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| **Texas Administrative Code** |

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| [TITLE 25](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=2&ti=25) | HEALTH SERVICES |
| [PART 1](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=25&pt=1) | DEPARTMENT OF STATE HEALTH SERVICES |
| [CHAPTER 448](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=448) | STANDARD OF CARE |
| [SUBCHAPTER H](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=448&sch=H&rl=Y) | SCREENING AND ASSESSMENT |
| RULE §448.804 | Treatment Planning, Implementation and Review |

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| (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 QCCs or mental health 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, and ***no less frequently than monthly in residential programs.***  (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 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. |