares the SOTP-R's treatment philosophy and program materials, but lacks the frequency of treatment groups and the program duration of the SOTP-R. In addition, because SOTP-NR participants reside in the general population, there is not a modified therapeutic community setting.

2.5.4 **CTS Sex Offender Referrals.** SOTP offenders will ordinarily be referred to community treatment providers with clinical documentation related to their criminal histories. This may include a summary of their in-prison treatment programming, including a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, and recommendations from Bureau clinicians.

An individual with a documented sex offense history or diagnosis who did not participate in SOTP may also volunteer to participate in CTS while residing at an RRC. All cases must meet the following eligibility criteria to participate:

- documentation to verify the specific sex offense, or history; and
- sex offender diagnosis or significant clinical record based on DSM criteria; or
- a moderate or higher static risk level based on an assessment of the offense history and other relevant factors.

2.6 **INSTITUTION MEDICATION-ASSISTED TREATMENT (MAT).** MAT is the use of medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders, including opioid use disorder. MAT operates to stabilize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and stabilize body functions without the negative effects of the short-acting drugs of abuse.

2.6.1 **Institution MAT Participants.** The Bureau offers MAT to offenders while incarcerated and during their community placement. Providing MAT during the high-risk re-entry period is particularly important as it enhances the ability to resist opioid-seeking behaviors while in the community. To address the increased risk of recidivism and relapse for offenders with a history of opioid use disorder, MAT is available on a voluntary basis and treatment may be declined at any time. Offenders are screened and evaluated by psychology and health services departments, and if they wish to participate, receive a medication regimen, and participate in counseling.

2.6.2 **CTS MAT Referrals.** Offenders who initiated MAT while incarcerated or are evaluated in the community and recommended for MAT will be referred by CTS for MAT services.

2.7 **PUBLIC SAFETY CONCERNS**. The Bureau will inform Contractors of any public safety concerns and prior criminal history during the referral process. The below categories will be indicated when applicable:

- **High Security Level:** Offenders who transfer to the community in a high security status will be identified to provide the Contractor the ability to exercise appropriate

security precautions. "High" is the Bureau's highest security level as assigned by a point system for various criteria and indicators.

- **Mental Health Care Level 3 or 4:** Offenders who transfer to the community with a mental health care level of 3 or 4 (defined in 2.4.3 above) will be identified so the Contractot may exercise appropriate precautions and allocate necessary resources.

- **Disruptive Group:** This public safety factor is assigned to an offender if the Presentence Investigation Report (PSIR) or other official documentation identifies the offender as a member of a disruptive group (gang or organization). Bureau investigators validate the information is true prior to assignment of the code.

- **Greatest Severity Offense:** This public safety factor is assigned to offenders whose current offense is considered by the Bureau to be among the most grievous. This includes, but is not limited to convictions of arson, assault, carjacking, escape, homicide/manslaughter, kidnapping, robbery, sexual crimes, and weapons charges."

- **Sex Offender:** This public safety factor is assigned to offenders if the PSIR or other official documentation clearly indicates that sexual offenses, or attempted sexual offenses, occurred (current or historical) regardless of conviction.

- **Violent Behavior:** This public safety factor is primarily assigned to female offenders whose current offense or history involves two (2) convictions for serious incidents of violence in the last five (5) years. Incidents while confined are also considered.

CHAPTER THREE: GUIDING PRINCIPLES OF TREATMENT

3.1 **METHODS AND STANDARDS.** Guiding principles refer to methods and standards for providing clinical services to offenders. They are based on clinical consensus of the most effective evidence-based practices available.

3.1.1 **Clinical Elements.** The Bureau has found that treatment programs with the most successful outcomes apply the following clinical elements:

- diagnose each offender through an established diagnostic assessment process;
- develop individualized treatment plans together with each offender;
- target criminogenic needs, such as antisocial attitudes and beliefs, to reduce the likelihood of misconduct and recidivism;
- promote activities that have a therapeutic impact (examples include: promoting peer feedback, improving negative attitudes through activities such as attitude checks, encouraging peers to assist each other in meeting goals, etc.);
- maintain knowledge of treatment progress and commitment of offenders, and discuss with supervisors, peers, and stakeholders; and
- provide clinical supervision to necessary clinicians (supervision should include direct observation of treatment).

3.2 **CLINICAL TREATMENT STANDARDS AND PRACTICES.** Expectations for treatment services include elements of the following standards.

3.2.1 **Treatment Services.** The Contractor shall deliver all services in-person, or by audio-visual, real time, two-way interactive communication, or, in limited circumstances, by audio-only with FAC COR pre-approval. The method of service delivery is contingent on the requirements of the contract (e.g., telehealth only), Contractor capabilities, offender accessibility and technical availability, and the type of service being rendered. All services require clinical interactions between the offender and an appropriately licensed and Bureau-approved Contractor.

3.2.2 **Assessments.** The Contractor must conduct an intake assessment, ordinarily conducted in-person, on all offenders prior to initiating treatment. The assessment must include a diagnosis as a basis for treatment.

3.2.3 **Clinician Engagement.** The Contractor must actively engage in all therapeutic sessions without distractions, to include phone calls, computer work, or paperwork.

3.2.4 **Frequency of Sessions**. The frequency of treatment shall be individualized based upon offender need. Generally, the Contractor will meet with offenders weekly and not require the offender to attend treatment more than twice per week to reduce the negative impact on employment, family integration, and other necessary requirements for reentry to the community. Deviations from weekly treatment must be pre-approved by the FAC COR and justified in the monthly progress report and/or treatment plan. The FAC COR reserves the right to adjust the frequency and quantity of treatment as deemed necessary by the Bureau.

3.2.5 **Standard Session Length.** Ordinarily, individual counseling sessions should be two (2) units in length. Group counseling sessions should ordinarily be three (3) units in length. Deviations above or below these standard session lengths require prior authorization from the FAC COR or written explanation after the session has completed. Those written explanations for session length should not be standard practice, but due to significant issues presented during the session.

3.2.6 **Session Breaks**. Standardized session breaks for all participants are not authorized during treatment. Brief individual breaks for immediate concerns may be granted by the Contractor. Brief breaks do not require the offender to sign in and out of the session, as this is a nominal pause in treatment.

3.2.7 **Schedules.** The Contractor shall accommodate various offender work schedules. The Contractor shall offer flexible and accessible treatment schedules. Ordinarily, this would include morning, evening, and weekend appointments, when practicable.

3.2.8 **Individual Counseling**. Sessions should utilize a cognitive-behavioral approach and focus on relevant treatment issues and expectations. The Contractor should verify progress is

being made toward goals and reassess the relevance of current treatment goals. The Contractor should explore treatment issues that surface in group sessions and medication concerns for offenders receiving psychiatric services or MAT (as applicable).

3.2.9 **Group Counseling**. All group sessions shall be process-oriented in nature with a cognitive-behavioral approach to address underlying clinical issues. Sessions should focus on targeting irrational thoughts, criminal thinking patterns, and maladaptive behavior. The Contractor is encouraged to focus on the here-and-now and direct discussion toward individual treatment progress, treatment activities, interpersonal dynamics, and be solution-focused. If didactic counseling is used, it must be limited in length. The practice of completing worksheets during the session is discouraged; however, clinically relevant homework is encouraged and can be reviewed and discussed during group sessions as a way to increase participation among members. If initial group check-ins are used, they should be limited in length and utilized to begin clinically relevant discussion and encourage feedback from the group.

3.2.10 **Group Size Limitations.** Ordinarily, group sessions shall consist of a minimum of three (3) offenders, not to exceed twelve (12) offenders for substance use disorder and sex offender groups and eight (8) offenders for mental health groups. All telehealth groups shall consist of a minimum of three (3) offenders and not to exceed five (5). The Contractor must obtain authorization from the FAC COR for a temporary change in group size.

3.2.11 **Group Composition.** Ordinarily, all group sessions must be comprised of Bureau referred offenders. If the Contractor wishes to mix non-Bureau referred offenders in a group forum, it must be based upon sound clinical judgement and preauthorized by the FAC COR.

3.2.12 **AV Media.** The Contractor shall not use videos or other types of audiovisual media during the course of treatment. This is strictly prohibited.

3.2.13 **Agency Rules**. The Contractor shall establish written rules, regulations, and expectations for offenders. At the intake session, offenders must be informed about the rules for individual and group sessions, attendance, and expectations of participation, as well as any other additional information necessary for successful treatment outcomes.

The Contractor may choose to have offenders recite group rules at the beginning of group sessions as a reminder to all participants, but no more than two (2) minutes should be devoted to this.

3.2.14 **Cell Phones**. The Contractor shall have a policy in place to limit the disruption of cell phones by offenders while at the facility and during all treatment sessions. Neither the Contractor nor the participants should place or answer calls or text during group sessions. It is encouraged that all cell phones be powered off during treatment to reduce distractions. Cell phones are a primary means for RRC offender accountability. Be advised that some locations use automated and randomized systems to call offenders and the systems may continue to call if the call is not acknowledged by the offender. Therefore, it is especially important for the RRC to be informed of the treatment schedule of every offender.

3.2.15 **Disruptive Behavior**. The Contractor shall inform the FAC COR of offender behavior that becomes disruptive to the treatment process. Significant actions must be reported to the FAC COR on the Behavior Notification form in accordance with section "4.9 Clinical Interventions". However, more routine nuisance actions that do not require immediate notification, but create an environment non-conducive to treatment, must be reported in the Monthly Progress Reports, or discussed with the FAC COR. The report should include how the behavior was addressed and how the offender responded.

3.2.16 **Favors and Items of Value**. The Contractor shall not offer, give, or receive any gift, favor, article, or item of value, to include unauthorized transportation or consumable goods, to offenders, former Bureau offenders, family members, or anyone associated with or related to the offender. Exchange of currency in any form is prohibited.

3.2.17 **Immediate Crisis Intervention Plan**. The Contractor shall maintain an emergency crisis intervention plan. It shall include specific local information for an emergency psychiatric care facility, a local hospital with a crisis unit, or other emergency crisis intervention resources. When necessary, the Contractor should take appropriate action (e.g., ensure the individual is transported to an emergency room) and immediately notify the RRC, and no later than the next business day, inform the FAC COR.

3.2.18 **Continuing Contract Performance During a Government Shutdown, Pandemic, Influenza or Other National Emergency.** Refer to the full clause, or similar updated clause, in the Standard Form 1449 contract.

3.3 **TREATMENT DOCUMENTATION.** All treatment documents are provided by the Bureau. Contractors must thoroughly complete and submit all documents to the Bureau's electronic file management system (EFMS). Contractors must use the most recent version of documents provided by the Bureau. When documents are updated, the Contractor shall implement use within twenty (20) business days.

Contractors may request to use compatible internal documents if they satisfy all requirements of those provided by the Bureau. Contractors may not use internal documents until they receive written authorization from the FAC COR. This authorization may be rescinded at any time with a twenty (20) business day notice.

If a document for a specific service is not provided by the Bureau, the Contractor may, by default, use a compatible internal document that satisfies all requirements specified herein.

3.3.1 **Electronic File Management System (EFMS).** The Contractor shall utilize the Bureau approved electronic system for the primary receipt of referrals and transmission of all treatment documents and notes. This system is a FISMA moderate system that meets NIST 800-53 security controls.

3.3.2 **Documentation Requirements.** All treatment documentation must be submitted to the EFMS and must be completed and signed by the Contractor who provided the service. All

treatment documentation must be detailed, individualized, and contain specific examples of an offender's thoughts, behaviors, feelings, progress toward specific treatment goals, and plans for future treatment. Generic content, templates, and general clinical themes do not constitute acceptable documentation of progress in treatment. Documentation that does not meet these standards will be returned for correction which may result in delay of payment until acceptable documentation is received.

3.3.3 **Electronic Signatures**. The Contractor shall provide legally acceptable signatures on all documentation in accordance with state and federal law. Signatures that are authenticated by the user, such as digital signature certificates or signature images, are acceptable. Typed signatures that are easily added by any staff, such as cursive script, are not acceptable as an electronic signature. Proof of signature authentication shall be provided to the FAC COR upon request.

3.4 **CASELOADS.** The Contractor shall establish limits on overall clinician caseload size, to include total work volume of Bureau and non-Bureau offenders, to ensure effective treatment delivery and quality documentation. The Contractor must establish caseload sizes based on the number of offenders to be served, program design, characteristics, and needs of the population served to include gender concerns and other factors. The volume or complexity of a clinician's overall caseload shall not negatively impact the treatment delivery or timeliness or quality of documentation.

3.5 **TREATMENT OF CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS.** Offenders with co-occurring substance use disorder and mental health issues are prevalent in the criminal justice system and present with challenging and complex needs. An integrated treatment approach of co-occurring substance use disorder and mental health diagnosis is recognized as an evidenced-based practice. Therefore, the Contractor shall follow a treatment and recovery philosophy that promotes the integrated treatment of substance use disorder issues and mental health. When possible, the offender should be seen by a clinician experienced in co-occurring disorders treatment.

Offenders who are referred for mental health treatment and also have a secondary diagnosis of substance use disorder, shall receive treatment focused on the mental health diagnosis and the impact of the substance use disorder issue. Upon intake for mental health services, the presence of a substance use disorder should be assessed. During treatment, substance use disorder should be reassessed on an ongoing basis and discussed with the offender in terms of its impact on and relationship to the primary mental health disorder.

Offenders who are referred for substance use disorder services should also be assessed for mental health issues at intake. Throughout treatment, mental health issues should be continually reassessed as they may manifest during the transition to the community. Offenders with mental health disorders should be identified and receive treatment to assist in their progress toward recovery and to increase prosocial skills and the likelihood of successful reentry to the community.

For offenders with co-occurring disorders assessed by a single Contractor, only one assessment that encompasses both diagnoses (CLIN 2012) should be completed and submitted for payment.

3.6 **MEDICATION-ASSISTED TREATMENT (MAT).** A critical element of MAT is participation in SUD treatment to modify attitudes and behaviors related to substance use and to increase healthy life skills. Offenders receiving medications for SUD are at increased risk for relapse to substance use, and interventions should target reducing relapse risk factors. The Contractor shall provide opioid-specific SUD treatment as a "whole-patient" approach in an offender's MAT program (e.g., cognitive behavioral therapies, relapse prevention, and motivational interviewing).

3.7 **SEX OFFENDER SPECIFIC TREATMENT (SOT).** The Bureau does not compel offenders in sex offender treatment to reveal the identity of past victims. The Contractor shall not act in any manner which coerces them to reveal the names or identities of past victims. The Contractor shall encourage disclosure of past thoughts, feelings, and behaviors to foster the development of treatment initiatives consistent with the Good Lives Model (GLM) and CBT. Treatment is designed and offered to promote personal development, resulting in public safety, and should not be conceptualized as an investigative function.

3.8 **BUREAU FORMULARY FOR MENTAL HEALTH SERVICES.** The Contractor must refer to the Bureau formulary when prescribing medications to offenders. Non-formulary medications may be denied by the Bureau; prior authorization from the FAC COR is encouraged prior to prescribing a non-formulary medication. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

- the likelihood of efficacy, based on clinical experience and evidence-based practice;
- the likelihood of adequate compliance with the medication regimen;
- minimal risks from medication side-effects and drug interactions; and
- offender preference.

If two (2) or more medications equally satisfy the above criteria, choose the medication available to the offender at the lowest cost.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication, unless there is superior efficacy for the brand name medication or the side-effect profile favors the brand name medication.

The FAC COR will ensure that all Contractors receive a copy of the latest Bureau formulary.

3.9 **MONITORING MEDICATIONS.** The following recommendations are not intended to interfere with or replace clinical judgment of the Contractor when evaluating an offender on psychotropic medications. Rather, it is intended to provide guidelines and assist the

Contractor with decisions in providing high quality care, ensuring that offenders receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

- at the initial psychiatric evaluation, a change in medications should not be prescribed unless there is a significant documented need to alter the medication regimen;
- positive and negative effects and all changes in medications to include dosage increase or decrease should be documented; and
- medications should not be prescribed for off-label uses or used in a manner not specified by the Federal Drug Administration (FDA) for offenders receiving psychiatric services or MAT.

3.9.1 **MAT State and Federal Regulations.** Federal and state laws and other policies may affect the prescribing and dispensing of medications for opioid use disorders. Medications for the treatment of opioid use disorders must be prescribed or dispensed by individuals who are licensed to perform these activities in their respective states; however, additional rules and regulations apply to methadone and buprenorphine because of their status as controlled substances under the Comprehensive Drug Abuse Prevention and Control Act (Controlled Substances Act, 1970).

The Comprehensive Addiction and Recovery Act of 2016 (CARA) amended the Controlled Substances Act to allow qualifying nurse practitioners and physician assistants to receive a DATA 2000 waiver and prescribe buprenorphine at the original thirty (30) and one hundred (100) patient limits. However, several states have scope of practice laws that limit the effect of this federal law.

In October 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act was signed into law, which contained provisions intended to increase access to and use of MAT.

3.9.2 **Methadone.** Methadone is a Schedule II drug that is used for the treatment of opioid addiction. For treating opioid addiction, methadone is dispensed only through an opioid treatment program (OTP) which has been certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered as a narcotic treatment program by the U.S. Drug Enforcement Agency (DEA).

3.9.2.1 **OTP.** An OTP is required to be licensed by the state and certified by SAMHSA in conformance with 42 Code of Federal Regulations (C.F.R.), Part 8, to provide supervised assessment and medication-assisted treatment for offenders with an opioid use disorder.

3.9.3 **Buprenorphine**. Buprenorphine is a Schedule III drug, indicating its lower potential for abuse or misuse than Schedule II substances. Pursuant to the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians can prescribe buprenorphine to patients for the treatment of opioid use disorder after completing a required training and submitting to SAMHSA a notification of intent to prescribe. This permits the physician to treat up to thirty (30) patients at a time in the first year and, if requested, one hundred (100) patients

at a time after that. Some physicians, with added qualification, or in specific practice settings, are allowed to treat up to two hundred seventy-five (275) patients at a time.

3.10 **TELEHEALTH.** The Contractor shall provide services over real-time, audio and visual interactive telecommunications for telehealth sessions. The Contractor must be aware of federal and state telehealth regulations and be familiar with the laws in the state where offenders are located, if delivering services across state lines.

3.10.1 **Security.** The Contractor must adhere to the Health Insurance Portability and Accountability Act (HIPAA) regulations and federal confidentiality rules when providing telehealth services. The Contractor shall verify audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the U.S. government to accredit encryption standards. If partnering with 3rd party telehealth vendors, the Contractor must verify if their encryption meets the FIPS 140-2 certified 256-bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on their own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

3.10.2 **Clinical Suitability.** The Contractor must determine which offenders are suitable for telehealth sessions based on clinical decision, available resources, and technology. The Contractor must also determine if a telehealth session is the most appropriate method of delivery for the type of service being rendered. Clinical judgment must guide the use of telehealth for the delivery of services, and not simply for the sake of convenience for the Contractor or offender.

3.10.3 **Familiarization.** The Contractor must be familiar with and comfortable operating and controlling their telehealth platform. Additionally, before conducting a telehealth session, the Contractor must provide information to the offender on telehealth delivery of care and using the selected technology. The Contractor shall also provide information to the offender on how to access any digital platform that may be used in the delivery of telehealth services.

3.10.4 **Informed Consent.** The Contractor shall obtain from the offender a telehealth specific informed consent that explains:

- what telehealth is,
- the potential benefits,
- the possible risks,
- confidentiality, including no recording of telehealth sessions,
- and alternatives to telehealth sessions, such as in-person treatment sessions.

The Contractor must document in the EFMS whether verbal or written consent was obtained from the offender. Written consent is preferred.

3.10.5 **Offender Verification.** The Contractor shall verify the identity of the offender prior to each telehealth session by confirming the offender's legal name, date of birth, and Bureau register number listed on the treatment referral form. The Contractor shall document the verification on clinical documents and notes added to the EFMS.

3.10.6 **Originating Site Location.** The Contractor shall be aware of the offender's originating site, to include the exact physical location and address, at the time of the telehealth session (e.g., the RRC, the offender's residence, or place of work), and document it in the EFMS and on the Treatment Services and Accountability Log. To maintain privacy, all individuals at the originating site location must be identified and the offender must consent to discussing confidential information with those individuals present or they should be asked to leave.

3.10.7 **Contractor Originating Site.** The Contractor shall make available their performance location as an originating site for telehealth sessions for offenders who do not have the availability of real-time audio and visual interactive telecommunication equipment.

3.10.8 **RRC Originating Site.** If the local RRC has available equipment, and a secure and private location for telehealth appointments as the originating site, the Contractor shall coordinate appointment times to mitigate scheduling conflicts with available equipment and space.

3.10.9 **Distant Site**. When conducting telehealth sessions at the distant site, the Contractor shall use a private location, with a neutral background, adequate lighting, and wear appropriate professional attire.

3.10.10 **Alternative Sessions**. The Contractor must conduct in-person sessions with the offender, if the offender does not have the technical capacity or ability, or if the offender does not consent to the use of real-time video technology. In some instances, audio-only communication for telehealth sessions may be utilized when pre-approved by the FAC COR.

3.10.11 **Standards.** The Contractor shall exercise the same standards of care for telehealth treatment, such as providing standard session lengths and documentation as in person services. If the standard of care would require information or treatment that is only obtainable in person, the Contractor must see the offender for an in-person session.

3.10.12 **Group Rules.** The Contractor shall require offenders to follow the same in-person group rules regarding participation and confidentiality. The Contractor shall maintain order in the group sessions using facilitator controls and have a plan for offenders who become disruptive during telehealth group sessions. Minimum group size is three (3) offenders and shall not exceed five (5).

3.10.13 **Crisis Intervention.** The Contractor must be aware of local crisis resources and have a plan for crisis intervention if a telehealth session with an offender requires such services.

CHAPTER FOUR: SCOPE OF SERVICES

4.1 **TREATMENT REFERRAL AND AUTHORIZATION.** The Contractor will receive a treatment referral via the EFMS. The referral will specify the authorized treatment services and service authorization period for each offender. Services are only authorized from the start date to the end date as indicated on the referral. Amendments will be made as necessary.

4.1.1 **Contract Line Item Numbers (CLINs).** The Contractor must be capable of providing all treatment services, or CLINs, awarded with the contract at all times. The Contractor must immediately inform the FAC COR of an anticipated temporary or permanent inability to provide any CLIN whether due to staffing, change of law, performance site, public health emergency, natural disasters, or any other reason.

4.1.2 **Authorized Services.** The Contractor shall only provide services authorized on the Treatment Referral and Authorization. The Bureau will not pay the Contractor for services that were not preauthorized. The Contractor may request clinically indicated changes to the offender's authorized services by contacting the FAC COR. Changes to the treatment regimen, including discontinuing treatment, must be preauthorized by the FAC COR.

4.1.3 **Obligation to Treat.** The Contractor must accept all referrals from the Bureau for treatment services. If the Contractor determines they cannot provide treatment to a particular offender or condition, they must submit documentation that explains the issue to the FAC COR within five (5) business days from receipt of the referral. Examples would include a violation of local or state laws or ordinances or if the offender's condition is outside the Contractor's scope of practice or competency. The Bureau reserves the right to pursue contractual remedies in the event the Contractor cannot provide contracted services.

4.1.4 **Initial Contact.** The initial contact to schedule an intake appointment must be made with the RRC (or other contact provided by the FAC COR) upon receipt of the referral. Prompt initial contact is necessary to ensure an intake session will take place within ten (10) business days from the treatment authorization start date.

4.2 **INITIAL INTAKE APPOINTMENT.** Within ten (10) business days from the treatment authorization start date, the Contractor must meet in person with the referred offender for an intake and clinical assessment, unless preauthorization is granted by the FAC COR on a case-by-case basis for the session to be conducted via telehealth. The intake session will consist of an admission and orientation to the program and completion of Bureau intake forms as well as any documentation required by state regulatory boards. Additionally, the intake session shall include providing introductory information to the offender regarding assigned counselors, appointments, and offender responsibilities. A diagnostic interview and assessment (found in 4.3) is conducted at this time and ordinarily completed in a single visit. The intake session will be billed as an Intake Assessment & Report.

4.2.1 **Intake Screening**. If an offender declines treatment, this session will be billed as an Intake Screening. Only one Intake Screening can be submitted for payment when an offender declines more than one service on the same day.

4.2.1.1 **Substance Use Disorder Intake Screening** (CLIN 2005): Upon arrival to the initial appointment, the offender declined participation in substance use disorder treatment.

4.2.1.2 **MAT Intake Screening** (CLIN 4005): Upon arrival to the initial appointment, the offender declined participation in MAT.

4.2.1.3 **Mental Health Intake Screening** (CLIN 5005): Upon arrival to the initial appointment, the offender declined participation in mental health treatment.

4.2.1.4 **Sex Offender Intake Screening** (CLIN 6005): Upon arrival to the initial appointment, the offender declined participation in sex offender treatment.

4.2.1.5 **Treatment Decline.** The offender must understand their option not to participate in treatment, and they must also understand the consequences of their failure to participate if they choose not to volunteer for treatment while in the community. If the offender declines to sign the intake forms or declines to participate in treatment, the Contractor must terminate the initial intake immediately and notify RRC and CTS staff. Upon terminating the intake, the Contractor must also immediately alert RRC staff of the offender's departure to the RRC to ensure accountability is maintained. The appropriate Intake Screening CLIN may be billed by having the offender sign the Informed Consent form or staff certifying "offender declined to sign" on the form. This must be submitted to the electronic file management system within one (1) business day of the intake screening.

4.2.2 **Intake Forms.** The Contractor must obtain the offender's signature on the following documents during the intake. If the intake is conducted via telehealth, the Contractor must receive verbal consent and then make arrangements through the offender and RRC to obtain signed documents as specified below. Contact the FAC COR if additional assistance is needed. These forms must be completed, signed, and uploaded to the EFMS within one (1) business day of the intake session. This notification is considered urgent, as it informs the Bureau of the timely start of treatment services.

4.2.2.1 **Authorization for Release of Information Form:** Authorizes the Contractor to release information to the Bureau of Prisons, U. S. Probation, and Court Services and Offender Supervision Agency (CSOSA). All sections of the Authorization for Release of Information Form must be completed. Ordinarily, the expiration date should be a year from the offender's release date (treatment end date).

4.2.2.2 **Agreement to Participate in Community Transition Program (Informed Consent):** Informed consent is a process for getting permission before conducting a healthcare intervention on a person. When completing the Informed Consent with the offender, the clinician must first determine the offender's competency to provide consent.

Competence to give informed consent means the offender has a basic understanding of his or her diagnosis or condition and that the treatment being offered is for that condition. It also means the offender has a basic understanding of the potential benefits, risks, and side effects, and that they understand what to do in the event of any side effects.

4.2.2.3 **Intake Contact Explanation of Delay**: The Contractor shall provide an explanation of delay of submission to the electronic file management system for any intake conducted after the ten (10) business day timeframe. Repeated submissions of late intakes will constitute a deficiency of the Contractor's performance.

4.2.3 **Limits of Confidentiality.** Referred offenders must be informed of the limits of confidentiality during the intake session and that information will be disclosed to U.S. Probation, CSOSA, or others on a need-to-know basis.

4.3 **CLINICAL ASSESSMENTS, PSYCHIATRIC EVALUATIONS, AND REPORTS.** Assessments, evaluations, and similar services provide the Bureau with in-depth clinical information on the current status and diagnosis of the offender. All reports must be uploaded to the EFMS system as soon as completed but no longer than the timeframes specified below. Unusual information must be conveyed to the FAC COR with the appropriate amount of urgency as deemed clinically necessary. The Bureau reserves the right to require Contractors to submit specific assessments in a shorter time frame when needed. Services may not be billed until the report is received by the FAC COR.

4.3.1 **Clinical Assessments.** Clinical assessment reports must be in narrative form and contain the following, at a minimum:

- significant background issues pertaining to family, relationships, health, mental health, substance use, education, medication, social issues and employment;
- involvement with drugs and/or alcohol, and indicate if use was within twelve (12) months of arrest for the current offense;
- summary of prior treatment experiences;
- criminal history, to include statements documenting any disparity between self-report and supporting documentation;
- specific test(s) administered during the assessment;
- DSM (latest version) diagnosis (including past diagnoses), where applicable; and
- specific recommendations for treatment.

4.3.2 **Clinical Recommendations.** If a clinical diagnosis is not warranted and/or continued treatment is not clinically indicated, the Contractor must document their analysis leading to the decision and address any identified disparities between prior and current diagnoses. When treatment is indicated, all recommended interventions must be detailed.

4.3.3 **Substance Use Disorder Intake Assessment and Report** (CLIN 2011): Contractor must meet in person with the referred offender for a clinical intake assessment, unless preauthorization is granted by the FAC COR on a case-by-case basis for the session to be conducted via telehealth. An initial comprehensive diagnostic interview is conducted to identify substance use diagnoses and treatment goals. A diagnosis is required to justify

continued substance use disorder treatment. Reports must be submitted to the electronic file management system within ten (10) business days of assessment. Assessment services will not be reimbursed prior to receipt of the report. Price is per report.

4.3.4 **Mental Health Intake Assessment and Report** (CLIN 5011): Contractor must meet in person with the referred offender for a clinical intake assessment, unless preauthorization is granted by the FAC COR on a case-by-case basis for the session to be conducted via telehealth. An initial comprehensive diagnostic interview is conducted to assess current mental health functioning and status as well as medication compliance, if applicable. The report must provide a diagnosis (where applicable), mental status examination, and treatment recommendations. Reports must be submitted to the electronic file management system within ten (10) business days of assessment. Assessment services will not be reimbursed prior to receipt of the report. Price is per report.

4.3.5 **Co-occurring Intake Assessment and Report** (CLIN 2012): Contractor must meet in person with the referred offender for a clinical intake assessment, unless preauthorization is granted by the FAC COR on a case-by-case basis for the session to be conducted via telehealth. When a Contractor completes a combined Substance Use Disorder and Mental Health Intake Assessment, the report must be submitted to the electronic file management system within ten (10) business days of assessment. Assessment services will not be reimbursed prior to receipt of the report. Price is per report.

4.3.6 **Sex Offender Intake Assessment and Report** (CLIN 5012): Contractor must meet in person with the referred offender for a clinical intake assessment, unless preauthorization is granted by the FAC COR on a case-by-case basis for the session to be conducted via telehealth. An initial comprehensive diagnostic interview to assess an offender's risk for reoffending and treatment needs. The assessment includes a diagnostic interview, a summary of sex offense history standardized static risk assessment protocol, standardized dynamic risk assessment for violence and sex offenses, resulting in a comprehensive psychosexual DSM diagnosis, risk factors (both static and dynamic), and treatment and management/supervision recommendations based upon evidenced based practices or published guides endorsed by Association for the Treatment and Prevention of Sexual Abuse (ATSA) or Center for Sex Offender Management (CSOM). The Contractor shall not require the offender to identify their victims. Reports must be submitted to the electronic file management system within ten (10) business days of assessment completion. Assessment services will not be reimbursed prior to receipt of the report. Price per report.

4.3.7 **MAT Psychiatric Evaluation and Report** (CLIN 4050): Must be conducted within five (5) business days of treatment authorization start date. The FAC COR may request a shorter evaluation timeframe if an urgent need is identified. An initial comprehensive diagnostic interview and any necessary medical testing to assess current mental health functioning and status, as well as physical ability to participate in MAT. The report must provide a diagnosis, mental status examination, and treatment recommendations. Reports must be submitted to the electronic file management system within five (5) business days of evaluation. Evaluation services will not be reimbursed prior to receipt of the report. Price is per report.

4.3.8 **Psychiatric Evaluation and Report** (CLIN 5030): Must be conducted within twenty (20) business days of treatment authorization start date, or sooner, if clinically indicated and/or requested by the FAC COR. The purpose of this evaluation is to establish a psychiatric diagnosis, assess the need for psychotropic medication, and prescribe such medication as necessary and reasonable to ensure optimal functioning of the individual. Reports must be submitted to the electronic file management system within ten (10) business days of evaluation. Evaluation services will not be reimbursed prior to receipt of the report. Price is per report.

4.3.9 **Crisis Intervention Evaluation and Report** (CLIN 6000): The crisis intervention assessment must be a comprehensive diagnostic interview and written report submitted to the FAC COR or the electronic file management system within twenty-four (24) hours of the request made by the Bureau, due to its urgent nature.

Crisis intervention evaluations reports, at a minimum, will include:

- mental health status examination;
- reason for and source of referral;
- narrative of event;
- risk and protective factors assessed;
- risk assessment findings;
- diagnosis; and
- follow-up recommendations.

The offender will be seen by the Contractor for the purpose of crisis intervention and assessment of any immediate and subsequent treatment needs. The findings of this initial crisis evaluation session shall be summarized in a crisis intervention assessment (CLIN 6000) and a copy provided to the FAC COR within twenty-four (24) hours of the referral. Additional treatment services will be authorized as clinically indicated. All treatment and evaluation sessions shall be properly documented to ensure continuity of care within, between, and outside of Bureau facilities.

4.3.9.1 **Prison Rape Elimination Action (PREA) Intervention Report** (CLIN 6000): following a PREA-related allegation, the FAC COR will contact the Contractor for a PREA intervention to evaluate the offender's current mental health adjustment, including assessing for possible suicidal thoughts or plan and need for follow-up mental health services. The report shall include treatment and criminal history, mental status, clinical observations, and current medications.

4.3.9.2 **Suicide Risk Assessment Report** (CLIN 6000): When necessary, or when referred, the Contractor will conduct a suicide risk assessment and report. The Contractor will evaluate the current mental health status and, at a minimum, address the following in the assessment: reason/source of referral, risk factors, risk assessment findings, diagnosis, and follow-up recommendations, including need for follow-up mental health services.

4.4 **MEDICATION SERVICES**. Medication services include regular reviews of psychiatric and MAT medication effects and compliance as well as administration and dispensing of psychiatric medications and medications for an opioid use disorder. The Contractor shall be aware of and comply with local RRC procedures for processing routine and emergency prescriptions. The Contractor must immediately notify the RRC of any emergency prescriptions and the FAC COR must be notified within one (1) business day.

4.4.1 **Medication Monitoring and Report** (CLIN 6051): Medication monitoring is used to evaluate the efficacy of the psychiatric medication, order and perform laboratory testing, monitor laboratory test results, and make changes to the treatment regimen when deemed clinically appropriate. The Contractor shall ensure medication is prescribed in compliance with formulary requirements specified in Section 3.7. Medication usage records can be obtained from the RRC to verify compliance. The Contractor shall coordinate care amongst the offender's treatment team. Medication monitoring services will not be paid prior to receipt of the medication monitoring report. Price is per report.

4.4.2 **MAT – Follow-up and Report** (CLIN 4004): MAT follow-up is used to evaluate the efficacy of the buprenorphine or naltrexone prescribed for the treatment of a substance use disorder, order and perform laboratory testing, monitor laboratory test results, and make changes to the treatment regimen, when deemed clinically appropriate. The Contractor shall ensure the medication used for MAT services is prescribed in compliance with all existing regulations and in a manner specified by the FDA. MAT Follow-up services will not be paid prior to receipt of the report. Price is per report.

4.4.3 **Administration of Medication** (CLIN 6050): Administer intramuscular injections of psychiatric medication and/or dispense oral or sublingual psychiatric medication and monitor its ingestion. The Contractor performing any administration of medication must be qualified and licensed to do so in the state where services are rendered and must meet all existing regulations. Price is per administration.

4.4.4 **Administration of MAT Medication** (CLIN 4045): Administer intramuscular or subcutaneous abdominal injections of naltrexone or buprenorphine and/or dispense oral or sublingual medications for an opioid use disorder. The Contractor performing any administration of medication must be qualified and licensed to do so in the state where services are rendered and must meet all existing regulations. Price is per administration.

4.4.5 **MAT – Buprenorphine and Administration** (CLIN 4021): When authorized, the Contractor provides buprenorphine (sublingual tablets or film) and dispenses and/or administers as required in CLIN 4045. Total price is per drug cost and dispensing and/or administration.

4.4.6 **MAT- Buprenorphine and Administration of Injection** (CLIN 4031): When authorized, the Contractor provides injectable buprenorphine and administers, as required in CLIN 4045. Total price is per monthly drug cost and monthly administration.

4.4.7 **MAT - Buprenorphine Implant and Removal** (CLIN 4032): When authorized, the Contractor inserts and removes a buprenorphine implant. Total price is per drug cost, implant, and removal once every six (6) months.

4.4.8 **MAT - Naltrexone and Administration of Injection** (CLIN 4041): When authorized, the Contractor provides injectable naltrexone and administers as required in CLIN 4045. Total price is per monthly drug cost and monthly administration

4.4.9 **MAT - OTP Services** (CLIN 4000): When authorized, the Contractor delivers MAT - OTP services, in accordance with SAMHSA's Federal Guidelines for Opioid Treatment Programs. Covered services for MAT – OTP include: intake activities, clinical assessment, preparation of a treatment plan, periodic assessment, opioid-specific substance use disorder counseling, urine drug testing, and dispensing and/or administration of methadone, including the medication and take-home dosing. The Contractor must provide at least one (1) of the covered services daily for payment. Price is per daily rate.

4.5 **COUNSELING SERVICES**. Counseling interventions target the offender's criminogenic needs, such as criminal thinking errors, to reduce the likelihood of misconduct and recidivism. The Contractor shall not provide counseling services to the offender prior to the intake and assessment being completed. Counseling sessions shall begin within ten (10) business days following completion of the intake and assessment.

4.5.1 **Substance Use Disorder Individual Counseling** (CLIN 2010): May be performed in person or via telehealth. One (1) offender with a focus on substance use and progress toward achieving treatment goals and addressing other immediate clinically relevant issues the offender is experiencing. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.2 **Substance Use Disorder Group Counseling** (CLIN 2020): May be performed in person or via telehealth. In-person groups must be a minimum of three (3) and maximum of twelve (12) offenders and process-oriented in nature. The maximum group size for telehealth group counseling is five (5) offenders. Ordinarily three (3) units. Special permission must be obtained from the FAC COR for groups that exceed the maximum allowed group size. Price is per unit. Services will be paid after receipt of the MPR.

4.5.3 **Substance Use Disorder Relationship and Parenting Counseling** (CLIN 2030): May be performed in person or via telehealth. One (1) or more family members or persons with close established relationships with the offender in attendance, with a focus on substance use and recovery, family functioning, parenting, communication, and healthy coping strategies. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.4 **Mental Health Individual Counseling** (CLIN 6010): May be performed in person or via telehealth. One (1) offender with a focus on mental health symptoms, medication compliance, and progress toward treatment goals. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.5 **Mental Health Group Counseling** (CLIN 6020): May be performed in person or via telehealth. In-person groups must be a minimum of three (3) and maximum of eight (8) offenders, with a focus on mental health symptoms and process-oriented in nature. The maximum group size for telehealth group counseling is five (5). offenders. Ordinarily two (2) to three (3) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.6 **Mental Health Relationship and Parenting Counseling** (CLIN 6031): May be performed in person or via telehealth. One (1) or more family members with the offender in attendance and a focus on current environmental conditions and stressors, family functioning, communication, and healthy coping strategies. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.7 **Sex Offender Individual Counseling** (CLIN 6012): May be performed in person or via telehealth. One (1) offender with a focus on sexual urges, coping skills, diagnosis, and progress toward treatment goals. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.8 **Sex Offender Group Counseling** (CLIN 6022): May be performed in person or via telehealth. Minimum of three (3) and maximum of eight (8) offenders, with a focus on sexual urges and process-oriented in nature. The maximum group size for telehealth group counseling is five (5) offenders. Ordinarily three (3) units. Price is per unit. Services will be paid after receipt of the MPR.

4.5.9 **Sex Offender Relationship and Parenting Counseling** (CLIN 6032): May be performed in person or via telehealth. One (1) or more family members with the offender in attendance and a focus on sexual urges, family functioning, communication, and healthy coping strategies. Ordinarily two (2) units. Price is per unit. Services will be paid after receipt of the MPR.

4.6 **COMPLEMENTARY SERVICES.** The following services are meant to supplement the clinical treatment of offenders. Price is per daily rate for the services provided.

4.6.1 **Case Management Services** (CLIN 6029): For offenders who require additional, non-clinical assistance for a successful return to society. While treatment targets unhealthy thinking and behaviors, in contrast, case management focuses on transitional assistance to high need offenders.

When an offender resides at or is in the care of an RRC, case management services provided by CTS may not conflict with or duplicate the services provided by the RRC. RRC provided case management services take priority.

Case management activities may include the following:

- facilitate service linkages in the community and coordinate integrated services from multiple providers (where applicable);
- make referrals to needed resources and monitor referrals;

- assist with obtaining transportation, housing, financial support, coordinating team meetings, filing application for services (including social security and other local assistance programs), escort to appointments, monitor medication compliance (if applicable);
- maintain contact with USPOS or CSOSA;
- respond to crises and provide general, ongoing, crisis intervention; and
- coordination of care and service delivery.

The Contractor shall submit daily case management details to the electronic file management system within one (1) business day. The note should include the date, service code, length of service, and comments (e.g., type of case management activity provided, type of contact, i.e., face-to-face with offender or contact with service provider, assessment of case management needs, offender's progress, service linkages provided to physical and/or mental health care, transportation, etc.).

A single comprehensive payment will be paid if one (1) or more of the services are provided in one (1) day. Case management may be provided via phone, email, telehealth, audio, etc.

4.6.2 **SUD Peer Support Services** (CLIN 1010): Virtual peer support service provided by a certified peer support specialist to an offender enrolled in the service with a focus on recovery from substance use disorders. SUD Peer Support involves non-clinical activities, to include the initial contact and any sessions provided in a one-day period to an offender in community placement. Price is per day of enrolled service.

4.6.3 **MH Peer Support Services** (CLIN 1020): Virtual peer support service provided by a certified peer support specialist to an offender enrolled in the service with a focus on recovery from mental health disorders. MH Peer Support involves non-clinical activities, to include the initial contact, and any sessions provided in a one-day period to an offender in community placement. Price is per day of enrolled service.

4.7 **CLINICAL TREATMENT PLAN.** The individualized clinical treatment plan must be based upon evidence-based practices and interventions. The treatment plan should focus on goals to eliminate criminality, identify specific criminal thinking errors/patterns, and offer necessary reentry goals to enhance family relationships, communication skills, pro-social problem solving, finances, education, etc. Goals stating "remain substance free" or "speak to family" are generic by nature and must be more specific in order for the offender to understand the focus of their actions/behaviors. A treatment plan should not focus on abiding by RRC rules, obtaining employment, or attending treatment. Treatment plan goal dates should be staggered throughout the course of treatment. An offender's release from custody should not be the ending date listed for completion of goals.

The clinical treatment plan must be based on a clinical interview, ongoing assessment of the treatment needs, as observed in counseling sessions, and clinical information provided by the Bureau. It should also be consistent with the diagnosis. A clinical treatment plan, signed by the clinician and offender, must be submitted to the electronic file management

system twenty (20) business days from the clinical assessment, unless additional time is granted by the FAC COR on a case-by-case basis.

A signed treatment plan follow-up is required every six (6) months when nine (9) or more months of treatment are authorized. However, the treatment plan may be amended at any time during the authorization period and should be updated whenever there is a significant development or change in the focus of treatment (e.g., the offender's needs were assessed, and the offender and his/her family could benefit from participating in relationship and parenting counseling, the treatment plan would be revised to include relationship and parenting counseling).

4.7.1 **Substance Use Disorder Treatment Planning and Follow-up** (CLIN 2001): Treatment planning services will not be reimbursed prior to receipt of treatment plan. The treatment plan must be submitted within twenty (20) days of the clinical assessment. Offenders participating in treatment for more than nine (9) months, must have a treatment plan follow-up every six months. This documentation shall be submitted to the electronic file management system.

4.7.2 **Mental Health Planning and Follow-up** (CLIN 5001): Treatment planning services will not be reimbursed prior to receipt of treatment plan. The treatment plan must be submitted within twenty (20) days of the clinical assessment. Offenders participating in treatment for more than nine (9) months, must have a treatment plan follow-up every six months. This documentation shall be submitted to the electronic file management system.

4.7.3 **Sex Offender Treatment Planning and Follow-up** (CLIN 6001): Treatment planning services will not be reimbursed prior to receipt of treatment plan. The treatment plan must be submitted within twenty (20) days of the clinical assessment. Offenders participating in treatment for more than nine (9) months, must have a treatment plan follow-up every six months. This documentation shall be submitted to the electronic file management system.

4.7.4 **Treatment Plan Requirements.** The completed treatment plan must include the following criteria:

- individualized;
- focus on risks and needs of the offender;
- include specific statements of the individual’s problem(s) that will be addressed;
- contain measurable, time-bound goals;
- list end dates for goals that are not the last day of the offender’s treatment or release from custody, with dates that should vary throughout the course of treatment;
- have specific action and activity steps to achieve each goal;
- strongly encourage, when appropriate, relationship and parenting sessions;
- be signed and dated by the offender and the Contractor; and
- be reviewed and updated as necessary.

Sex offender specific treatment plans must additionally:

- address evidenced-based risk factors including intimacy deficits;

- list deviant sexual scripts, arousal patterns, emotional dysregulation, and antisocial cognitions; and
- use "approach" goals while minimizing "avoidance" goals.

4.8 **MONTHLY PROGRESS REPORTS (MPRs)**. The individualized MPR is a required document that synopsizes treatment needs and progress during months that include counseling services, except for the final month. The termination report will replace the MPR for the final month of treatment. The MPR should be in narrative form and will contain the following, at a minimum:

- a description of engagement in treatment sessions, attitude toward treatment, clinical impressions, interventions used, and any emerging treatment issues;
- instances of inappropriate behavior, any intervention taken to address the behavior, and offender's response to intervention;
- treatment response and progress toward treatment goals;
- significant issues affecting transition to the community (e.g., problems with family integration, negative interpersonal interactions, negative peer influence), medication compliance, reasons for missed appointments (excused and unexcused);
- current treatment and follow-up plan, to include changes, and reassessment of frequency and duration of treatment needs; and
- follow SOAP note format as outlined on the Monthly Progress Report.

4.8.1 **Treatment Timeline.** The MPR form includes a treatment timeline column to track required documents and deadlines.

4.8.2 **Multiple Clinicians.** The MPR must specify the name(s) of various treatment staff providing services (CLINs). This would include a summary of all interventions and progress the offender is making with all treatment staff contracted or subcontracted by the Contractor.

4.8.3 **Medication Monitoring and MAT – Follow-up.** If the offender receives medication monitoring or MAT – Follow-up services, a report must be completed by the authorized practitioner who provided the medication monitoring or MAT – Follow-up, to include the date, service code, length of contact, and comments (e.g., adjustment, responsiveness, need for change in medication regimen, etc.). This information may be submitted in lieu of an MPR or in addition to an MPR.

4.9 **TERMINATION REPORT.** The Termination Report must be in narrative form and summarize the offender's course of treatment, prognosis, and recommendations for further treatment, if indicated. This document is required at the end of treatment and removal or withdrawal from treatment for any reason. Ordinarily, this document replaces the MPR for the final month of treatment. The Contractor shall amend a termination report when clinically indicated or at the request of the FAC COR.

The Termination Report must be completed and forwarded to the FAC COR and the receiving U.S. Probation Office or CSOSA ten (10) business days prior to the projected treatment end date. When treatment is abruptly terminated (removal or withdrawal) the

termination report must be sent within ten (10) business days from termination of treatment. The Contractor must maintain email or fax verifications of all termination reports sent to USPO or CSOSA. Verifications must be available for review by the FAC COR, upon request. Termination reports are important for USPO and CSOSA staff to determine ongoing risk factors, need for continued treatment, and release planning. When necessary, the FAC COR can provide necessary USPO or CSOSA contact information.

The Contractor shall inform offenders of appropriate community mental health resources in the area should the offender release from custody prior to completion of all treatment goals.

In the instance of contract expiration, the Contractor is required to provide termination reports on all offenders currently in services within ten (10) business days prior to contract expiration date.

4.10 **CLINICAL INTERVENTIONS.** Immediately following a treatment session, the Contractor must notify the RRC via phone call of incidents listed below (or similarly significant incidents). In instances where an offender is excused from sessions early, the Contractor must inform the RRC of the offender's earlier than expected departure for accountability purposes. Additionally, the Contractor shall send the Bureau-provided Behavior Notification to the RRC, and upload it into the electronic file management system for the FAC COR. Contact the FAC COR or SCTC via phone immediately if deemed clinically necessary.

Incidents that must be immediately reported following a treatment session to the RRC:

- repeated or exceptionally disruptive behavior;
- ongoing refusal to participate (e.g.: sleeping, a lack of motivation, incomplete assignments, resistance, tardiness, or missed appointments);
- noncompliance with medication;
- mental health crisis to include suicidal ideation; and
- allegations of misconduct to including illicit drug use, use of alcohol, demonstration of violent behavior, threatening or abusive statements.

4.10.1 **Reporting.** In addition, the Contractor is obligated to report other relevant negative behaviors that come to their attention regarding treatment progress or a potential threat to the offender or to public safety, immediately following a treatment session. In response to negative behavior, the FAC COR may request the Contractor to deliver an intervention and/or CTS may provide an intervention.

4.10.2 **Removal or Extension.** The Contractor may request that the FAC COR remove an offender from treatment, or in some cases, extend treatment due to disruptive behavior or unsatisfactory progress in treatment. The Bureau has a full range of progressive disciplinary procedures developed for modifying behavior, as outlined in Program Statement 5270.09, *Offender Discipline Program*.

4.11 **BILLING**. The Contractor must have a method in place to accept electronic payment for monthly invoices. The Contractor shall ensure all services rendered pursuant to this SOW are accounted for and billed monthly. All billing information is required to be accurate (e.g., calculations, unit prices, unit quantities, and CLINs). Failure to provide the necessary documentation in a timely manner may likely result in a delay of payment. Invoices will be handled in accordance with the Prompt Payment Act (31 U.S.C. 3903) and Office of Management and Budget (OMB) prompt payment regulations at 5 CFR Part 1315.

4.11.1 **Submittal**. The preferred method of submitting invoices and supporting documentation is electronically via encrypted e-mail, or other Bureau-approved electronic method, on or before the 10th of each month. If invoices are expected to be late, or need to be submitted via another means, promptly notify the FAC COR.

4.11.2 **Invoice**. Invoices must include an itemized log of all services provided. This includes the dates of each service, CLINs, full offender names, offender register number, and quantity of units for each service provided. The Contractor must also list all authorized clinicians who provided services for that month. Invoices will be reviewed to verify the list of clinicians submitted to ensure only those contract staff who have received written approval and are authorized to work with Bureau offenders rendered services for the month. Invoices lacking the appropriate information or containing errors will be returned to the Contractor for correction which may result in a delay of payment. All invoices must be signed and dated prior to submission.

4.11.2.1 **Invoice Requirements.** FAR 52.212-4(g) states the following must be included in all invoice submissions:

- name and address;
- contract number and contract CLIN numbers;
- description and quantity of items;
- dates of services;
- name, title, and phone number of whom to notify of invoice errors; and
- Taxpayer Identification Number (TIN).

4.11.3 **Treatment Services and Accountability Logs**. Treatment Services and Accountability Logs must be submitted with every invoice as supporting documentation. These logs must match the itemized invoice log and any discrepancies or errors must be clearly identified and explained. All logs must be completed in real-time and indicate the mode of treatment delivery (e.g. in-person, telehealth, etc.). Logs shall include offender signature of in-person services and signatures of all staff providing services. The logs must accurately reflect the offender arrival and departure times, as well as service start and end times. The Contractor must maintain all original Treatment Services and Accountability Logs on-site for inspection. The Bureau reserves the right to require the Contractor to submit original hand-written hardcopy versions of these documents at any time for auditing purposes.

4.11.3.1 **Multiple Daily Appointments.** When multiple appointments occur on the same day, the log should account for each session separately. Each entry requires signatures.

4.11.3.2 **Telehealth Treatment Services and Accountability Logs.** When telehealth services are provided, the primary purpose of this form will be to document accountability of the offender. The Contractor shall complete and sign this log to certify services were rendered and to document the originating site of the offender's location, ordinarily, the RRC, home, or place of work. If the offender received telehealth services at the performance site, the offender must sign the log.

4.11.4 **Documents and Reports.** The Contractor must ensure that all documents are submitted to the electronic file management system within the specified time frames. These documents must be completed with all required information. Unsatisfactory documentation will be returned for correction, which may result in delayed payment of the entire invoice. Accuracy and timeliness of billing and clinical documentation will be reflected in the monitoring report and CPAR.

4.11.5 **Option Year Prices**. It is the responsibility of the Contractor to verify and update CLIN prices in accordance with the Pricing Schedule (see Standard Form 1449, Block 20) each option year.

4.11.6 **Authorized Services**. The only services permitted by this contract are the CLINs listed in the Pricing Schedule (SF 1449). The government will not pay the Contractor for services that were not specifically authorized for an offender in advance of the services being provided.

4.12 **TRANSPORTATION** (CLIN 1202). In locations where the local RRC is providing transportation, the Contractor shall not provide transportation to the offender without prior approval from the FAC COR. Individual Transportation Expenses may be authorized on a contract to facilitate individual transportation to and from the Contractor's facility by public transportation. As all locations are unique, transportation will be paid in the method specified in the contract Pricing Schedule (see Standard Form 1449, Block 20).

4.13 **SUMMARY OF CONTRACT LINE ITEM (CLIN) PRICING**.

4.13.1 **Intake Screening:**

CLIN	Unit Type	Unit Billed
2005	Substance Use Intake Screening	1 unit per declined informed consent
5005	Mental Health Intake Screening	1 unit per declined informed consent
6005	Sex Offender Intake Screening	1 unit per declined informed consent
4005	MAT Intake Screening	1 unit per declined informed consent

4.13.2 **Treatment Plans, Clinical Assessments, Evaluations and Reports:**

CLIN	Unit Type	Unit Billed
2001	Substance Use Disorder Treatment Planning and Follow-up	1 unit per report
5001	Mental Health Treatment Planning and Follow-up	1 unit per report

6001	Sex Offender Treatment Disorder Treatment Planning and Follow-up	1 unit per report
2011	Substance Use Disorder Intake Assessment & Report	1 unit per report
2012	Co-occurring Intake Assessment & Report	1 unit per report
4050	MAT Psychiatric Evaluation & Report	1 unit per report
5011	Mental Health Intake Assessment & Report	1 unit per report
5012	Sex Offender Intake Assessment & Report	1 unit per report
5030	Psychiatric Evaluation & Report	1 unit per report
6000	Crisis Intervention Evaluation & Report	1 unit per report

4.13.3 **Medication Services:**

CLIN	Unit Type	Unit Billed
4004	MAT –Follow-Up and Report	1 unit per report
4021	MAT – Buprenorphine and Administration	1 unit per administration
4031	MAT – Buprenorphine and Administration of Injection	1 unit per administration
4032	MAT – Buprenorphine Implant and Removal	1 unit per administration
4041	MAT – Naltrexone and Administration of Injection	1 unit per administration
4045	MAT – Administration of Medication	1 unit per administration
6050	MH – Administration of Medication	1 unit per administration
6051	MH – Medication Monitoring and Report	1 unit per report
4000	MAT – OTP Services	1 unit per day

4.13.4 **Complementary Services:**

CLIN	Unit Type	Unit Billed
6029	Case Management	1 unit per day
1010	SUD – Peer Support	1 unit per day
1020	MH – Peer Support	1 unit per day

4.13.5 **Counseling Services:**

<table>
<tr><th>CLIN</th><th>Unit Type</th><th>Unit Billed</th></tr>
<tr><td>2010</td><td>Substance Use Disorder Individual Counseling</td><td rowspan="10">Ordinarily, billed units are in 30-minute increments, however, to accommodate administrative needs, accountability logs must show the following minimum treatment lengths for invoice purposes.
<table><tr><th>Units</th><th>Minutes</th></tr><tr><td>1</td><td>25</td></tr><tr><td>2</td><td>55</td></tr><tr><td>3</td><td>85</td></tr><tr><td>4</td><td>115</td></tr></table></td></tr>
<tr><td>2020</td><td>Substance Use Disorder Group Counseling</td></tr>
<tr><td>2030</td><td>Substance Use Disorder Relationship and Parenting Counseling</td></tr>
<tr><td>6010</td><td>Mental Health Individual Counseling</td></tr>
<tr><td>6012</td><td>Sex Offender Individual Counseling</td></tr>
<tr><td>6020</td><td>Mental Health Group Counseling</td></tr>
<tr><td>6022</td><td>Sex Offender Group Counseling</td></tr>
<tr><td>6031</td><td>Mental Health Relationship and Parenting Counseling</td></tr>
<tr><td>6032</td><td>Sex Offender Relationship and Parenting Counseling</td></tr>
</table>

4.13.6 **Transportation:**

CLIN	Unit Type	Unit Billed
1202	Transportation: one-way, round-trip, weekly, monthly	Per Contract

4.14 **DEDUCTIONS**. In the event the Contractor fails to meet obligations in the SOW, monetary deductions may be made. The below stipulations do not modify or waive the rights of the Bureau to terminate a contract for cause under the terms and conditions of the contract.

4.14.1 **Location Change.** In the event the Contractor is authorized to change sites or locations, the Contractor may be required to reimburse the Bureau for all reasonable costs associated with the disruption of services to Bureau offenders due to the Contractor's change in location. Any modification to the site or location must be deemed in the best interest of the government.

4.14.2 **Loss of Key Personnel.** In the event the Contractor fails to have a counselor available to provide services, the Contractor is required to reimburse the Bureau for each day services are unavailable.

CHAPTER FIVE: STAFFING

5.1 **STAFFING.** The Contractor shall identify and submit to the electronic file management system all personnel by name, position, and responsibility as changes occur for the life of the contract. The Contractor must notify the FAC COR and indicate in the electronic file management system when a staff member is removed from the contract. The Contractor must ensure all personnel providing clinical services to Bureau offenders meet the experiential, educational, and appropriate licensure/certification as required by the state authority and the clinical licensing requirements listed in the Decisional Rule Criteria (DRC) (Section 2.1 of SF 1449).

5.2 **KEY PERSONNEL**. The Contractor shall maintain and identify key personnel who meet SOW and the initial DRC requirements from the contract solicitation to provide all services awarded to the contract. These personnel are considered primary points of contact for various aspects of the contract.

5.3 **CLINICAL EXPERIENCE**. The Contractor shall verify the education, experience, and training of all staff. This verification includes credentials for all professional staff. Clinical staff should have documented experience providing substance use disorder treatment and/or mental health services to a criminal justice population. For sex offender treatment, clinical staff must have experience working with a sex offender population. The Contractor shall voucher potential employees through reference and employment checks and document information regarding reference and employment checks. Resumes verifying clinical experience for new clinical staff must be provided with requests for approval to work with Bureau offenders.

5.4 **CONTRACTOR LICENSURE**. The Contractor shall ensure all clinicians providing direct services to Bureau offenders are licensed or certified by the respective state board in the state where the contract will be performed. All staff providing direct clinical services must hold a valid state-issued license or certification listed in the original Decisional Rule Criteria of the contract solicitation. State regulation waivers do not supersede this requirement. Clinicians may only provide services within their respective scope-of-work. The Supervisory Community Treatment Coordinator (SCTC) must approve in writing all clinicians by position title to provide the scope of work for specific contracts. The SCTC may review any request for clinical staff outside of the original DRC licensing requirements and provide written authorization, if deemed in the best interest of the government.

5.4.1 **Unapproved Clinicians**. The Contractor shall not bill for services provided by unapproved clinicians, to include a clinician whose license is not confirmed as active and in good standing, not qualified to provide rendered services by state regulations, and/or not approved by the SCTC in writing to provide services for the specific contract.

5.4.2 **Professional Clinician**. A mental health professional whose training, experience and demonstrated achievements clearly meet or exceed the minimum standards required for recognition as a professional in their discipline, and whose broad-based skills and knowledge in their specific areas of specialty are recognized by the members of their profession to be at the highest level. This person must be licensed under the respective state statutes. Examples include: Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Mental Health Counselor or Licensed Marriage and Family Therapist.

5.4.3 **Substance Use Disorder Counselor**. A clinical staff member with experience in substance use disorder assessment, diagnosis, treatment, and knowledge and application of motivational interviewing techniques. Must be certified and/or licensed as a substance use disorder counselor (or state equivalent) in the state where services will be rendered. These clinicians are to provide only the services governed by their state statutes, unless they possess a clinical license which allows more expansive practice, such as meeting the requirements of trained supervisory personnel or providing mental health services for co-occurring offenders. However, this level of clinician should only provide mental health services within the scope of state requirements.

5.4.4 **Provisionally Licensed Clinicians, Licensed Interns, and Qualified Mental Health Professional** (herein called a non-independently licensed clinician). A non-independently licensed clinician is defined as a person whose experience, training, and supervision are commensurate with the assigned tasks but has not yet met the criteria of their own profession for recognition as an independently licensed clinician. When listed in the DRC (Section 2.1 of SF 1449) a non-independently licensed clinician may provide treatment services within the scope of their license and under the direction of a fully licensed practitioner. When not listed in the DRC, the SCTC may authorize a non-independently

licensed clinician to provide treatment services within their scope of practice, and under the direction of a fully licensed practitioner, on a temporary or permanent basis.

5.4.4.1 **Supervision.** "Under the direction" means the independently licensed clinician directing the service is providing direct or functional supervision. Although the clinician directing the service is not required to be physically present during treatment sessions to exercise direction, unless required by state regulations, the licensed clinician directing a service assumes ultimate responsibility for the services provided.

The Contractor shall ensure the non-independently licensed clinician receives clinical supervision as required by the state licensing boards. The Contractor shall ensure trained supervisory personnel conduct and document clinical supervision meetings at least monthly regardless of state requirements. Appropriate supervision for clinical and administrative experience shall also include monthly documentation review. The Contractor shall document the supervision and make it available upon request by the FAC COR.

5.4.4.2 **Counselors-in-Training, Trainees, Unlicensed Interns, Practicum Students.** Upon approval from the SCTC, students and trainees may assist an independently licensed clinician to obtain clinical hours for license and forensic experience. However, when co-facilitating with an independently licensed clinician, only the direct services provided by the independently licensed clinician can be submitted for payment. Students and trainees cannot provide services independent of a fully licensed practitioner, unless they hold an additional clinical license as listed in the DRC (Section 2.1 of SF 1449).

5.4.5 **Medical Staff**. The Contractor must have a qualified practitioner (e.g., Medical Doctor, Physician, Psychiatrist, Physician Assistant, Advanced Practice Registered Nurse Practitioner/ Specialist) with prescriptive authority (DEA Registration Certificate), who meets the standards of practice established by the applicable state's professional regulatory board to provide psychiatric evaluations, medication monitoring, MAT evaluations, and follow-up services, when these CLINs are required for the contract. Medical staff licenses are not ordinarily listed in the original DRC of the contract solicitation. There are no restrictions on licensing as long as all required services can be provided in the state where services will be rendered.

5.4.6 **MAT Providers**. The Contractor must have a qualified practitioner (e.g., Medical Doctor, Psychiatrist, Physician Assistant, Advanced Practice Registered Nurse Practitioner/ Specialist) with prescriptive authority (DEA Registration Certificate) who meets the standards of practice established by the applicable state's professional regulatory board to provide MAT evaluations, medication services, and follow-up services in the state where services will be rendered.

5.4.7 **Active Licenses**. The Contractor shall ensure that active professional licenses/ certifications are uploaded to the EFMS for all key personnel who will provide services for the contract. Thereafter, renewed licenses and certifications must be uploaded to the EFMS no later than twenty (20) business days from expiration. If unable, justification must be provided to the FAC COR for lateness.

5.5 **BACKGROUND INFORMATION**. The Bureau requires that all contract staff, both administrative and clinical, are approved in writing by the Bureau prior to any contact with Bureau offenders, clinical information, billing information or any contract related materials. This includes all employees, subcontractors, volunteers, and interns. The Contractor must only submit approval requests for staff who will actively participate in the administration of the contract.

5.5.1 **NCIC Check**. After the Contractor determines that a person is appropriate to work with Bureau offenders, the Contractor will request a background check from the Bureau. The Contractor will submit to the FAC COR all relevant information, including a completed and signed NCIC Check form and driver's license or government issued identification. This begins the background check process. The information provided on the form includes full name, all aliases used, date of birth, place of birth, sex, race, and social security number. The Contractor shall notify the individual that a National Crime Information Center/National Law Enforcement Telecommunication System (NCIC/NLETS), criminal records, and other appropriate background checks will be processed by the Bureau to verify this information.

5.5.2 **Initial Check**. All proposed staff on the initial Technical Personnel document who meet the solicitation requirements must be submitted for approval. Prior or current approvals from other contracts do not substitute for this process. Ordinarily, the initial background check process for proposed staff is completed when the Contractor becomes the apparent awardee. The Authorized Negotiator is responsible for ensuring timely submission of all requested information and documentation for the background checks to avoid delays of contract award.

5.5.3 **Approved**. Contract staff shall not begin working with Bureau offenders prior to obtaining written approval from the FAC COR. Approval may be granted after the NCIC/NLETS check is completed with satisfactory results as reviewed by the SCTC. Prior approval on a previous Bureau contract does not extend to new contracts, nor does it guarantee that the individual will be approved again.

5.5.4 **Prohibited**. There may be occasions when an individual is prohibited from working with Bureau offenders. This determination does not preclude the Contractor from employing the staff member to work with non-Bureau offenders.

5.5.4.1 **Previous Criminal Convictions.** The Contractor shall not submit anyone for Bureau approval who is under the supervision or jurisdiction of any parole, probation, or correctional authority. Contract staff with previous criminal convictions, who are not under supervision, may be considered for approval to work with Bureau offenders,

however, the Supervisory Community Treatment Coordinator (SCTC) reserves the right of approval in such cases. Consideration will be given to such factors as criminal history, time elapsed since conviction(s), and subsequent adjustment in the community.

5.5.4.2 **Substandard Performance.** The SCTC reserves the right to deny approval of staff who have previously provided substandard performance. This includes clinical and non-clinical staff who repeatedly failed to satisfy the requirements of the contract. Substandard clinical care can include, but is not limited to, a Contractor not providing documentation to show they are practicing within the standard of care. Clinical records must be kept for each offender receiving treatment, to include information about their diagnosis and assessment, the presenting issue, treatment goals, interventions used by the Contractor, and the offender's progress in treatment. Derogatory information from the clinical licensing board may also be considered for SCTC denial.

5.5.5 **Appeal**. If the Contractor wishes to appeal the initial decision, the prohibited staff member may submit to the FAC COR a detailed description of criminal history and reasons why the individual should be approved to work with Bureau offenders. This information will be reviewed by the SCTC for a final decision.

5.5.6 **Revoked Approval**. The Bureau reserves the right to revoke the approval for any clinical or administrative staff member pending investigation of alleged misconduct by the Bureau's Office of Internal Affairs, Office of the Inspector General, or the applicable state licensing boards. The Contractor shall report to the FAC COR all pending investigations or sanctions involving personnel providing services under the contract with the Bureau. Additionally, the clinician's Standards of Conduct for their respective license shall be practiced, along with the Bureau's standards of conduct and the Contractor's internal standards and expectations for their employee. If ethical concerns or practices are observed, they must be reported to the FAC COR within twenty-four (24) hours.

The SCTC reserves the right to revoke the approval of staff who fail to meet contract requirements. Ordinarily, identified contract deficiencies are addressed with the authorized negotiator for corrective action(s). The clinical or non-clinical staff member may be removed from working with Bureau offenders if they fail to adhere to corrective actions approved by the Bureau. (Additional information is found at 5.5.4.2 Substandard Performance.)

5.6 **CRITICAL VACANCIES**. The Contractor shall notify the FAC COR in writing if key personnel vacate a position permanently which may disrupt services. If employment is terminated in a routine manner in which the employee gives an advanced notice, the Contractor must submit notification to the FAC COR as soon as the Contractor becomes aware of the proposed change in staff. In some situations, when a staff person's employment may be terminated abruptly, the Contractor must notify the FAC COR in writing within one (1) business day. Upon notification to the FAC COR, the Contractor must submit all proposed substitutes that have qualifications that are equal to or higher than the qualifications of the person being replaced. If a substitute is not identified, the Contractor must submit a plan to replace the key personnel position within five (5) business

days. The Bureau reserves the right to pursue contractual remedies if the Contractor cannot provide a staff member with equivalent credentials and experience of the clinical personnel that were originally approved at contract award.

5.6.1 **Staff Absence**. Treatment services must continue without interruption despite staff absences (e.g., vacancy, vacation, illness). The Contractor is responsible for providing services with Bureau-approved, equally credentialed staff for key personnel during these instances.

5.7 **SUBCONTRACTING**. The Prime Contractor shall request approval from the FAC COR and the Contracting Officer advance of executing any subcontract or modification. All subcontracted staff and modifications must be approved by the Bureau. The submitted request must include the following information and meet applicable criteria of original DRC:

- identification, location, and selection of the proposed subcontractor;
- a description of the services to be subcontracted; and
- technical personnel list.

The Contractor has the additional responsibility to ensure proper management and oversight of their program and any subcontractors. Absentee ownership will not absolve responsibility for program integrity, responsiveness, or requirements.

5.8 **LANGUAGE SERVICES**. The Contractor shall provide bilingual services for non-English speaking offenders and interpretive services for American Sign Language (ASL), through use of bilingual staff, approved language line, or approved interpretive services, as long as there is a need for these services.

CHAPTER SIX: STAFF TRAINING REQUIREMENTS

6.1 **STAFF TRAINING REQUIREMENTS**. The Contractor shall ensure all staff are adequately trained. The Contractor must provide initial and refresher training to all employees approved to work with Bureau offenders.

6.1.1 **Post-Award Introduction**. Ordinarily, within ten (10) business days of the contract award, the FAC COR and an authorized negotiator will hold an orientation discussion, a key factor for successful contract performance is communication.

Topics shall include:

- introduction of Bureau staff and Contractor key personnel;
- roles and responsibilities;
- overall scope of the contract and CLINs;
- general overview of technical and reporting requirements;
- invoicing requirements and payment procedures;
- identifying potential problems; and
- answer any questions.

This introductory discussion may transition into the initial staff training. If so, the full review of SOW requirements will be addressed.

6.1.2 **Initial Staff Training**. Prior to the contract effective date, or within ten (10) business days for contracts that begin immediately, the Contractor must conduct a comprehensive training on all topics below to all approved staff. New staff must complete initial staff training within ten (10) business days after Bureau approval to work for the contract. Training should be interactive in nature, cover all elements of the SOW, be at a minimum two (2) hours in length, and resolve all questions and concerns of participants. The Bureau reserves the right to be present during training sessions. The Contractor will notify the FAC COR of training dates and obtain any additional topics deemed relevant by the Bureau based on current trends and/or changes in Bureau policy after publication of this SOW. The Contractor must submit the CTS Training Record (Attachment C) to the FAC COR demonstrating that this training was conducted, and all staff must acknowledge that they understand the SOW and all additional topics discussed. Documentation must include the name, signature, date, and topics covered.

Topics must include:

- SOW administrative and technical requirements;
- PS 3420.11 Contractor's Standards of Employee Conduct;
- PS 3735.04 Drug Free Workplace; and
- PS 5324.06 Sexually Abusive Behavior Prevention and Intervention Program.

6.1.3 **Annual Training**. The Contractor shall provide annual training to all approved staff. Training should be interactive in nature, be minimally one (1) hour in length and resolve all questions and concerns of participants. The Contractor shall notify the FAC COR of training dates and obtain any additional topics deemed relevant by the Bureau based on current trends and/or changes in Bureau policy after publication of this SOW. Standard topics must include a review of all initial training and any specific areas of concern or noted deficiencies. The Bureau reserves the right to be present during training sessions. This training also requires completion of the CTS Training Record (Attachment C).

6.1.4 **Additional Training**. The Contractor shall conduct additional training when deficiencies or other significant issues are identified and develop a corrective action plan to prevent a recurrence of the problem. The Contractor shall train all key personnel on all aspects of the corrective action plans when applicable within ten (10) business days of acceptance by the Bureau. The training also requires completion of the CTS Training Record (attachment B).

6.1.5 **Training Record**. The Contractor shall retain signed copies of the Bureau provided CTS Training Record (Attachment B) for all approved employees. Training acknowledgement forms must be available for review by the FAC COR upon request. The Contractor must maintain training records for the life of the contract.

6.1.6 **Bureau Contractor's Training.** At least one key staff member must attend the Community Treatment Services Contractor's Training when conducted by the Bureau.

This training will not occur more than once per year. All costs associated with this requirement will be the responsibility of the Contractor and should be factored into the contract costs. Continuing education credits may be provided for attendees.

6.1.7 **Continuing Education.** The Contractor must allow key personnel to participate in continuing education to ensure they are aware of the latest approaches for evidence-based practices and interventions. The Contractor shall encourage key personnel to attend virtual CTS provided training classes when made available to contract staff.

6.1.8 **Psychology Treatment Program**. The Contractor shall become familiar with RDAP and its curriculum. Mental health and sex offender treatment Contractors shall become familiar with treatment programs in the Bureau, to include specific curriculum used in these programs. Programming and training materials will be provided by the Bureau with initial staff training and upon request. The Contractor, with the approval and assistance of the FAC COR, is encouraged to schedule a visit to a nearby Bureau institution with Psychology Treatment Program staff or invite Bureau institution staff to their facility for cross training.

6.2 **STANDARDS OF CONDUCT**. The Contractor shall develop and use written policy, procedures, and practices for employee conduct, ethics, and responsibility consistent with Bureau Program Statement 3420.11, *Standards of Employee Conduct*. The Contractor shall notify its employees of the Contractor's Standards of Employee Conduct and require all employees to sign the CTS Training Record (Attachment B) as an acknowledgment that they understand the expectations.

6.3 **DRUG FREE WORKPLACE**. The Contractor shall implement and follow policies consistent with Bureau Program Statement 3735.04, *Drug Free Workplace*. Regardless of state or local laws. The Contractor shall provide a mechanism for employee assistance and education regarding the dangers of drug abuse. The Contractor shall require all employees to sign the CTS Training Record (Attachment B) as an acknowledgment that they understand the expectations.

6.4 **SEXUAL ABUSE INFORMATION**. The Contractor has the responsibility to provide a working environment that is free from sexual harassment and intimidation in accordance with Title VII of the Civil Rights Act of 1964, as amended. Sexual abuse, assault, and misconduct are not tolerated. Sexual abuse, assault, and misconduct are defined as verbal or physical conduct of a sexual nature directed toward a Bureau offender or employee by another Bureau offender, employee, or volunteer of the facility in accordance with the Prison Rape Elimination Act of 2003. Complete information is found in the Bureau Program Statement 5324.06, *Sexually Abusive Behavior Prevention and Intervention Program*.

The Contractor shall develop and implement a comprehensive staff training program addressing the facility's sexual abuse, assault, and misconduct prevention and intervention program. Written policy, procedure, and practice shall require that all staff receive such training during employee orientation and on an annual basis as part of the facility's in-

service training plan. The Contractor shall require all employees to sign the CTS Training Record (Attachment B) as an acknowledgment that they understand the expectations.

The Contractor shall maintain a policy that prohibits sexual abuse and harassment by employees against Bureau offenders or other employees. Sexual misconduct is illegal and a violation of Federal law.

CHAPTER SEVEN: ADMINISTRATION

7.1 **FACILITY REQUIREMENTS**. Treatment must be provided at the performance site specified in the contract, unless otherwise authorized by the Bureau. The site must be Americans with Disabilities Act (ADA) compliant and accessible by public transportation. The Contractor shall provide, and have on-site, documentation indicating necessary legal measures are taken to provide for continuity of service in the event of bankruptcy or incapacitation. The Contractor shall meet the filing requirements necessary to maintain the legal authority to operate.

7.1.1 **Rooms**. The Contractor shall ensure the location for counseling services meets the requirements for the treatment population. The counseling space must be accessible, ADA compliant, near the waiting room (if applicable) and restroom facilities, private to ensure conversations are not audible outside the room, quiet and free from extraneous noise, allow for confidentiality (to include doors and covered windows, if necessary), free from clutter, and furnished with comfortable and moveable chairs. The Contractor shall adhere to all local safety requirements for occupancy and egress. The group room should be set up for a process group. Chairs should be set in a circle with no desk or obstruction in the middle of the circle. Empty chairs should be moved outside the group circle. The use of audio/video monitoring or recording of treatment sessions, is prohibited, unless authorized by the FAC COR, on a case-by-case basis.

7.1.2 **Pets and Animals**. The Contractor shall not allow pets or animals of any kind at the performance site(s) while treating Bureau offenders, except for a service animal as defined by the ADA. The Contractor shall not allow offender access to service animals that pose a direct threat to others, are not under the handler's care and control, or would fundamentally alter the nature of the goods, services or programs provided by the Contractor. The Contractor shall make necessary accommodations for any identified allergies of offenders. The Contractor shall inform the FAC COR of all animals on site for any reason.

7.1.3 **Site/Name/Banking Changes**. The Contractor's approved location of services or official name shall not change without prior approval of the Contracting Officer, through a request to the FAC COR, including all applicable proposed performance site information. The Contractor must also notify CTS of any banking changes and submit the necessary form. The Contractor is encouraged to submit all changes as soon as possible to allow time for review of requests.

7.2 **ACCOUNTABILITY.** In addition to the Treatment Services and Accountability form, the Contractor shall have comprehensive offender accountability procedures. The Contractor shall have a plan to maintain accountability of offenders at the performance site(s) from arrival until departure, including all common areas, and offender restroom facilities. The local areas of concern must be incorporated into the overall accountability procedures for offenders arriving to and departing from the facility. Accountability is part of the treatment process and offenders are required to take personal responsibility for the decisions they make.

7.2.1 **Local Areas of Concern**. The Contractor must continuously update and maintain their originally submitted Local Areas of Concern document, including when a change of location occurs. The document must identify areas of concern that are within the solicitation restrictions listed in the DRC (2.1 of SF 1449), to include the same space and/or same building, of each proposed performance site that cares for, educates, or entertains minors or other vulnerable populations and provide a plan to mitigate contact with and risk to these populations. The Local Areas of Concern document must be made available for review by the FAC COR at each contract monitoring or at any time upon request. The Contractor must maintain this document and implement the risk mitigation plans throughout the life of the contract.

7.2.2 **Weekly Appointment Schedule**. The Contractor shall provide a weekly appointment schedule to an RRC point of contact. The schedule must include all dates and times for each offender appointment. The schedule must be transmitted to the RRC and to the FAC COR no later than Thursday, 9:00 PM local time.

7.3 **COMMUNICATION.** The Contractor shall maintain a professional and respectful relationship with RRC staff.

7.3.1 **Documentation Sharing.** The Contractor shall not provide treatment-related Bureau or Contractor documentation without a signed release of information and FAC COR approval. Regularly provided documents will include weekly appointment schedules, behavioral notifications, and prescriptions.

7.3.2 **Prescriptions.** The Contractor shall inform the RRC of all routine prescriptions written for offenders within one (1) business day. The Contractor shall immediately inform the RRC of all emergency prescriptions.

7.3.3 **Administrative Documents Transmission.** The Contractor shall manage staffing, invoicing, and other miscellaneous documents within the EFMS as directed by the FAC COR.

7.3.4 **E-Mail.** The Contractor shall securely transmit documentation to the Bureau, as needed. The Contractor must have provisions to safeguard electronic health information during the exchange of that information, in accordance with HIPAA and/or 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records.

7.4 **FACILITY LICENSURE/CERTIFICATION**. The facility where services are provided must be appropriately licensed and certified to provide all services listed in the contract and as required by the state authority where services are being rendered. All services for the contract shall be conducted at the facilities approved by the Bureau. At no time will services be conducted at alternate locations, (e.g., personal homes, public areas), or any location not previously approved by the Bureau. Renewed licenses and certifications must be uploaded to the electronic file management system no later than twenty (20) business days from expiration. If the Contractor is unable to provide updated licenses and certifications within the time frame, justification must be provided to the FAC COR for lateness.

7.4.1 **Residential Reentry Center (RRC)**. The Bureau may authorize the Contractor to provide treatment services at the RRC. Prior to authorization, the Contractor shall have a letter from the RRC's authorized negotiator granting permission to use the facility. Permission must be granted for the entire length of the contract. The space provided by the RRC shall be reserved for community treatment services, and the setting must be conducive to effective treatment as outlined in the "7.1 Facility Requirements" section of this SOW. If required by the state, the RRC shall also be licensed to have all services specified in the contract.

Any rental or lease contract required by the RRC for use of their facility, and any fax machine, telephone, computer, other property, or equipment owned by the RRC, is solely between the Contractor and the RRC's authorized negotiator. The Contractor shall continue to maintain overall responsibility of the requirements in this SOW. If the RRC discontinues the use of the Contractor utilizing the space, the Contractor shall be responsible for resolving the issue and continuing services without interruption. Refer to 7.1.2 for further information.

7.5 **FILE MAINTENANCE**. The Contractor shall maintain a treatment file for each offender. The Bureau must receive complete access to electronic medical records, upon request, to all clinical information for Bureau offenders. This information must be safeguarded and meet the Bureau's electronic security requirements.

7.5.1 **File Requirements**. The Contractor shall include the following documents in all offender treatment files at a minimum:

- Treatment Referral and Authorization
- Agreement to Participate in Community Transition Program (Informed Consent)
- Authorization for Release of Information Form
- Acknowledgment of Agency Rules/Regulations/Expectations (as applicable)
- Treatment Services and Accountability Log
- Assessment/Evaluation (if applicable)
- Clinical Treatment Plan
- Clinical Notes
- Homework Assignments
- Behavior Notification Forms
- Monthly Progress Reports

- Termination Report
- Chronological Contact Sheet

7.5.2 **Hard Copy Treatment Files**. Similar file structure is expected if hard copy files are maintained by the Contractor. Treatment files for Bureau offenders shall be maintained separately from non-Bureau files. The files shall be maintained on-site, in a secure area using approved protocol. File material must be well organized. The Contractor must ensure complete confidentiality of all Bureau treatment records in accordance with HIPAA.

7.6 **HIPAA**. The Contractor shall require its clinicians and all agents and subcontractors to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records). The Contractor must document in writing the policies and procedures that will be used to meet such obligations.

7.6.1 **Document Requests**. Bureau offender requests for documentation regarding their treatment must be addressed in a timely manner and communicated to the FAC COR. HIPAA is binding on Contractors and allows Bureau offenders to obtain copies of their existing treatment records with the following exclusions:

- information that could place a third party at risk;
- clinical case notes; and
- information that a third party provides on a confidential basis.

7.7 **RECORDS RETENTION**. The Contractor must retain both treatment files and contract records for the period required by legal, regulatory, and ethical requirements.

7.7.1 **Treatment Files.** Specific state and federal laws and regulations govern retention of treatment file records. To the extent possible, these guidelines are generally consistent with these laws and regulations. In the event of a conflict between the guidelines and any state or federal law or regulation, the law or regulation in question supersedes these guidelines. In the absence of a superseding requirement, Contractors may consider retaining full treatment records until seven (7) years after the last date of service delivery. In some circumstances, the Contractor may wish to keep records for a longer period of time, considering the risks associated with outdated information, or privacy loss, versus the potential benefits associated with preserving the records.

7.7.2 **Contract Records.** The Contractor is required to retain all pertinent records and materials involving transactions related to the contract for three (3) years after final payment is received. Records include books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form or in the form of computer data, and other supporting evidence to satisfy contract negotiation, administration, and audit requirements.

CHAPTER EIGHT: CONTRACT AND CONTRACT MONITORING

8.1 **MODIFICATIONS**. The FAC COR does not have the authority to alter the Contractor's obligations under the contract or modify any of the expressed terms, conditions, specifications, or cost of the agreement. If, as a result of technical discussions, it is in the government's best interest to change contractual obligations or the Scope of Work, the Contracting Officer shall issue necessary modifications.

8.2 **MONITORING ACTIVITIES**. Various activities will take place throughout each performance year to ensure Contractors are adequately performing the contracted services, per this Statement of Work. The Contractor must be responsible for meeting all contract requirements throughout the year for quality, specificity, clarity, and timeliness.

8.2.1 **Representation**. The Contractor shall have all key personnel present and participate in all announced on-site monitoring inspections. The FAC COR must be notified of any anticipated absences.

8.2.2 **On-Site Inspections**. The FAC COR or designated staff will conduct on-site visits to ensure contract compliance. On-site visits are often scheduled in advance with the Contractor but may also be conducted without notice. The primary purpose of the on-site inspection is to observe treatment sessions, provide routine and issue-specific training, and interact with Bureau offenders and contract staff.

8.2.3 **Remote Inspections**. The FAC COR may conduct remote inspections to ensure contract compliance. These inspections will include phone interviews, listening to treatment sessions telephonically, and observing sessions via real time or two-way audiovisual telecommunication.

8.2.4 **Training**. The FAC COR or designated staff may conduct training, in addition to the requirements of Chapter 6, during on-site visits or if significant concerns with contract performance require Bureau staff to provide additional training.

8.2.5 **Documentation Audits and Perpetual Review**. The FAC COR will regularly conduct treatment file reviews to ensure all required documentation is received and meets minimum quality requirements. The FAC COR will request missing documentation or corrections to poor quality or incomplete documentation. Sustained underperformance, to include lack of key personnel, location disruptions, chronic billing errors, etc. will result in an interim deficiency and require corrective action. The Contractor shall maintain communication with the FAC COR, address issues and concerns in a timely manner, and follow technical direction and guidance.

8.2.6 **Contract Monitoring Letter**. The FAC COR will complete a monitoring summary letter to identify areas of strength and may detail the performance of the contract after a formal inspection. The letter may detail deficiencies that require corrective action. The Contractor must acknowledge receipt of the monitoring letter.

8.2.7 **Corrective Action Plan (CAP)**. The Contractor must respond to all deficiencies with a CAP within fifteen (15) business days of written notification. The FAC COR will inform the Contractor in writing when the CAP is accepted, and the monitoring is closed. CAPs will be closely monitored for sustained compliance. Failure to comply with accepted CAPs will result in a repeat deficiency.

8.2.8 **Cure Notice**. Sustained non-compliance may result in additional contract remedies such as a cure notice, which could lead to a termination for cause. A cure notice is issued to a Contractor identifying the deficiency(s) in the performance of the contract and allows time, e.g., 10 days, to "cure" or correct the problem. The government's right to terminate the contract for cause may be exercised if the Contractor does not cure or fails to perform the services within the time specified after receipt of the notice, or provide the government adequate assurances of future performance

8.2.9 **Contractor Performance Assessment Reporting System (CPARS)**. The web-based CPARS system is used to provide Contractor performance evaluations. Contractors may submit information to the FAC COR that could be considered for the CPARS report. The Contractor shall provide and maintain a valid email address throughout the life of the contract. The Contractor must be registered in the CPARS to access and review the evaluation and/or provide a response. If assistance is required, the Contractor must contact their assigned Contracting Officer.

RELEVANT PROGRAM STATEMENTS

The following policies may be obtained from the Bureau's website at www.bop.gov:

*Program Statement 3420.11, Standards of Employee Conduct
*Program Statement 3735.04, Drug Free Workplace
Program Statement 4100.06, Bureau of Prisons Acquisition Policy
Program Statement 4324.08, Suicide Prevention Program
Program Statement 5100.08 CN-1, Inmate Security Designation and Custody Classification
Program Statement 5270.09, Inmate Discipline Program
Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness
Program Statement 5324.10, Sex Offender Programs
*Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program
Program Statement 5330.11, Psychology Treatment Programs
Program Statement 6010.03, Psychiatric Evaluation and Treatment
Program Statement 7430.02, Community Transitional Drug Abuse Treatment

* Denotes required training

Contract Name:

Contract Number:

Dates of Monitoring Inspection:

Monitoring Staff:

Location:

Signature:

The following individual working papers are the product of the monitoring inspection.

SOW CHAPTER 2: BUREAU INFORMATION			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
2.2*	Contractor providing CBT during treatment sessions.		

SOW CHAPTER 3: GUIDING PRINCIPLES OF TREATMENT			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
3.2.3	Clinicians are engaged in services without distractions.		
3.2.5	Individual/Family sessions are two (2) units unless authorized by the FAC COR.		
3.2.5	Group sessions are three (3) units unless authorized by the FAC COR.		
3.2.6	Standardized session breaks for all participants are not authorized during treatment.		
3.2.8	Individual sessions focus on relevant treatment issues and expectations.		
3.2.9	Group treatment sessions are process-oriented with a cognitive-behavioral approach. Check-ins should be limited in length and clinically relevant.		
3.2.10	In-person group size is a minimum of three (3) offenders and does not exceed twelve (12) for SU/SO sessions, or eight (8) offenders in MH without prior approval by the FAC COR.		
3.2.10	Telehealth groups consist of three (3) to five (5) offenders.		
3.2.11	Group sessions are comprised of CTS offenders unless preauthorized.		
3.2.12	Contractor does not use videos or other AV media during treatment.		
3.2.13/ 3.2.14	Established written rules, regulations, and expectations, including a cell phone policy that is implemented and upheld.		
3.4	Clinicians maintain manageable overall caseloads.		

CHAPTER 4: SCOPE OF WORK			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
4.5.1	Substance Use Individual counseling sessions focus on substance use and progress toward achieving treatment goals and other immediate clinical needs.		
4.5.2	Substance Use Group Counseling focus on substance use and are process-oriented in nature.		
4.5.3	Substance Use Disorder Relationship and Parenting Counseling includes the offender and one or more family members and focuses on substance use and recovery, family functioning, and healthy coping strategies.		
4.5.4	Mental Health Individual counseling focuses on mental health symptoms, medication compliance, and progress toward treatment goals.		
4.5.5	Mental Health Group counseling focuses on mental health symptoms and functionality.		
4.5.6	Mental Health Relationship and Parenting Counseling includes the offender and one or more family members in attendance and focuses on family functioning, communication, current environmental conditions and stressors, and healthy coping strategies.		
4.5.7	Sex Offender Individual counseling focuses on sexual urges, coping skills, diagnosis, and progress toward treatment goals.		
4.5.8	Sex Offender Group counseling focuses on sexual urges and is process oriented.		
4.5.9	Sex Offender Relationship and Parenting Counseling focuses on sexual offending, family functioning, communication, and healthy coping strategies.		
4.6.1	(As applicable) Case Management Services provided do not conflict with RRC case management services.		
4.9	Contractors maintain proof of transmittal for Termination Reports.		

CHAPTER 6: STAFF TRAINING			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
6.1.2	Initial staff training was conducted timely and included all necessary topics.		
6.1.2	All new staff received initial staff training within ten (10) business days of CTS approval.		
6.1.2	Initial staff training was at least two (2) hours long, interactive, and addressed all concerns.		
6.1.3	Contractor provided annual training to all approved staff.		
6.1.4	Contractor maintains training records for all approved staff.		
6.1.6	At least one (1) key staff member attend Community Treatment Services Contractor's Training when conducted.		
6.2/6.3/6.4	Staff trained on Standards of *Employee Conduct, Drug Free Workplace, Sexually Abusive Behavior Prevention and Intervention Program.*		

* Decisional Rule Criteria (DRC)

SOW CHAPTER 7: ADMINISTRATION			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
7.1*	All performance locations are ADA compliant.		
7.1*	All performance locations are authorized and accessible to inmates via public transportation.		
7.1.1*	Contractor ensures individual and group rooms are private and confidential during treatment sessions.		
7.2	Contractor has comprehensive inmate accountability procedures.		
7.2.1*	The Local Area of Concerns document has been maintained and includes accurate information.		

ADDITIONAL OBSERVATIONS AND NOTES:

Contract Name: Monitoring Staff:

Contract Number: Location:

Dates of Monitoring Inspection: Signature:

The following individual working papers are the product of the monitoring inspection.

TIMEFRAMES			
REF	**Requirement**	**SAT SOW**	**Timeframe**
4.2/ 4.2.2	Seen for intake and clinical assessment.		Within **ten** (**10) business days** from the treatment authorization start date
4.2.2	Intake forms submitted.		Within **one (1) business day** of the intake session.
4.3/ 4.3.1	Assessments, Evaluations, and Reports.		Within **ten (10) business days** of the assessment.
4.3.7	MAT Psychiatric Evaluations.		Conducted within **ten (10) business days** of the authorization date.
4.3.9*	Crisis Intervention Evaluation and Report, PREA Intervention Reports, and Suicide Risk Assessment Reports submitted.		Within **twenty-four (24) hours** of the referral or request.
4.4	Emergency prescriptions.		Notifies RRC **immediately**, and CTS within **one (1) business day.**
4.5	Counseling services.		Begins within **ten (10) business days** of the intake and assessment.
4.6	Submits daily case management details to EFMS (as applicable).		Within **one (1) business day.**
4.7/4.7.4	Treatment plans submitted.		Within **twenty (20) business days** of the clinical assessment.
4.7	Treatment plans are completed for offenders receiving more than nine (9) months of treatment.		Every **six (6) months.**
4.9	Termination Reports are submitted and sent to USPO/CSOSA.		Submitted **ten (10) business day**s prior to, or after discharge (as applicable)
4.11.1	Submits invoices and documents.		By the **10th of each month.**
5.4.7*	Submits renewed licenses and certifications.		No later than **twenty (20) business days from expiration.**
5.6	Contractor notified CTS in writing of key personnel vacancies that could or did disrupt services. A plan to replace the key position was submitted.		Within **five (5) business days.**
7.3.2	Routine prescriptions.		Notify RRC within **one (1) business day.**
7.4*	Contractor maintains necessary state facility license or certification and provides CTS with renewals or notifies CTS with justification for lateness.		**Twenty (20) days** prior to expiration.

* Decisional Rule Criteria (DRC)

Disclaimer: This document is a guide and worksheet for a monitoring inspection. It is not all-inclusive. All information gathered from interviews and observation may be documented in accordance with the SOW.

SOW CHAPTER 2: BUREAU INFORMATION			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
2.2*	Contractor documentation provides evidence of CBT.		

SOW CHAPTER 3: GUIDING PRINCIPLES OF TREATMENT			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
3.2.1	Treatment services are in-person, or by audio-visual, real time, two-way interactive communication, or in limited circumstances, by audio-only with FAC COR pre-approval.		
3.2.4	Frequency of services is individualized and weekly not exceeding twice per week unless preapproved by FAC COR.		
3.2.5	Individual/Family sessions are two (2) units unless authorized by the FAC COR.		
3.2.5	Group sessions are three (3) units unless authorized by the FAC COR.		
3.2.7	Accommodates various offender work schedules.		
3.2.10	In-person group size is a minimum of three (3) offenders and does not exceed twelve (12) for SU/SO sessions, or eight (8) offenders in MH without prior approval by the FAC COR.		
3.2.10	Telehealth groups consist of three (3) to five (5) offenders.		
3.2.15	Disruptive behavior is appropriately reported.		
3.3	Use most recent Bureau-provided documents, unless they are approved for use of their own compatible documents that meet all requirements.		
3.3.2	Documentation submitted in EFMS.		
3.3.3	Contractor provides legally acceptable signatures.		
3.4	Clinicians maintain manageable overall caseloads.		
3.5	Contractor utilizes evidence-based treatment for dual diagnosis offenders.		
3.7*	Contractor utilizes appropriate treatment for sex offender services rooted in the Good Lives Model and CBT.		
3.10.4/ 3.10.7	Telehealth specific informed consent completed for all telehealth clients. Telehealth procedures are followed including: signing the Telehealth-informed consent; offender verification; the originating site location; maintaining privacy; and documenting in EFMS.		

* Decisional Rule Criteria (DRC)

CHAPTER 4: SCOPE OF WORK			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
4.1.1*	Contractor can provide all awarded contract line items (CLINs) at all times.		
4.1.2	Contractor provides services authorized on the Treatment Referral and Authorization.		
4.2.1.5	Offenders who decline treatment are documented appropriately and submitted within one business day of the intake screening.		
4.2.2.1	Authorization for Release of Information Form completed appropriately and signed at all intake appointments.		
4.2.2.2	Informed Consent completed appropriately and signed at all intake appointments.		
4.2.2.3	Explanation of delay submitted for all late intakes.		
4.3.8	MH Psychiatric Evaluations are conducted when needed by authorized clinicians, provide appropriate diagnoses and required information.		
4.4.2	MAT follow-up is used for efficacy of medication prescribed as well as lab testing.		
4.8	Monthly Progress Reports (MPRs) are individualized, in narrative form and contain the minimally required information.		
4.8.2	MPRs contain information from all treating clinicians.		
4.8.3 4.4.1	Medication Monitoring and MAT Follow-up reports are submitted with MPRs by the authorized practitioner and include all minimally required information.		
4.10	Contractor notifies RRC and CTS immediately following treatment sessions of significant incidents via phone call and uploads the Behavior Notification into the electronic file system.		
4.11.2	Monthly invoices are accurate and include all required information.		
4.11.3	Treatment Service and Accountability Logs support all services listed on the itemized invoice logs, are individualized, not pre-filled, and include clinician and inmate signatures. Original logs are maintained by the contractor.		

CHAPTER 5: STAFFING			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
5.2*	Contractor maintained key personnel to provide all services awarded to the contract, and the contractor informed CTS of all staff by name, position, and responsibility.		
5.4.5*	Medical licenses and DEA certificates are current.		
5.6.1*	Contractor maintained services during staff absences with equivalent staff for key personnel.		

* Decisional Rule Criteria (DRC)

Disclaimer: This document is a guide and worksheet for a monitoring inspection. It is not all-inclusive. All information gathered from interviews and observation may be documented in accordance with the SOW.

CHAPTER 7: ADMINISTRATION			
REF	**Requirement**	**SAT SOW**	**Performance Comments**
7.2.2	Weekly schedule sent to RRC point of contact, including all date and times for each offender's appointments no later than Thursday, 9:00pm, the local time of the RRC.		
7.3	The contactor maintains a professional and respectful relationship with the RRC.		

ADDITIONAL OBSERVATIONS AND NOTES:

COMMUNITY TREATMENT SERVICES TRAINING RECORD

IN ACCORDANCE WITH THE 2022 STATEMENT OF WORK, CHAPTER SIX

Contract Name:	Training Topic(s):
Contract Number:	Training Date(s):

Staff Name	Initial or Review	SOW Technical Requirements	Standards of Conduct SOW 6.2	Drug Free Workplace SOW 6.3	Sexual Abuse Information SOW 6.4	Other (Specify Above)	Signature
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Instructor Name	Instructor Signature