CCD Counseling P.A.

Substance Abuse Treatment Policies and Procedures

(7/2017)

[Note: These Policies and Procedures are in addition to Agency Policies and Procedures contained in a separate document.]

Table of Contents

This section is structured to reflect the requirements of the Texas Administrative Code, Title 25("Health Services"), Part 1 ("Department of State Health Services"), Chapter 448 ("Standards of Care'), related to the provision of substance abuse services in Texas. The number in parentheses cites the rule number that each section is responsive to.

Note: Many of the following Policies and Procedures are required by our treatment facility licensing. Staff should be aware that these requirements may duplicate or conflict with those required by either the agency, licensing bodies, or law. Staff should assume that the policies set forth in this section apply only to staff providing, or clients who are receiving a service that requires this licensure, unless the same or more rigorous requirement is required of that staff or service by the agency, the staff's licensing body (rules or ethics), or law.

50. STANDARDS OF CARE (SUBCHAPTER B)

General Standard (448.201)
Staff shall provide adequate and appropriate services consistent with best practices and industry standards. Staff shall maintain objectivity. Staff shall respect each individual's dignity, and shall not engage in any action that may cause injury and shall always act with integrity in providing services.

Scope of Practice (448.202)
Staff shall recognize the limitations of their ability and shall not offer services outside their scope of practice or use techniques that exceed their professional competence. Staff shall not make any claim, directly or by implication, that they possess professional qualifications or affiliations that they do not possess.

Competence and Due Care (448.203)
Staff shall plan, supervise adequately, and evaluate any activity for which they are responsible. Staff shall render services carefully and promptly. Staff shall follow the technical and ethical standards related to the provision of services, strive continually to improve personal competence and quality of service delivery, and discharge their professional responsibility to the best of their abilities. Staff are responsible for assessing the adequacy of their own competence for the responsibility to be assumed. Services shall be designed and administered as to do no harm to recipients. Staff shall always act in the best interest of the individual being served. Staff shall terminate any professional relationship that is not beneficial, or is in any way detrimental, to the individual being served.

Appropriate Services (448.204)
Services should be appropriate for the individual's needs and circumstances, including age and developmental level, and should be culturally sensitive. Staff shall possess an understanding of the cultural norms of the individuals receiving services. Services shall be respectful and non exploitative.

Accuracy (448.205)
Staff shall report information fairly, professionally, and accurately when providing services and when communicating with other professionals, DSHS , and the general public. Staff shall document and assign credit to all contributing sources used in published material or public statements. Staff shall not misrepresent either directly or by implication professional qualifications or affiliations.

Documentation (448.206)
Staff shall maintain required documentation of services provided and related transactions including financial records.

Discrimination (448.207)
Staff shall not discriminate against any individual on the basis of gender, race, religion, age, national origin, disability (physical or mental), sexual orientation, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected. Staff may consider economic condition and financial resources in admission criteria, but economic condition shall not affect the services once an individual is admitted.

Access to Services (448.208)
Staff shall provide access to services, including providing information about other services and alternative services, taking into account an individual's financial constraints and special needs.

Location (448.209)
Staff shall not offer or provide services in settings or locations that are inappropriate or harmful to individuals served or others.

Confidentiality (448.210)
Staff shall protect the privacy of individuals served and shall not disclose confidential information without express written consent, except as permitted by law. Staff shall remain knowledgeable of, and obey, all State and Federal laws and regulations relating to confidentiality of records relating to the provision of services. Staff shall not discuss or divulge information obtained in clinical or consulting relationships except in appropriate settings and for professional purposes that demonstrably relate to the case. Confidential information acquired during delivery of services shall be safeguarded from illegal or inappropriate use, access and disclosure or from loss, destruction or tampering. These safeguards shall protect against verbal disclosure, prevent unsecured maintenance of records, or recording of an activity or presentation without appropriate releases.

Environment (448.211)
Staff shall provide an appropriate, safe, clean, and well-maintained environment.

Communications (448.212)
Staff shall inform the individual receiving services about all relevant and important aspects of the service relationship.

Exploitation (448.213)
Staff shall not exploit relationships with individuals receiving services for personal or financial gain of the agency or staff. Staff shall not charge exorbitant or unreasonable fees for any service. Staff shall not pay or receive any commission, consideration, or benefit of any kind related to the referral of an individual for services.

Duty to Report (448.214)

When staff have knowledge of unethical conduct or practice on the part of a person or provider, they have a responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public. Any staff who receive an allegation or have reason to suspect that an individual has been, is, or will be subject to abuse, neglect or exploitation by any Provider shall immediately inform DSH's investigations division. Staff shall also take immediate action to prevent or stop the abuse, neglect, or exploitation and provide appropriate care and treatment. Staff shall report allegations of child abuse or neglect to the Texas Department of Protective and Regulatory Services as required by the TEX. FAM. CODE ANN. §261.101 (Vernon 2002 & Supp. 2004). Staff shall report allegations of abuse, neglect or exploitation of elderly or disabled individuals to the Texas Department of Protective and Regulatory Services as required by the TEX. HUM. RES. CODE ANN. §48.051 (Vernon 2001 & Supp. 2004). If the allegation involves sexual exploitation, the service Staff shall comply with reporting requirements listed in the TEX. CIV. PRAC. & REM. CODE ANN. §81.006 (Vernon 1997 & Supp. 2004).

Impaired Staff (448.215)

Staff should recognize the effect of impairment on professional performance and should be willing to seek needed treatment. Where there is evidence of impairment in a colleague, staff should be supportive of assistance or treatment. An employer shall provide access to information regarding available services to impaired employees.

Ethics (448.216)

Staff shall adhere to established professional codes of ethics. These codes of ethics define the professional context within which staff works, in order to maintain professional standards and safeguard the client or participant. The agency and staff shall protect consumers and act in an ethical manner at all times.

Specific Acts Prohibited (448.217)

In addition to staff's general duty to provide services in a professional manner, the following acts are specifically prohibited and shall constitute a violation of these rules:

(a) Staff shall not provide services, interact with individuals receiving services, or perform any job duties while under the influence or impaired by the use of alcohol, or mood altering substances, including prescription medications not used in accordance with a physician's order.

(b) Staff shall not commit an illegal, unprofessional or unethical act (including acts constituting abuse, neglect, or exploitation).

(c) Staff shall not assist or knowingly allow another person to commit an illegal, unprofessional, or unethical act.

(d) Staff shall not falsify, alter, destroy or omit significant information from required reports and records or interfere with their preservation.

(e) Staff shall not retaliate against anyone who reports a violation of these rules or cooperates during a review, inspection, investigation, hearing, or other related activity.

(f) Staff shall not interfere with DSHS reviews, inspections, investigations, hearings, or related activities. This includes taking action to discourage or prevent someone else from cooperating with the activity.

(g) Staff shall not enter into a personal or business relationship of any type with an individual receiving services until at least two years after the last date an individual receives services from Staff.

(h) Staff shall not discourage, intimidate, harass, or retaliate against individuals who try to exercise their rights or file a grievance.

(i) Staff shall not restrict, discourage, or interfere with any communication with law enforcement, an attorney, or with DSHS for the purposes of filing a grievance.

(j) Staff shall not allow unqualified persons or entities to provide services.

Standards of Conduct (448.218)

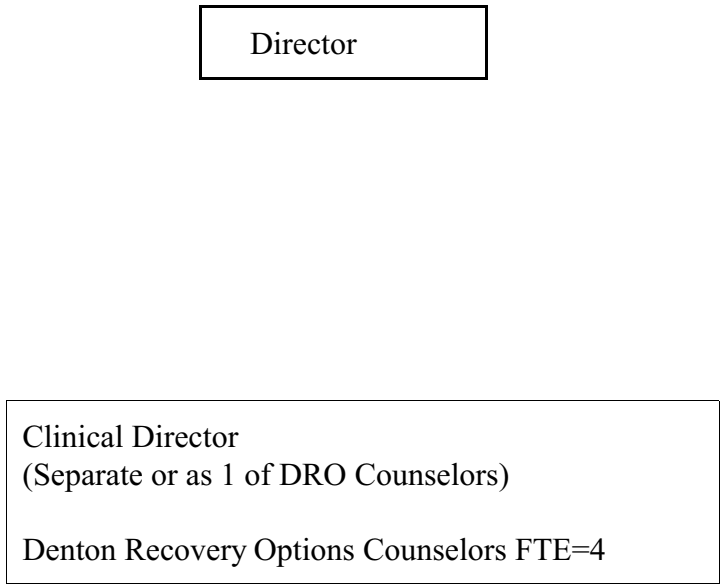
(a) The facility and all of its personnel shall protect clients' rights and provide competent services.

(b) Any person associated with the facility that receives an allegation or has reason to suspect that a person associated with the facility has been, is, or will be engaged in illegal, unethical, or unprofessional conduct shall immediately inform the DSHS investigations division and the director or their designee. If the allegation involves the director, it shall be reported to the DSHS.

(c) The facility and its personnel shall comply with TEX. HEALTH & SAFETY CODE ANN. ch. 164 (Vernon 2001 & Supp. 2003)(relating to Treatment Facilities Marketing and Admission Practices).

60. FACILITY (SUBCHAPTER E)

61. DENTON RECOVERY OPTIONS ORGANIZATIONAL CHART (448.501B)



62. OPERATIONAL PLAN (448.502)

62.1 Mission

The mission of CCD Counseling, P.A. outpatient substance abuse treatment services is to provide the best of a diversified and comprehensive array of outpatient alcoholism/chemical dependency clinical services in the most efficient and cost effective manner possible.

62.2 Services

[From Section *102. OUTPATIENT REQUIREMENTS (448.904)* (d) Each client's treatment shall include individualized treatment planning based on a comprehensive assessment, educational and process groups, and individual counseling.]

Phase I (Substance Abuse Outpatient Program) Description

Group Meetings

Frequency: 4 nights per week for 6 weeks.
Duration: 3 hours per night
Staff: Client Ratio 1:16
Content of each session:
1.0 hour of chemical dependency education
1.5 hours of Process Groups
.5 hour of active planning/maintenance of sobriety

Individual Services

IOP Intake
Individual Counseling
Individual Treatment Planning
Individual Treatment Plan Review
(minimally, midway through the projected duration of treatment)

Documented Discharge to Recovery Maintenance

Phase II and III (Supportive Outpatient /Aftercare) Description

Phase II

Group Meetings

Frequency: 2 night per week for 5 weeks.
Duration: 2.0 hours per night
Staff: Client Ratio 1:16
Content of each session:
1 hour of chemical dependency education
1 hours of Process Groups

Individual Services

Recovery Maintenance Intake
CD Individual Counseling
Individual Treatment Planning
Individual Treatment Plan Review
(minimally, midway through the projected duration of treatment)

62.2 Services(cont)

Phase II and III (Supportive Outpatient /Aftercare) Description (cont)

Phase III

Group Meetings

Frequency: 1 night per week for 7 weeks.
Duration: 2.0 hours
Staff: Client Ratio 1:16
Content of each session:
1 hour of chemical dependency education
1 hours of Process Groups

Individual Services

Individual Counseling
Individual Treatment Planning
Individual Treatment Plan Review
(minimally, midway through the projected duration of treatment)
Recovery Maintenance Discharge

62.3 Target Population

All clients will be 18 years of age or older, unless otherwise mandated by the Criminal Justice System (16 or 17 years of age and adjudicated as an adult.)

62.4 Program Goals and Objectives

1) to pursue individualized courses of treatment which address the physical, emotional, spiritual and social needs of the chemically dependent or substance abusing individual, and,

2) to identify and intervene in the illness of addiction in order to arrest the progression, treat the illness, reduce the consequences and return full life to the client and their loved ones.

63. ANNUAL REPORT (448.503)

Staff will maintain the following data, and submit it annually to SDH:

(1) total number of clients served by diagnosis;
(2) gender of clients served;
(3) ethnicity of clients served;
(3) ages of clients served;
(4) primary and secondary drug at admission;
(5) discharge reason per treatment episode; and
(6) length of stay at time of discharge.

64. QUALITY MANAGEMENT (448.504)

A quality management meeting including the clinical director, agency director, and all staff providing services for the DRO program will be held quarterly to address:

(1) current program goals and objectives;
(2) corrections or changes needed;
(3) a review of any incident reports, rules violations, client relapses, or quality deficiencies, including development of a plan to address them, including implementation and monitoring;
(4) the appropriateness of client placement, adequacy of services provided and length of stay; via the review of randomly selected cases.

This quality management process will be documented.

65. GENERAL ENVIRONMENT (448.505)

a) The facility shall comply with the Americans with Disabilities Act. The facility shall maintain documentation that it has conducted a self-inspection to evaluate compliance and implemented a corrective action plan within reasonable time frames to address identified deficiencies.

b) Smoking is prohibited inside the building, within 15 feet of any entrance, and/or during structured program activities. Staff shall not provide or facilitate client access to tobacco products.

c) Firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence are prohibited .

66. REQUIRED POSTINGS (448.506)

The following documents will be posted at all times in English and a second language:

a) the Client Bill of Rights,
b) the commission's current poster on reporting complaints and violations, and
c) the client grievance procedure.

67. CLIENT RECORDS (448.508)

(a) The staff shall establish and maintain a single record for every client at the time of admission. The content of client records shall be complete, current, and well organized.

(b) The staff shall protect all client records and other client-identifying information from destruction, loss, tampering, and unauthorized access, use or disclosure.

(1) All active client records shall be stored at the facility and inactive records in off-site storage shall be fully protected.

(2) Information that identifies applicants shall be protected to the same degree as information that identifies clients.

(3) Electronic client information shall be protected to the same degree as paper records and shall have a reliable backup system.

(c) Access to client records is restricted to staff with job duties requiring their use.

(d) Staff shall keep records locked at all times unless an authorized person is continuously present in the immediate area.

(e) The staff shall ensure that all client records can be located and retrieved promptly at all times.

(f) Staff shall comply with federal and state confidentiality laws and regulations, including 42 CFR Part 2 (the federal regulations on the Confidentiality of Alcohol and Drug Abuse Client Records) and Texas Health and Safety Code, Chapter 611 (relating to Mental Health Records), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility shall also protect the confidentiality of HIV information as required in Texas Health and Safety Code §81.103 (relating to Confidentiality; Criminal Penalty).

(g) The facility shall not deny clients access to the content of their records except as provided by the Texas Health and Safety Code, §611.0045 and HIPAA.

(h) Client records shall be kept for at least six years. Records of adolescent clients shall be kept for at least five years after the client turns 18.

(i) If client records are microfilmed, scanned, or destroyed, the facility shall take steps to protect confidentiality. The facility shall maintain a record of all client records destroyed on or after September 1, 1999, including the client's name, record number, birth date, and dates of admission and discharge.

68. INCIDENT REPORTING (448.509)

(a) The staff shall report to the Commission's investigations division, all allegations of client abuse, neglect, and exploitation.

(b) The facility shall complete an internal incident report for all client incidents, including:

(1) a violation of a client rights, including but not limited to, allegations of abuse, neglect and exploitation;
(2) accidents and injuries;
(3) medical emergencies;
(4) psychiatric emergencies;

(6) illegal or violent behavior;
(7) loss of a client record;

(9) release of confidential information without client consent;
(10) fire;
(11) death of an active outpatient or residential client (on or off the program site);

(13) suicide attempt by an active client (on or off the program site);
(14) medical and psychiatric emergencies that result in admission to an inpatient unit of a medical or psychiatric facility; and
(15) any other significant disruptions.

(c) The incident report shall be completed and delivered to the director within 24 hours of the occurrence of an incident on-site, or within 24 hours of when the staff became aware of, or reasonably should have known of an incident that occurred off-site. The incident report shall provide a detailed description of the event, including the date, time, location, individuals involved, and action taken.

(d) The individual writing the report shall sign it and record the date and time it was completed.

(e) All incident reports shall be stored in a single, separate file.

(f) The director is responsible for reviewing incident reports. All incidents will be evaluated through the quality management process to determine opportunities to improve or address program and staff performance.

69. CLIENT TRANSPORTATION (448.510)

Staff shall never transport clients.

70. PERSONNEL PRACTICES AND DEVELOPMENT (SUBCHAPTER F)

71. HIRING PRACTICES (448.601)

(a) The program will not use counselor interns.

(b) The facility shall verify the current status of all required credentials with the credentialing authority by internet, telephone or letter.

(d) The facility shall obtain and assess the results of a criminal background check from the Department of Public Safety prior to new hires having any contact with clients.

(e) The facility shall not hire an individual who has not passed a pre-employment drug test that meets the criteria established by the commission.

(g) The staff's personnel files shall document compliance with each of these requirements.

72. JOB DESCRIPTION: DENTON RECOVERY OPTIONS COUNSELOR (448.601F)

Qualifications: Have sufficient education, licensure and experience to qualify under the law in the State of Texas and under the provisions of DSHS as a qualified chemical dependency counselor. If the counselor is designated as Clinical Director, they will also have a minimum of two years post-licensure experience providing chemical dependency treatment.

Duties: Execute all aspects of the Denton Recovery Options Services in a manner which:

a) benefits the client,
b) advances the reputation of the agency, and,
c) complies with all relevant licensure, including, but not limited to the following duties:
1. Assessment,
2. Screening and Intake,
3. Providing Direct Service(s),
4. Ongoing Evaluation,
5. Discharge, and
6. Documentation

73. STUDENTS AND OTHER VOLUNTEERS (448.602)

The program will not utilize students or volunteers.

74. STAFF TRAINING (448.603)

(a) Unless otherwise specified, video, manual, or computer-based training is acceptable if the supervisor discusses and documents the material with the staff person in a face-to-face session to highlight key issues and answer questions.

(b) The facility will maintain documentation of all required training.

(1) Documentation of external training shall include:

A) date;
B) number of hours;
C) topic;
D) instructor's name; and
E) signature of the instructor (or equivalent verification)

(2) Documentation of internal training shall include:

A) an outline of the content;
B) instructor's name, credentials, relevant qualifications; and
C) method of delivery

(3) For each group training session , a dated attendee sign-in sheet will be maintained.

(c) Prior to performing their duties and responsibilities each staff will complete an orientation which includes the following information:

(1) TCADA rules;
(2) facility policies and procedures;
(3) client rights;
(4) client grievance procedures;
(5) confidentiality of client-identifying information (42 C.F.R. pt. 2; HIPAA);
(6) standards of conduct; and
(7) emergency and evacuation procedures.

(d) The following initial training(s) must be received within the first 90 days of employment and must be completed before the employee can perform a function to which the specific training is applicable. Subsequent training must be completed as specified.

(1) Abuse, Neglect, and Exploitation. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.

(2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.

(A) The initial training shall be three hours in length.

(B) Staff shall receive annual updated information about these diseases.

(4) Nonviolent Crisis Intervention. All direct care staff shall receive this training. The face-to-face training shall teach staff how to use verbal and other non-physical methods for prevention, early intervention, and crisis management. The instructor shall have documented successful completion of a course for crisis intervention instructors or have equivalent documented training and experience.

(A) The initial training shall be four hours in length.

(B) Staff shall complete two hours of annual training thereafter.

(6) Intake, Screening and Admission Authorization. All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses.

(A) The initial training shall be eight hours in length.

(B) Staff shall complete eight hours of annual training thereafter.

(C) The training shall be completed before staff screen or authorize applicants for admission.

80. CLIENT RIGHTS(SUBCHAPTER G)

81. THE CLIENT BILL OF RIGHTS (448.701)

(a) The facility shall respect and protect clients' rights. The Client Bill of Rights includes:

(1) You have the right to accept or refuse treatment after receiving this explanation.
(2) If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
(3) You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
(4) You have the right to be free from abuse, neglect, and exploitation.
(5) You have the right to be treated with dignity and respect.
(6) You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
(7) You have the right to be told about the program's rules and regulations before you are admitted.
(8) You have the right to be told before admission:
    (A) the condition to be treated;
    (B) the proposed treatment;
    (C) the risks, benefits, and side effects of all proposed treatment and medication;
    (D) the probable health and mental health consequences of refusing treatment;
    (E) other treatments that are available and which ones, if any, might be appropriate for you; and
    (F) the expected length of stay.
(9) You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
(10) You have the right to meet with staff to review and update the plan on a regular basis.
(11) You have the right to refuse to take part in research without affecting your regular care.
(12) You have the right not to receive unnecessary or excessive medication.
(13) You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
(14) You have the right to be told in advance of all estimated charges and any limitations on the length of services of which the facility is aware.
(15) You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.
(16) You have the right to make a complaint and receive a fair response from the facility within a reasonable amount of time.
(17) You have the right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.
(18) You have the right to get a copy of these rights before you are admitted, including the address and phone number of the Texas Commission on Alcohol and Drug Abuse.
(19) You have the right to have your rights explained to you in simple terms, in a way you can understand, within 24 hours of being admitted.

82. CLIENT GRIEVANCES (448.702)

(a-d) Each client will receive a copy of the agency's Grievance procedures at intake. Staff will explain the policy in clear, simple terms that the client understands, including the clients right to:

a) file a grievance about any violation of client rights or commission rules;
b) submit a grievance in writing and get help writing if they are unable to read or write;
c) request writing materials, postage, and access to a telephone for the purpose of filing a grievance;
d) submit a complaint directly to the commission at any time at the current mailing address or the toll-free number of the commission's investigation division.

e) Any staff receiving a client grievance will submit it to the Director immediately. Upon receiving such grievance, the Director or their designee shall:

(1) evaluate the grievance thoroughly and objectively, obtaining additional information as needed;
(2) provide a written response to the client within seven days of receiving the grievance;
(3) take action to resolve all grievances promptly and fairly; and
(4) document all grievances, including the final disposition, and keep the documentation in a central file.

(f) Staff shall not:

(1) retaliate against clients who try to exercise their rights or file a grievance; or
(2) restrict, discourage, or interfere with client communication with an attorney or with the Commission for the purposes of filing a grievance.

83. CLIENT ABUSE, NEGLECT AND EXPLOITATION (448.703)

Abuse, neglect, and exploitation of clients and/or participants is prohibited.

(a) Any person who receives an allegation or has reason to suspect that a client or participant has been, is, or will be abused, neglected, or exploited by any person shall immediately inform the Commission's investigations division and the Director or designee. If the allegation involves the Director, it shall be reported directly to the LPC board.

(1) The person shall also report allegations of child abuse or neglect to the Texas Department of Protective and Regulatory Services as required by TEX. FAM. CODE ANN. º 261.101 (Vernon 2002 & Supp. 2004).

(2) The person shall also report allegations of abuse or neglect of an elderly or disabled individual to the Texas Department of Protective and Regulatory Services as required by TEX. HUM. RES. CODE ANN. º 48.051 (Vernon 2001 & Supp. 2004).

(b) If the allegation involves sexual exploitation, the director or designee shall comply with reporting requirements listed in TEX. CIV. PRAC. & REM. CODE ANN. º 81.006 (Vernon 1997 & Supp. 2004).

(c) The director or designee shall take immediate action to prevent or stop the abuse, neglect, or exploitation and provide appropriate care.

(d) The director or designee shall ensure that a verbal report has been or is made to the Commission's investigations division as required in subsection (a) of this section.

(e) The person who reported the incident shall submit a written incident report to the director within 24 hours.

(f) The director or designee shall send a written report to the Commission's investigations division within two business days after receiving notification of the incident. This report shall include:
(1) the name of the client or participant and the person the allegations are against;
(2) the information required in the incident report or a copy of the incident report; and
(3) other individuals, organizations, and law enforcement notified.

(g) The director or designee shall also notify the consenter. If the client is the consenter, family members may be notified only if the client gives written consent. If the consenter is not the client, the director may withhold notification to the the consenter if this action may place the client at additional risk. In this situation, the director will notify the Commission's investigations division in writing of this decision.

(h) The provider shall investigate the complaint and take appropriate action unless otherwise directed by the Commission's investigations division. The investigation and the results shall be documented.

(i) The director or her designee shall take action needed to prevent any confirmed incident from recurring.

(j) The director shall:

(1) document all investigations and resulting actions and keep the documentation in a single, segregated file;

(3) enforce appropriate sanctions for confirmed violations; including, but not limited to, termination of personnel with confirmed violations of client or participant physical or sexual abuse or instances of neglect that result in client or participant harm.

84. PROGRAM RULES (448.704)

(a) Staff shall maintain therapeutically sound written program rules addressing client behavior designed to protect their health, safety, and welfare.
(b) The consequences for violating program rules shall be defined in writing and shall include clear identification of violations that may result in discharge. The consequences shall be reasonable, take into account the client's diagnosis and progress in treatment, and shall not include:
(1) physical discipline or measures involving the denial of food, water, sleep, or bathroom privileges; or
(2) discipline that is authorized, supervised, or carried out by clients.
(c) At the time of admission, every client shall be informed verbally, and in writing, of the program rules and consequences for violating the rules.
(d) The facility shall enforce the rules fairly and objectively and shall not implement consequences for the convenience of staff.

85. CLIENT LABOR AND INTERACTIONS (448.705)

(a) The agency shall not hire or utilize current or former clients to fill staff positions.
(b) The agency shall not require clients to participate in any fund raising or publicity activities for the facility.
(c) The agency or staff shall not enter into a business or personal relationship with a client, give a personal gift to a client, or accept a personal gift of value from a client until at least two years after services to the client cease.

86. RESTRAINT AND SECLUSION (448.706)

Client's in need of personal restraint are not appropriate for any program in this agency. Clients indicating such a need will be immediately discharged and referred to a more appropriate level of care.

87. RESPONDING TO EMERGENCIES (448.707)

In addition to ***CCD Policies and Procedures Section 8***:

(c) Emergency numbers shall be posted by all telephones.
(d) The agency shall have fully stocked first aid supplies that are visible, labeled and easy to access.

88. SEARCHES (448.708)

Staff shall never conduct a search of a client.

90. SCREENING AND ASSESSMENT (SUBCHAPTER H)

91. SCREENING (448.801)

(a) *To be eligible for admission to a treatment program, an individual shall meet the DSM criteria for substance abuse or dependence (or substance withdrawal or intoxication in the case of a detoxification program). The facility shall use a screening process appropriate for the target population, individual's age, developmental level, culture and gender which includes the Texas Department of Insurance (TDI) criteria [*See Full Citation Below] to determine eligibility for admission or referral including an assessment of the client's financial resources and insurance benefits.*

*Texas Administrative Code
TITLE 28 INSURANCE
PART 1 TEXAS DEPARTMENT OF INSURANCE
CHAPTER 3 LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES
SUBCHAPTER HH STANDARDS FOR REASONABLE COST CONTROL AND UTILIZATION REVIEW FOR CHEMICAL DEPENDENCY TREATMENT CENTERS

(b) *The screening process shall collect other information as necessary to determine the type of services that are required to meet the individual's needs. This may necessitate the administration of all or part of validated assessment instruments.*

(c) *TDI criteria shall guide referral and treatment recommendations as well as placement decisions.*

(d) *Sufficient documentation shall be maintained in the client record to support the diagnosis and justify the referral/placement decision. Documentation shall include the date of the screening and the signature and credentials of the Qualified Credentialed Counselor (QCC) supervising the screening process.*

(e) TAC 448.01(e) Admission to detox does not apply to this program.

(f) *For admission to this treatment programs, the screening will be conducted by a counselor or counselor intern*.

91.1 Community Supervision and Corrections Department Screening

a. Screening shall include the administration, scoring, interpretation and referral for assessment of a client to determine the probability the defendant is chemically dependent.

b. Screening must be conducted by a Licensed Chemical Dependency Counselor or by an otherwise qualified person to conduct such screening who is exempt under DSHS's licensure rules and/or CJAD standards. Qualified Community Supervision Officers (CSOs) may also conduct the screening.

c. The screening instruments that are approved for use by Proposer for a substance abuse treatment services defendant are the following: (1) Substance Abuse Subtle Screening Inventory (SASSI), (2) Substance Abuse Life Circumstances Evaluation (SALCE), or (3) Texas Christian University Drug Scale V.

d. Defendants meeting the following criteria must bypass the screening process:

(1) A defendant with a documented criminal history of two or more prior arrests for offenses which involve the use or possession of alcohol or the use, possession, or sale of illegal substances;

(2) A defendant who has submitted positive urine specimens or admitted recent use of alcohol or drugs;

(3) A defendant who has previously attended an outpatient or inpatient substance abuse program;

(4) A defendant with a completed and documented screening or assessment/evaluation from another referral source that determined further assessment/evaluation of the subject defendant's substance abuse history was needed;

(5) The sentencing judge orders that the offender submit to an evaluation in order to determine treatment options.

91.5. Admission Criteria (TDI 3.8023**)**
All clients admitted to the program will meet the following criteria:

1. Diagnosis: Must meet one of the following categories:

a) **Chemical Dependence:** The diagnosis must meet the criteria for the definition of chemical dependence, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, accompanied by evidence that some of the symptoms have persisted for at least one month or have occurred repeatedly over a longer period of time; OR

b) **Chemical Substance Abuse:** the individual must meet the criteria for the definition of chemical substance abuse, as detailed in either the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners.

2. Medical Functioning: the patient is not bed-confined or has no medical complications that would hamper the patient's participation in the outpatient service.

3. Family, Social, Academic Dysfunction:

Either:

A. Patient's social system and significant others are supportive of recovery to the extent that the patient can adhere to a treatment plan and treatment service schedules without substantial risk of reactivating the patient's addiction. **OR**

B. Patient has no primary or social support system to assist with immediate recovery, but has the social skills to obtain such a support system or to become involved in a self-help fellowship.

4. Emotional/Behavioral Status:

(i) Patient is coherent, rational, and oriented for treatment; AND
(ii) Mental state of the patient does not preclude the patient's ability to:
(I) comprehend and understand the materials presented; and
(II) participate in rehabilitation/treatment process; AND
(iii) There is documentation that the patient expresses an interest to work toward rehabilitation/treatment goals.

5. Least Restrictive: Patient is unlikely to succeed in their course of treatment in a less restrictive available setting.

91.6. Additional Phase I Admission Criteria (TDI 3.8019**)**

In addition to meeting General admission criteria, all clients admitted to the program will also meet the following TDI criteria:

6. Recent Chemical Substance Use: the patient's chemical substance use is excessive and maladaptive.

91.7. Inappropriate for Admission - Criteria

Clients who meet the admission criteria, but also possess any of the following characteristics will be refused admission and referred to a more appropriate level of care:

1. Diagnosable with Intoxication or Withdrawal or other diagnosis that may produce delusions, hallucinations, psychosis, or other cognitive distortions that suggest a need for either detoxification or a more structured treatment program,
2. At high risk of withdrawal,
3. Actively suicidal or at risk of violence to self or others.

92. ADMISSION AUTHORIZATION AND CONSENT TO TREATMENT (448.802)

(a) *A QCC shall authorize each admission in writing and specify the level of care to be provided. If the screening counselor or intern is not qualified to authorize admission, the QCC shall review the results of the screening with the applicant, directly or indirectly, before authorizing admission. The authorization shall be documented in the client record and shall contain sufficient documentation to support the diagnosis and the placement decision.*

(b) *The facility shall obtain written authorization from the consenter before providing any treatment. [Note: This program does not provide medication]. The consent form shall be dated and signed by the client, the consenter, and the staff person providing the information, and shall document that the client and consenter have received and understood the following information:*

(1) the specific condition to be treated;
(2) the recommended course of treatment;
(3) the expected benefits of treatment;
(4) the probable health and mental health consequences of not consenting;
(5) the side effects and risks associated with the treatment;
(6) any generally accepted alternatives and whether an alternative might be appropriate;
(7) the qualifications of the staff that will provide the treatment;
(8) the name of the primary counselor;
(9) the client grievance procedure;
(10) *the Client Bill of Rights as specified in TAC §148.701*
(11) the program rules,
(12) violations that can lead to disciplinary action or discharge;
(13) any consequences for violation of program rules [This program does not search clients];
(14) the estimated fees, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources and insurance benefits;
(15) the facility's services and treatment process; and
(16) opportunities for family to be involved in treatment.

(c) *This information shall be explained to the client and consenter in simple, non-technical terms. If an emergency or the client's physical or mental condition prevents the explanation from being given or understood by the client within 24 hours, staff shall document the circumstances in the client record and present the explanation as soon as possible. Documentation of the explanation shall be dated and signed by the client, the consenter, and the staff person providing the explanation.*

(d) The client record shall include a copy of the Client Bill of Rights dated and signed by the client and consenter.

(e) If possible, all information shall be provided in the consenter's primary language.

(f) If an individual is not admitted, the program shall refer and assist the applicant to obtain appropriate services.

(g) When an applicant is screened and determined to be eligible for services but denied admission, the facility shall maintain documentation signed by the examining QCC which includes the reason for the denial and all referrals made..

93. ASSESSMENT (448.803)

(a) A counselor or counselor intern shall conduct and document a comprehensive psychosocial assessment with the client admitted to the facility. The assessment shall document and elicit enough information about the client's past and present status to provide a thorough understanding of the following areas:
(1) presenting problems resulting in admission;
(2) alcohol and other drug use;
(3) psychiatric and chemical dependency treatment;
(4) medical history and current health status, to include an assessment of Tuberculosis (TB), HIV and other sexually transmitted disease (STD) risk behaviors as permitted by law;
(5) relationships with family;
(6) social and leisure activities;
(7) education and vocational training;
(8) employment history;
(9) legal problems;
(10) mental/ emotional functioning; and
(11) strengths and weaknesses.

(b) The assessment shall result in a comprehensive listing of the client's problems, needs, and strengths.

(c) The assessment shall result in a comprehensive diagnostic impression, as detailed in the most current revision of the international classification of diseases, or the most current revision of the diagnostic and statistical manual for professional practitioners, as allowed by the QCC's license and scope of practice.

(d) If the assessment identifies a potential mental health problem, the facility shall obtain a mental health assessment and seek appropriate mental health services when resources for mental health assessments and/or services are available internally or through referral at no additional cost to the program. These services shall be provided by a facility or person authorized to provide such services or a qualified professional as described in TAC §448.901 of this title (relating to Requirements Applicable to all Treatment Services).

(e) The assessment shall be signed by the therapist and filed in the client record within three individual service days of admission.

(f) The program may accept an evaluation from an outside source if:

(1) it meets the criteria set forth herein;
(2) it was completed during the 30 days preceding admission or is received directly from a facility that is transferring the client; and
(3) a counselor reviews the information with the client and documents an update.

(g) TAC 448.03(g) Criteria for residential clients does not apply to this program.

93.1 Community Supervision and Corrections Department Assessment

a. The Proposer's assessment must include the use of the Addiction Severity Index (ASI), the Substance Abuse Evaluation (SAE), or other TDCJ-CJAD approved evaluation instruments as a structured or semi-structured interview.

b. The assessor must use the information and scoring to determine and document the nature and extent of a client's chemical dependency.

c. The assessor must determine and document an appropriate referral or document why a referral is not necessary.

d. The ASI interview/other instrument interview, scoring, referral, and treatment plan shall be performed by a Licensed Chemical Dependency Counselor, appropriately supervised Counselor Intern, or by an otherwise qualified person to conduct such assessments who is exempt under DSHS rules/CJAD Standards. Qualified Community Supervision Officers (CSOs) may conduct the SAE interview, interpret the results, and make appropriate referrals for treatment services.

94. TREATMENT PLANNING, IMPLEMENTATION AND REVIEW (448.804)

(a) The counselor and client shall work together to develop and implement an individualized, written treatment plan that identifies services and support needed to address problems and needs identified in the assessment. When appropriate, family shall also be involved.
  (1) When the client needs services not offered by the facility, appropriate referrals shall be made and documented in the client record. When feasible, other professionals serving the client from a referral agency should participate in the treatment planning process.
  (2) The client record shall contain justification when identified needs are temporarily deferred or not addressed during treatment.

(b) The treatment plan shall include goals, objectives, and strategies.
  (1) Goals shall be based on the client's problems/needs, strengths, and preferences.
  (2) Objectives shall be individualized, realistic, measurable, time specific, appropriate to the level of treatment, and clearly stated in behavioral terms.
  (3) Strategies shall describe the type and frequency of the specific services and interventions needed to help the client achieve the identified goals and shall be appropriate to the level of intensity of the program in which the client is receiving treatment.

(c) The treatment plan shall identify discharge criteria and include initial plans for discharge. The Texas Department of Insurance criteria shall be used as a general guideline for determining when clients are appropriate for transfer or discharge, but individualized criteria shall be specifically developed for each client.

(d) A treatment plan shall include a projected length of stay.

(e) The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan.

(f) The treatment plan shall be completed and filed in the client record within five individual service days of admission.

(g) The treatment plan shall be evaluated on a regular basis and revised as needed to reflect the ongoing reassessment of the client's problems, needs, and response to treatment.

(h) The primary counselor shall meet with the client to review and update the treatment plan at appropriate intervals defined in writing by the program. At a minimum, treatment plans shall be reviewed midway through the projected duration of treatment.

(i) The treatment plan review shall include:
  (1) an evaluation of the client's progress toward each goal and objective;
  (2) revision of the goals, objectives; and
  (3) justifications of continued length of stay.

(j) Treatment plan reviews shall be dated and signed by the client, the counselor and the supervising QCC, if applicable.

(k) When a client’s intensity of service is changed, the client record shall contain:
  (1) clear documentation of the decision signed by a QCC, including the rationale and the effective date;
  (2) a revised treatment plan; and
  (3) documentation of coordination activities with any receiving treatment provider.

(l) Program staff shall document all treatment services (counseling, chemical dependency education, and life skills training) in the client record within 72 hours, including the date, nature, and duration of the contact, and the signature and credentials of the person providing the service.

(1) Education, life skills training, and group counseling notes shall also include the topic/issue addressed.

(2) Individual counseling notes shall include the goals addressed, clinical observation and new issues or needs identified during the session.

94.1 Continued Stay Criteria (TDI 3.8020 & 3.8024)

An individual is considered eligible for continued stay in the program if they meet the following criteria:

Alcohol/drug rehabilitation/treatment complication:

(A) Patient demonstrates an insight and understanding into the patient's personal relationship with mood-altering chemicals, yet is not effectively addressing the life functions of work, social, or primary relationships without the use of mood-altering chemicals; OR

(B) Patient, while physically abstinent from chemical substance use, remains mentally preoccupied with such use to the extent that the patient is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the patient will effectively address these issues; OR

Psychiatric or medical complications

Documentation in the record indicates an intervening medical or psychiatric event which was serious enough to interrupt rehabilitation/treatment, but the patient is again progressing in treatment.

95. DISCHARGE (448.805)

(a) The counselor and client/consenter shall develop and implement an individualized discharge plan.
(b) Discharge plans shall be updated as the client progresses through treatment and shall address the continued appropriateness of the current treatment level.
(c) The discharge plan shall address continuity of services to the client.
    (1) When a client is referred or transferred to another chemical dependency or mental health service provider for continuing care, the facility shall contact the receiving program before the client is discharged to make arrangements for the transfer.
    (2) Coordination activities shall be documented in the client record, including timeframe for client being able to access needed services and any constraints associated with the referral.
    (3) With proper client consent, the facility shall provide the receiving program with copies of relevant parts of the client's record.
(d) The program shall involve the client's family or an alternate support system in the discharge planning process when appropriate.
(e) Discharge planning shall be completed before the client's scheduled discharge.
(f) A written discharge plan shall be developed to address ongoing client needs, including:
    (1) individual goals or activities to sustain recovery;
    (2) referrals; and
    (3) recovery maintenance services, if applicable.
(g) The completed discharge plan shall be dated and signed by the counselor, the client, and the consenter (if applicable).
(h) The program shall give the client and consenter a copy of the plan, and file the original signed plan in the client record.
(i) The program shall complete a discharge summary for each client within 30 days of discharge. The discharge summary shall be signed by the therapist and shall include:
    (1) dates of admission and discharge;
    (2) needs and problems identified at the time of admission, during treatment, and at discharge;
    (3) services provided;
    (4) assessment of the client's progress towards goals;
    (5) reason for discharge; and
    (6) referrals and recommendations, including arrangements for recovery maintenance.
(j) The facility shall contact each client no sooner than 60 days and no later than 90 days after discharge from the facility and document the individual's current status or the reason the contact was unsuccessful.

95.1 Discharge Criteria for Phase I (TDI 3.8021)

The patient is considered eligible for discharge from Phase I when the patient meets any of the following **three** criteria:

(1) Psychiatric Illness or Medical Complication:

Either:

(A) documentation that a psychiatric or medical condition should be treated in another setting; **OR**

(B) documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.

(2) Alcohol/Drug Rehabilitation/Treatment:

Either:

(A) Patient displays behaviors which demonstrate that the patient:

(i) recognizes or identifies with the severity of chemical substance use;

(ii) has insight into the patient's defeating relationship with alcohol/drugs; **and**

(iii) is applying the essential coping skills necessary to cope with the alcohol and/or drug problem and to maintain abstinence; **or**

(B) Patient is functioning adequately in assessed deficiencies in the life tasks areas of work, social functioning, or primary relationships.

(3) Behavioral factors:

(A) Patient is consistently uncooperative, to the degree that no further progress is likely to occur; **AND**

(B) Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

95.2 Discharge Criteria for Outpatient Treatment Service (TDI §3.8025)

The patient is considered eligible for discharge from the program when the patient meets any of the following **four** criteria:

(1) A documented assessment which supports that the patient does not meet the diagnostic criteria for alcohol/drug dependence or abuse.

(2) Psychiatric Illness or Medical Complication:

Either:

(A) documentation that a psychiatric or medical condition should be treated in another setting; **OR**

(B) documentation that a psychiatric or medical condition which is interfering with alcohol/drug recovery is not being treated.

(3) Alcohol/Drug Rehabilitation/Treatment:

Either:

(A) Patient displays behaviors which demonstrate that the patient:

(i) recognizes or identifies with the severity of chemical substance use;

(ii) has insight into the patient's defeating relationship with alcohol/drugs; **and**

(iii) is applying the essential coping skills necessary to cope with the alcohol and/or drug problem and to maintain abstinence; **or**

(B) Patient is functioning adequately in assessed deficiencies in the life tasks areas of work, social functioning, or primary relationships.

(4) Behavioral factors:

(A) Patient is consistently uncooperative, to the degree that no further progress is likely to occur; **AND**

(B) Greater intensity of service or transfer to another treatment provider would not have a positive impact on the problem.

100. SUBCHAPTER I. TREATMENT PROGRAM SERVICES

101. REQUIREMENTS (448.901)

(a) Each client's treatment shall be based on a treatment plan developed from the client's comprehensive assessment.

(b) Group counseling sessions are limited to a maximum of 16 clients. Group education and life skills training sessions are limited to a maximum of 35 clients. This limit does not apply to multi-family educational groups, seminars, outside speakers, or other events designed for a large audience.

(c) Chemical dependency education and life skills training shall follow a written curriculum. All educational sessions shall include client participation and discussion of the material presented.

(d) The program shall provide education about Tuberculosis (TB), HIV, Hepatitis B and C, and sexually transmitted diseases (STDs) based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.

(e) The program shall provide education about the health risks of tobacco products and nicotine addiction.

(f) The program shall provide access to screening for TB and testing for HIV antibody, Hepatitis C, and STDs by referral to the client's primary care physician or the Denton County Health Department.

(1) HIV antibody testing shall be carried out by an entity approved by the Texas Department of Health.

(2) If a client tests positive, the program shall refer the client to an appropriate health care provider.

(g) The program shall facilitate access to physical health, mental health, and ancillary services if those services are not available through the program and are necessary to meet treatment goals and shall document these efforts.

(h) Individuals shall not be denied admission or discharged from treatment because they are taking prescribed medication.

(i) The agency shall maintain an adequate number of qualified staff to comply with licensure rules, provide appropriate and individualized treatment, and protect the health, safety, and welfare of clients.

(j) All personnel shall receive the training and supervision necessary to ensure compliance with Commission rules, provision of appropriate and individualized treatment, and protection of client health, safety and welfare.

(k) All direct care staff shall be awake and on-site during all hours of program operation.

101. REQUIREMENTS (448.901) (cont)

(o) Individuals responsible for planning, directing, or supervising treatment programs shall be QCCs. The clinical program director must have at least two years of post-licensure experience providing chemical dependency treatment.

(p) Chemical dependency counseling must be provided by a qualified credentialed counselor (QCC), graduate, or counselor intern. Chemical dependency education and life skills training shall be provided by counselors or individuals who have the specialized education and expertise.

102. OUTPATIENT REQUIREMENTS (448.904)

(a) DRO programs are designed for clients who do not require the more structured environment of residential treatment to maintain sobriety.

(b) DRO staff shall ensure access to full continuum of care and ensure sufficiency of treatment intensity to achieve treatment plan goals. Intensity and content of treatment shall be appropriate to the client's needs and consistent with generally accepted placement guidelines and standards of care.

(c) Each individual admitted to DRO shall be appropriate for this treatment setting, with written justification to support the admission.

(d) Each client’s treatment shall include individualized treatment planning based on a comprehensive assessment, educational and process groups, and individual counseling.

(e) Each client's progress will be assessed regularly by clinical staff to help determine the length and intensity of the program for that client.

103. Access to Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) Clients(448.906)

(a) DRO will not exclude an individual based on the following factors:
(1) the individual's past or present mental illness;
(2) medications prescribed to the individual in the past or present;
(3) the presumption of the individual's inability to benefit from treatment; or
(4) the individual's level of success in prior treatment episodes.

(b)If DRO determines that a client’s needs or level of care is out of the scope of the DRO program, DRO staff will make appropriate referrals and assist the client in getting the treatment they need.