§711.81. **Intake and admission.**

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

1. **Criteria for admission.**
   
   *Criteria should relate to project capabilities and resources and 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, and interpersonal relationships, etc.*

4. **Involuntary discharge/termination criteria.**
   
   *Example – involuntary discharges (acts of violence, use/misuse of chemicals, etc.) and administrative discharges (absenteeism, 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 shall include, 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 of 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, if applicable.

The results of the physical examination should be documented according to the following: evidence of injuries, 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 physically 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.

(6) 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 should 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.

(7) 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.

§711.82. Treatment and rehabilitation services.

(a) The project shall adopt a written plan for the coordination of client treatment and rehabilitation services which includes, but is not limited to:

(1) Defined target population.

That portion of the general population toward whom facility services are directed.
(2) Treatment models utilized by the project.

Examples – Behavior modification, reality therapy, conjoint family therapy, ego psychology, transactional analysis, gestalt, etc. Documentation of client services should be consistent with the conceptual treatment model.

(3) Written procedures for the development, approval and ongoing management of treatment/rehabilitation services for clients.

This procedure should indicate who is responsible for the development, approval, monitoring, and evaluation of client services (intake through discharge).

(b) The project shall obtain written letters of agreement or understanding with primary referral sources.

Letters should be renewed every two years or more often if a project’s key staff, services or admission criteria change.

(c) 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.

(d) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 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.

(e) 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.

(f) Counseling shall be provided to a client on a regular and scheduled basis. The following services shall be included and documented:

   (1) Individual counseling, at least twice weekly.

   (2) Group counseling, at least twice weekly.

   (3) Family counseling, as appropriate.

   (4) Couple counseling, as appropriate.

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

   Where a project cannot directly provide a supportive service, it should assist the client in receiving these services through outside agencies. 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.

(6) Vocational.

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

(7) Recreational/social.

Examples – arts and crafts, games, organized sports activities.

§711.83. Client records.

(a) Record requirements. There shall be a complete client record on an individual which includes information relative to the client’s involvement with the project. In addition to the requirements in §115.32 (relating to contents), the client record shall include the following:

(1) Drug and alcohol 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) Referral contact.

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

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

(4) 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.

- 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.

(5) Aftercare plans, 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 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.

(6) 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.

(7) 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 written policy.
(8) Verification that work done by the client at the project is an integral part of this treatment and rehabilitation plan.

      Exception: Client’s cleaning of personal living space.

(b) Client access to records. A client has the right to inspect his own records. The Project Director may temporarily remove portions of the record, prior to the inspection by the client, if that director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented and kept on file.

(c) Confidentiality.

   (1) A written procedure shall be developed by the project director which complies with 4 Pa. Code §255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure shall include, but not be limited to:

           (i) Confidentiality of client identity and records.

           Projects should include a description of how they plan to address security and release of records. They should also identify the person(s) responsible for maintenance.

           (ii) Staff access to client records.

           Project staff having access to records should be identified either by name or position. The methods by which staff gain access to records also should be outlined.

   (2) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent shall be in writing and include, but not be limited to:

           (i) The name of the person, agency, or organization to whom disclosure is made.

           (ii) The specific information disclosed.

           (iii) The purpose of disclosure.

           (iv) The dated signature of the client or guardian.

           (v) The dated signature of a witness.

           (vi) The expiration date of the consent.
Expiration date should reflect time, date, event or condition depending upon the nature of the information disclosed.

(3) A copy of any client consent shall be offered to the client and a copy maintained in the client records.

Compliance with this standard may be demonstrated by indicating on the consent whether the copy was accepted or refused, posting a policy statement or including it in the client’s orientation packet, etc.

(4) Where consent is not required, the project personnel shall:

(i) Fully document the disclosure in the client records.

(ii) Inform the client, as readily as possible, that the information was disclosed, for what purposes, and to whom.

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Disclosure of the Client-Oriented Information. With or without the client’s consent, information may be released to those judges who have imposed sentence on a particular client where such sentence is conditioned upon the client entering a project. Information released shall be limited to that provided for in subsection (b) of this section.

With or without the client’s consent, information may be released to those duly authorized probation or parole officers who have assigned responsibility to clients in treatment if the client’s probation or parole is conditioned upon his being in treatment. Information released shall be limited to that provided for in subsection (b) of this section. With or without the client’s consent information may be released to judges who have assigned a client to a project under a pre-sentence, conditional release program. Pre-sentence, conditional release programs include pre-indictment or pre-conviction conditional release (such as ARD) probation without verdict or disposition in lieu of trial pursuant to section 17 and 18 of Act 64 (35 P.S. 780-117 and 780-118).

In emergency medical situations where the client’s life is in immediate jeopardy, projects may release client records without the client’s consent to proper medical authorities solely for the purpose of providing medical treatment to the client.

Information released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials, pursuant to paragraphs (1), (2), (4), (7), (8) or subsection (a) of this section, is for the
purpose of determining the advisability of continuing the client with the assigned project and shall be restricted to the following.

(1) Whether the client is or is not in treatment.

(2) Client’s prognosis.

(3) The nature of the project.

(4) A brief description of the client’s progress.

(5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

§711.84. Project management services.

(a) The partial hospitalization project shall operate at least 5 days of the week and for a minimum of 40 hours per week. Additional hours should be appropriate to the population served by the partial hospitalization project.

Partial hospitalization is designed for those clients with drug/alcohol problems who would benefit from more intensive service than if offered in outpatient treatment projects, but who do not require 24 hour inpatient hospital care. This activity should provide a variety of diagnostic drug/alcohol treatment services on both a scheduled and non-scheduled basis. It is recommended that each client receive a minimum of 15 hours of therapeutic services per week.

(b) The hours of project operation shall be displayed conspicuously to the general public.

(c) A telephone number shall be displayed conspicuously to the general public for emergency purposes.

The number should be the one used to contact the person(s) responsible for building/office security during non-office hours.

(d) The project shall develop a written 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.

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

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

§711.85. Uniform Data Collection System.

(a) If a project utilizes Department funds, it shall comply with the Department’s UDCS.

(b) A data collection system shall be developed that allows for the efficient retrieval of data needed to measure the project’s performance.

*The project needs to demonstrate the utilization of data in relationship to program planning and evaluation.*

§711.86. Notification of termination.

(a) The project director shall notify the client, in writing, of a decision to involuntarily terminate the client’s treatment at the project. The notice shall include the reason for termination.

*A copy of this notice should be maintained in the client’s record.*

(b) The client shall have an opportunity to request reconsideration of a decision to terminate treatment.

*The client should be informed of this right in the termination notice itself and/or in a client rights statement disclosed to the client during intake/orientation.*

*The request should be in writing and a copy maintained in the client record.*

§711.87. Medication control.

(a) When the drug and alcohol project is not physically located within the parent health care facility, it shall have a written policy regarding all medications used by clients which includes, but is not limited to:

(1) Administration of medication.

*Under Pennsylvania law, the only persons legally permitted to administer medication (controlled substances) are physicians, physician’s assistants, registered nurses and LPNs.*
In projects that permit the self-administration of drugs with abuse potential, there should be a written policy and procedure governing such activity. Project decisions to permit self-administration must be based on individual needs and be undertaken in a manner that complies with any laws and regulations applicable to such acts.

Clients who receive drugs from the project for self-administration must be given instructions concerning the safe storage and usage of such drugs, and the appropriate emergency procedures to be followed if adverse reactions occur. The client receiving these drugs must be encouraged to instruct his or her family on emergency procedures, especially when there are children living with the client.

All drugs that are to be self-administered must be packaged in a manner complying with the Poison Prevention Packaging Act of 1970 and all current regulations, stemming from said Act.

(2) Drug storage areas.

The policy should state where and how drugs are stored. All drugs including those stored for clients by the project must be secured in locked containers (areas) with keys accessible only to authorized staff.

(3) Inspection of storage areas.

The policy should state what is to be verified through the inspection, who inspects, how often, and in what manner it is to be recorded.

Inspections of all drug storage areas, medication center and nurses’ stations are to be conducted at least quarterly to ensure that these areas are maintained in compliance with federal, state and local regulations. A dated record of these inspections shall be maintained in order to verify that:

- Disinfectants and drugs for external use are stored separately from oral and injectable drugs;
- Drugs requiring special conditions for storage to insure stability are properly stored;
- Outdated drugs are removed;
- Administration of controlled drugs are adequately documented;
- Controlled substances and other abusable drugs are stored in accordance with federal, state and program regulations; and,
• Copies of drug-related regulations are available in appropriate areas.

(4) Methods for control and accountability of drugs.  
*The policy should indicate who is authorized to remove drugs from the storage area and the means of accountability for all stored drugs. A system should be developed to record drugs withdrawn indicating the name of the drug, staff person, amount, time and date.*

(5) Security of drugs.

*Include loss, theft, or misuse of drugs.*

(6) Inventories.

*The policy should include who performs the inventory, how often, and the manner of recording.*

*(A regular account/record of stored drugs should include the date, person performing the inventory, amount of drugs on hand, amount used, amount needed and/or amount ordered [if applicable], balance, comments, etc.)*

(7) Medication errors and drug reactions.

*The policy should include reporting medication errors and adverse drug reactions. A dated entry of the medication given and any drug reaction shall be recorded in the client record.*

§711.88.  Physical plant. RESERVED*  
See Chapter 705. Physical Plant Standards