

LIFE IS PRECIOUS

PROGRAM MANUAL

Columbia University
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1. Introduction

a. Life is Precious Program History

The Life is Precious (LIP) program model was developed by Comunilife, Inc., led by Dr. Rosa Gil, with input from Latina adolescents and parents in New York City. The program was designed to supplement outpatient mental health treatment by providing a range of services in an after-school, clubhouse program model. LIP activities are centered on several goals: promotion of family relationships, academic support, creative expression, and wellness education. LIP does not have a defined catchment area, and accepts participants from a wide range of schools and neighborhoods. Referrals can come from outpatient mental health clinics, schools, hospitals, and self-referrals from Latinas and their families (Humensky et al, 2013). All participants must be adolescent Latinas (ages 12-18). Adolescents must have experienced suicidal ideation or attempts prior to referral, and continue to experience suicidal ideation at the time of referral. Participants must be receiving mental health treatment, either at Comunilife or another clinic.

LIP currently operates in three locations in New York City (Bronx, Brooklyn, and Queens). The program runs after school (3:00pm-7:00pm) on weekdays and on Saturday mornings. Participants come on a drop-in basis and can take advantage of any or all of the services offered by LIP; there is no set curriculum or sequence in which services must be received. Communication education is designed primarily to educate the adolescent on improving communication with family members; if other family members choose to participate, they may also learn these skills. Because LIP operates as an after-school program, many parents are working or otherwise not available at those hours, and so the program is designed primarily to provide adolescents with the tools and strategies that they may find beneficial, regardless of the level of participation by other family members (Humensky et al, 2016).

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b. Why LIP?

LIP and Latina Adolescent Suicidality

Historically, studies have shown that Latina adolescents consistently have higher rates of suicidal behavior compared to non-Latina black and white adolescents. Latina adolescents face risk factors confronted by all female adolescents, in addition to risk factors that have been identified as unique to Latinas. General risk factors common to many populations include history of child abuse or sexual abuse; history of suicide attempt; family history of attempted or completed suicide; history of or current mental illness, especially depression; physical illness; past or current alcohol abuse and abuse of other substances; loss (relational, social, work, or financial); easy access to lethal means; impulsive or aggressive tendencies; history of being bullied and social isolation; peer suicides or local epidemics of suicide; failure in school; hopelessness; unwillingness to seek help because of stigma; and barriers to accessing mental health care (Price, 2016; Langhinrichsen-Rohling, 2009).

Moreover, community-level risk factors that contribute to an increased risk of suicidality include poverty and residing in high-crime, disadvantaged neighborhoods with low-quality housing and education (Zayas and Pilat, 2008). During adolescence, girls may face developmental struggles related to identity formation, self-esteem, and body image (Zayas and Pilat, 2008).

In addition to these risk factors that are common to many populations, some risk factors have been identified as affecting Latina adolescents specifically. *Familism* is thought to play an important role in suicidal behaviors, as it is a core system of values centered on the family, prioritizing the family over self. *Familism* calls for family unity and reverence of parents and elders. Latino adolescents struggle with their need for autonomy, which is emphasized in American culture, on the one hand, and cultural values of *familism* on the other; therefore, a family conflict may lead to suicidal behavior when autonomy begins to threaten family order (Zayas and Pilat, 2008; Langhinrichsen-Rohling, 2009). Latinas, specifically, may feel pressure to display nurturing, controlled, family-oriented behavior. This gender role tends to conflict with the values of personal autonomy and independence common in U.S. society. Moreover, the immigration process can be traumatic for those who may be leaving important family members behind in their countries of origin (Langhinrichsen-Rohling, 2009).

Barriers to care, including the financial inability to afford treatment, add to the risk of suicidal behavior. Latino youth made up nearly 40% of U.S. uninsured youths in 2014, but comprise 24% of the youth population; many have long waiting periods for insurance coverage. They also face language barriers and transportation challenges (Price, 2016). While Latino adolescents are less likely to die by suicide than other ethnic groups, in 2008, they reported higher rates of suicide plans, attempts, and hopelessness; therefore, this population has a particular risk for nonfatal suicidal behavior (Langhinrichsen-Rohling, 2009).

Life is Precious aims to address these specific needs of Latina adolescents in order to reduce suicidality, with an emphasis on improving the lives of girls in the LIP community. The five core components of the LIP program are Wellness, Creative Expression Therapy, Outpatient Mental Health Services, Family Support, and Supported

Education Services. These components are included to address the unique intersection in this community of the struggles that many female adolescents experience with self, peers, family and school (Zayas and Pilat, 2008; Goldston et al., 2008; Humensky et al., 2013); and the bicultural challenge balancing the push toward autonomy against the pull toward a family-centered role (Zayas and Pilat, 2008).

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Expected Outcomes

Through mental health treatment, encouragement of healthy behaviors, and advice on communication and coping skills, the LIP program aims to help the client to:

- Reduce suicidal behavior (attempts, thoughts, and ideation),
- Improve psychological functioning (reduction in depressive symptoms), and
- Promote functional outcomes.

These mechanisms of influence facilitate improved academic performance, positive family relationships, and a reduction in substance use and high-risk sexual behavior that contribute to suicidality in Latina adolescents (Humensky et al, 2013). The LIP program addresses these risk factors through the intervention's core components: Wellness, Creative Expression, Outpatient Mental Health Services, Family Support, and Supported Education Services. The reasoning behind each component and its expected influence on these outcomes follows.

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Core Components

Outpatient Mental Health Treatment

LIP is a culturally competent mental health and youth development program with a community-defined practice model that aims to reduce suicidal risk and attempts in Latina adolescents. It incorporates a Multicultural Relational Approach for Diverse Populations into its treatment plans and interventions; however, it is a non-clinical after-school program (3:00pm-7:00pm) that runs on weekdays and Saturday mornings. As a result, participants are required to attend outpatient mental health treatment, which includes therapy and psychiatry services, and be under the care of a clinician to be eligible for the program. According to Nestor, Cheek, and Liu (2016), psychiatric outpatient treatment is the “receipt of service from a partial day hospital or day treatment program, mental health clinic or center and/or a therapist, psychologist, social worker, or counselor for suicidal ideation and/or behavior” (p. 198).

Adolescent suicidality is often left untreated (Husky et al. 2012). A study using a nationally representative sample of adolescents with suicidal ideation, suicide plans or suicide attempts showed that 67.3% of adolescents with suicidal ideation, 54.4% of those with a plan, and 56.9% of those with an attempt did not receive specialty mental health treatment or contact a mental health specialist in the past 12 months (p. 992). Furthermore, Nestor et al. (2016) gathered data from the National Survey on Drug Use and Health, including 4176 depressed adolescents with suicidal ideation and behavior in the previous year. In the study sample, mental health service utilization fell below 10% for suicidal ideators and below 50% for suicide attempters; outpatient utilization fell below 10% for ideators and 40% for attempters (Nestor et al., 2016, p. 199). Furthermore, racial/ethnic minorities were generally less likely to receive and seek treatment than their non-Hispanic white counterparts (p. 200). The lag or absence of treatment may negatively affect effective early interventions

Block et al. (2013) conducted a mixed methods study with 25 adolescents referred for mental health care through a school-based referral program on how adolescents understand mental health treatment and make treatment decisions, and how they differ from adolescents who do not attend outpatient treatment. In the ten-week study, three themes emerged that affect adolescents’ decision: autonomy, importance of peer reactions, and need for privacy (28). Adolescents may be resistant to outpatient mental health treatment when it undermines their autonomy, brings stigma, or is open to parents as opposed to individual treatment. Attitudinal behaviors, such as stigma against mental health treatment and cultural attitudes about mental health, are related to whether a patient desires mental health treatment (Nadeem et al., 2007; Nestor et al., 2016). Nadeem et al. (2007) showed that U.S.-born Latina women were less likely than U.S.-born white women to want treatment, whereas immigrant Latinas were more likely to want it (p. 1549); however, immigrant Latinas were less likely than their U.S.-born white counterparts to be in treatment (p. 1551). As LIP requires all the girls to attend outpatient treatment, stigma is reduced and provides a space for the adolescents to speak in privacy and share things they would not have shared with their families, in addition to the group sessions they have during creative expression therapy with LIP. By making outpatient mental health treatment obligatory, all LIP participants will have had to address these barriers.

When compared to adolescent boys receiving outpatient counseling or psychotherapy, adolescent girls were more likely to exhibit internalizing symptoms such as anxiety, depression, or withdrawal, presented with more psychosocial factors or stressors, and demonstrated greater levels of risk to self or others, suicidal ideation in particular (Holtberg, Olsen, & Brown-Rice, 2016, p. 224). The meta-analysis performed by Holtberg, et al. emphasized the gender differences in clinical characteristics of adolescents receiving mental health treatment. Finally, Mehlum et al. (2016) measured treatment outcomes in adolescents who either received 19 weeks of dialectical behavior therapy adapted for adolescents (DBT-A) or enhanced usual care (EUC), defined as standard care with no less than 1 weekly treatment session per patient (p. 295). Results showed that at 19 weeks, adolescents receiving DBT-A had a significantly lower level of suicidal ideation than those receiving EUC, but that at the follow-up 1 year later, there was no statistically significant difference between the two groups (p. 297), showing that both treatments were effective at reducing self-harm episodes, psychiatric admissions, and emergency department visits. Furthermore, the study suggested that adolescent patients are treatable and the long-term prognosis after treatment is favorable; the participants continued to improve or sustained the benefits of outpatient mental health treatment after the trial (p. 299). In essence, while LIP is being implemented to improve outcomes for the girls, outpatient therapy will play a strong role in the treatment process.

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Family Support

According to Dr. Gil, many parents “have a lot of challenges and stressors themselves, like lack of money or poor housing” and many mothers also express feeling overwhelmed by their circumstances without support from their partners. LIP provides a support system for both the child and parent. Assistance with concrete services is provided when a family has issues with housing, finances, employment, etc. LIP services can indirectly help participants because “if moms feel stronger in self-esteem, they can open up a dialogue without being punitive.”

Another aspect of providing support is by helping the family communicate more effectively. Dr. Gil expresses that LIP staff must have the ability to act as “cultural brokers” and help the client understand their unique circumstances, their parents’ culture, and vice-versa, to foster positive communication between parents and children. While American culture values individualism, the Latino culture focuses on familism, prioritizing the family over individual wants and needs (Goldston et al, 2008). The goal of family support is to create awareness of these factors among family members and reduce the cultural and societal barriers that strain communication between Latino families and their daughters.

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Supported Education Services

Prior to the development of LIP, community members, specifically adolescent Latinas, expressed that educational enrichment would improve the girls' low self-esteem. The adolescents felt that lack of educational attainment and low marks in school negatively affected their sense of identity, which, in conjunction with their community-wide and familial struggles, contributed to a diminished sense of self-worth. Feelings of distress related to academic failure can be seen as a part of the adolescent Latina narrative where suicidal ideation is a concern (Gulbas and Zayas, 2015).

LIP focuses on academic growth by helping participants with current school work, as well as engaging in activities that will help them further their education. According to Rosa Cifre, Chief Program Officer, girls' academic success increases when they know there is always a resource at LIP to get the help and attention they need with their schoolwork. Studies find that very few Latino children and their immigrant parents have academic expectations congruent with their career aspirations (Chavira, Cooper, and Vasquez-Salgado; Hausmann-Stabile, Gulbas, and Zayas, 2013). Similarly, a qualitative study of Latino students in low-income communities provides suggestions to improve their chances of attending college (McWhirter, Luginbuhl, and Brown, 2014). The most common suggestions among these adolescents thematically include pleas for their school to provide motivational and informational support, structured community engagement, and academic support (McWhirter, Luginbuhl, and Brown, 2014), all of which are addressed in the Supported Education Services component of LIP. The role of LIP staff is to become a resource for the child and family. Furthermore, discord between child aspirations and parental expectations for their future can be detrimental, especially because the parents of suicidal Latinas show lower aspirations for their girls (Gulbas & Zayas, 2015). Therefore, LIP's role in guiding Latinas through the steps required to obtain their goals is crucial to their success and wellbeing.

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Creative Expression Therapy

LIP provides girls with an emotionally- and culturally-informed outlet for coping and expressing feelings through creative expression therapy. In therapy, “communication covers the transformation of the experience to dialogue between client and therapist” (Blomdahl et al, 2013).

According to Blomdahl and colleagues (2013), art therapy mediates the client’s ability to self-express by providing a non-verbal outlet through the “use of colors, symbols... and physical movement.” In addition to art therapy, participants may also engage in music therapy, which can include expression using instruments, voice, and improvisation in both an individual and collaborative atmosphere. Dance therapy has also been used when certified therapists have been available.

Communication becomes especially important in the lives of Latina adolescents experiencing suicidal ideation because both emotional suppression and thoughts of suicide are linked to future suicide attempts, especially if the adolescent has been exposed to adverse events (Kaplow et al, 2014). In adolescents, art therapy has been shown to reduce trauma-related symptoms and provide imagery as a guide for verbalizing their experiences among peers (Lyshak-Stelzer, Singer, & Chemtob, 2007). Additionally, both adult and adolescent Latinos endorse a need for social connection and cultural enrichment activities in suicide prevention and cite creative engagement as a means of fulfilling this (Ford-Paz et al, 2015). The use of creative expression therapy in LIP combines the need for adolescent Latinas to communicate and to engage in culturally-relevant activities.

The Focus on Group Therapy

While LIP clients receive individual psychotherapy, the group component is considered equally important. Anecdotally, Dr. Gil expresses that, frequently, a cultural gap may impede expression in a one-on-one psychotherapeutic setting and that Latina girls may better communicate themselves in a group context, feeling validated by the experiences of their peers. This is why the creative expression therapies are offered in a group format.

Prior research supports culturally-sensitive group treatment for Latinas specifically (Stracciarini, O’Keefe, and Mathews, 2007). Group therapy has been recognized as most effective when the leader is able to incorporate Latino values, cultural activities, and accessibility to their participants (Stracciarini, O’Keefe, and Mathews, 2007). Since Latinas experiencing suicidal ideation endorse an “inability to forge a grounded experience” (Gulbas & Zayas, 2015) and a desire for community involvement (Ford-Paz et al, 2015), the validation and social connection that can occur in a group context of peers, in gender, age, and culture, can be therapeutic to the individual.

Dr. Gil also shares a concern over the forward approach of interpersonal psychotherapy, where the client is asked to speak about their concerns in a one-on-one setting, stating that Latinas may never have learned this concept as an option. This speaks to the theme of “confianza” (Roll, Millen, & Martinez, 1980) and “personalismo,” (Organista, 2000) which, together, represent building interpersonal trust in a relationship. This is not unlike the idea of creating a therapeutic alliance; which, according to Wintersadolescent, Mensinger, & Diamond (2005), requires that the clinician be cognizant of both gender and

race-related needs in adolescents to maintain both patient and therapists' sense of alliance. For Latinas, this may not be achieved in a one-on-one setting, where the therapist can come across as an authoritative other instead of a leader that embraces the identity of a Latina adolescent. LIP, therefore, focuses on maintaining a bilingual and culturally-sensitive staff with knowledge of the unique challenges faced during female adolescence, which reinforces these factors necessary to maintain engagement and help clients achieve their goals.

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Wellness

To promote overall wellness, LIP also focuses on helping adolescent Latinas make healthy choices for their physical wellbeing. During the initial stages of the LIP program, adolescent Latinas in the community expressed concerns over low self-esteem stemming from negative appearance-related comments from their peers, what we refer to as “bullying” today. Adding to the issue, access to a proper diet is a challenge in the communities LIP serves. The interaction between community concerns revolving around negative self-image and inadequate diet or exercise contributed to developing the Wellness component of LIP.

Studies link access to a healthy, fruit-and-vegetable rich diet to consumption. However, a study by Jack et al (2013) specifically analyzes the consumption of such a diet by New Yorkers living in areas where access is limited shows that access alone is not enough. For females especially, education about food-related health behaviors increases the likelihood of consumption across neighborhoods and remains salient despite zip-code poverty levels (Jack et al, 2013). In adolescents, negative body image may also serve as a risk factor for self-injury in both clinical and general populations (Muehlenkamp & Brausch, 2011). Providing LIP clients with adequate knowledge and self-efficacy to make healthier choices related to their bodies can thus act as a mediator and be potentially life-saving. Clients learn about healthy diet and exercise. The girls are able to develop mastery in this area by cooking for the group and on Family Day, when they can cook for their families. Exercise activities should include relaxation techniques such as yoga as well as active techniques such as dance or cardio. The Wellness component of LIP addresses the educational aspect of health behaviors to empower young Latinas to make healthier food choices.

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2. Intervention

a. Recruitment

Sources

Recruitment and referral activities are the under the responsibility of the Program Director and Case Manager. All outreach efforts are documented and kept on file.

Participants are referred from community agencies, including:

- Comunilife's Vida Guidance Center,
- Hospitals,
- Medical facilities,
- Schools,
- Churches,
- Courts, and
- Other Comunilife programs.
- Many are self-referred or referred by other clients.

Recruitment activities

LIP should already have marketing strategies in place in conjunction with outreach efforts. LIP should prepare pamphlets and materials informing potential LIP participants and family about LIP activities and services.

Recruitment materials can be found in Appendix.

b. Referrals

Process for New Referrals

The Program Director is responsible for:

- Screening all referrals made by telephone.
- Ensure that a Referral Form is completed for all cases referred.
- Walk-in potential participants will be seen by the Program Director or Case Manager.
- All referrals, callers, and walk-ins deemed appropriate will be scheduled for intake.
- All crisis/emergency calls or walk-ins are immediately referred to:
 - 911;
 - Police, if appropriate;
 - Hospital Emergency Room;
 - In the Bronx, Vida Guidance Center.
- Adolescents are encouraged to attend the program activities without expectations to continue to participate.

Inclusion Criteria

Criteria for admission to the LIP Program are:

- Must be a Latina female;
- 12-17 years of age with a psychiatric diagnosis: mood disorder and symptoms of suicide ideation and suicide attempts;
- Receiving psychiatric treatment in an out-patient client mental health clinic;
- Attending school.
- Parental consent and agreement to participate in the program is required.

The Life is Precious Program serves Latina adolescents and their families without regard to race, religion, sex, disability, national origin, sexual preference, immigration status. There is no cost for the services provided.

Intake Process

A staff member is assigned to a potential client, and an appointment for an initial assessment is scheduled. The intake process consists of gathering, preparing and obtaining signatures for the following:

- Psychosocial information is gathered and documented involving the adolescent and parent(s)/Guardian(s)
- Multicultural Relational Approach Assessment is conducted
- Activity Assessment is conducted

- Services Agreement is prepared for parent/guardian to consent accepting Life is Precious services
- School Release of Information
- Adolescent Depression Scale (Reynolds)
- Suicide Ideation Questionnaire (Reynolds)
- Trauma Symptom Checklist for Children (Briere)
- Family Adaptability & Cohesion Evaluation Scale (FACES II)
- Participant's long-term and short-term goals

Initial Assessment

The staff member:

1. Gathers information relevant to the adolescent and family current status.
2. Discusses the meaning of services with the adolescent and family, and assesses their understanding and willingness to be involved in the program.
3. Explains the confidential nature of services and the legal exceptions to confidentiality such as cases of child abuse and neglect, suicidal/homicidal ideation, etc.
4. Obtains a signed consent for treatment.
5. If a parent refuses to sign, the worker must clarify that this constitutes a refusal of services.
6. If the consent for services is not signed, services should not be provided. In this case, the refusal to sign and a summary of the discussion are to be noted on the Consent Form.
7. Where relevant, obtains a signed HIPAA compliant "Request for Release of Confidential Information" from the client to obtain information from other providers.
8. This consent must be obtained and mailed immediately.
9. No signed consent forms should be placed in the chart for future use.
10. If at any point during the adolescent/family participation in the program, information regarding the adolescent/family is requested by another service provider, it may be released ONLY with the signed consent of the parent.
11. The parent must be informed that s/he has the right to revoke consent at any time prior to the release of information.
12. If consent is revoked, information will not be sent unless the record is subpoenaed by a judge.
13. Completes a Psychosocial.
14. A Psycho-social or Psycho-social Update can be completed on an adolescent/family who received services before and the case was closed.
15. Completes a client Health Assessment and advises the parent of the program's requirement for an annual physical exam/medical evaluation.
16. Discussion of the need for medical evaluation must be conducted and documented. Continuous refusal to obtain an annual physical exam may be incorporated in the

counseling and case management efforts, with the goal of enabling the adolescent/parent to seek medical care.

17. When necessary and requested, the worker will make a referral and facilitate the client's receipt of a physical examination.
18. If the health assessment reveals tobacco use, the worker will offer a referral to cessation programs.
19. If the adolescent is not appropriate for services, the worker will recommend and/or make the appropriate referral.
20. Enters the dates of appointments scheduled and whether they were kept, failed or canceled in the adolescent's case record.
21. Enters a "Progress Note" in the case record for each session indicating the date, the length of the session in minutes and significant content of the session.

Intake Disposition and Admission

1. Admission to the program occurs after the intake is completed. Life is Precious is respectful of the adolescent/family need for time to accept services; therefore, it may take several weeks for the family to decide to enroll the adolescent in the program. During this time the program staff is expected to maintain contact with the family and document outreach efforts.
2. All intakes are presented and discussed with the Program Director.
3. If the adolescent is not admitted:
4. A referral must be offered and documented in the Case Record b. The reason not to admit must be recorded in the Case Record; and
5. A letter will be sent to the referral source informing it of the case disposition.
6. If the adolescent/family does not return for further services while in the midst of the intake process, a Disposition Note is to be entered in the Case Record or the "Client Screening Information Form"; and
7. The record is to be filed in the "Not Accepted" file.
8. At the time of admission, and throughout the course of their participation in services, families should be assessed for the need and eligibility for supportive social services. The Case Manager is responsible for facilitating the client's receipt of the following and similar entitlements:
 - a. Public Assistance
 - b. Food Stamps
 - c. Medicaid
 - d. Supplemental Security Income
 - e. Home Energy Assistance
 - f. Reduced fares for public transportation

Readmission Procedure

Previously discharged participants seeking readmission will go through the standard intake procedure. A Psychosocial Update can be completed on an adolescent/family who received services before and the case was closed.

Process for Ineligible Referrals

When a Case Manager encounters a referral that is ineligible for LIP's services based on the abovementioned criteria, s/he advises the referral to visit other local services that may be able to provide assistance (e.g. a local Boys and Girls Club).

c. Engagement

As has been discussed, the presence of an alliance in therapeutic relationships is important in engaging clients throughout treatment. Part of relating to the client when working with Latinas is building this sense of interpersonal trust, or *confianza* (Roll, Millen, and Martinez, 1980). Becoming familiar with team members can encourage client engagement.

Activities that support strong engagement include the following:

1. Introduce the team to clients and their families.

“Clients and family members need to know all team members.” The client will have the opportunity to meet team members as they attend the program and participate in group activities. During this time, they will also be introduced to other participants who will be joining the client in group.

The Case Manager’s priority upon client admission is to conduct an initial home visit. During this home visit, the parent will meet the case manager and a needs assessment will be conducted. This initial visit helps to establish the LIP team as allies of the client and their parents. Thereafter, parents will have ample opportunities to meet team members and the parents of other participants.

2. Build rapport and provide support.

“Many things, large and small, are important in building rapport but a few stand out as critical. First, the team must always solicit the client’s view of what’s going on. Coming to terms with any diagnosis is a process, and the team needs to be involved respectfully in that process. As progress or setbacks occurs, the understanding of “what the problem is” will undergo revisions in light of the experience. This is all part of the process of coming to terms with a diagnosis. Some clients and families will need basic educational information regarding *suicidality*. The team must support clients and families as they make treatment decisions, be respectful when clients ask for additional information, and provide practical support as needed within specific domains. “

“Practical support may be needed in many areas, including ensuring provision of adequate housing *for the family*, securing financial resources, or helping clients’ *families* get their needs met in the community.

For Case Managers especially, rapport-building does not end with the clients and their families. The LIP team will be expected to become familiar with community resources and each client’s school support team (teachers, counselors, principals) and therapist. Building collaborative relationships within the child’s system will allow the LIP team to best address the needs of the participant within and outside of the program. Case Managers and LIP staff should not be discouraged if parents and participants are reluctant to share during the initial interview and assessment. Sharing personal and family information can be overwhelming; therefore, be thorough, but do not rush to gain confidence and trust. These are made by building the rapport and relationships over time.

3. Involve families.

For Latina adolescents, family involvement is critical to engagement and a necessary part of recovery. Showing respect for parents’ concerns begins at the doors of LIP, where

the child is required to contact their guardian with the LIP office phone to inform them they have arrived. Likewise, when the child leaves, the parent is informed. This maintains open lines of communication and ensures that parents are connected and aware of their child's activities.

"The team involves family members in recovery planning and supporting the clients. It is important to remember that clients and family members will not always agree. Mediating conflicts between clients and family members will be an important role for the team." Family Day, which occurs weekly on Tuesdays, Fridays, and Saturdays, allows families the opportunity to bond and provide support for their children and one another.

In addition, clients and families often have little or no experience with *suicidality* or the mental health system. Any previous contact with the mental health system may have resulted in ambiguous diagnoses and uncertain prognosis; thus, clients and family members may have negative feelings towards mental health treatment and may have difficulty coping with the trauma of *suicidality*. Families may need help adjusting their expectations so that they are able to convey hope for recovery, while clients may need help restoring self-confidence following their experience with *suicidality* and treatment.

4. Conduct needs assessment.

"The needs assessment will reflect an ongoing process of discussion and collection of information. While this process is initially headed up by the Case Manager, the ongoing review and evaluation of needs requires the involvement of all team members." *The Case Manager will be the main resource between the parents, child, and the child's educational and support system.*

For example, all individuals will be screened for lifetime traumatic events and possible associated symptoms, and history of and current suicidality. There is also an element of needs assessment that is processes that unfolds over time as the members of the team and the client work with and learn about each other. Importantly, needs assessment must include identifying and highlighting clients' strengths, and team members must remember to ask about and build on strengths as they begin work in their individual domains." *Although the Case Manager is mainly responsible for this task, it is necessary to work with team members to understand the changing needs to the child and address those as needed.*

d. Conduct Assessments

Evaluation and Data Collection Procedures

Assessments

The program utilizes multiple methods (e.g., focus groups, interviews, surveys, review of meeting minutes, chart reviews) to capture information related to the effectiveness of the program and the degree of adolescents' and parents' satisfaction. The following baseline instruments are being administered before, during (on a quarterly basis), and after the program:

- Columbia Suicide Severity Rating Scale (C-SSRS)
- "About My Life" - High School Suicide Ideation Questionnaire (SIQ)
- "About Myself" – Reynolds Adolescent Depression Scale (RADS-2)
- Trauma Symptom Checklist for Children (TSCC)
- Family Adaptability & Cohesion Evaluation Scale (FACES II)

In addition, case managers follow up with participants to assess progress made on short-term and long-term goals. Depending on their attendance rate to the LIP program, these assessments can be conducted more frequently or less frequently. Case managers work with participants to help them vocalize and plan to reach their goals.

Treatment Planning

All participating clients in Life is Precious must be engaged in mental health services with both a therapist and psychiatrist. If a client is accepted into the program and does not have a mental health provider, the program must refer and ensure that she receives treatment.

The program must establish and maintain collaborative relationship with the mental health providers working with enrolled adolescents.

e. Ongoing Interventions and Treatment

Ongoing Interventions

Ongoing interventions stem from among the core LIP components: Outpatient Mental Health Treatment, Family Support, Supported Education, Creative Expression Therapy, and Wellness.

Outpatient Mental Health Treatment

All participants are required to receive mental health treatment at an outpatient clinic, either through Comunilife's clinic or another provider, for continued care of the psychiatric diagnosis. The Latinas have both a therapist and psychiatrist as part of their mental health treatment team. The therapist discusses and listens to how the girl is feeling and what is going on in her life, while the psychiatrist conducts the medical aspect of treatment and prescribes medications, if necessary. For example, participants who attend LIP in the Bronx site receive therapy from Vida Guidance Center, an out-client mental health clinic located on the first floor of the same building as LIP. Some of the girls in Brooklyn are referred to Woodhull Medical Center. Referrals are also provided for those girls who do not meet eligibility requirements to participate in LIP.

If participants enter the program and need referrals, LIP case managers can assist the participant and family in obtaining ones for local providers, and assisting with making the initial appointment. In particular, case managers follow up with the girls who are referred from emergency departments to assure continuity of mental health treatment, and provide case management and counseling to connect the clients with services and improve their coping and interpersonal skills. There are cases in which the participant's health insurance is not accepted; then, LIP helps the parents and girls to transfer elsewhere.

The LIP program uses a Multicultural Relational Approach for Diverse Populations as the core of service delivery. Upon gaining parental permission and within federal privacy guidelines, LIP case managers contact participants' therapists, and maintain relationships with them to receive regular updates and understand the girls better. Some of the participants feel more vulnerable with the therapist and will share thoughts and feelings that they hide at LIP. Case managers discuss what is going on in therapy, what areas or topics to focus on, and methods in which LIP can help.

Family Support

Before providing services to the participant and the family, LIP is required to obtain HIPAA consent forms. Consent allows case managers to disclose information to parents and members involved in the participants' care, and for participants and their family members to disclose information to LIP. During the initial intake, both the child and the parents are interviewed. As some problems may stem from home and the family, it is important that everyone understands the confidentiality agreement. The parents are briefed about their child before the case manager talks to therapists; therefore, LIP must create an outline with the participant to inform her about what will be shared with her parents, as LIP is required to disclose any necessary information.

LIP maintains regular communication with the parents, and should build a rapport with them. Parents may call when they cannot get in touch with girls. Upon arrival at LIP, the girls hand in their cell phones to the case managers or LIP staff, and call their parents

using the LIP phone so the parents can confirm that the girls are at LIP. Parents are welcome to call or walk-in whenever they desire if they need anything. In addition, all the participants receive home visits, including an introductory visit soon after enrollment.

LIP addresses family conflicts and tension in various ways. Programs may designate particular days as Family Days, where family activities are planned. Family Days may take place on Saturdays, and/or another weekday, to provide flexibility to working families. Parents and siblings accompany the participants to the program and engage in activities or special events together. There are family art activities, group discussions, games, field trips, and drum circles with the music teacher and therapist. Parents can communicate concerns and progress at this time and LIP can assist with conflict mediation and resolution. Some activities are performed together such as healing circles with a therapist, during which parents and girls apologize for mistreatment and talk about things that have happened. Other activities such as group family interventions are done separately. LIP strongly encourages the parents to attend consistently to connect with the girls, communicate concerns, and discuss progress in an open environment.

LIP may serve as a mediator between the girls and their parents, allowing both parties to express their concerns in a neutral environment. LIP performs outreach to the parents to see how the girls are doing, whether anything is new, and encourages them to attend group sessions.

In addition, LIP offers programs specifically for the parents: *Tertulias* and Dominoes Club. A *tertulia* is an intimate gathering of trusted friends where women can explore any areas of importance to them. LIP borrows this well-known and comfort-inducing name and approach to engage the participants' mothers. They learn how to better communicate with their daughters, recognize and be sensitive to struggles for independence, realize the importance of confidentiality and trust, and learn how to negotiate and arrive at mutually satisfactory compromises within the context of unconditional love and acceptance. The Dominoes Club capitalizes on a universally popular game and venue for socialization among men in Hispanic countries. LIP brings fathers and other significant male figures together, involving them in their children's lives, and helping with jobs, housing, legal issues, and other social services. Parents discover the cross cultural issues that can result in conflict with their daughters, such as perspectives on dating and women's domestic roles and responsibilities.

Concrete services available for parents beyond the needs of the kids include: English as a Second Language (ESL) classes, housing advocacy and resources, transportation, food, and referrals to community services. LIP case managers can accompany parents to court to settle problems such as child support, and provide employment services for parents who are having trouble finding a job. They also help with food stamps, financial guidance, health insurance such as Medicaid, and home goods. Understanding the financial situation of many of the participants and their families, LIP provides MetroCards for transportation and snacks.

When participants have stronger communication among family members and more support, they develop more positive attitudes. These attitudes and change in perspective translate to how they act in school. The participants are more open to speaking with people and making friends, and are less shy. LIP also commits to strong communication between LIP staff and participants' families, conducting outreach via phone calls and letters. LIP remains involved with the girls, even when they do not show up to LIP for a few weeks. The

girls are more likely to attend LIP when they are encouraged by the parents, so the family is of great importance to the overall effectiveness of the LIP program. Although parental involvement and contact can be a great challenge, LIP must continue forging positive relationships with the parents. Activities that parents can help with include cooking, chaperoning during trips, and both motivating one another and sharing with one another. Parents can be a support system for each other.

Supported Education Services

All participants are required to be in school while attending LIP. Before getting involved in the participants' schools, the case managers need to get HIPAA training and consent from the participants and the parents to contact the schools and disclose information with the guidance counselors, teachers, administration, and principals, adhering to federal privacy guidelines. Tutors get HIPAA training as well to learn legal boundaries, and comply with LIP regulations and policies.

Supported Education Services include: tutoring and homework help; SAT and standardized test preparation; college preparation; writing workshops; computer lab with Internet access; vocational exploration and internships; and linkages, collaboration and advocacy with the participants' schools. As LIP is a drop-in program, girls arrive at different times. Case managers, therapists, and tutors first ask if they have any homework so the girls can work on it until the group session or snack time starts. (LIP hours are from 10am-7pm, and group hours usually range from 3pm-7pm.)

One of the main academic services at LIP is tutoring, and the girls start off each day at LIP with their homework. Tutors help participants individually or in groups with math, English, science, social studies and history. English language arts assignments usually consist of common core assignments, composition writing, narratives, and book reports. There are both paid and unpaid tutors; some are recruited from nearby universities while others apply independently. Fordham University students can get course credit for tutoring. Paid tutors must be able to travel (rotate among the three sites), go through a separate onboarding process with the case manager, and get fingerprints taken. They have flexible schedules, working a few days a week, and commit to work with LIP for a minimum of one academic year. Only paid tutors are authorized to access personal health information and input data into the system as participants' information is sensitive. Tutors look for additional methods to motivate the girls to study; for example, LIP has an "Academic All-Star Wall" to display academic achievements.

In addition, case managers conduct school visits to obtain report cards, develop plans for improvement, speak with the guidance counselor, or attend parent-teacher conferences if a parent cannot attend or wants to go together due to language barriers. They also help parents navigate the education systems. Case managers retrieve missed work for students if they are hospitalized. Case managers work with the guidance counselor if participants need help with their individualized education programs (IEP) or have problems going to school or cutting class. Visiting schools not only establishes cooperation with teachers, guidance counselors, principals, and administration, but also reinforces the relationships built with the girls as they get very excited when case managers show up to their schools. They also meet with teachers to see how students can improve. Parents appreciate the help because teachers and guidance counselors may only speak English, while some parents may only speak Spanish.

Case managers work with school staff to help solve behavioral problems by understanding why girls are cutting classes and providing ideas and ways to have them attend. They seek to resolve conflicts and bullying through mediation. Participants' behaviors in school have changed; when the girls understand the work and lessons, their grades improve and they feel more comfortable in the classroom. They do not feel as much pressure to compete for help in the classroom, and are more willing to put in more effort and attend classes. Therefore, the ability to help girls pass their exams and improve in classes is crucial to LIP staff; improved academic performance helps the girls improve their self-esteem and look toward the future and aspire to go to college.

In order to build relationships with the schools and communities, LIP can optionally perform outreach and attend health fairs. They can provide training programs and workshops on suicidal ideation and mental health first aide at schools. However, these are not integral components of LIP.

Creative Expression Therapy

Creative Expression Therapy, a key clinical therapeutic component of the program, integrates human development, fine arts and psychotherapy, while enhancing recovery, health and wellness. This modality enables an indirect and thereby safer way to communicate, which in turn helps the girls identify, experience, and verbalize emotions that may be blocking the actualization of their interests and talents. Rather, creative expression therapy provides a visual or auditory way to communicate. This is particularly important for Latina adolescents who are often expected to be submissive and introverted. It also facilitates staff assessment of participants' developmental, emotional, and cognitive levels.

As part of the creative expression therapy program, licensed art and music therapists conduct a variety of activities, which may include: self-portraits, dance and movement, movement exploration, relaxation, drumming, photography, framing artwork, jewelry making, sewing, stationery and card making, yoga, singing, song writing or song building, instrumental lessons, drama and acting. The therapists and teachers look at the goals for each participant, using a strength-based approach. Creative expression therapy occurs after the girls complete their homework. At the beginning of each session, staff members formally introduce themselves and anyone who is new to LIP; again, as LIP is a drop-in program with new participants enrolling at various times, therapists should make an extra effort to help the girls feel comfortable during group sessions.

Art Therapy

The art therapist does not follow a set curriculum, but works with the girls wherever they are at the present moment; sometimes, they are allowed to do freestyle art activities in which they work on whatever they want with no direction. More often, the art therapist uses a mixture of Cognitive Behavioral Therapy (CBT), psychoanalysis, and object relations therapy, focusing on relationships, and being mindful of one's thoughts and feelings. S/he can choose to use directives, which are lesson plans with activities and follow up questions, or choose to improvise the lessons as directives are scarce and limited. Before running group sessions, the art therapist asks case managers if they have anything they want to address that day, whether it is self-confidence, body issues, drug use,

prostitution, adolescent development or puberty. During the session, the art therapist can point out aspects that show up in the art itself that the girls may not have been aware of.

Different mediums should be utilized during art therapy: air dry clay, paint, drawing, oil pastels, chalk pastels, and photography. The girls enjoy crafts such as beadwork and box decoration. The art therapist can use the theme of boxes to hide things inside or create things to put in there that the girls don't want to share with other people.

Additional activities include cultural and educational field trips. The girls visited El Museo del Barrio, where teaching artists held sessions, the Brooklyn Museum, and the Studio Museum in Harlem. Completed art projects can be posted in the hallways. Throughout the sessions, the therapist can discuss different needs, goals, and problems for each girl and formulate a plan with them. Art therapists should speak closely with case managers and other therapists in order to build activities with a common purpose.

At a minimum, the program should have space for art with a large table and access to materials needed to produce it. There needs to be an annual budget for equipment and art supplies in different mediums. Additionally, depending on available resources, programs may wish to provide a separate room for art, so that art materials can dry or sit after group sessions, and so the girls do not need to clear their workspaces for snack. Other staff members should receive initial training about how art therapy groups function and what it is. For example, other people may want to intervene and say "I really like that drawing," but that's not the goal of art therapy because it makes people self-conscious about their work and might prevent them from adding a certain element that they would've added otherwise. The training needs to teach how non-art therapists can help and how to back off. We need to educate other staff. A program may also want to provide an art teacher, distinguished from the art therapist, to teach students about the mechanisms of creating art and various art skills.

Music Therapy

The music component of creative expression therapy includes a therapeutic part and a technical part. The music therapist, in contrast to the music teacher, works with the psychological component, thoughtful process of music, and cognizance that comes to playing music. The therapist is more flexible and encourages the girls to write songs, sing live karaoke, and build cohesion, teamwork, communication skills, and eye contact with each other. The therapist helps run group sessions, choosing activities depending on what's happening at the moment and who is attending the session, and looking at the therapeutic goals for each participant and using the groups to help facilitate reaching the goals. LIP has team meetings to discuss where every student is and their interests; collaboratively, case managers and therapists can provide the best therapy and activities for them. A strength-based approach is used because a lot of girls are told they can't do things or it's harder for them to do things. Through music and art, the therapists can work on countering that mindset. The therapist helps participants practice focus, which is a big goal for adolescents in general because now, people are constantly using their cell phones and getting distracted. During music therapy, the girls are constantly redirected to stay on task.

Before the girls arrive at LIP, the music therapist displays the different instruments and arranges the chairs in a circle so everyone can see each other during group. Small instruments can be placed in the middle or on the chairs; that way, the girls can pick whichever instrument they gravitate to on that day. To start or warm up, the therapist

leads an introductory activity and everyone gets a turn. The therapist can work on songs the girls bring in, whether they are Spanish songs or the last three songs the girls have listened to. If they are listening to Drake, they discuss the lyrics and music. The therapist needs to build positive rapport with each participant first to gain the trust to talk about more serious topics such as cutting or hospitalization. During group session, everyone is included, even if a girl is not playing on an instrument. Then, she can become familiar with music and instruments, and open up more. In fact, some girls may have an aversion to music, saying “I’m not a musician” or “I don’t play piano.” However, that is irrelevant to music therapy because everyone is musical and gets the opportunity to try. After, the girls can work on beats and rhythms to create an atmosphere where everyone and the music naturally fit together. Using familiar songs helps in large groups so that more people can join in. The therapist needs to look out for everyone so the more musical girls do not take over the session, and then s/he closes group in a way that no one is left out.

The music therapist can also help the girls with their college applications and auditions if they are interested in pursuing music. In addition, the therapist or another LIP employee who knows how to play instruments can play outside of the group session; at times, girls feel more comfortable doing homework when there is music or drumming in the background. Finally, only a trained music therapist can analyze the lyrics if a girl wants to bring in her lyrics and talk about them.

Music Teacher

The music teacher’s role is to be more instructive as far as teaching music theory, musical instruments, group lessons, and individual lessons. The teacher instills discipline and musical skills to LIP participants. The music teacher does not use a specific curriculum because, as a walk-in program, the girls are not obligated to attend LIP every day. In addition, girls are at different musical levels as some have had exposure in school while others have not. Developing music skills is more effective when the girls show up consistently and practice what they have learned. Still, it would be helpful to have organization or structure throughout a given week, and coordination with the other music teacher so the girls have some continuity in the music lessons.

During sessions with the music teacher, the girls learn instruments, work on voice, have karaoke sessions, attend traditional music classes, learn about song writing, and have jam sessions. The girls can come in with lyrics, and the teacher can help her find the chords and complete the song. During group activities such as imitation games, the girls learn teamwork. Moreover, some girls find music production more fun and interesting than playing the instruments. They can work on the computer and software to record or make music that way. On Saturdays, the girls compose, making lyrics and music for an annual performance in October.

The music therapist and teachers believe that the minimum necessary to start the music program are:

- Keyboard or piano
- Guitar
- Full drum set, djembes, congas, shakers
- Recording equipment: microphones, speakers, amps and a computer
- Supplemental Instruments: violins, violas, cellos, xylophones, electric instruments
- Sound-proof room

Drum circles help build cohesion and release stress and anger. Song writing allows girls to express their feelings and share what is going on in their lives. Every year, they write a song to present at a corporate meeting. Pop music serves as a means of engagement; when the girls have a common song they are interested in, the music therapist prints out the lyrics and puts them in a binder so everyone knows the songs and can sing together. They also enjoy “improv” and freestyle with the beat-making software as many are interested in rap music; sometimes, the girls sit in a circle and pass around the mic to give everyone a chance to freestyle or say something.

Participants enjoy the creative arts component because it creates a social environment where the girls can be themselves and be relaxed. They can build positive rapport and feel comfortable and accepted, whereas they may be bullied at school. The group activities teach better suicide prevention and coping skills with a professional therapist, and build cohesion because everyone is working together. Finally, the participants can display their artwork in the hallway, listen to their recordings, and even have performances in front of others, which act as a finalized or substantial product for their efforts. LIP puts on annual and public performances such as holiday concerts and the annual Comunilife Anniversary Breakfast in October or November.

Wellness

The wellness component and healthy initiative focuses on helping the participants build a healthy lifestyle every day, including physical, emotional, and mental wellness. They are taught healthy living and which foods are nutritious and cheap at local supermarkets. Other topics such as weight, friendships, romantic relationships, and family relations are discussed. Some of the girls suffer from obesity, which makes them targets for bullying at school and conflict at home, and have issues with body image. They may eat alone in their rooms, and eat whatever they want. At the same time, the mothers may not realize that the foods they buy and are accessible to the girls are not nutritious. LIP seeks to change the way the girls think about themselves, making nutrition a part of the therapy process.

With the healthy living initiative, LIP seeks to motivate autonomy and independence by allowing the girls to plan a recipe once a month according to a pre-set schedule, prepare and cook meals together, teach one another recipes, wash the dishes, and clean their space. During other days, the girls’ mothers help out and cook the snacks for the girls. Some locations also have urban gardens where participants can grow their own food. As Latinas come from varying ethnic backgrounds (ie. Asian Latina, European Latina), LIP encourages the girls to explore and teach each other foods from diverse cultures. In addition, LIP seeks to educate parents about healthy eating and living because while the girls may learn about nutrition at LIP, they may be back eating unhealthy food at home. LIP needs to show the parents that they can have a healthy lifestyle on a budget. LIP employees need to be conscious of healthy eating while they are at work because the girls notice and are affected when staff members are eating chips and junk food, but prohibit them from having any.

Participants have access to varying levels of exercise equipment. LIP offers dance therapy, yoga classes, Zumba classes, and exercise during group sessions as well. Other educational programs are provided. The girls get sexual health education through collaboration with Planned Parenthood, and learn about healthy relationships through a domestic violence prevention program in family courts. Case managers cultivate trust with

the participants, and are able to offer relationship advice to them. Every Friday, the girls help clean the LIP office to gain a sense of ownership, pride, and clean space.

In order to implement the wellness component at a minimum, LIP needs a budget for food. The wellness component changes the girls' social behavior; there is a decrease in fighting incidents, and the girls learn to voice and advocate for themselves during instances of bullying. They learn how to seek help, who to go to, how to make friends in a healthy way, and to love themselves. They learn what a healthy friendship looks like and practice communication with other girls in the group, reducing cursing and aggression to interact with others.

As a common goal among all therapists, case managers, and LIP staff, LIP seeks to teach girls general life skills to thrive beyond LIP and high school graduation. Therefore, LIP employees do not always guide the girls throughout the whole process, whether it is during group or snack time; they push the girls to work hard, advocate for themselves at school or at home, and meet in the middle. Because LIP is a flexible program, the girls have control over when to arrive and when to leave; they can make their own choices. They can also view LIP as a consistent alternative and a comfortable place to be without fears of being judged; in the same regard, LIP should help foster positive decision making for the girls and teach them that they can have control over their lives.

High Risk Clients

Policy:

A High Risk List shall be maintained by each program. The High Risk Policy is intended to keep everyone at each program informed as to the clients who are at risk for negative outcomes, the interventions that are in place to address the identified issues, and as a means to assure that all clients are receiving the service they need.

Purpose:

The High Risk List is intended to improve client safety by establishing criteria to identify clients who are at risk for negative outcomes and to assure that approved client-specific interventions are put into place to reduce that risk.

Criteria for Identifying High Risk Clients:

- a) Persistent non-compliance to medication or treatment service plan;
- b) Re-occurring hospitalizations;
- c) Persistent failure to keep scheduled appointments with healthcare providers;
- d) Increase in symptoms/change in physical condition;
- e) Homicidal and/or suicidal threats/ideation;
- f) Involvement in an incident with a harm and/or risk at level 3.

Procedure for Placing Client on High Risk List:

- a) Any staff member can recommend that a client be placed on the High Risk List
- b) The Program Manager *decides whether to* accept the recommendation to add the client to the High Risk List
- c) Date and reason for placement on list is added to the progress notes by the Program Manager;
- d) Program Manager adds client's name to the High Risk List and the date (use of attached High Risk List form is suggested)
- e) High Risk List is maintained in a location accessible to staff so that all are aware of High Risk clients

Guidelines for Developing Client-Specific Interventions to Reduce Client Risk for Negative Outcomes:

- a) Increase in staff observations/face to face contacts (specify frequency)
- b) Check client's medications against prescribed medications
- c) Monitor medication compliance at every client contact. Document client's compliance OR client's reason for non-compliance. If needed, specify interventions utilized to address non-compliance
- d) Review client's scheduled appointments with all healthcare providers
- e) Monitor compliance to scheduled appointments with health care providers at every client contact. Document compliance OR client's reason for non-compliance. If needed, specify interventions utilized to address non-compliance
- f) Specify interventions for persistent drug/alcohol use (if applicable)
- g) Other client-specific interventions to reduce client risk for negative outcomes

- h) Notify client's health care providers about high risk issues and ask for their collaboration
- i) Case Manager and Program Manager/Supervisor meet weekly to evaluate progress.
- j) Program Manager/Supervisor documents meetings in progress notes

Procedures for Removal of Client from High Risk List:

- a) High Risk List is reviewed daily by the program *staff* to ensure compliance with planned interventions and to determine the need of the client to continue *on* or be removed from the list.
- b) Program Manager/Supervisor removes the client's name from the High Risk List when service/treatment goals are met for High Risk issues (when high risk criteria is resolved)
- c) Date and reason for removal are documented in progress notes by Case Manager
- d) If client's name remains on the High Risk List for more than 2 months, the Vice President, Assistant Vice President, and Quality Improvement Office must be informed.

Monitoring High Risk Client Activities:

- a) Increase observations/face to face contacts. Specify frequency.
- b) Monitor client's compliance to medications
 - Monitor compliance to prescribed medications
 - Document compliance OR client's reason for non-compliance
 - Document interventions to address non-compliance
- c) Review client's scheduled appointments with all health care providers
 - Monitor compliance to scheduled appointments
 - Document compliance OR client's reason for non-compliance
 - Document interventions to address non-compliance

Crisis and Emergency Procedures

Crisis

The Program Director is responsible for handling individual crises that come to the attention of the program.

Responsibilities include:

- Providing immediate response and rapid service to adolescents/families currently in crisis suffering a recent trauma.
- Referring such individuals to appropriate agencies for assistance.
- All such contacts will be noted in the case record progress notes.

On-site medical emergencies

An on-site medical emergency occurs when a client becomes physically ill while at the program.

Responsibilities include:

- 9-1-1 Emergency Medical Service (EMS) will be called by the program staff.
- Parent(s) will be called immediately by program staff.

On-site psychiatric emergencies

A psychiatric emergency occurs when a client reports suicidal or homicidal ideation or seems to be presenting acute psychotic symptoms. In case of a psychiatric emergency the following steps must be taken to insure the safety of the client, other participants on the premises, and staff:

- If possible, the adolescent will be taken to a private office or the clinic's conference room by a staff member.
- If the client requires hospitalization, the program staff contacts emergency services (911) while another staff member remains with the client.
- Under no circumstance should the client in crisis be left unsupervised in the office.
- In the Bronx, the psychiatrist writes a referral to the ER specifying the client's symptoms, and the referral is given to the EMS worker to take to the ER.
- The worker will get the 4-digit EMS. Work Order Number to trace the case later if necessary
- Once the adolescent has been taken to the hospital the worker contacts the adolescent's parents and/or emergency contact.
- The worker contacts the Emergency Room Department to inquire about the adolescent's condition and/or disposition.
- If applicable, the Program Director completes an Incident Report.
- The report is faxed to the Quality Improvement Department by the end of the following business day.
- The worker documents the incident and follows up in the adolescent's chart.

Absence from Services

- While quite structured in its underlying program model, LIP presents itself as an informal drop in center where clinical interventions are wrapped around enjoyable activities that engage the adolescents. They are free to attend as frequently as they wish. There are no attendance expectations; however, the program staff maintains contacts with them and their families during period of absences.
- A case may remain inactive for a maximum of 90 days at which point it must be closed. When an inactive case is closed, the LIP case manager completes a Discharge Summary that is placed in the case record.

f. Transition and Discharge Criteria

Discharge:

Due to the inherent flexibility and unconditional acceptance for the client's level of participation, clients may stop attending for periods and may return at some point when they are experiencing hardship. The program maintains an open door policy where we may label a case inactive for up to 90 days.

Discharge Criteria

- Goal Achievement
- Absent for 90 days
- Become of age 18+
- Moved out of the area
- Other (e.g. adolescent pregnancy, residential placement)

Case Records

Each client has a written Case Record that is initiated at her first contact with Life is Precious. The Case Record is a legal and confidential document. Its safety and confidentiality must be ensured at all times. Records are to be kept in locked file cabinets and removed only for the amount of time needed to work with them. Records may not be left in staff offices overnight; they must be returned to the cabinets at the end of each business day. Records must remain on the program premises unless subpoenaed by Court. Access to Case Records is available only to members of the program staff and any agency providing funding.

Documents related to allegations of child abuse must be filed in the Program Director files. Grievances are not to be filed in the Case Record

Case Record and Progress Note Requirements

Case Records:

1. Entries shall be made in non-erasable ink.
2. Must be legible.
3. Will be reviewed periodically for quality and completeness.
4. Entries must be dated and signed by appropriate staff.
5. No white out.

Progress notes must:

1. Be written after every contact with a client or collateral.
2. Document significant events and/or untoward incidents.
3. Be kept in chronological order.
4. Be dated.
5. Indicate the length of session.
6. Be signed by the worker with full signature and title.
7. Be countersigned by a Program Director or designated supervisor if written by an intern.

Quality Assurance

Quality Assurance refers to activities designed to guarantee appropriate, timely, thorough, high quality service provision.

The following activities constitute the Quality Assurance Plan for the program:

- Incident reporting, investigation and management - This is the process by which certain identified occurrences are reported, investigated and reviewed. Review is designed to identify patterns and causes of incidents, and to consider changes in program policies or procedures to minimize or contain incident occurrence
- Monitoring program performance:
 - Program review
 - Program evaluation
 - Client grievance procedure
 - Staff supervision

Incidents

Program staff members are immune from liability when acting in accordance to reporting procedures. The Incident Reporting Policy is intended to:

- Ensure the health and safety of persons receiving services.
- Identify and institute preventive and corrective measures.

Life is Precious staff must report:

- Allegations of child abuse or neglect
- Crimes committed by or against a adolescent/family
- Allegations of abuse or mistreatment
- Deaths
- Missing participant
- Hospitalizations

Incidents are investigated and reported to the appropriate agency in the specified manner.

Definitions:

Comunilife complies with the New York State Office of Mental Health regulation, part 524. The staff at Life is Precious reports incidents occurring under the following definitions:

Client abuse: may include physical, sexual or psychological maltreatment of an adult client by an administrator, employee, consultant or volunteer.

Crime: an event that is or appears to be a crime under local, state or federal law and involves a client, either as a victim or as a perpetrator.

Incident: An event which involves an injury, allegation of abuse or neglect, suicide attempt, unexpected death of a client, any a missing client and/or the possibility of a crime.

Injury: bodily harm, pain or impairment which results in client requiring medical, dental treatment or first aid

Missing Client: a client in a psychiatric hospital, residential treatment facility or other residential program, who has not been accounted for when expected to be present.

Neglect: any action or inaction of a static member that impairs or places an imminent danger of impairment of a client's physical, mental or emotional condition.

Physical Abuse: non-accidental contact with a client that causes or has the potential to cause physical harm or pain such as: hitting, kicking, choking, etc.

Psychological Abuse: any verbal or nonverbal action which is intended to cause a client emotional distress (examples: teasing, taunting, name calling, threats)

Sexual Abuse: sexual contact involving a client and a staff member (the term "staff member" includes employees and volunteers); any sexual contact among non-consenting clients that is allowed or encouraged by any staff member. (Persons under 17 of age are considered non-consenting)

Unexpected Death: death of a client resulting from unexplained or accidental causes; a homicide or suicide; or any death occurring within 24 hours of admission into a program.

Incident Reporting Requirements

Life is Precious complies with Incident Reporting as it may apply.-*The following steps are taken when an incident involves suspected child abuse or neglect on the part of Comunilife staff:*

- Immediate consultation with the Senior Vice President for Programs.
- File report as required (see "Reporting Suspected Child Abuse", below).
- Document incident in the adolescent's chart.
- Incidents will be reviewed by the Incident Review Committee.
- Implementation of administrative/programmatic changes by Program Director.
- Documentation of incident follow-up in the client's chart.

Incident Review Committee

The purpose of the Incident Review Committee is to review all "Untoward Events." An "Untoward Event" is defined as an act or situation that adversely affects the wellbeing of a client. Such an event may include, but is not limited to:

- Serious drug reaction
- Medication error
- Suicide, suicide attempt, or client self-abuse, including
- Accidents and accidental injury
- Fights and assaults
- Fire setting
- Sudden death
- Alleged abuse of clients
- Termination of services against professional advice when such termination presents a risk of hospitalization or danger to the client or others

Composition:

The committee is comprised of the Clinic Director (Bronx), Senior Vice President for Programs, Assistant Vice President for Mental Health Services, and other program staff.

Exemption: Those committee members who are directly involved in the untoward incident being discussed shall be excluded from the meeting as applicable.

Incidents that may require an extraordinary meeting of the Committee include:

- Suicide and suicide attempts
- Sudden deaths
- Child abuse reports

- Assaults

Duties:

- Holds a meeting within a week of an incident.
- Keeps written minutes of its meetings.
- Determines the facts surrounding the incident.
- Recommends any changes in policies, practices, procedures or other action indicated.
- Assures that all death and un-towards incidents have been properly reported.
- The Quality Management Office will be informed regularly of the incidents reviewed by the committee.

Child abuse

A suspected occurrence of child abuse by anyone other than a staff member is not considered an incident as noted above. It is, however, a serious issue, and has reporting obligations laid out in the law. Life is Precious, under New York State Social Service Law 412, is mandated to report suspected incidents of child abuse and neglect.

Definitions:

An "abused child" means a child less than 18 years of age who suffers from sexual abuse, physical beatings, burns, physical dependency on addictive drugs at birth, or substantial risk of physical injury. Child abuse is done when a parent or person legally responsible for the wellbeing of a child commits those acts.

A "maltreated or neglected child" refers to a child less than 18 years of age who suffers from malnutrition, lack of adequate clothing, shelter, medical care, educational care, supervision and/or serious emotional injury. Maltreatment or neglect are acts of omission by a parent or person legally responsible for a child's care.

Basis for Suspicion

The list of descriptive symptoms, facts, opinions, diagnosis or alleged consequences or evidence of abuse or maltreatment may include but are not limited to the following:

Fatality: The consequence of abuse or maltreatment was so severe as to result in child's death.

Fractures: The nature of the fracture or the conditions under which the fracture occurred are such that is reasonable doubt to suspect that such fractures were the result of abuse or maltreatment.

Internal Injuries: Medical evidence indicates the nature of these injuries or there is reasonable cause to suspect such injuries were the result of abuse or maltreatment.

Laceration, Bruise, Welts: The nature of the laceration, bruises, or welts, or the conditions under which they were incurred are such that there is reasonable cause to suspect they were the result of abuse or maltreatment.

Burns, Scalding: The nature of the burns or the conditions under which the scalding was incurred are such that there is reasonable cause to suspect such burns were the result of abuse or maltreatment.

Excessive Corporal Punishment: The excessive use of corporal punishment or discipline to the extent that results in physical injury.

Child's Drug/Alcohol Use: This means that the child is using drugs and/or alcohol and that such activity is the result of parental neglect.

Drug Withdrawal: This means that the child is exhibiting signs of drug withdrawal. This is usually associated with newborn infants.

Lack of Medical Care: This means that the child is showing general evidence of being in poor health and the parents are unable or unwilling to obtain medical advice and/or treatment.

Malnutrition or Failure to Thrive: These are medical conditions usually diagnosed by a physician where the child is exhibiting physical and emotional symptoms such as developmental retardation, dehydration, loss of weight and other physical and emotional signs.

Sexual Abuse: This relates to attempted or actual sexual molestation of the child(ren) committed or allowed to be committed by the parent(s), guardians or other person legally responsible.

Educational Neglect: This refers to children not attending school in accordance with the Compulsory Education Act (Part I of Article 65 of the Education Law).

Emotional Neglect: This refers to children who are showing evidence in their behavior of emotional or mental instability and whose parents are unable or unwilling to acknowledge these problems, the need for treatment, or accept such treatment when available or offered.

Lack of Food, Clothing, Shelter: This means that at least one of the following exists: inadequate supply of food and the child is not getting enough to eat; inadequate supply of clothing and the child does not have clothing sufficient to meet his basic needs; or there is deficiency in housing and living arrangements to the extent that neglect or abuse exists (such deficiencies may relate to housekeeping practices, space, utilities and household equipment).

Lack of Supervision: This means that are either periods of no supervision or an inadequate quality of supervision is provided. "Periods of no supervision" refers to children being left alone without supervision or children being allowed to roam or remain away from home for extended periods and the parents do not know where they are. "Inadequate quality of supervision provided" refers to children being left with a caretaker who is inadequate to the task of supervising them; this also refers to children exposed to hazardous conditions in the home, without the proper safeguards.

Abandonment: This refers to a child who has been deserted by a parent whose present whereabouts are unknown and who apparently has no intention of returning to assume parental responsibilities.

Reporting Suspected Child Abuse

In our professional capacity, as providers of services to individuals and families, we are, by law (SSL Sec. 413), officially mandated reporters. The Social Service laws relative to reporting child abuse also provide for:

Immunity: Officials (Clinicians) are immune to liability when acting in accordance to the reporting requirement.

Penalties: Officials (Clinicians) who willfully fail to do so (report) will be guilty of a Class A misdemeanor and will be civilly liable for the damages proximately caused by such failure.

Confidentiality of reports

The subject of the report may receive, upon request a copy of all information contained in the Central Register. The Commissioner is authorized to prohibit release of data that identifies the person who made the report or who cooperated with the investigation.

However:

There have been instances where the name of the reporter has been revealed. Clinicians should request that their name be withheld if this is important in a specific situation.

Cases of suspected child abuse are reported in accordance with the Child Protective Service Law 84-5 and the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services Administrative Directive 86-1.

This procedure is to be used at Life is Precious when child abuse or neglect is suspected:

- A worker who suspects child abuse or neglect immediately consults with the Program Director.
- The Program Director immediately contacts the Senior Vice President for Programs and a conclusion is reached about the merits of the concern.

If a report is indicated, the Program Director and/or worker must:

- Call the New York State Central Register of Child Abuse-Maltreatment at 1-800-342-3720
- Immediately complete a DDS 2221A and mail it to the local Child Welfare Administration Office: ACS Bronx Office, 192 E 151th Street, Bronx N.Y 10451
Phone: 1-718-579-8890 and 1-718-5579-8889
- The DSS 2221A is kept separate from the chart to insure confidentiality.
- All reports filed are reviewed by the Incident review committee, as noted above.

All Staff and volunteers are required to attend Comunilife's internal Training and Seminar on Child Abuse & Maltreatment and Reporting Guidelines on an annual basis. Upon the completion of this training and seminar, each staff member is required to sign an acknowledgement form stating that he or she has read and understands the information provided regarding the responsibilities and procedures for the reporting of suspected incidences of child abuse or neglect.

Failure to report a suspected case of abuse and/or neglect, and failure to comply with the above procedures constitutes grounds for disciplinary action and will become part of the clinician's personnel record.

Considerations:

Staff are required to evaluate the presence of absence of all minors in the family home including the participating adolescent and the effect of the parent's disability on such minors and to document it in the appropriate section of the client's record.

Where there is a reason to believe that a family has an active case with the Administration for Children's Services (ACS), staff should contact the appropriate ACS field office Case Clearance System to determine if an active case exists. If so, joint management can be initiated if appropriate.

The issues related child abuse or neglect will be addressed in counseling on a regular basis throughout the length of the adolescent's participation in LIP.

Workers may use the list of descriptive symptoms contained in this Manual as a guide for the identification of possible child abuse, maltreatment or neglect. (The list is only a guide and it is not by any means exhaustive).

Client Grievances

The following steps are taken in the resolution of a client's grievance:

- Clients who report any complaint are invited to either complete the "Client Complaint Form," or, if they choose, to present it verbally to the Program Director.
- The Program Director or designee meets with the adolescent/parent to hear the complaint.
- If appropriate, and with the client's and parent's consent, persons involved may be interviewed together to clarify and help resolve the issue.
- At the end of the meeting, the adolescent/parent is advised of his/her right to appeal by either contacting the Senior Vice President for Programs and/or Comunilife's Central administration.
- All grievances are resolved as soon as possible.
- The process is documented on the "Consumer Grievance Review Form" which includes the following data:
 - Date of the Grievance
 - Name of the client
 - Nature of the Grievance
 - Description of disposition
 - Date of disposition
 - Date the client is informed of disposition
 - Client's response to disposition
- The result of the grievance is documented in the case record, if applicable
- Grievance and follow-up is presented on the next Incident Review Committee Meeting

3. Team

Team Member Roles and Responsibilities

Program Director

The Program Director is responsible for directing the overall operations of Comunilife's Life Is Precious. Responsibilities include, but are not limited to management, planning, program development, implementation, monitoring, and budgeting. The Program Coordinator will perform evaluations and maintain Comunilife policies and procedures, quality assurance, utilization review, and outreach activities. The Program Director will collaborate with the Sr. Vice President of Programs to assure quality psychiatric and psychosocial assessments are conducted prior to referral to the Life Is Precious Program.

1. Assume responsibility for the continuous direction and day-to-day operations of the Life is Precious program.
2. Provide supervisory conferences with program staff and maintain relevant documentation.
3. Supervise all program activities and scheduling to be implemented by Case Managers and Creative Art Therapist consultant.
4. Ability to think outside of the box with creating programs that stimulate the interest and are relative as well as age appropriate for young adults.
 - a. Ability to plan and execute career development opportunities for the participants, such as visits to a law firm, mayor's office, or major corporation
5. Ensure that a system of reporting is used in assessing the efficiency and effectiveness of the program staff.
6. Ensure that all program participants are receiving mental health services.
7. Ensure that the staff receives all the necessary support via workshops regarding the management of grief while maintaining professional focus. Ensure staff education and training in multi-cultural, clinical and other issues relevant to the programs' focus.
8. Triage referrals and patient assignments to staff; monitor quality of clinical service and maximize number of individuals served, maintain high level of group therapy.
9. Track outcome studies. Monitor patient satisfaction surveys are completed at time of termination.
10. Collaborate with various community agencies, public officials, and organizations.
11. Supervise all recruitment efforts and ensure timely completion of all staff performance evaluations.
12. Meet on a regular basis with the Vice President of Programs to discuss accomplishments and administrative matters.
13. Represent the program at community providers (e.g. schools, churches and community centers) relevant to the program focus and populations.
14. Plan, organize and supervise all program and family oriented activities; in addition, the Coordinator is responsible for all intake and family engagement.

15. Manage volunteers/tutors
16. Document community activities, outings and development involving families

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES

1. Proven ability to provide strong clinical supervision, administrative skills and analytical thinking to business matters regarding the Life is Precious Program.
2. Thorough knowledge of program development, implementation methodology, and research methods and techniques.
3. Responsible, organized and efficient.
4. Demonstrated ability to perform in a team approach and accomplish multiple assignments simultaneously.
5. Demonstrated skill to communicate effectively in writing, verbally, and to listen actively.
6. Related experience that demonstrates that applicant is community minded, patient, creative, flexible, compassionate and culturally sensitive
7. Ability to deal tactfully and diplomatically with other Comunilife employees, Federal, State and City officials, professional and technique groups, clients and the general public.
8. Ability to plan and successfully implement and gather patient related data for programs.

Qualifications:

M.A. in Psychology
Administrative experience
Bilingual in Spanish/English a plus

Case Manager

The case manager will work with both participants and participants' families. The case manager also acts as a liaison between the participants and corresponding schools and mental health treatment staff. Field work is required (e.g. food shopping for the program, physical activities with participants, outreach and recruitment of tutors and volunteers, most of whom are from Fordham University). In addition, home visits are required, at least once as an introductory visit for every client, and afterward in the case of an emergency, crisis, or if the client is still in contact with the program, but has not attended group. Most case managers opt to visit their clients' homes twice a month for half an hour. The purpose of the home visit is to look at the living space, kitchen and food, and discuss any problems, changes, or improvements with the family. The case manager is actively involved in family interventions, and engagement with school faculty, staff, or administration. Regular school visits are conducted to obtain report cards and get updates on how the participant is doing at school, and to discuss how LIP can improve student's performance in regards to tutoring sessions and annual IEPs; accompany parents and act as an interpreter, as needed, to parent-teacher conferences. Finally, the case manager performs outreach and referral processing. This may include: outreach presentations to hospitals, outpatient mental health providers, and schools. Referrals are processed to ensure timely intake evaluations.

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES

1. Proven ability to provide strong clinical, social skills and analytical thinking to program matters regarding the Life is Precious Program.
2. Thorough knowledge of program development, creativity, and the ability to engage and motivate adolescents.
3. Responsible, organized and efficient.
4. Demonstrated ability to perform ~~in~~ on a team and accomplish multiple assignments simultaneously.
5. Ability to demonstrate active listening and effective written and oral communication.
6. Related experience that demonstrates that the applicant is community-minded, patient, creative, flexible, compassionate, and culturally sensitive
7. Ability to deal tactfully and diplomatically with other Comunilife employees, Federal, State and City officials, professional groups, clients, therapists, and the general public.
8. Ability to plan and successfully implement and gather patient related data for programs.
9. Flexibility to help with participants' and staffs' needs as they arise, such as helping participants with homework
10. Familiarity with the college application process. Ability to aid in education services and resources for the SATs, CollegeBoard, CommonApp, financial aid and FAFSA, fee waivers, and scholarships

Qualifications:

BA or BS in human services field

Experience working with children and families
Bilingual, English/Spanish.

Therapist

Although there is no position for a clinical therapist on the LIP team, every participant must be receiving psychological treatment outside of the program. The therapist can act as a great resource for the LIP team, specifically the Case Manager. A Case Manager may find it beneficial to schedule a meeting with the client, her family, and the therapist should the need for such an intervention arise. The rapport between Case Managers and therapists should be built on reciprocity and partnership. As Case Managers may feel the need to contact the child's therapist with concerns, they may also offer to share how the services provided by LIP can help the client achieve their goals to, ultimately, reduce suicidality and improve the participant's quality of life.

Creative Art Therapist

The Art Therapist is responsible for the delivery of Creative Art Therapy to program clients. Basically the development and implementation of a quality Art therapy through the preparation in one or more of the creative arts therapies, including but not limited to art, music, dance, drama, psychodrama, or poetry therapies. Major responsibilities include the administration of art therapy testing, development and administration of the program, monitoring clients Art therapy progress and building relationships with other agencies.

1. Completion of the Art Therapy assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel, or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts for all clients entering the program.
2. The use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate creative arts therapy services.
3. Establish and maintain all relationships with service providers in the community who provide Art Therapy.
4. Identify new and untapped community resources and share them with management and staff.
5. Responsible for monitoring all clients receiving Art Therapy services in the community and case record documentation.
6. Supervise the timely development of all residents' individualized service plans inclusive of Art Therapy goals.
7. Ensure that program measurable outcomes are attained in a timely manner as per contract.
8. Ensure that the Monthly Report and Summaries are completed on time.
9. Provide residence staff with relevant education and training on Art Therapy issues.
10. Facilitate individual and group counseling to residents.
11. Responsible for liaison functions between the agency and the Art Therapy community service providers.
12. Actively participate in the admission and discharge planning for all residents.
13. Provide statistics for the program progress to include clients progress and success stories of clients' progress and growth in this discipline.
14. Active participation in the weekly interdisciplinary team case conferences and maintain appropriate working relationships with the clinical team members.
15. Attend weekly supervisory conferences with the Assistant Program Director and/or Program Director of Mental Health services, review case records and client's status and progress updates.
16. Participate in mandated in-service training programs.
17. Provide the Asst. Director with information on the status on new referrals on a weekly basis.
18. Aide with non-art related group activities when necessary

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES:

1. Extensive knowledge of principles and practices of Art Therapy services and the various modalities to clients.
2. Responsible, organized, effective, and efficient.
3. Ability to perform multiple assignments simultaneously.
4. Skill to communicate effectively in writing, vocally, and to listen actively.
5. Community minded, patient, creative, flexible, compassionate, and culturally sensitive to persons who are diagnosed with severe/persistent mental illness and Substance Use issues.
6. Ability to deal tactfully and diplomatically with other Comunilife employees, Federal, State, and City officials, professional and technical groups, and the general public.

Qualifications:

Masters or Doctoral Degree in Creative Art Therapy

Two (2) years to five (5) years' experience working as a Creative Art Therapist, being part of a case management team

Individual and group counseling experience

Preference given to persons with experience in bilingual, bicultural programs in Spanish preferred

Experience working with sensitive adolescents preferred

Certifications & Licenses Required:

Valid Bachelor or Masters in Art Therapy.

Music Teacher

Responsible for teaching beginners level Latina adolescents, ages 12 - 17, in varied instruments or one particular instrument such as acoustic guitar, in a group and individual setting. Must be able to develop an appropriate curriculum and help prepare the students for public performances. A concert is planned every year that will take place annually in October. Lessons will take place in the late afternoon/early evening and Saturdays.

1. Develop age-appropriate lesson plans;
2. Conduct group and/or individual lessons;
3. Work with program staff, including the Program Director and creative arts therapists to ensure that the goals of students are being met;
4. Help prepare the students for annual performances, public performances including holiday concerts and annual Comunilife Anniversary Breakfast in October/November.

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES:

1. Some experience in the instruction of varied instruments, but open to someone experienced in one instrument.
2. Familiarity with different music genres
3. Patience for students with no music background
4. Ability to relate to sensitive adolescent girls

Qualifications:

Teaching experience

Experience working with adolescents preferred

Bilingual, English-Spanish, preferred

Physical Demands:

Two hours per day within hours listed, Mon and Wed, from 3:30pm- 7:30pm and Sat 9:00am- 2:00pm

Music Therapist

Responsible for providing music therapy for Latina adolescents, ages 12 - 17, using a variety of instruments, music technology, and lyrical writing, in a group and individual setting. Must be able to develop an appropriate curriculum and participants express themselves through music. The music therapist collaborates with the music teacher and art therapist for creative expression therapy.

1. Conduct group music therapy sessions using varied modalities
2. Work with program staff to ensure client is meeting therapeutic goals
3. Collaborate with other therapists and teachers during group activities
4. Aide with non-music related group activities as needed

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES:

1. The Music Therapist will be able to utilize varied musically therapeutic techniques on a daily basis.
2. Understanding the mechanisms of group techniques. Group protocol includes the following activities: guitar class, hip-hop music therapy, community jam ("La Voz"), Our Song ("La Banda"), and Our Groove.
3. Must be able to work collaboratively on a team.
4. Desire and ability to work with sensitive, Latina adolescents and their families on therapeutic goals.

Qualifications:

Board Certification/State Licensure: Music Therapist
Experience working with adolescents preferred

Physical Demands:

Outreach visits to schools

Tutor

Responsible for providing academic assistance to LIP participants, including, but not limited to: daily homework assignments and studying for up-coming exams, including subject-specific tests and standardized tests, such as the SAT. Must be able to direct participants to the right resources and help as needed.

1. Help with homework assignments and exam review
2. Aid in the college application process, including the essay, college search, scholarship search, applications
3. Review cover letters and resumes for summer internships or jobs
4. Provide additional assistance to LIP, as needed

REQUIRED KNOWLEDGE, SKILLS, & ABILITIES:

1. Understanding of high school level English, Literature, History, Math, and Science.
2. Knowledge of the college application process and CommonApp.
3. Must be able to work collaboratively on a team.
4. Desire and ability to work with sensitive, Latina adolescents and their families on therapeutic goals.

Qualifications:

Minimum of high school diploma

Currently pursuing an undergraduate degree or in the process of completing it

Experience working with adolescents preferred

4. Implementation

Typical Day at LIP

1. Homework
 - a. All participants start the LIP day by studying or completing their homework.
2. Group
 - a. The case manager or therapist gathers all the girls and leads a group session. Each group session has a specific theme. Examples of themes include anti-bullying, reproductive development and sex, personal hygiene, suicidality – ideation and attempts, and current events. The participants hold a discussion on the topic, then express themselves through painting, drawing, music, or poetry. *(It would also be interesting if the group could incorporate dance as a mode of expression as well)*
3. Free Choice
 - a. With whatever remaining time, the participants are free to do the activity of choice, whether that be painting or music or working on college applications.

Goals and Range of Services

Life is Precious has three overarching goals:

1. To ameliorate the level of depression and frequency of suicide ideation among Latina adolescents;
2. To strengthen parent/child relationships and improve family functioning;
3. To demonstrate effectiveness of successful interventions to prevent suicide attempts among young Latinas.

The objectives Life Is Precious uses to further these goals include:

- To improve the social, psychological, academic and vocational competencies of program participants;
- To support the exploration of their interests and the development of their skills and creativity;
- To foster parent/child communication, support parents' involvement with their children, and reduce acculturation stress leading to intergenerational conflicts; and
- To provide concrete and social services for parents, such as advocacy and referrals for immigration, entitlements, employment and housing.

GOAL 1: To ameliorate the level of depression and frequency of suicidal ideation among Latina adolescents

A. Counseling, case management, and concrete services

B. Creative Arts Therapy

Creative Arts Therapy, a key component of the program, integrates human development, fine arts, and psychotherapy, while enhancing recovery, health and wellness. This modality

enables an indirect and thereby safer way to communicate, which in turn helps the girls identify, experience, and verbalize emotions that may be blocking the actualization of their interests and talents. This is particularly important for Latina adolescents that are often expected to be submissive and introverted. It also facilitates staff assessment of participants' developmental, emotional, and cognitive levels.

Specific arts therapy activities may include:

- Self Portraits
- Dance and Movement
- Movement Exploration
- Relaxation
- Drumming
- Photography
- Framing Artwork
- Jewelry Making
- Sewing
- Stationery and Card Making
- Singing, Drama and Acting

C. Educational Enrichment

- SAT and College Preparation
- Writing Workshops
- Tutoring and Homework Help
- Individual and group tutoring is offered daily in math, English, science, and social studies/history.
- "Academic All-Star Wall" - to display the participants' academic achievements and take pride in their work.
- The Internet Cafe: Computer Lab
- Linkages, Collaboration and Advocacy with Schools
- Vocational Exploration/Internships

D. Mentoring

- Peer Ambassadors (Mentors)
- Adult Mentors (Madrinas/Padrinos)

E. Trips, Celebrations and Special Events

GOAL 2: To strengthen parent/child relationships and improve family functioning

A. Family Day

Saturday is designated as "Family Day," where parents may accompany their daughters to the program and engage in activities or special events together. Parents may engage in a separate, parents-only sessions and/or may engage in activities with their daughters, such as working together on an art project.

B. Promoting cultural pride and understanding

Staff facilitates group discussions and activities for adolescents that include presentations about different countries and cultures. This is designed to help adolescents understand why their parent's mode of thinking/acting might be different from theirs.

C. Tertulias

In Hispanic cultures, a tertulia is an intimate gathering of trusted friends where women can explore any areas of importance to them. LIP borrows this well-known and comfort-inducing name and approach to engage participants' mothers. They learn how to better communicate with their daughters, recognize and be sensitive to their struggles for independence, realize the importance of confidentiality and trust; and learn how to negotiate and arrive at mutually satisfactory compromises within the context of unconditional love and acceptance.

D. Dominoes Club

The Dominoes Club is the male counterpart to Tertulias, capitalizing on a universally popular game and venue for socialization among men in Hispanic countries. To bring fathers and other significant male figures together, involve them further in their children's lives, and offer help with jobs, housing, legal issues, etc.

E. Services for Parents (as needed)

- Referrals to English as a Second Language (ESL) classes
- Housing Advocacy
- Transportation
- Food
- Referrals to Community Services

GOAL 3: To contribute to the existing knowledge of the causes of, and successful interventions for, suicide attempts among young Latinas.

- Media and community exposure
- To contribute to the existing knowledge of the causes of suicide among Latina adolescents
- To contribute to the identification of effective interventions
- To decrease the stigma associated with receiving mental health services
- To serve as a healing tool for the participating adolescents

Staffing

Life is Precious continuously maintains an adequate number and appropriate mix of staff to carry out the objectives and to assure the outcomes of the program. Staff positions include:

- Program Director
- Case Manager
- Creative Arts Therapist and/or Creative Arts Therapist Consultant
- Music Teacher
- Tutor

Supervision

Initial probation and performance evaluation

All newly-hired staff has a three month introductory period, which may be extended with the approval of the Senior Vice President for Programs. After the introductory period has been completed, each staff member's job performance is evaluated annually by the Program Director in consultation with the Senior Vice President for Programs.

Ongoing supervision

The Program Director provides regularly scheduled supervision for all staff. Individual supervision occurs by weekly or more frequent if needed, and there is a weekly Clinical Supervision Group. Supervision includes oversight of policy and procedure, and discussion of clinical issues.

Training

Comunilife provides in-house training seminars for employees throughout the year. The seminars cover clinical and socio-cultural issues, and are provided by experienced Comunilife employees and guest speakers.

Training seminars include the following topics:

- Multicultural Relational Approach
- Assessment and Reporting child abuse and neglect (587.89(c)(8))
- Domestic violence
- Assessment of Suicide and Violence
- Mental illness- Depression, Anxiety, etc.
- Substance abuse and drug addiction
- Medication
- HIPAA and confidentiality issues
- Psychological Scales

Comunilife also encourages and facilitates clinical staff attendance at relevant off-site seminars, conferences, etc.

CLIENT RECORDS

Client records include assessment results, which are conducted and recorded every 4 months. Then, the assessments are analyzed, and the information is recorded into the Columbia data sheet as a means of quantitative data. Complying with federal privacy guidelines, LIP updates personal health information, and demographic and academic information (grades, report cards, switches in guidance counselor), and charts notes such as daily notes and group notes.

C-SSRS. (Columbia Suicide Severity Rating Scale) – risk of suicidal behavior: C-SSRS is a suicide rating scale used to assess suicidality. It acts as a successful suicide attempt predictor in both suicidal adolescents and non-suicidal adults. The assessment analyzes the full range of suicidal ideation and behavior items with criteria for next steps.

<http://www.cssrs.columbia.edu/>

Suicidal ideation questionnaire (risk of suicidal behavior): SIQ was developed by William M. Reynolds, PhD to differentiate between adolescents (12-18 years old) who are depressed and those with suicidal ideation. The short assessment with 30 items only takes 10 minutes to administer, and an additional 10 minutes to score. The questionnaire asks how often the adolescent experiences the thoughts described in the question, with six possible responses, ranging from “never” to “almost every day.”

<http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/JJ-6-R2-Screening-Assessment.pdf>

RADS-2. (Reynolds Adolescent Depression Scale 2) – depressive symptoms: RADS-2 was also developed by William M. Reynolds, PhD to screen for depression in adolescents (11-20 years old) with significant depressive symptoms. RADS-2 has 30 items that assesses four dimensions of depression: Dysphoric Mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints. It then uses four subscale scores, and a Depression Total score that represents the overall severity of the individual’s depression. The cutoff score can discriminate between adolescents with Major Depressive Disorder and an age- and gender-matched control group.

<http://www4.parinc.com/Products/Product.aspx?ProductID=RADS-2>

FACES II (Family Adaptability and Cohesion Evaluation Scale) – family functioning: FACES II assesses the cohesion and flexibility dimensions within the family system, using 30 items. FACES II identifies six family types that ranged from happy to unhappy: Balanced, Rigidly Cohesive, Midrange, Flexibly Unbalanced, Chaotically Unbalanced and Unbalanced.

**The newest edition is FACES IV, with 62 items, six new family scales, two balanced scales, and four unbalanced scales.*

<http://www.facesiv.com/>

TSCC (Trauma Symptom Checklist for Children) – trauma: TSCC was developed by John Briere, PhD to evaluate the effects of trauma (ie. physical or sexual abuse, major loss, natural disasters, violence), measure stress and related psychological symptomatology in adolescents (8-16 years old), and identify patients who need further treatment. The

assessment contains 54 items, and uses two validity scales (Underresponse and Hyperresponse), six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns), and eight critical items.

<http://www4.parinc.com/Products/Product.aspx?ProductID=TSCC>

APPENDIX

TAB 1

- Initial Referral Form (Appendix)
- Agreement for Service (Appendix)
- Psychosocial Assessment
- Activity Assessment (Appendix)
- TSCC Test Booklet
- Trauma Symptom Checklist for Children
- RADS-2 Test Booklet
- Reynolds Adolescent Depression Scale 2
- About My Life SIQ Form HS
- FACES II
- Family Adaptability and Cohesion Evaluation Scale

(See links in Appendix for TSCC, RADS2, SIQ, FACES purchasing information)

TAB 2

- Progress Notes
- Case Management Notes

TAB 3

- School Consent Form
- School Report Form
- School Report Card
- Letters Sent and Received
- Consent and Request Forms

CLIENT CONFIDENTIALITY

I. Policy:

It is the policy of Comunilife, Inc. to establish and maintain an agency-wide procedure on the management of client case records consistent throughout all programs that properly protects the confidentiality as required by regulatory agencies as well as the Health Insurance Portability and Accountability Act (HIPPA).

The confidential relationship which exists between Comunilife and our clients requires Comunilife and its staff to protect the rights of our clients and at the same time act in the best interest of Comunilife.

Confidentiality includes, but is not limited to, the secure maintenance of clients' records that are on our premises, day-to-day movement of the record, transmission of information, the release of information, and client access to their own record.

II. Purpose

To ensure confidentiality, privileged communication, and client access to records according to the requirements of regulatory agencies, applicable regulations, and laws.

III. Procedures

A. Authorization for Release of the Client's Record or A Portion of the Record

Authorization for the release of a record may be given by:

- A mentally competent adult consumer (18 years of age or older),
- The parents or legal guardian of a dependent minor (under 18 years of age),
- The legally authorized representative for a mentally incompetent person, or
- The next of kin of a deceased person.

Written authorization by the client, the parent, legal guardian, or the legally authorized representative is required for request by:

- private physicians,
- insurance companies,
- attorneys (must also be notarized),
- SSI,
- Welfare and other government agencies,
- law enforcement, and/or
- other psychiatric institutions.

The authorization must include the name of the person to whom information is to be given, the specific information that is being requested, and the signature of the client, parent, legal guardian, or legally authorized representative.

Authorization is not required for requests by:

- Medicare, Medicaid, and the New York State Department of Health and/or for required reports of child abuse and neglect.
- Office of Mental Health (OMH) Licensed Programs to release the discharge summary ONLY to another OMH licensed facility.

In order to facilitate family involvement and enhance the care that is provided, the client may be requested to authorize disclosure of information, by the program, to family members, significant others, and/or other agencies providing services to the client.

B. Telephone Request for Information

In general, no information should be given over the telephone without a written, signed authorization on behalf of the client. The only exceptions are medical emergencies and/or psychiatric admissions. Telephone requests are to be handled by the appropriate supervisor or manager.

C. Procedure for Releasing Treatment/Service Information

1. Log Book: A log book indicating the source of the request (name, title, and contact information), the specific information that is being requested, the date of the request, and the date the information was sent.
2. A section of the Log Book will be solely dedicated to Subpoenas.
3. All requests for summaries, SSI, or Social Security Disability forms, are to be given to the Record Room Clerk or assigned staff to be logged.
4. The manager or clinical supervisor will complete the request and ensure that the client's record is up-to-date and in order before it is released. ONLY INFORMATION GENERATED BY THE PROGRAM MAY BE RELEASED. Information obtained from other sources must be kept in a separate section of the record and it can NEVER be released. Request for such information must be made directly to the original source of the information.
5. All written information leaving the program must be stamped PRIVILEGED and CONFIDENTIAL
6. Only information about the client named in the request and only the specific information that is requested e.g., diagnosis, treatment dates, etc. will be released.

Substance Abuse and EITV/AIDS:

Information regarding treatment for substance abuse and HIV/AIDS is protected by special regulations and may not be divulged. Therefore, the release of information must be specifically related to these conditions. (See Authorization for Release of Confidential HIV Related Information and Consent for Release of Information Concerning Alcoholism/Drug Abuse patient). The implementing regulations specify the information that should be included in a consent form (42 C.F.R. § 2.31), including:

- the specific name or general designation of the program or person permitted to make the disclosure;
- the name of the person or organization to which disclosure is to be made;
- the name of the patient;
- the purpose of the disclosure;
- how much and what kind of information is to be disclosed;
- the signature of the patient or other person authorized to give consent;
- the date the consent is signed; and
- a statement that the consent is subject to revocation and the conditions or date upon which the consent will expire.

D. Subpoenas

1. All subpoenas (for client records or staff members) must be brought to the program manager or supervisor upon receipt.
2. When a client's record is subpoenaed, the program manager/supervisor will forward the subpoena and a copy of the client chart to the Vice President of Programs,

3. When a staff member is subpoenaed a copy will be sent to the Vice President of Programs with a copy of the client's record.
4. The original subpoena will be filed in the consumer's record,
5. A copy of the subpoena with a copy of the record is sent to the court, requesting the information, by the Vice President of Program's office,
6. In all cases, a copy of the record, a copy of the subpoena, and a letter of certification must be hand delivered,
7. A copy of the subpoena, with a receipt (letter/acknowledgement) signed by the court evidencing receipt, must be logged in the Subpoena section of the Log Book (in alphabetical order).

E. Record Security and Retention

1. Records must be kept in a secure area and/or cabinet that is kept locked at all times,
2. Records are to be pulled on a daily basis by assigned staff,
3. Records are to be returned to the record room or designated area/space on a daily basis,
4. Records transferred/transported to another program are to be hand delivered only. The staff designated to deliver the record must log this transition in the Log Book,
5. Records that are closed/terminated must be reviewed and endorsed by the program manager to ensure that all required documentation is up-to-date and that it conforms to regulatory standards and guidelines,
6. The closed/terminated record must be logged in the Discharged Book and the record must be filed in the inactive/closed file.

Records will be retained as follows:

1. Adult (18 years of age or older) Case Records are to be retained for a period often (10) years from the close/termination of the case.
2. Children Case Records (under 18 years of age) are to be retained for a period often (10) years after their 18 Birthday.
3. HIV/AIDS Service Administration (HASA) Case Records are to be retained a minimum of seven (7) years AFTER the expiration of the CONTRACT.
4. Discharge Summaries and Face Sheets are to be retained for 25 years after the last contact, and
5. Referral information for clients not accepted into residential or clinical programs are to be retained for three (3) years.

F. Client Access to Record

By law, clients may request to read their records or request copies of their records. In the event that a client requests to read their record or requests a copy the following procedure will be followed:

1. The client, parent, legal guardian, or legal representative will have to make a request in writing,
2. The program manager must acknowledge the clients request within 72 hours,
3. The Director AND the Assistant Vice President (AVP) (for the particular division) will review the record and make a determination on whether disclosing the information will either be detrimental or not detrimental to the client and/or

others. In an OMH licensed program the determination MUST be made in conjunction with the treating psychiatrist or medical director.

Determination to grant access:

- Only documentation generated by the program can be made available to the client, parent, legal guardian, or legal representative;
- The program manager will schedule the date and time the record may be reviewed; within 10 days of the request; and
- The program manager must remain with the client, parent, legal guardian or legal representative while the record is reviewed.
- Copy of the record is issued after the review is completed.
- Efforts should be made to provide a prepared summary of the record.

Determination of detriment:

- The AVP shall determine whether part of the information may be released without detriment,
- The determination of detriment shall be made within 3 business days from the date of the request,
- The AVP shall provide written notification of the determination of detriment and justification for the determination,
- A determination of detriment shall not be made if the benefit to the client from the disclosure outweighs the detriment,
- If a determination of detriment has been made and the person seeking the disclosure disagrees with the decision, an appeal can be filed with the office of the VP for Programs,
- The VP of Programs will convene the agency's internal "Records Access Committee" which is chaired by VP for Programs and representative of the program(s), and Risk Management.
- The VP of Programs shall acknowledge the request for appeal within 3 business days,
- The Records Access Committee shall review the record, AVP's justification for determination of detriment; and may seek independent counsel in order to render a final decision; which may include granting access to a prepared summary of the record,
- The Record Access Committee shall provide a written decision within 30 days of the appeal request

For OMH licensed programs:

- if the Record Access Committee affirms the denial in whole or in part, the written response must explain how the client/guardian can request a review by the "Clinical Record Access Review Committee" appointed by the State Office of Mental Health Commissioner (MHL section 33.16 (c)).

G. Thinning/Purging of the Record

When records become so thick that they are unwieldy, they may be "thinned" or "purged" to reduce the quantity of documents contained within. The purged documentation is to be maintained intact in a separate record which is clearly identifiable and accessible to staff.

- The primary record must be marked to indicate the existence of the separate, secondary record.
- The contents are to be divided as follows:
 - The cover of the purged record is to be marked "Volume I", and
 - The cover of the new and primary record is to be marked "Volume II", (Additional volumes may be established as needed).
- The thinning/purging of the record is authorized by the program manager/supervisor. Content of the new/primary record, Volume II (as applicable):
 - All consents and program agreement(s) for the current period of service,
 - Authorization(s) for the current period of service,
 - The most recent:
 - Screening,
 - Intake,
 - Assessment,
 - Psychiatric evaluation,
 - Treatment plan, and
 - Service plan
 - Initial Service Plan or Comprehensive Treatment Plan,
 - Progress notes for the last six (6) months, and
 - The physician's medication orders for the last year.

H. Sealing the Record

A case record should be sealed in the event of legal proceedings against the agency and/or in case of a serious incident. A serious incident includes death, serious physical or psychological injury, and/or an event perpetrated by or involving the client which is construed to be criminal or harmful to self or others. For programs with electronic records, the program manager must immediately alert the IT Department to ensure that the security and integrity of the electronic record is preserved.

1. When a serious incident occurs:
2. The program manager is to be notified immediately,
3. The program manager/supervisor is to allow no one access to the record.
4. The program manager/supervisor should immediately make an entry in the record stating that, due to a serious incident involving the consumer, the record is being transferred to the care of the Quality Improvement Office. (In the case of the client's death, this note should be labeled 'Late Entry.'),
5. The program manager/supervisor is to immediately arrange for the case record to be hand-delivered to the Quality Improvement Office, where it will be kept in a locked file until the incident is resolved. In case the incident occurs at night. During the weekend or on a holiday:
 - a. The person in possession of the record shall lock the record in the record file/room at his/her service site.
 - b. Program managers will arrange for hand-delivery of the record to the Quality Improvement Office at the beginning of the next business day.

Upon receipt of the record the Quality Improvement Office:

1. An entry will be made in the record stating that it has been received and is being sealed until required internal/external investigations and any litigation(s) are completed. (In case of the consumer's death, this note should be labeled 'Late Entry')
2. The record will be kept in a locked and secure location to assure that no further entries will be made until an internal/external investigation and any resulting litigations are completed, at which time it will be returned to the primary service site.

I. Breach of Confidentiality

Penalties for breach of privacy under HIPPA are significant. The Act provides that a person who wrongfully discloses individually identifiable health information to another person shall be subject to a fine up to \$50,000 and/or imprisonment of up to 1 year. If the disclosure is committed under false pretenses, the penalties are increased to a fine of up to \$100,000 and/or imprisonment up to 5 years. Moreover, "if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm," a fine of up to \$250,000 and/or imprisonment up to 10 years may be imposed. (42 U.S.C. § 1320d-6).

HIPPA establishes civil and criminal penalties for violations of the regulation. There is a \$100 civil penalty up to a maximum of \$25,000 per year for each standard violated.

Criminal penalties are imposed for wrongful disclosures of protected health information. It is a graduated penalty that may escalate to a maximum of \$250,000 for particularly egregious offenses.

In addition to the above civil and criminal penalties, staff violating the recipient's rights to the confidentiality provisions contained in this policy may also have such action subject to disciplinary proceedings up to and including termination.

MULTICULTURAL MODULES

MULTICULTURAL RELATIONAL APPROACH FOR DIVERSE POPULATIONS EDUCATIONAL PROGRAM™

It is now widely recognized that understanding patients/clients presenting problem within their cultural context is crucial for effective treatment as well as to continuity of treatment gains. Delivering quality health services to ethnic and racial communities is about incorporating the person's unique world view.

Culture is a broad concept defined as a shared system of values, beliefs, and learned patterns of behaviors of a group. Culture defines language preference, religion, gender, sexual preference, kin and non-kin relationships. Culture influences a patient's personal perspective on health and illness including etiology of a disease, treatment alternatives, and expectation of outcomes. Culture is a dynamic concept that is in constant change that can also be impacted by educational levels, economic status and immigration.

To learn every aspect of each culture that could influence the therapeutic encounter is impractical, if not impossible, given the diversity of New York City. Therefore, the Multicultural Relational Approach creates a framework that can be used with patients from different cultural backgrounds.

New York City populations (e.g. Hispanic, Asians and Blacks) are far from being monolithic. Socio-political, economic reasons for migration, number of years in the United States, legal status and levels of acculturation to mainstream society accounts for some of the differences among the same ethnic/racial groups. However, each group have some common cultural aspects, for example Hispanics share a common language and values such as "familismo", "personalismo", spirituality, explanatory models of health and illness, folk belief systems, loyalties and support system that cuts across kin and non-kin relationships. It has been reported that Latinos, as well as, African-American individuals and families have denser and larger social networks and rely on informal social networks for a help to a greater degree than families of euro-American decent (Muir, Schwartz & Szapocznik, 2004; Guarhacia, 1998 and. (Garrison, 1978). This cultural value orientation can foster a sense of interdependence, inclusiveness, and participation in large family networks which define close connections with this unit, often made up of three or four generations of relatives as well as horizontal relationships with adult siblings, cousin, and kin and non-kin relationship and social networks that are part of their daily life. The immediate family and non-kin support relationships can be an effective tool in creating clinical interventions working with persons living with chronic illnesses including HIV/AIDS, substance abuse and mental illness.

More and more it is accepted that service provides need to be culturally competent. However, this often leaves workers stranded in their attempt to adapt the professional models of their training alternative practices for treatment, ascertain their expectations of treatment and diminish cross-cultural misunderstandings.

The Multicultural Relational Approach that we developed is respectful of people and of differences, and of what clients/patients bring into the relationship with the worker and the organization. Culture is viewed as one of the most important elements influencing the individual and family's functioning. Problems arise when the worker's and the individual and family's values clash and these differences are labeled and pathologized. Thus, the self

of the worker is viewed as a central tool promoting change. A humanistic, open stance of curiosity, respect, and collaboration with our clients is crucial. It is from this collaborative spirit that therapy is constructed and that culturally appropriate alternatives arise for our clients. Leading clinicians have emphasized the need for therapists to be aware of their own biases and opinions, which are based both on therapists' own multiple contexts and experiences and which significantly affect the therapy process (Falicov, C., 1998).

To obtain a full picture of our clients' problems and resources is and also of community resources, this training will present a *culturally competent systemic assessment* that allows workers to develop an *ecosystemic* understanding of the presenting problem (a "map" that guides workers through systemically relevant ways of integrating in their diagnosis and treatment planning information in the areas of cultural values, health beliefs, and help-seeking behaviors, immigration history, socioeconomic status, ecological niche, family configuration, lifecycle stages, family organization/structure, community and social networks). We believe that for providers to be culturally competent it is imperative that they integrate this kind of approach in the assessment and treatment whether providers work with individual patients, families, couples or members of the patient's social support networks. It is *way of thinking and intervening* that will produce *better outcomes* in working with patients of diverse backgrounds. The participants in the training will present their work with patients. The group of participants will utilize these cases to refine their skills in case conceptualization, goal setting, treatment planning and evaluation of intervention effectiveness from the Multicultural Relational Approach. We will also focus on continuity of treatment and the impact of this way of intervening should be reflected in the chart notes in order to be able to evaluate the outcome. The ecosystem approach can truly allow providers to document the mobilization of individual, family member, members of their social support network and the community as a resource in their clients' lives. It is important to remember that while individual patients, families and social support networks can certainly create "problems", but they also have "hidden treasures" that can be part of the solution.

It has already been established in the literature that government policies and procedures, organizational and health and human services systems level issues can be barriers to cultural competent service delivery in community health care agencies. The greatest resource for change may be found, precisely in the recognition of *the impact of the clients' multiple outside contexts*.

MULTICULTURAL RELATIONAL APPROACH TRAINING CONTENT SUMMARY OUTLINE

Module #1: Understanding Patients from Diverse Backgrounds: A Systemic Perspective

- Cultural Competence in Treatment: Implications of a Strength-Focused Systemic Approach
- Discussion of theories for applying systemic models with clients of diverse backgrounds and at different levels of acculturation
- Some useful generalization of cultural values and implications for treatment among several ethnic and racial groups.

Module #2: Paradigm Shift: From Individual to Systemic Perspective

- From individual relational-focus, from pathology to strength-focus
- Culturally Competent Eco-Systemic Assessment Model
- Exploration of the patient(s) explanatory model of illness
- Engaging individual patients and families (broadly defined) during Assessment and Beginning Phases of Treatment
- Impact of culture on the individuals and family life cycle
- Impact of substance Abuse and Chronic Illness (e.g. HIV/AIDS)

Module #3: “Hidden Treasures” or Resources: Focusing on Strength

- Ecosystem Mapping
- Systemic diagnosis
- Treatment planning: Setting goals
- Specific treatment/intervention techniques
- Measuring outcomes
- Engaging individual, families and members of the social support network in treatment

Module #4: Culture and the Client-Provider Relationship

- Differences in value between providers and clients
- Differences in values between clients and larger system
- Similarities in values between providers and clients: useful and problematic
- How to recognize what does not need to be “fixed”
- Searching for “Competence” with patients from diverse cultures

Module #5: The Impact of Larger Systems on Service Efficacy

- Review of possible larger system factors impacting treatment of patients from diverse backgrounds
- Systemic view of obstacles to treatment
- Identifying indicators of problematic larger systems issues

**APPENDIX
TAB 1**

Initial Referral Form

Client Information

Client Name:		Client DOB:	
Is the Client a Foster Child? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Person/Agency with full custody must sign consent forms attached. ***Foster parent must also be willing to participate in the program***			
Guardian Name:		Relationship:	
Ethnic Background:		Primary Language Spoken:	
Address:			
Phone (H):	Phone (C):	Other:	
School:	Grade:	Special Education: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referral Information

Referred by:		Relationship:	
Phone:			
Agency:			
Called in by: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Referent <input type="checkbox"/> Other			
Reason for Referral (Symptoms/Behaviors/Issues client is experiencing):			
Name of Mental Health Facility (Client must be in treatment):			
Therapist Name:		Phone:	
Currently prescribed medications: <input type="checkbox"/> Yes <input type="checkbox"/> No Names of medication:			

Have you been previously treated by Oasis/Vida Clinic: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is parent willing to participate in the program: <input type="checkbox"/> Yes <input type="checkbox"/> No

For Staff Use Only:

Date:	Call Taken by:
Comments:	
How did you hear about us?	

AGREEMENT FOR SERVICES:

1. I want to enroll my daughter, _____, and family in the Comunilife, Inc. Life Is Precious Program.
2. I understand that it is not a substitute of regular clinical services with my social worker or psychiatrist.
3. I understand I am to provide a working telephone number at all times in case of emergency to be ~~outreached~~ reached while my child is at the program.
4. I understand that in order for my daughter to fully benefit from the program and its activities, she has to attend a minimum of three (3) times a per week. ~~Parents~~ Parent and family involvement is expected a minimum of two (2) times a week.
5. I understand that for time to time, field trips will be offered and my child will have to bring signed parental permission slip in order to participate.
6. I have informed Comunilife, Inc., Vida Guidance Center, and the Life Is Precious Program of all potential health-related issues, such as known allergies to art material and/or animals that might prevent my child from full participation in the program or any part thereof.
7. I understand that my daughter is attending a drop in center and it was explained to me that she can ~~arrived~~ arrive any time after 3:30PM when the program starts, and can leave no later than 7:30 PM when the program ends on weekdays. (Saturdays 10:00AM-2:00PM).
8. I give the Life is Precious staff consent to share and disclose information with my daughter's provider of Mental Health Services (Therapist) at _____.

9. Child's commute/travel alone to and from LIP program:
 I agree for child to commute/travel alone to and from LIP program.
 Specify recommendations:

I disagree for child to commute/travel alone to and from LIP program.
 Specify recommendations:

Print Parent/Guardian Name:	Telephone Number(s):
Parent/Guardian Signature:	Date:
Address:	
Staff Conducting Assessment/Intake:	Date:

ACTIVITY ASSESSMENT:

Name:	Age:
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Please place an X next to the art activities you enjoy or want to try:

<input type="checkbox"/> Drawing	<input type="checkbox"/> Painting	<input type="checkbox"/> Wood-Sculpting	<input type="checkbox"/> Ceramics
<input type="checkbox"/> Mask-Making	<input type="checkbox"/> Doll-Making	<input type="checkbox"/> Quilting	<input type="checkbox"/> Sewing
<input type="checkbox"/> Making Collages	<input type="checkbox"/> Journal Writing	<input type="checkbox"/> Poetry	<input type="checkbox"/> Fashion Design
<input type="checkbox"/> Hair Styling/Manicures	<input type="checkbox"/> Dancing	<input type="checkbox"/> Acting	<input type="checkbox"/> Music
<input type="checkbox"/> Interior Design	<input type="checkbox"/> Industrial Design		

Other (Please describe):

Please place an X next to the media you enjoy or want to use:

<input type="checkbox"/> Charcoal	<input type="checkbox"/> Oil Pastels	<input type="checkbox"/> Chalk Pastels	<input type="checkbox"/> Colored Pencils
<input type="checkbox"/> Graphite Pencil	<input type="checkbox"/> Markers	<input type="checkbox"/> Watercolor	<input type="checkbox"/> Gouache
<input type="checkbox"/> Acrylic Paint	<input type="checkbox"/> Oil Paint	<input type="checkbox"/> Clay	<input type="checkbox"/> Model Magic
<input type="checkbox"/> Wood	<input type="checkbox"/> Papier Mache	<input type="checkbox"/> Plaster	<input type="checkbox"/> Decorative Paper
<input type="checkbox"/> Tissue Paper	<input type="checkbox"/> Glitter	<input type="checkbox"/> Felt	<input type="checkbox"/> Fabric

Please place an X next to the physical activities you enjoy or want to do:

<input type="checkbox"/> Hiking	<input type="checkbox"/> Horseback Riding	<input type="checkbox"/> Sailing	<input type="checkbox"/> Swimming	<input type="checkbox"/> Walking
<input type="checkbox"/> Basketball	<input type="checkbox"/> Running	<input type="checkbox"/> Yoga	<input type="checkbox"/> Meditation	<input type="checkbox"/> Softball

Please place an X next to the relaxing activities you enjoy or want to try:

<input type="checkbox"/> Watching Movies	<input type="checkbox"/> Horticulture	<input type="checkbox"/> Reading	<input type="checkbox"/> Watching Television
<input type="checkbox"/> Playing Board Games	<input type="checkbox"/> Playing Card Games		

Please list any media that causes an allergic reaction in you:

Please list any activity that might be too strenuous for you:

Parent/Guardian Signature:	Date:
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Assessments:

1. Reynolds Adolescent Depression Scale, 2nd Edition (RADS-2)
<http://www.sigmaassessmentsystems.com/assessments/reynolds-adolescent-depression-scale-2/>
2. Suicidal Ideation Questionnaire (SIQ)
<http://www4.parinc.com/Products/Product.aspx?ProductID=SIQ>
3. TSCC (Trauma Symptom Checklist for Children)
<http://www4.parinc.com/products/product.aspx?Productid=TSCC>
4. FACES II (Family Adaptability & Cohesion Evaluation Scale)*
<http://www.facesiv.com/>

* Updated FACES IV version is available.

**APPENDIX
Patient Safety Plan**

Step 1: Warning signs (thoughts, images, moods, situations, behaviors) that a crisis may be developing:	
1.	
2.	
3.	
Step 2: Internal coping strategies or things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):	
1.	
2.	
3.	
Step 3: People and social settings that provide distraction:	
1. Name:	Phone Number:
2. Name:	Phone Number:
3. Place:	
4. Place:	
Step 4: People whom I can ask for help:	
1. Name:	Phone Number:
2. Name:	Phone Number:
3. Name:	Phone Number:
Step 5: Professionals or agencies I can contact during a crisis:	
1. Clinician Name:	Phone Number:
Clinician Page/Emergency Contact #:	
2. Clinician Name:	Phone Number:
Clinician Page/Emergency Contact #:	
3. Local Urgency Care Services:	Phone Number:

Urgency Case Address:	
4. Suicide Prevention Lifeline: 1-800-273-TALK (8255)	
Step 6: Making the environment safe:	
1.	
2.	
The one thing that is most important to me and worth living for is:	

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