Fifth Judicial District Department of Correctional Services Policy Manual		Page 1 of 1 Approved By:  Sally Krearner, Director Fifth Judicial District Department of Correctional Services Approval Date: 09/09
Unit: 5th Judicial District Substance Abuse Treatment Programs	Subject: Client Case Files	

POLICY

The 5th Judicial District Substance Abuse Treatment Program will provide and keep uniform client files and maintain proper file compilation, storage and dissemination of client case files.

The files will be safeguarded and stored in suitably locked file cabinets, readily accessible to the Program staff providing services, and the Program will maintain client files for no less than seven (7) years from the date the file is officially closed.

PROCEDURES

1. The Program will keep accurate records for each client. The client file will contain at minimum, the following:
   A. Results of all examinations, tests and intake/assessment information
   B. Treatment plans
   C. Reports from referring sources
   D. Reports from outside resources, which shall contain the name of the resource and the date of the report, signed by the person making the report or by the Program staff member receiving the report
   E. Multidisciplinary case conference and consultation notes if applicable, including the date of the conference or consultation, recommendations made and action taken
   F. Correspondence related to the client, including all letters and dated notations of telephone conversations relevant to the client's treatment
   G. Treatment consent forms if applicable
   H. Information release forms
   I. Progress notes
   J. Records of service provided
   K. Discharge Summary
2. Medication records will be kept as outlined in the Residential Services Policy Manual: Health Services Medication. (Attached)
3. The content and format of the client file will be kept uniform, and all entries will be signed and dated by the person responsible for the entry and filed chronologically with most recent entry on top.
4. A client's progress and current status in meeting the goals set in the treatment plan as well as efforts by staff members to help the inmate achieve these stated goals shall be recorded in the client's case record in the form of progress notes as follows:
   A. Information shall be noted following each client's counseling session.
   B. Group counseling sessions shall be summarized at least monthly.
   C. All entries shall be filed in chronological order and shall include the date of service or the observation made, the date of entry, and the signature and title of the staff rendering the service.
   D. Subjective interpretations of a client's progress should be supplemented with a description of the actual behavioral observations which were the basis for the interpretations.
   E. The use of abstract terms, technical jargon, slang and abbreviations should be avoided.
5. The Program shall develop a uniform progress note format to be used by all clinical staff. This progress note will contain the following:
   1) Narrative (N) - A detailed description of the individual or group session which may include but not be limited to progress toward treatment goals, objective data and observations of the client
   2) Assessment (A) - An assessment of the client which may include but not be limited to an evaluation of the client's strengths, weaknesses, problems, current status and needs
   3) Plan (P) - A detailed description of the plan of action for the client and/or Counselor
   4) Time (T) - Length of Session
6. All active client files will be maintained in the facility where treatment services are being provided. All active and inactive files will be stored in locked file cabinets labeled "confidential."
7. Program staff shall at no time leave a client file unattended.
8. All client files will be maintained for a period of no less than seven (7) years from the date the file is officially closed. At the end of seven (7) years, the entire client file and all records will be shredded.