§ 709.121. Applicability.

A psychiatric hospital intending to provide ongoing, structured and systematic drug and alcohol activities shall first be licensed by the Department. These facilities shall comply with this subchapter, subchapters A, B, and applicable sections of Subchapter C.

§ 709.122. Detoxification.

(a) Intake and admission.

(1) Intake procedures, other than initial medical or psychiatric care, shall be performed at a time when the client is mentally and physically capable of comprehension and response.

(2) Intake procedures shall include documentation of:

(i) Drug or alcohol history, or both.

A history including 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.

(ii) 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, support plan, intake and orientation verification.
(b) **Client Records.** There shall be a complete client record on every individual which includes all 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. **Drug and alcohol support plan.**
   
   *A plan that reflects the project’s efforts to motivate and support the client to seek formal treatment after the detox process.*
   
   *This plan should also delineate counseling methods to be used that are designed to cope with denial, promote better understanding of chemical dependence and to encourage client participation in treatment.*

3. **Record of service provided.**
   
   *There 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. **Drug and alcohol 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. This plan should also 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 instance follow-up should suffice.

(5) 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.

When 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.

(c) Client management services.

(1) There shall be a written plan that delineates specific service planning and counseling approaches used to promote client interest in participating in necessary treatment following the detoxification process.

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

Indicate the staff members responsible for the aftercare plan, when and how it is to be developed and the format to be used.

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

Note who is responsible, method and frequency of contact and the manner of documentation.

709.123. Treatment and rehabilitation.

(a) Intake and admission.

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

(i) Criteria for admission.

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.

(ii) Treatment methodology.
Examples – individual, group, family counseling, bio-feedback, antabuse, or other medication.

(iii) 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.

(iv) Involuntary discharge/termination criteria.

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

(2) Intake procedures shall include documentation of:

(i) 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.

(ii) Drug and alcohol history.

Documentation should include the substances most frequently abused, the length and patterns of use, prior treatment episodes and 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) 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, examples – liability determination, preliminary treatment plan, intake and orientation verification.

(iv) Treatment and rehabilitation plan.

A Preliminary Treatment Plan should be developed based upon information derived from the initial interview, psychosocial and other evaluations. This plan should identify critical client problems and strategies for their resolution.
(b) *Treatment and rehabilitation services.*

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

(i) 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.*

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

*Examples – group counseling twice a week, family therapy every three weeks, bio-feedback bi-weekly.*

(iii) Proposed type of support service.

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

(2) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days. For those projects whose client treatment regimen 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?*

*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.*

(3) 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.

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

(c) Client Records. There shall be a complete client record on every 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) Record of services provided.

Include type of service, date, and provider.

(3) Individualized drug and alcohol treatment and rehabilitation plan.

(4) Drug and alcohol 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.
(5) Follow-up information.

The procedure by which a project determines the status of a client who has been referred to an outside service provider for services or who has been discharged from the project.

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.

(d) Client management services.

(1) 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.

(i) Job development and placement.

(ii) Economic.

   e.g., housing, income, food supplements, general/medical assistance, transportation.

(iii) Legal.

   e.g., court representation, bail services, legal assistance.

(iv) Recreational/social.

   e.g., athletics, arts and crafts, games, cultural field trips, picnics.

(2) 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.

(3) 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.