TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control___**580**____Department or Agency__**Mental Health** ___
Rule No. ___**Chapter 580-9-43** _____
Rule Title: ___**Client Records**
_____New _____Amend ____X___Repeal _____Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? _____NO_____

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? _____ NO_____

Is there another, less restrictive method of regulation available that could adequately protect the public? _____NO_____

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? _____NO_____

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? _____NO_____

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? _____ YES_____

Does the proposed rule have an economic impact? _____NO_____

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer_____Debbie L Boswell

Date 10/14/11

Alabama Department of Mental Health

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Department of Mental Health

RULE NO. & TITLE: Chapter 580-9-43 Client Records "Repealed"

INTENDED ACTION: Repeal

SUBSTANCE OF PROPOSED ACTION:
Replaced by proposed new chapter 580-9-44, Program Operation

TIME, PLACE, MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments in writing to Debbie Popwell, Director, Office of Certification Administration, Alabama Department of Mental Health, 100 North Union Street, Montgomery, Alabama 36130 by mail or in person between the hours of 8:00AM and 5:00PM, Monday through Friday, or by electronic means to debbie.popwell@mh.alabama.gov until and including Dec 5, 2011. Persons wishing to submit data, views, or arguments orally should contact Ms. Popwell by telephone at (334) 353-2069 during this period to arrange for an appointment.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Dec. 5, 2011

CONTACT PERSON AT AGENCY:
Persons wishing a copy of the proposal may contact
Debbie Popwell
Department of Mental Health
100 North Union Street
Montgomery, Alabama 36130
(334) 353-2069
A copy of the proposed change is available on the department's website at http://mh.alabama.gov
Click on Commissioner's Office and then Certification Administrative to find code with changes.

Debbie Popwell, Director
Office of Certification

ALABAMA DEPARTMENT OF MENTAL HEALTH

AND MENTAL RETARDATION

ADMINISTRATIVE CODE

SUBSTANCE ABUSE SERVICES

CHAPTER 580-9-43 CLIENT RECORDS "Repealed"

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580-9-43-.01 Case Files.

(1) A case file must be established for each client admitted by the entity.

(2) The entity must maintain a system that provides for the control/location of all case files.

(3) The entity must establish a system to secure client records from unauthorized access.

(4) There shall be a staff member responsible for the storage and protection of client records in each location where records are stored.

(5) All entries and forms completed by the service provider in the client record shall be dated and signed, or appropriately authenticated in an electronic system. Written entries shall be made in ink and be legible.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: New Rule: Filed July 22, 1992. **Extended:** September 30, 1992. **Extended:** December 31, 1992. **Certified:** March 30,

1993; effective May 5, 1993. **Amended:** Filed November 19, 2003; effective December 24, 2003.

580-9-43-.02 Control And Maintenance.

(1) The client record shall include a Service Record which includes the date, service type, and service provider. The Service Record shall be filled out each time there is a contact with the client/collateral or correspondence and at case consultation and case review.

(2) Written clinical documentation shall be maintained to support each service, activity, or session for which services are rendered and the documentation must be failed in the client's clinical record within ten (10) working days from the delivery of the service, activity, or session. The following are required elements of this documentation:

(a) Specific type of service being rendered.

(b) Setting in which the service was rendered.

(c) Date and amount of time spent on delivering the service.

(d) Client's involvement in the activity.

(e) Relationship of the service to the client's treatment or rehabilitation plan.

(3) Following the completion of the problem assessment and assignment for treatment, the following information, if available, shall be recorded in the client record.

(a) Documentation of the Problem Assessment must include information as appropriate from among the following:

1. family history,

2. educational history,

3. relevant medical background,

4. employment/vocational history,

5. psychological/psychiatric history,

6. military history

7. legal history

8. alcohol/drug abuse history

9. mental status examination.

(b) Client identifying data including:

1. Case Number

2. Client Name

3. Date of Birth

4. Sex

5. Race/Ethnic Background

6. Home Address

7. Home Telephone Number

8. Next of kin or person to be contacted in case of emergency

9. Marital Status

10. Social Security Number

11. Referral Source

12. Reason for Referral

13. Date of admission to the program

14. Admission type (new, or readmission)

(c) Assessment: There must either be: (a) a diagnosis substantiated by an adequate diagnostic data base and, when indicated, a report of a medical examination. The diagnosis must be signed by a licensed physician, or a licensed

psychologist, or (b) a psycho social assessment, conducted and signed by an individual meeting standard #580-9-41-.02(1).

(d) Summary of Significant Problems: A description/summarization of the significant problem(s) that the client is experiencing, including those that are to be treated and those that impact upon treatment.

(e) Treatment Plans: Treatment programs must have a written treatment plan for each client that:

1. Are completed within 10 working days after admission.

2. Describe the focus of treatment based on clinical issues identified in the psych-social assessment.

3. Specify services necessary to meet the client needs.

4. Document referrals as appropriate for needed services not provided directly by the agency.

5. Identify measurable treatment objectives toward which the client and therapist will be working to impact on the specific clinical issues.

6. Be approved in writing by the program coordinator, clinical director or medical director.

7. The treatment planning process includes the client's signature/mark on the treatment plan/treatment plan update to document the client's participation in developing the plan/update.

(f) Rehabilitation Plans: Residential rehabilitation programs must have a written rehabilitation plan that includes independent living issues and expected process/outcomes completed within 10 working days after admission in the residential program. The rehabilitation plan must address the following key elements:

1. Identify the individual living issues that will be the focus of rehabilitation.

2. Specify services necessary to meet the client's needs and addressing the following:

(i) Alcohol and illicit drug free resident living

(ii) Supportive counseling

(iii) Rehabilitation support including linkages to Vocational Rehabilitation, job placement opportunities, educational opportunities, social rehabilitation opportunities, and motivational counseling.

3. Include referrals as appropriate for needed services not provided directly by the agency.

4. Identify expected outcomes and progress milestones toward which the client will be working to impact on the specific individual living issues.

5. Be approved in writing by the program coordinator or clinical consultant.

6. The rehabilitation plan shall document the client's participation in developing the plan.

(g) Progress Assessments: Written assessments of the client's progress, or lack thereof, which are related to each of the goals and objectives must be entered in the client record for:

1. intensive outpatient: weekly

2. crisis stabilization: weekly

3. residential rehabilitation: monthly

4. outpatient and Opiate Replacement Treatment: every 90 days

(h) Treatment and residential rehabilitation plans shall be reviewed and updated at least:

1. Residential stabilization: every 14 days

2. intensive outpatient program: every 90 days

3. residential rehabilitation: every 90 days

4. outpatient: every 20 visits or every 12 months whichever comes first.

5. Opiate Replacement Treatment every 90 days for the first year, then every 20 visits or every 12 months, whichever comes first.

(i) A medication chart containing a profile of medication reported by the client (psychotropic, non-psychotropic, agency prescription, other physician prescription, and non-prescription) at intake and ongoing account of prescription medications taken by the client during the course of treatment;

1. For medications prescribed by the agency, the date prescribed, the date refilled, and number of refills permitted and the prescribing physician's name shall be included:

(j) Discharge Summary: At discharge or 90 days after receipt of last service, documentation shall be completed within 15 days that shall specify the reason(s) for treatment termination or transfer to inactive status including discharge plan as appropriate.

(k) Confidentiality: The service provider organization will comply with the Federal Confidentiality guideline 42 CFR, Part II, as well as comply with HIPPA confidentiality guidelines.

1. Consents for disclosure and other pertinent documentation shall be filed in the client record.

2. A consent for follow-up must be completed prior to any follow-up contact.

Author: Substance Abuse Services Division

Statutory Authority: Code of Ala. 1975, §22-50-11.

History: **New Rule**: Filed: July 22, 1992. **Extended**: September 30, 1992. **Extended**: December 31, 1992. **Certified**: March 30, 1993; effective May 5, 1993. **Amended**: Filed April 19, 1996; effective May 24, 1996. **Amended**: Filed November 19, 2003; effective December 24, 2003.

580-9-43-.03 **Reserved**.

580-9-43-.04 **Reserved**.