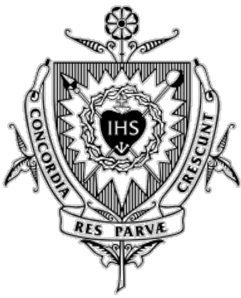

Xaverian Brothers

Clinical Treatment Assistance Program

Background

The Xaverian Brothers have long-standing policies regarding sexual abuse of minors by members of the congregation. One dimension of these policies is to offer appropriate assistance to victims of any such abuse in order to assist in their healing and personal adjustment. The Clinical Treatment Assistance Program ("the Program") has been designed to help implement this commitment.

Mental health treatment covered in the Program should focus on the effects of childhood sexual abuse. The Xaverian Brothers offer these services to those who voluntarily request them. The Program is designed to help participants with a minimum of intrusion.

The Program

The Program will help participants access the services of licensed, qualified clinicians to help resolve issues that may have begun with, or been exacerbated by, sexual abuse by members of the congregation. Mental health services must be provided by qualified psychiatrists, psychologists or social workers, and the Program must approve any clinician before treatment begins to ensure proper credentials and licensure. No treatment services will be reimbursed without prior approval.

Clinical services will begin with sufficient visits to ensure an accurate diagnosis (usually four sessions). Treatment may proceed for as long as clinically necessary and reasonable, according to the standards and best practices of the treating professional. Treatment will be reviewed periodically as it proceeds. The participant may select his/her own clinician, or the Program will provide assistance in locating appropriate resources in a specific geographic area. Payment will only be made to a treating clinician pre-approved by the Program.

An Independent Clinician will administer and monitor the Program. The Independent Clinician is a licensed mental health practitioner experienced in services to sexually abused children and adults.

Insurance

Participants are expected to access their maximum allowable health insurance benefits during each year that they are in the Program. After insurance benefits have been fully used in a given year, or when a deductible or co-payment is required, the Program will reimburse the costs of

services not covered by insurance. When treatment continues into a new calendar year, the participant is expected to access insurance benefits again.

Confidentiality

The Xaverian Brothers recognize and respect that participants are concerned about protecting their privacy. The Program will try to protect each participant's identity to the extent permitted by law and regulation. An exception to providing confidentiality will be made for information required to be disclosed by law enforcement agencies or requested by an insurer.

At the beginning of participation in the Program, a participant must provide the Independent Clinician with a signed ***Release of Information***, permitting the Independent Clinician to obtain a diagnosis, treatment outlook and projected length of treatment from his/her clinician. The Release will also permit the Independent Clinician to obtain periodic updates to ensure appropriate treatment progress. Clinicians will be required to complete a ***Treatment Review Form*** during the course of treatment. A copy of both the Release and the Form are attached.

Process for Accessing the Program

A participant requesting assistance with mental health services will be interviewed by the Independent Clinician (or designee) to determine the most appropriate course of treatment.

It is the responsibility of the Program to:

- Obtain a ***Release of Information*** from the participant permitting the Independent Clinician to confer on his/her behalf regarding treatment.
- Help the participant determine the best course of treatment and geographic location for the treatment.
- Explain the similarities and differences between various treatment options.
- Review the credentials of a clinician selected by the participant.
- Help determine the participant's insurance coverage.
- For those without a selected clinician, help identify credentialed clinicians in a specific geographic area.
- Verify that treatment has commenced.
- Obtain a completed ***Treatment Review Form*** after completion of sufficient sessions to provide a clear diagnosis (generally four sessions).

- Monitor treatment by obtaining an updated ***Treatment Review Form*** for ongoing treatment after completion of 25 sessions.

- Review bills and forward invoices to the Xaverian Brothers for payment.

Xaverian Brothers

Clinical Treatment Assistance Program

Release of Information

Participant's name: ______________________________

Date of birth: ______________________________

I give permission to my clinician:

Name:
Address:
Telephone:

to provide to the Xaverian Brothers Independent Clinician:

Name:
Address:
Telephone:

information regarding my diagnosis and treatment progress. I understand that the information will not be re-released to any person or agency without my express consent, except as provided by law.

I authorize my clinician to complete the Xaverian Brothers ***Treatment Review Form*** as requested by the Independent Clinician. No information on the ***Treatment Review Form*** will be re-released to any person or agency without my express consent, except as provided by law.

______________________________ ______________
Signature of participant Date

______________________________ ______________
Signature of witness Date

Xaverian Brothers

Clinical Treatment Assistance Program

Treatment Review Form

(to be completed by clinician after initial diagnosis and to authorize ongoing treatment)

Participant's Name: ______________________________

Date of birth: ______________________________

Clinician's Name: ______________________________

Address: ______________________________

Date participant first seen: ______________________________

DSM-IV Axis I Diagnosis: ______________________________

DSM-IV Axis II Diagnosis: ______________________________

Treatment duration to date: __________ weeks __________ sessions

Projected frequency:

Starting date: ______________________________

Individual therapy: __________ times per week

Group therapy: __________ times per week

Medication management: __________ times per __________

Total sessions projected: ______________________________

Clinician's comments:

______________________________ ______________

Clinician's signature Date

______________________________ ______________

Independent Clinician Authorization Date

Date forwarded for reimbursement: ______________