§709.51. Intake and admission.

(a) The project director shall develop a written plan providing for intake and admission which includes, but is not limited to:


   Criteria should include age, sex, physical and/or mental conditions, geographic requirements and nature of the D/A problem. Any special project limitations should also be noted, e.g., serving the handicapped, psychotic, non-English speaking populations.

2. Treatment methodology.

   Examples – individual, group, family counseling, bio-feedback, antabuse, or other medication.

3. Requirements for completion of treatment.

   Requirements for completion of treatment should be viewed from both the project and the client perspectives, including the length of treatment, employment, financial independence, substance usage, interpersonal relationships, etc.

4. Involuntary discharge/termination criteria.

   Examples – involuntary discharges (acts of violence, use/misuse of chemicals, etc.) and administrative discharges (AWOL, failure to actively follow the treatment plan, etc.).

(b) Intake procedures shall include documentation of:

1. Disclosure to the client of criteria for admission, treatment, completion and discharge.
Disclosure may be documented in initial progress notes, the consent to treatment, or orientation packet.

(2) Client orientation to the project which includes, but is not limited to, a familiarization with:

See b (1) above for acceptable documentation of client orientation.

(i) Project policies.

Project rules and requirements related to treatment.

(ii) Hours of operation.

(iii) Fee schedule.

(iv) Services provided.

(3) Histories, which include the following:

Histories should be constructed to collect as much personal information about a client as possible since they form the basis from which the psychosocial evaluation and subsequent treatment plans are formulated.

(i) Medical history.

A history documenting the client's personal medical history, family medical history, and history of illness and symptoms.

(ii) Drug or alcohol history, or both.

A history documenting the substances most frequently abused, the length and patterns of use, prior treatment episodes. Include the client’s perception of their effect on his/her social, physical and mental state. It is recommended that any substance abuse history within the family, or that of significant others be noted.

(iii) Personal history.

Historical and current personal data including: family, legal, employment/vocational, educational, military, recreational, sexual, and others where appropriate.

(4) Consent to treatment.
A consent to treatment form should be signed by both the client and the staff person at intake. This consent could be integrated with other forms/procedures, e.g., liability determination, preliminary treatment plan, intake and orientation verification.

(5) Physical examination.

The results of the physical examination should be documented according to the following: evidence of injuries, a serial neurological examination, an investigation of the organ systems for possibilities of infectious disease, pulmonary, liver, and cardiac abnormalities, dermatologic sequelae of addiction, and concurrent problems. In addition, the physical examination should include a determination of the patient’s vital signs (temperature, pulse, and blood pressure and respiratory rate); an examination of the client’s general appearance, head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs and breasts), abdomen, extremities, skin assessment, and the project physician’s overall impression of the client.

The project should make every effort to utilize results of physicals in determining related medical care needed and the appropriateness of client involvement in all project activities.

It is recommended that the following laboratory tests be completed for each client at admission to a project in addition to the required examination stated in the above paragraph:

- STAT blood alcohol level;
- Complete blood count and differential;
- Blood or urine drug screen for the detection of multiple drug use;
- Serological test for syphilis;
- Routine and microscopic urinalysis;
- Liver function profile, e.g., SMA-12, etc.;
- Tuberculin skin test, and when positive, a chest X-ray;
- When clinically indicated, Australian Antigen HG Ag Testing (HAA testing), EKG; and,
- When appropriate, pregnancy test and a pap smear.

When a client is readmitted to a project within one year, the physical exam or lab tests should be at the discretion of the physician.
Psychosocial evaluation.

The evaluation should provide a composite picture of the individual in relationship to the collected historical information in order to identify possible relationships, conditions and causes leading to the client’s current situation.

It is recommended that this evaluation also include:

- a clear description of the client’s presenting and underlying problems.
- client needs or problems that can or cannot be resolved through treatment or that might inhibit treatment.
- client assets, strengths or other factors that can contribute to the resolution of identified problems.
- the potential or available client support systems.
- negative factors that might affect treatment.
- the client’s preferred coping mechanisms.
- conclusions regarding the client’s appearance, behavior and reactions during the intake process.
- conclusions regarding the client’s attitude toward and ability to participate in the treatment process.

Preliminary treatment and rehabilitation plan.

A Preliminary Treatment Plan should be based upon information derived from the initial interview, psychosocial and other evaluations. This plan should also identify critical client problems and strategies for their resolution.

§709.52. Treatment and rehabilitation services.

(a) An individual treatment and rehabilitation plan shall be developed with a client. This plan shall include, but not be limited to, written documentation of:

(1) Short and long-term goals for treatment as formulated by both staff and client.

Goals should be realistic and stated in terms of measurable criteria.

(2) Type and frequency of treatment and rehabilitation services.

Examples – group counseling twice a week, family therapy every three weeks, bio-feedback bi-weekly.
(3) Proposed type of support service.

*These services may include medical, psychiatric or psychological services, economic, legal, AA, NA, etc.*

(b) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days.

*The treatment plan update should include an assessment of the client’s progress in relationship to the stated goals of the comprehensive treatment plan. The following issues should be considered:*

- Have problems or issues that have been identified in the comprehensive treatment plan been impacted upon through treatment?
- Do the goals need to be revised or restated?
- Do the treatment strategies or action steps need to be modified?
- Is closure reflected when goals have been achieved?

*The treatment plan updates should be signed and dated by the primary counselor and it is recommended that it be countersigned and dated by the supervisory counselor.*

(c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan.

*Counseling services may be documented within the progress notes and the record of services.*

(d) Counseling shall be provided to a client on a regular and scheduled basis.

(e) The project shall assist the client in obtaining the following supportive services when necessary:

*Examples of documentation may include letters of agreement/understanding, referral log, progress notes, etc.*

(1) Medical/dental.

(2) Psychiatric.

(3) Legal.

*Examples – court representation, bail services, legal assistance.*
(4) Economic.

Examples – housing, income, food supplements, general/medical assistance, transportation.

(5) Educational.

Examples – GED services, reading development, special tutoring, ongrounds school.

(6) Vocational.

Examples – vocational assessment, skill development, preparation for job applications/interviews.

(7) Recreational/social.

Examples – athletics, arts and crafts, games, cultural field trips, dances, picnics.

§709.53 Client records.

(a) There shall be a complete client record on an individual which includes information relative to the client’s involvement with the project. This shall include, but not be limited to, the following:

(1) Consent forms.

A copy of any and all consent forms signed by the client while undergoing treatment (intake through discharge) should be maintained in the client record.

(2) Medication records.

All medications being taken by a client whether prescribed by the project’s physician or the client’s private physician should be recorded in the chart indicating the name of the drug, dosage, and frequency of use.

[Note: Where projects act as custodians of a client’s medication, a log should be maintained including: the client name, type of medication, amount, time and date, and staff signature. Refer to section on Medication Control.]

(3) Record of services provided.

This should be a chronological listing (separate from progress notes) of the various specific services provided to the individual client. This listing should also include the date, the provider(s), and the duration of the service.
(4) Referral contact.

Include the nature and disposition of referrals made to outside resources.

(5) Progress notes.

There should be a progress note after each significant client contact which should be dated and signed by the individual making the entry.

Progress notes should include data, assessment and plans relative to treatment.

- The data should include information presented by the client during the counseling session, counselor observations and information about the client from other sources.

- The assessment is the interpretative statement(s) based upon both new and previous information and includes the counselor’s analysis of and conclusions regarding the client’s current situation or status.

- The plan (strategies) should reflect the counselor’s actions to be taken in light of the evaluation and indicate the direction of treatment and include action steps, counselor plan(s) and client assignments or tasks.

If group sessions are conducted, individual notes need not be written for each client. One group note will suffice provided that it includes a comment relative to each individual’s response or participation in the group session.

(6) Individualized treatment and rehabilitation plan.

(7) Client-related correspondence.

(8) Case consultation notes.

Include the following: date of consultation, names of persons attending and their disciplines, name(s) of clients reviewed, summary of the discussion and disposition of cases reviewed. Each client’s progress should be reviewed at least quarterly at a case conference consisting of representatives from the various client service components. Where the length of treatment is less than 90 days, at least one case conference should be conducted for each client. Where a multi-disciplinary staff does not exist, case consultation should include the primary counselor and one other clinician.

For clients in treatment longer than one year, case consultations need to be documented at least once annually. Provisions should be made for more frequent case consultation if dictated by client response to treatment.

Case conferences may be held for a variety of reasons:
• To discuss a “problem” client who is not responding to the treatment strategy or has violated a project rule.

• To discuss a client or a group of clients whose characteristics or response to treatment afford a unique opportunity for counselor training.

• To assess client(s) who are due or need to progress to another phase of treatment.

• To give each counselor an opportunity to present one or more cases for review and to obtain the benefits of a multi-disciplinary evaluation of some of his/her cases.

(9) Aftercare plan, if applicable.

A plan for clients to follow after they leave formal treatment. It is the client’s individual plan for the future, including an identification of the client’s personal goals and objectives. It should focus on sustaining and building on the progress achieved during treatment and should have input from all significant persons, especially the client. The plan should include the following:

• The client’s future goals with time frames.

• A description of the services that can be provided by the project after discharge, if necessary.

• The method and frequency of continuing contact to provide client support.

• Criteria for re-entry into the project.

• Provision for the periodic re-evaluation and termination of the plan.

Aftercare plans are not required where clients have left treatment against project advice or refuse to participate in an aftercare plan. Plans are also not required if a client is being referred to another facility for further treatment. In this case follow-up should suffice. This action should be documented in the client record.

(10) Discharge summary.

Within one week after discharge, there should be entered into the client’s case record a discharge summary describing the reasons for treatment, services offered, response to treatment and client’s status or condition upon discharge.

(11) Follow-up information.
When a client has been discharged and referred to an outside resource, the project should, with the written consent of the client and within one week from the day the referral is to be completed, attempt to determine from the resource the disposition of the referral. Once the attempt has been made and documented, a project may consider its obligation to the individual fulfilled.

Where clients are not referred after discharge, some attempt should be made to follow-up the ex-client's progress and status in accordance with the agency's written policy.

(12) Verification that any work done by the client at the project is an integral part of his treatment and rehabilitation plan.

Exception: Client’s cleaning of personal living space.

(13) Documentation of special dietetic needs, if applicable.

(b) The project shall develop and maintain client records on standardized project client record forms.

§709.54. Project management services.

(a) An inpatient nonhospital project shall have written policies and procedures for its dietetic services which include, but are not limited to:

1. Purchasing of food and equipment.
2. Receiving, storing and preserving of food stuff.
3. Proper preparation of food.
4. Safety and sanitation, including the preparation, handling, and storage of foods; the care and cleaning of dishes, utensils and work area.
5. Personal hygiene for those in food preparation areas.
6. Special dietary needs.

(b) The project shall develop a written client aftercare policy.

The policy should indicate the staff members responsible for the aftercare plan, when and how it is to be developed and the format to be used.

(c) The project shall develop a written client follow-up policy.

The policy should note who is responsible, method and frequency of contact and the manner of documentation.
(d) The project shall develop a written plan providing for outreach services which includes, but is not limited to:

(1) Identifying persons in need of project services.

(2) Alerting persons and their families to the availability of project services.

(3) Encouraging persons to utilize the service delivery system.