Sec. 17-226d-6. Treatment and rehabilitation programs

(a) **Admission criteria**

(1) Each program shall have and utilize written admission criteria which shall be available to clients, staff, the community and the Commission.

(2) No person shall be admitted to a program unless he meets the program's admission criteria and any person who is ineligible because he does not meet the admission criteria shall be referred back to the original referring agency or to another appropriate agency.

(3) The written admission criteria shall include, but need not be limited to consideration of the following factors:

(A) age
(B) sex
(C) physical health
(D) mental status
(E) previous treatment history
(F) history of substance abuse
(G) current use of mood altering substances

(b) **Intake procedure**

(1) Each program shall have and utilize a written intake procedure which shall include, but need not be limited to:

(A) A procedure for making and accepting referrals pursuant to the requirements of section (i) of this regulation.

(B) A procedure for determining whether or not the client meets the program's admission criteria and is appropriate for the program.

(C) A time limit or number of visits within which initial assessment of persons admitted to the program will be completed. In no case shall the time for completing the intake procedure exceed 90 days or 3 counseling sessions.

(2) Each program shall, during the intake procedure, collect at least the following demographic information on a standardized form from each person seeking admission to the program:

(A) name
(B) home address
(C) telephone number
(D) date of birth
(E) sex
(F) race/ethnicity
(G) marital and family status
(H) employment status and employer
(I) education
(J) current family income
(K) next of kin
(L) social security number
(M) criminal justice system status
(N) referral source
(O) insurance coverage

(P) date of initial contact
(Q) date of interview
(R) signature and title of intake worker

(3) Each client's history shall be completed by a member of the program's treatment staff and shall include, but need not be limited to the following information:

(A) presenting problem
(B) history of substance abuse and problems
(C) family and personal history
(D) education and employment history
(E) medical history
(F) history of arrests and convictions
(G) previous treatment history

(c) **Orientation**

(1) Each client admitted to a program shall receive an orientation in accordance with a written orientation policy and procedure.

(2) Such orientation shall include, but need not be limited to explaining in language understandable to each client:

(i) the program's policies, goals and objectives;
(ii) the services offered by the program and through referral to other service providers;
(iii) the program's hours of operation;
(iv) the fee policy and fee schedule;
(v) the client's rights;
(vi) the program's expectations of the client;
(vii) the protection and restrictions which derive from state and federal confidentiality law and regulations;
(viii) the program's rules and procedures and the consequences to the client of infractions of such rules; and,
(ix) the program's termination and discharge procedures

(d) **Assessment procedure**

(1) Each program shall have and utilize a written policy and procedure for assessing all clients admitted to the program. At a minimum the assessment shall include a written synthesis of information obtained during the intake procedure, which synthesis shall identify the client's strengths and the staff person's observations of the client's personality functioning and those situational factors which have contributed to the client's current dysfunction.

(2) The assessment shall be used as a guide to the formulation of the client's treatment plan.

(e) **Treatment plan**

(1) Each program, except detoxification programs shall, with the participation of the client, prepare a written individualized treatment plan for each client which shall address client needs of care within the context of community and client resources. Development of such plan shall begin upon admission.

(2) Each treatment plan shall be in writing and shall include at a minimum:

(A) a description of the client's identified problems to be addressed during treatment;

(B) goals which include a specific time for achievement

(C) methods of attainment by which such goals may be achieved;

(D) the name and title of the client's primary counselor;

(E) evidence that the client has participated in the formation of his own treatment plan, such as:

(i) the client's signature on the treatment plan;

(ii) a contract between the client and the program;

(iii) treatment goals identified by the client through notations on a checklist of possible goals or a narrative signed by the client and made a part of the treatment plan.

(3) Each client's treatment plan shall be reviewed periodically for completeness and appropriateness in accordance with a written standardized policy and procedure designed to ensure that the plan remains applicable to the changing needs of the client. The client's individual record shall contain written evidence of such periodic review, assessment of the client's progress and any revisions which have been made in the plan based on the required reviews. Treatment plans shall be reviewed no less frequently than:

(A) weekly for residential intensive programs;

(B) for residential intermediate and long term treatment and rehabilitation programs and day/evening programs, 30 days after preparation of a treatment plan, then every 60 days thereafter;

(C) for outpatient programs 30 days after preparation of a treatment plan for the first review, 60 days after the first review for the second review and 90 days thereafter; and,

(D) for methadone maintenance programs 30 days after preparation of the treatment plan, 90 days after the first review for the second review and every 6 months thereafter.

(f) **Aftercare**

Each treatment and rehabilitation program, which has an aftercare component, shall offer aftercare services to clients in accordance with a written aftercare plan.

The plan shall include, but need not be limited to:

(1) a description of the objectives, policies and procedures of its aftercare services;

(2) a description of the specific aftercare services available to clients; and,

(3) policies and procedures for periodic review of aftercare services which are provided.

(g) **Discharge summary**

Each program shall prepare a written discharge summary for each client who completes a course of treatment or leaves the program. Such summary shall be prepared by the client's primary counselor and shall be recorded in the clients record and shall include but need not be limited to:

(1) an evaluation of the client's progress toward the goals described in the client's treatment plan,

(2) the reason for discharge and other information, if any, pertaining to the client's course of treatment,

(3) a summary of all recommendations, if any, made to the client upon the clients leaving the program, and

(4) a list of any referrals made to other organizations or service providers at the time the client leaves the program.

(h) **Referrals**

(1) Each program shall have and utilize a written policy and procedure for client referrals as part of a comprehensive network of care, which shall include, but need not be limited to:

(A) a procedure for referral and monitoring of persons on a waiting list for admission to the program;

(B) procedures for referral of clients between specific components of the awardee's program; and,

(C) current information on, and referral to, self-help groups.

(2) Each program shall maintain a list of referral sources and resources which is periodically updated.

(i) **Client record system**

(1) Each program shall use a standardized record keeping system and maintain an individualized record for each client admitted to the program which shall document the changing status, needs and activities of the client as treatment progresses and shall include, but need not be limited to:

(A) all standardized statistical information as required by sections (b) of this regulation, and emergency information;

(B) all parts of the client's individualized treatment plan as required by section (e) of this regulation;

(C) all client assessments performed, including documentation of client problems and needs;

(D) the results of all physical, psychological, medical, laboratory and vocational examinations and tests shall be included with the signature and title of the person administering the test or performing the examination;

(E) all referrals to services deemed to be necessary to the client but not provided by admitting facility;

(F) progress notes, signed and dated by the originator and listing all events which have impacted the client's progress in attaining goals such notes shall be kept as follows:

(i) daily for residential detoxification programs

(ii) weekly for residential and day/evening programs

(iii) per counseling sessions for outpatient and methadone programs;

(G) a discharge summary for all clients who have left the program.

(2) Each program shall have and utilize a policy and procedures for maintaining the security of client records which shall be in conformity with the requirements of the federal confidentiality regulations, 42 CFR 2.17.

(3) Each program shall have and utilize a policy and procedure for closing and storing client records. The policy and procedure shall include, but need not be limited to the following provisions:

(A) the entire record shall be maintained for a period of at least five years after closure and shall be protected against loss, damage or breach of client confidentiality;

(B) after 5 years such records may be destroyed by shredding or burning; and,

(C) the policy shall specify under what circumstances a record is to be closed.

(j) **Provision of medical services and medication**

(1) Medical alcohol detoxification programs, residential programs and methadone programs shall ensure that each client shall have a complete medical history and physical

examination.

(2) Methadone programs shall perform the following laboratory tests:

(A) complete blood count and differential

(B) serological test for syphilis

(C) routine and microscopic urinalysis

(D) routine screening for drugs

(E) Multi-phasic chemistry profile

(F) Tine test followed by a chest x-ray only if the skin test is positive

(G) Australian Antigen, EKG and biological tests for pregnancy if clinically indicated.

(3) Each program shall have and utilize a written policy and procedure for administration, storage and self-administration of all medications. All medications shall be marked, regularly inventoried and stored in a locked cabinet.

(4) Each program shall have a fully-equipped first aid kit on the premises at all times the program is in operation.

(5) When a client is referred from another program and there is no break in the treatment regimen, a physical examination as required by subsection (2) above need not be repeated by the program accepting the referral. A record of physical examination from the referring program shall be included in the intake information in the client's record.

(k) **Meals**

Residential programs and detoxification programs shall provide at least three nutritionally balanced meals for each client each day.

(Effective September 20, 1984)