
CLINICAL DOCUMENTATION MANUAL

FOR
OUTPATIENT SPECIALTY
MENTAL HEALTH SERVICES



June 2019^{Updated}

To All BCDBH Specialty Mental Health Service Providers:

We are pleased to present the new Butte County Department of Behavioral Health Specialty Mental Health Services Documentation Manual for Outpatient Mental Health Treatment Services. This manual is intended to be a living document that is regularly updated as future guidance is provided by the State on Medi-Cal documentation standards.

Butte County Department of Behavioral Health (BCDBH) Quality Management and Compliance supports implementation of the written documentation policies, practices and standards of the Butte County Department of Behavioral Health and represents an integral part of our culture of high quality and compliance in the care we provide to our community.

This manual is intended to serve as a teaching, training, and documentation resource for the behavioral health workforce across our entire system of care. This new manual updates the 2016 BCDBH Outpatient Documentation Manual and is intended to be used for guidance in our clinics, but does not substitute clinical supervision or direction. Policies and Procedures must also be followed, and in some instances a policy is referenced within this manual to assist. Policy and Procedure #169 officially designates this manual as BCDBH guidance on how to document for outpatient specialty mental health services. Policy #213 reiterates the completion/timeliness of clinical documentation and service logs.

If you have any questions regarding this manual, or need technical assistance in how to use the manual, or any aspect of this guidance, please contact:

**Quality Management and Compliance
Butte County Department of Behavioral Health**

530.879.2456 or visit:

<http://www.buttecounty.net/qualitymanagement>

MISSION STATEMENT

To partner with individuals, families and the community for recovery from serious mental health and substance abuse issues and to promote wellness, resiliency and hope.

CORE VALUES

The following core values are fundamental to our actions and reflect how we choose to conduct ourselves. Although our external environment may vary greatly, these values remain constant. Our commitment to these values will guide our actions and be consistently reflected in our relationships with one another, our clients, our community partners and providers.

RESPECT: We will honor the value of all individuals and their experiences.

GRACE: We hold the trust of others through kindness and respect.

DIGNITY: We believe in an individualized approach to care that honors the person.

HOPE: Is a life-affirming component to self-determination, recovery and resiliency.

SELF-DETERMINATION AND GROWTH: As individuals, we have the right to determine how we live. Change is always possible.

DIVERSITY: Embracing and respecting diversity is vital to an individual's and community's success.

COLLABORATION: Working together through integrity and the collective wisdom of our partners, we become stronger.

EFFICIENCY AND ACCOUNTABILITY: We are stewards of the public trust.

EXCELLENCE IN PREVENTION, TREATMENT AND CARE: We will provide continuity in prevention, treatment and care with a minimum of delay and the best possible outcomes for the individuals and families we serve.

VISION

For the Department's vision, we sought to develop a statement that appealed to our core values, yet was simple in serving as a guide and providing focus. Our vision is:

“A continuum of care that promotes the behavioral health of the entire community.”

PHILOSOPHY

Butte County Department of Behavioral Health (BCDBH) values our clients and encourages each client to participate in their care. With this in mind, we encourage our staff to involve clients in their documentation when appropriate to include using client(s) own words when applicable. Our desire is to partner with our clients in care to promote wellness and recovery at every step of care.

OVERVIEW

Butte County Department of Behavioral Health Department has produced the Clinical Documentation Manual to serve as a guide for all clinical chart records, but does not take the place of clinical supervision. This manual serves as a guidance document to promote excellent, accurate and timely documentation of the services we provide to our community. We strive to provide excellent care to our clients, and accurate documentation is a crucial step in the process of delivering excellent care. A client's chart should depict a comprehensive record of treatment and have a "flow" often referred to as "The Golden Thread".

APPLICATION

Managers and supervisors are encouraged to use the documentation manual as a reference and resource to train staff. The documentation manual defines key concepts, explains documentation requirements, and provides examples of how to document various types of mental health services. All staff providing clinical services should refer to the manual whenever they need an answer to a documentation question.

Inevitably, situations arise when staff will need clarification or further direction. In such cases, the program manager or supervisor should be consulted. Quality Management and Compliance staff will be available to address any further questions concerning documentation.

The manual will be used for all client* records regardless of payer source. Specialty programs within the department may have unique documentation requirements (i.e. a grant funded program may have specified additional items to include in the chart). Samples and examples are meant to illustrate the topic and are not meant to replace clinical supervision or sound clinical judgment.

*Note: A client is a person who accesses and receives outpatient mental health services; a client is also known as individual, patient, consumer, client, beneficiary, etc.

SOURCE OF INFORMATION

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The MHP Contract also aligns with the contract between DHCS and the federal Centers for Medicare and Medicaid Services (CMS). That contract and its amendments are referred to as the California's Medicaid State Plan and State Plan Amendments.

ORGANIZATION AND SYMBOLS

This manual is organized into sections and clickable links to help navigate it with as much ease as possible. This manual contains many links connecting to either online resources or to other parts of the document. If ANY word or phrase is underlined, this means that it can be clicked on for instant access to another part of the manual; these are called "Section Shortcuts." The following symbols and graphics are used to help bring clarity and simplicity to the manual as a whole:

DOCUMENTATION TIP

These can be found throughout this document and provide answers to some frequently asked questions. All 'Documentation Tips' will be denoted with the above graphic.



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NAVIGATION

Each section of the Table of Contents and Section page contain navigation links that will link to the named section in the *Documentation Manual*. To navigate to the Section Page, click on the section name in the Table of Contents.

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The Golden Thread

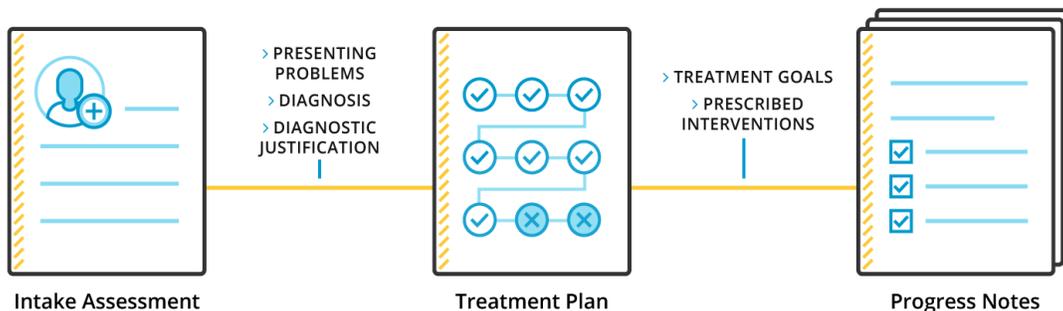
DOCUMENTATION AT ITS CORE

Documentation is a written account that tells the story of how the person receiving treatment’s needs were met by service providers:

- Who
- What
- Where
- When
- Why
- How the service benefitted the client



The Golden Thread is not only important for compliance and reimbursement, but it can also be an important tool for delivering quality care.



Think of the service you are providing as a part of a bigger picture!

Care is justified if you can show a reduction in care will lead to an increase in symptoms (if they weren’t getting crisis services, what would happen?).

What is going to happen when the crisis is over?

Does the client have the services needed for recovery?

Table of Contents

To All BCDBH Specialty Mental Health Service Providers	0.1
Mission / Core Values / Vision	0.2
Philosophy / Overview	0.3
Application	0.3
Organization of Symbols	0.4
Technical Assistance.....	0.4
Sources of Information.....	0.5
Section 1 – Scope of Practice.....	1.1
Signatures.....	1.8
Section 2 – Informed Consent	2.1
Specialty Mental Health Services.....	2.1
Specialty Mental Health Services for Children 12 Years and Older.....	2.1
Consent for Medication	2.2
Psychotropic Medication Consents for Wards of the Juvenile Court	2.2
Advance Directives	2.3
Section 3 – Medical Necessity	3.1
Medical Necessity Criteria	3.1
Documenting Medical Necessity.....	3.2
Documentation Timelines	3.4
NOABD Summary	3.7
Section 4 – Assessment	4.1
Initial Assessment	4.1
Assessment Requirements.....	4.1
Assessment Timeline	4.3
Provision of Services Prior to Completion of Assessment.....	4.6
Included/Excluded Diagnoses Categories.....	4.7
Section 5 – Outcome Measures	5.1
Child and Adolescent Needs and Strengths (CANS)	5.1
Pediatric Symptom Checklist (PSC-35)	5.1

Table of Contents

Milestones of Recovery Scale (MORS)	5.2
Section 6 – Treatment Plan.....	6.1
Treatment Plan Basics	6.1
Treatment Plan Timeline	6.2
Services Prior to a Treatment Plan.....	6.4
Treatment Plan Requirements	6.5
Treatment Plan Components	6.6
Problems	6.6
Goals	6.7
Strengths	6.8
Objectives (Template Included)	6.8
Interventions (Template Included)	6.10
Treatment Plans for Dual Diagnosis Clients	6.12
Signatures	6.13
Section 7 – Care Coordination	7.1
Section 8 – Cultural and Linguistic Services	8.1
Language Line Solutions	8.1
Directions for Accessing Language Line Solutions.....	8.2
Determining Language Preference.....	8.5
Bilingual Staff.....	8.7
Contracted Translators	8.9
Tips for working with Telephone Interpreters.....	8.11
Section 9 – Progress Notes	9.1
Frequency of Documentation.....	9.1
Required Elements for Progress Notes	9.1
General Rules for Progress Notes	9.3
Progress Note Intervention Statement	9.4
Multiple Provider Notes	9.6
D.I.R.T. Format for Progress Notes	9.7
Section 10 – Service Types – Code Definition.....	10.1
Direct Service Codes	10.2
Intensive Youth Services	10.5

Table of Contents

Medical Staff	10.6
Codes for Lock-Out Settings	10.8
Codes for Indirect Services	10.11
Codes for MHSA Planning Personnel	10.13
Section 10.1 – 10.11 – Activities and Progress Note Examples for Service Types
10.1 – Assessment	10.1
Examples.....	10.1.3
10.2 – Plan Development	10.2
Examples.....	10.2.3
10.3 – Collateral.....	10.3
Examples.....	10.3.3
10.4 – Rehabilitation.....	10.4
Examples.....	10.4.4
10.5 – Therapy	10.5
Examples.....	10.5.3
10.6 – Targeted Case Management (TCM).....	10.6
Examples.....	10.6.3
10.7 – Intensive Services.....	10.7.1
Intensive Care Coordination (ICC)	10.7.1
Intensive Home Based Services (IHBS)	10.7.2
Therapeutic Behavioral Services (TBS)	10.7.3
Examples.....	10.7.6
10.8 – Crisis Intervention.....	10.8.1
Examples.....	10.8.2
10.9 – Crisis Stabilization	10.9.1
Example	10.9.3
10.10 – Community Residential Treatment Settings (CRTS)	10.10.1
Adult (Social Rehabilitation)	10.10.1
Crisis (Short Term)	10.10.4
Examples.....	10.10.7
10.11 – Medication Support Services.....	10.11.1
Examples.....	10.11.3

Table of Contents

Section 11 – Discharge	11.1
Section 12 – Non-Reimbursable Services	12.1
Section 13 – Lockouts	13.1
Billing Lock-out Grid	13.3
Section 14 – Documentation Manual Glossary	14.1
Section 15 – Psychological Glossary	15.1
Section 16 – Approved Acronyms	16.1
Section 17 – Youth Authorization	17.1
Authorization Process.....	17.1
MCA Completion Standards	17.1
MCA Rationale for Services	17.2
Referrals/Updates.....	17.2
Documentation Examples	17.4
Appendix A – Documentation FAQs	A.1
Appendix B – Approved Diagnoses for Outpatient SMHS	B.1
Approved Outpatient Diagnoses	B.1
Excluded Primary Categories for SMHS	B.8
Approved SUD Diagnoses for Dual Diagnoses.....	B.9
Appendix C – Med Necessity Z Codes	C.1
Appendix D – Mandated Reporting	D.1
Child Abuse Reporting	D.1
Elder/Dependent Abuse Reporting.....	D.6
Suggested Mandated Reporting Procedure	D.12
Frequently Asked Questions.....	D.13
Appendix E – Confidentiality	E.1
What MUST be disclosed	E.2
May be Disclosed with Written Authorization.....	E.3
May be Disclosed with Verbal Authorization	E.4
May be Disclosed without Authorization	E.5
Tarasoff Threat	E.7
Minor Consent	E.8

Table of Contents

Releasing Records.....	E.10
Filling Out the ROI.....	E.12
Confidentiality FAQs.....	E.15
Appendix F – Managed Care Authorizations	F.1
Appendix G – Agency Resources.....	G.1
Appendix H – Help Sheets	
Assessment.....	H.1.1
Treatment Plan.....	H.2.1
Progress Notes.....	H.3.1

SECTIONS

Section	Title	Overview
Section 1	Scope of Practice	Guide on the scope of practice and answers the basic question: “Who can provide each service?” and Signature requirements.
Section 2	Informed Consent	Provides information regarding informed consent
Section 3	Medical Necessity	Covers medical necessity and how to establish this for each client prior to delivering any service and throughout client care. Also covered is the Documentation Timelines.
Section 4	Assessment	Provides detail on how to complete a clinical assessment. Gives detailed information on what is expected to be included in each of these forms/options.
Section 5	Outcome Measures	Provides detailed information on what is expected to be included in each of these forms/options.
Section 6	Treatment Plan	Provides detail on how to complete clinical treatment plan. Gives detailed information on what is expected to be included in each of these forms/options.
Section 7	Care Coordination	Provides information on the coordination of care for services when a client has multiple providers.
Section 8	Cultural and Linguistic Services	Provides information on the cultural and linguistic services available.
Section 9	Progress Notes	Presents general guidelines for writing progress notes

Section	Title	Overview
Section 10	Service Types	Addresses the service (modalities) activities that are reimbursable. Definitions, descriptions of the activities, and other useful information is provided. This section includes documentation examples for each service type.
Section 10.1	SMHS – Assessment	
Section 10.2	SMHS – Plan Development	
Section 10.3	SMHS – Collateral	
Section 10.4	SMHS – Rehabilitation Services	
Section 10.5	SMHS – Therapy	
Section 10.6	SMHS – TCM/Brokerage	
Section 10.7	SMHS – Youth Intensive Services	
Section 10.8	SMHS – Crisis Services	
Section 10.9	SMHS – Crisis Stabilization Services	
Section 10.10	SMHS – Residential – Adult & Crisis	
Section 10.11	SMHS – Medication Support Services	
Section 11	Discharge	Presents general guidelines for the discharge process.
Section 12	Non-Reimbursable Services	Provides information on activities that are not reimbursable.
Section 13	Lockouts	Simplifies the lockout rules.
Section 14	Glossary	
Section 15	Psychological Glossary	
Section 16	Approved Acronyms	
Section 17	Youth Authorizations	MCA Process and Documentation Examples

Appendices and Help Sheets

Appendix	
Appendix A	Documentation FAQs
Appendix B	Approved Diagnoses for Outpatient SMHS
Appendix C	Functional Impairment Z-Codes
Appendix D	Mandated Reporting
Appendix E	Confidentiality
Appendix F	Managed Care Authorizations
Appendix G	Contract Agency Resources
Appendix H	Resource Sheets for assessments, outcome measures, treatment plans and progress notes
Appendix H1	Assessment Tools
Appendix H2	Treatment Plan Tools
Appendix H3	Progress Note Tools
Sources	

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SCOPE OF PRACTICE

“Scope of practice” is terminology used by state licensing boards “for various healthcare-related fields that defines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the individual has received education and clinical experience, and in which he/she has demonstrated competency” (Wise, 2008).

It is expected that staff will provide services allowed in their job classification and by credentials (i.e. licensure, Board registration, education, training, and experience). Further limitations may be due to level of experience in a specific service category or by department restrictions.

STAFF ELIGIBLE TO PROVIDE SERVICE	SERVICE ACTIVITIES
<p>Physicians, Physician’s Assistants Nurse Practitioners</p>	<ul style="list-style-type: none"> ▪ Assessment/Diagnosis ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Individual Therapy ▪ Family Therapy ▪ Group Therapy ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/Intensive Care Coordination ▪ Therapeutic Behavioral Services ▪ Medication Support (education, monitoring) ▪ Medication Administration ▪ Medication Evaluation

STAFF ELIGIBLE TO PROVIDE SERVICE	SERVICE ACTIVITIES
<p>RN with Master’s in Mental Health Nursing</p>	<ul style="list-style-type: none"> ▪ Assessment/Diagnosis ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Individual Therapy ▪ Family Therapy ▪ Group Therapy ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/Intensive Care Coordination ▪ Therapeutic Behavioral Services ▪ Medication Support (education, monitoring) ▪ Medication Administration
<p>Registered Nurse with ADN or BSN</p>	<ul style="list-style-type: none"> ▪ Nursing Assessment Only ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/Intensive Care Coordination ▪ Therapeutic Behavioral Services ▪ Medication Support (education, monitoring) ▪ Medication Administration
<p>Licensed Vocational Nurse & Licensed Psychiatric Technician</p>	<ul style="list-style-type: none"> ▪ Nursing Assessment Only (with co-signature) ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/ Intensive Care Coordination ▪ Therapeutic Behavioral Services ▪ Medication Support (education, monitoring) ▪ Medication Administration

STAFF ELIGIBLE TO PROVIDE SERVICE	SERVICE ACTIVITIES
<p>Behavioral Health Clinicians (BBS Licensed and Registered Interns)</p>	<ul style="list-style-type: none"> ▪ Assessment/Diagnosis ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Individual Therapy ▪ Family Therapy ▪ Group Therapy ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/Intensive Care Coordination ▪ Therapeutic Behavioral Services
<p>Behavioral Health Counselors</p>	<ul style="list-style-type: none"> ▪ Crisis Assessment ▪ Plan Development ▪ Crisis Intervention ▪ Collateral ▪ Rehabilitation (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/Intensive Care Coordination ▪ Therapeutic Behavioral Services
<p>Behavioral Health Workers</p>	<ul style="list-style-type: none"> ▪ Crisis Intervention (when co-signed by licensed staff) ▪ Brokerage/Targeted Case Management/Intensive Care Coordination
<p>Family Partner, Peer Advocate, and Behavioral Health Education Specialist</p>	<ul style="list-style-type: none"> ▪ Plan Development ▪ Crisis Intervention (when accompanied by licensed staff) ▪ Collateral ▪ Rehabilitation Services (individual, group)/Intensive Home Based Services ▪ Brokerage/Targeted Case Management/ Intensive Care Coordination

STAFF ELIGIBLE TO PROVIDE SERVICE	SERVICE ACTIVITIES
<p>2nd Year Graduate Student Intern (ex. MSW 2nd year, MFT Trainee) & One-year program Graduate Student Interns</p>	<ul style="list-style-type: none"> ▪ Assessment* ▪ Plan Development* ▪ Crisis Intervention* ▪ Collateral* ▪ Individual Therapy* ▪ Group Therapy* ▪ Family Therapy* ▪ Rehabilitation Services (individual, group)/Intensive Home Based Services * ▪ Brokerage/Targeted Case Management/Intensive Care Coordination * <p>*All services require a co-signature by licensed LPHA.</p>
<p>1st Year Graduate Student Intern</p>	<ul style="list-style-type: none"> ▪ Plan Development* ▪ Crisis Intervention* ▪ Collateral* ▪ Rehabilitation Services (individual, group)/Intensive Home Based Services * ▪ Brokerage/Targeted Case Management/Intensive Care Coordination * <p>*All services require a co-signature by licensed LPHA.</p>
<p>Undergraduate Student Interns</p>	<ul style="list-style-type: none"> ▪ Plan Development* ▪ Collateral* ▪ Rehabilitation Services/Intensive Home Based Services * (individual and group**) ▪ Brokerage/Targeted Case Management/Intensive Care Coordination * <p>*All services require a co-signature by licensed LPHA.</p> <p>**Group Rehabilitation Services can only be provided with a BCDBH Staff co-leader.</p>

Licensed Practitioner of the Healing Arts (LPHA)

The Federal Medicaid rules introduced the term “Licensed Practitioner of the Healing Arts” (LPHA), but did not provide a definition. Generally, LPHA is taken to mean “any health practitioner ...who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.”

The following are identified as a LPHA staff:

1. Licensed Physician (MD/DO)
2. Licensed Nurse Practitioner (NP)
3. Licensed Clinical Nurse Specialist (CNS)
4. Licensed Clinical Social Worker (LCSW)
5. Licensed Marriage and Family Therapy (LMFT)
6. Licensed Professional Clinical Counselor (LPCC)
7. Licensed Psychologist (PhD/PsyD)

These seven categories of licensed mental health staff are also referred to as “Licensed Mental Health Professionals” (LMHP) by DHCS.

Waivered/Registered Licensed Practitioner of the Healing Arts (LPHA)

§1810.254 of CCR Title 9 defines “Waivered/Registered Professionals” as an individual who has a waiver of psychologist licensure issued by the Department or has registered with the corresponding state licensing authority for psychologists, marriage and family therapist, [professional counselor] or clinical social workers to obtain supervised clinical hours for psychologist, marriage and family therapist [professional counselor] or clinical social worker license.”

The following are identified as a Waivered/Registered LPHA staff:

1. Associate Clinical Social Worker (ACSW)
2. Associate Marriage & Family Therapist (AMFT)
3. Associate Professional Clinical Counselor (APCC)
4. Waivered PhD/PsyD

The scope afforded to “Waivered/Registered LPHA” staff hinges on: (a) their current and appropriate registration with the state Board and (b) the direction, supervision and oversight of their work by the licensed mental health professional (i.e., by a LPHA).

Non-LPHA Nurses, Psychiatric Technicians & Pharmacists

The BCDBH Scope of Practice identifies the following as a non-LPHA Nurses, Psychiatric Technicians and Pharmacists:

1. Registered Nurse with only Bachelor's or Associates degree
2. Licensed Vocational Nurse
3. Psychiatric Technician
4. Pharmacist

These staff have a more narrow scope assigned to them because their training is more narrowly focused on medication and biological interventions.

“Other Qualified Providers”

California's Medicaid State Plan defines another category of provider in the SMHS program, an “Other Qualified Provider”:

An individual at least 21 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department (SPA # 12-025; “Qualification of Providers”; BCDBH Department Standards).

Within BCDBH, the “Other Qualified Provider” category has been operationalized as:

1. Behavioral Health Counselor
2. Behavioral Health Worker
3. Family Partner, Peer Advocate, and Behavioral Health Education Specialist
4. Undergraduate Student Intern

As seen in the Scope of Practice, the Other Qualified Provider has a more narrow scope and additionally, some positions must have a co-signature on every progress note by a LPHA.

Graduate-Level Students-Enrolled in Academic Program

Within BCDBH, the “Graduate-Level Students” category has been operationalized as a:

1. 2nd Year Graduate Student Intern (ex. MSW 2nd year, MFT Trainee)
2. One-year program Graduate Student Interns
3. 1st Year Graduate Student Intern

DHCS recently provided guidance on the category of graduate-level students enrolled in an academic program but not yet eligible to be registered or waived:

The scope of practice depends on the particular program in which the student or trainee is enrolled and the requirements for that particular program, including any scope, supervision, or registration requirements set forth in the Business and

Section 1: Scope of Practice

Professions Code or associated regulations. In accordance with the Business and Professions Code, the Board of Psychology, and the Board of Behavioral Sciences, non-licensed trainees, interns, and assistants must be under the immediate supervision of a LMHP who shall be responsible for ensuring that the extent, kind, and quality of the services performed are consistent with his or her training and experience and be responsible for his or her compliance with applicable state law. (Business and Professions Code §§2913, 4980.03, 4980.43(b), and 4996.18(d))

An individual participating in a field internship/trainee placement, while enrolled in an accredited and relevant graduate program, working “under the direction” of a licensed, registered, or waived mental health professional and determined to be qualified by the MHP, may conduct [specific service activities]...within the scope of practice of the discipline of his/her graduate program.

If students and trainees do not meet the definition of any of the other defined providers under the State Plan, they may provide some services as Other Qualified Providers under the direction of a LMHP who is authorized to direct services. (See Section 3, Supplement 3 to Attachment 3.1-A; Cal. Code Regs., tit. 9, §1840.314(e))

As seen in the Scope of Practice, “Graduate Students Enrolled in School” have broader scope to provide services, but they are required to have a LPHA co-signature on every progress note. As with all SMHS providers, graduate students may only provide a service that is within the scope of practice of the discipline of their graduate program.

SIGNATURES

REQUIREMENTS

- A. **Complete Signature:** Every clinical document must be followed by a “complete signature,” which includes the writer's signature, appropriate credential/license (or job title if you do not have a credential or license), and date.
- B. **Legibility:** Signatures should be legible.
 - If signatures are illegible, the associated document may be subject to disallowance. Therefore, BCDBH recommends that the name and appropriate credential (see below) be typed under signature lines. Many EHRs will include typed signatures under the signature line. Be certain to ensure your signature is accurate and reflects your correct name, credential/license or job title if you do not have a credential or license.
 - Electronic signatures, utilizing electronic signature pads, are also allowed.
- C. **Credentials/Licenses:** Every provider signature must also include the provider’s credential/license that allows them to bill Medi-Cal and authorizes a specific scope of services: MD, DO, NP, CNS, PA, RN, LVN, Psych Tech, NP/CNS/ PA Student or Intern; PhD-L or PsyD-L (licensed); PhD-W or PsyD-W (waivered); LMFT, LCSW, LPCC, LPCC-F (includes family counseling credentialing) (licensed); MHRs; AMFT or ASW or APCC Waivered; Trainee (Student in Mental Health Program: MA/MS/MSW/PhD/PsyD program); or Adjunct staff (Peer or family provider, and CCAPP-Certified & CCAPP-Registered for SUD).
- D. **Dates:** All signatures require a date.

INFORMED CONSENT

Informed Consent for Treatment must be obtained prior to providing services (first face-to-face contact) to a client and is the first step to be completed between the clinician* and the client or the client's parent/guardian. Per Title 22, section 101, "informed consent means that a [client] grants, refuses or withdraws consent to treatment after the MH provider presents the [client] with information about the proposed mental health services, mental health supports, or treatment, in language and manner that the [client] can understand". At BCDBH, a written informed consent is obtained at the initial admission (first face-to-face contact) to services and if a client discharges from services a new informed consent must be obtained upon return to treatment. This consent covers both outpatient and inpatient services and is valid unless the client withdraws the consent. Discussion about informed consent must be documented in the client's clinical record. If a client is unwilling or unable to provide informed consent the reason, as well as attempts to obtain informed consent must be documented in the client's clinical record. Clients should be offered a copy at admission.

* During a crisis on an unopened client, it is permissible for a behavioral health counselor to obtain informed consent during the face-to-face contact.

Specialty Mental Health Services For Minors 12 Years and Older

Under California Health and Safety Code 124260 "a minor who is 12 years of age or older may seek mental health treatment or counseling services." Minors will be required to sign the Informed Consent for Treatment.

In the event that a therapist determines that the minor is **not** mature enough to participate intelligently in the mental health treatment or counseling services in accordance with Health and Safety code §124260, the parent/guardian would need to sign the Informed Consent for Treatment.

Minors are not able to consent to Inpatient mental health treatment, psychotropic medication, convulsive therapy or psychosurgery.

The minor controls the medical record regardless of parental/guardian involvement, provided that minor could have or did consent for services. Additionally the minor must sign a written authorization for any medical record release to a third party that requires authorization, including release of chart information to the parent.

CONSENT FOR MEDICATION

For treatment with psychotropic medications there are additional documentation requirements for informed consent. A **Consent for Psychotropic Medication Therapy** must be completed by the medical staff prescriber and the client or the client's parent/guardian.

Psychiatric medication consent forms must contain the following elements to be considered compliant with Medi-Cal requirements, all of which must be discussed with the client and/or parent/caregiver:

1. What condition or diagnoses the client has that medications are prescribed to address;
2. Which symptoms the medication(s) should reduce and how likely the medication(s) will work;
3. What are the chances of getting better without taking the medication(s);
4. Reasonable options or alternatives to taking the medication(s);
5. Name, dosage, dosage range, frequency, route of administration and duration of each prescribed medication;
6. Common side effects of the medication(s), including possible additional side effects which may occur beyond three months or long-term;
7. If antipsychotic medications are prescribed, notice that antipsychotic medications may cause additional side effects for some persons, including persistent involuntary movements which are potentially irreversible, and may continue after the antipsychotic medication has been stopped; and
8. Any special instructions the client should know about taking the medication(s).

In addition, there must be documentation that clients and/or legal guardians have been counseled that medication consent, once given, may be withdrawn at any time.

Medication consent must be obtained prior to prescribing medication and whenever a new medication is prescribed.

PSYCHOTROPIC MEDICATION CONSENTS FOR DEPENDENTS OF THE JUVENILE COURT SYSTEM

If a child is a dependent child of the court, the juvenile court judicial officer has the authority to make orders regarding the administration of psychotropic medications for that child. BCDBH physicians must follow the legal procedures in order to be compliant with all mandates. As such an application must be completed and presented to the court, using [Application Regarding Psychotropic Medication \(form JV220\)](#) and [Prescribing Physician's Statement-Attachment \(form JV220-A\)](#). These must be completed in addition to the Consent for Medication as these forms do not include all of the required elements of a medication consent for as prescribed by Title 9 CCR § 851.

ADVANCE DIRECTIVES

An Advance Directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

It is the policy of the BCDBH that all BCDBH and contract providers offer all **adult clients** information concerning their rights under California state law regarding Advance Medical Directives at the first face to face contact for services and thereafter upon request by the client.

In the event a client presents a specific, completed, appropriately witnessed and signed executed Advance Medical Directive to a staff member, the document shall be placed in the client's mental health chart and the presence of the Advance Medical Directive shall be documented in the chart.

MEDICAL NECESSITY

Butte County Department of Behavioral Health may either conduct a brief screening assessment with clients to establish medical necessity or complete the initial assessment.

The screening includes completion of the following:

- Informed Consent which includes:
 - Acknowledgement of Receipt of Guide to Medi-Cal Mental Health Services
 - Acknowledgement of Receipt of Medi-Cal Provider List
 - Acknowledgement of Information on Advanced Directive (Adults)
 - Acknowledgement of Receipt of Notice of Privacy Practices
- Medical Necessity Determination
- Mental Status Exam
- Diagnosis

Any client open for 60 days or greater is considered a long term client

If a client meets medical necessity, an initial assessment and a treatment plan will also be completed. The initial assessment must include all diagnostic criteria required in the DSM to support the primary diagnosis and describe the functional impairments that significantly impact the client's day-to-day life. All long-term clients are required to have an initial assessment and treatment plan on record.

MEDICAL NECESSITY CRITERIA

Clients must meet the following medical necessity criteria as described in Title 9 (§1830.205, 1830.210) in order to be eligible for outpatient specialty mental health services:

- The client must have an included qualifying current Diagnostic and Statistical Manual (DSM) mental health diagnosis that is the focus of treatment.
 - See [APPENDIX B](#) for a list of included diagnoses
- As a result of the mental health diagnosis, there must be one of the following criteria:
 - a. A significant impairment in an important area of life functioning (e.g., Living Arrangement/Housing, Activities of Daily Living, Primary Support Group, Education, Financial Economic Issues, Access to Health Care Services, Social Relationship/Environment/Community, or School Situation)
 - See [APPENDIX C](#) for a list of examples of impairments in functioning

Section 3: Medical Necessity

- b. A reasonable probability of significant deterioration in an important area of life functioning
- c. For a child (a person under the age of 21 years), a reasonable probability that the child will not progress developmentally as individually appropriate
- Must meet each of the interventions criteria listed below:
 - a. Focus of the proposed intervention must address the condition identified
 - b. The proposed intervention will do, at least, one of the following:
 - i. Significantly diminish the impairment
 - ii. Prevent significant deterioration in an important area of life functioning
 - iii. Allow the child to progress developmentally as individually appropriate
 - c. The conditions would not be responsive to physical health care based treatment (Primary Care Physician)



DOCUMENTATION TIP

if they are a Medi-Cal beneficiary, when a person is found to not meet medical necessity during a screening appointment, a NOABD-Denial must be issued to the client by the clinician.

Documenting Medical Necessity

In order to meet Medical Necessity Regulation, every note and every document (treatment plan, assessment, medical necessity determination, etc.) must be unique and an accurate description of the client's current state at the time that documentation is written.

Each document must be able to "stand alone" and therefore meet medical necessity criteria without referring to another document. This includes every document in the chart used to ensure Medi-Cal billing requirements are met.

1. **Assessments/ Medical Necessity Determination/ Mental Status Exams:** client's not only age each year, but will likely have made some life changes, have at least some symptom differences, and have a response to our treatment that can be accurately captured in an annual assessment. It should be an update and include a summary of the client's care and services over the past year. Documents that are capturing the client's current functioning such as a Mental Status Exam, should not be exactly the same as the year prior as well. It would be expected that at least some changes are present due to treatment.

Section 3: Medical Necessity

2. **Treatment plans:** should be unique and are meant to be updated annually or more frequently as the client either makes progress, or the needs or goals change. Treatment plans remaining the same each year can potentially be viewed as if services are not helping or they are not really in tune with the client's goals.
3. **Progress notes:** each time a client comes in for a service, each progress note should "stand alone" and include the client's unique presentation and response to our intervention in each session. Notes that are exactly the same each week, or have very little variance are not only subject to disallowance, but can indicate a quality of care concern, or be viewed as fraud or abuse.



**BCDBH does not allow
for Cut and Paste
templates or cloning of
any kind to be used in
our medical records.**

BCDBH DOCUMENTATION TIMELINES

NAME OF DOCUMENT	INITIALLY COMPLETED	UPDATED
Consent for Treatment <ul style="list-style-type: none"> • Acknowledgement of Receipt of Guide to Medi-Cal Mental Health Services • Acknowledgement of Receipt of Medi-Cal Provider List • Acknowledgement of Information on Advanced Directive (Adults) • Acknowledgement of Receipt of Notice of Privacy Practices 	Obtained the day of the first face-to-face contact.	Not Required + (unless need updated form) +
Pay or Financial Information Form (PFI)	Obtained the day of the first face-to-face contact.	Annually or if situation changes
Client Registration (Client Demographics Data)	Obtained the day of the first face-to-face contact.	Annually (or if client moves)
Client CSI Data (CA State Info)	Given to client on the day of the first face-to-face contact.	Annually
Emergency Contact Information Form	Obtained the day of the first face-to-face contact.	Annually
Release of Information (Authorization for Use or Disclosure of Protected Health Information)	As needed to obtain, disclose, or exchange protected health information.	Annually (unless otherwise specified in release or updated as needed)

Forms in all sections should be in chronological order with the most current on top

+ Unless legal status changes – i.e. Youth turns 18 or conservatorship or ward/dependent of the court, etc.

Section 3: Medical Necessity

NAME OF DOCUMENT	INITIALLY COMPLETED	UPDATED
Episode Opening and Period Information/Last Page of Assessment <i>(For Contract Providers only)</i>	Completed at first visit.	Annually or rewritten to update changes
Medical Necessity Determination	Obtained the day of the first face-to-face contact.	Annually – May be updated at any time
Mental Status Exam	Obtained the day of the first face-to-face contact.	Annually – May be updated at any time
Diagnosis	Obtained the day of the first face-to-face contact.	Annually – May be updated at any time
Initial Assessment	Within 60 days of first face to face.	May be updated as needed
Outcome Measures (MORS, CANS, PSC-35)	Due with Assessment	Every 6 months or as needed
Client Treatment Plan	No later than 60 days from first face to face. Until a client plan is finalized with necessary signatures, the only services that can be provided are assessment, plan development, and crisis intervention.	Annually – May be updated at any time or when a significant change occurs in a client’s life
Case Coordinator	At Treatment Plan, but within 60 days of first face-to-face.	May be updated as needed
Progress Notes	For each client contact based on requirement.	N/A
Consent for Psychotropic Medication Therapy	By M.D. or prescribing nurse when medication is prescribed.	Completed when a new medication is added

Forms in all sections should be in chronological order with the most current on top

+ Unless legal status changes – i.e. Youth turns 18 or conservatorship or ward/dependent of the court, etc.

Section 3: Medical Necessity

NAME OF DOCUMENT	INITIALLY COMPLETED	UPDATED
JV 220	By M.D. or prescribing nurse when medication is prescribed based on order of the court.	Completed when a new medication is added
Therapeutic Behavioral Services (TBS) Referral	When a client who is eligible is referred.	N/A
Client Discharge	Complete at time of last service with client to close or transfer case. Discharge diagnosis is entered as well as completing MyAvatar Discharge option.	N/A
NOABD	Complete NOABD when client meets criteria (See NOABD Summary).	N/A
Managed Care Authorizations (MCAs)	A request for services for medically necessary adjunctive services available from the BCDBH contract providers. Completed at time of request.	30 days prior to the expiration of the MCA.

Forms in all sections should be in chronological order with the most current on top

+ Unless legal status changes – i.e. Youth turns 18 or conservatorship or ward/dependent of the court, etc.

NOABD SUMMARY

A Notice of Adverse Benefit Determination (NOABD) is defined to mean any of the following actions have been taken by BCDBH:

- 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- 2) The reduction, suspension, or termination of a previously authorized service;
- 3) The denial, in whole or in part, of payment for a service;
- 4) The failure to provide services in a timely manner;
- 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or
- 6) The denial of a beneficiary's request to dispute financial liability.

Beneficiaries must receive a written NOABD when BCDBH takes any of the actions described above. The Plan must also communicate the decision to the affected provider within 24 hours of making the decision. **Client or parent/legal guardian receives the notice.**

NOTE: Services that are reduced, modified, or terminated by outpatient providers that are not subject to prior authorization (treatment plan is expired) and are the result of a treatment Team/Clinician decision based on the individual's clinical condition and/or progress in treatment is not subject to an adverse benefit determination notification. The client may appeal the decision with the appropriate advocacy agency. A NOABD is also not required if the treatment team and client make this decision whether or not a treatment plan is in place (e.g. client "graduates" or is amicable/agrees to a step down in treatment).

Each NOABD needs to be sent with the following required attachments: Your Rights; Beneficiary Non-Discrimination Notice; Language Assistance Taglines.

For specific information regarding NOABDs, please see Policy and Procedure 171.

Days described below are business days. Highlighted sections are what would be needed in the clinics.

NOABD SUMMARY

NOABD Name	Avatar Form Name	Staff	Criteria for Beneficiary Notice	When to Send
Notice of Action A (NOABD A)	Notice of Action A (NOABD A)	Clinicians	Doesn't meet medical necessity, referred to MCP, used for all "one shots"	Within two days
Notice of Action B (NOABD B)	Notice of Action B (NOABD B) Modification	QM	Modifies payments, or modifies/limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services	Within two days of decision
Notice of Action C (NOABD C)	Notice of Action C (NOABD C) Payment Denial	QM	Used when services have been provided but payment is denied, in whole or in part, for any reason	When decision is made
Notice of Action E (NOABD E)	Avatar (NOABD E database for initial service requests and Psychiatric Referral)	MRTs	Initial (10 business days) and Psychiatric (15 business days) timelines are not met	Within two days
NOABD F	NOABD F Letter Template Word.doc	Billing or QM	Appeal Denial, client denied request to dispute financial liability, including cost-sharing/other financial liabilities	When decision is made
NOABD G	NOABD G Auth Denial / NOABD H Auth Delay	QM or PM	When a client is denied/modified additional treatment based on medical necessity, appropriateness, or effectiveness of a requested service	Within two days of decision
NOABD H	NOABD G Auth Denial / NOABD H Auth Delay	QM	Authorization decision (approve, modify, deny) was not made within required timeframes	Within two days of decision
Notice of Action I (NOABD I)	Notice of Action I (NOABD I) Termination Notice	Clinician/ Counselor	Client has an active tx plan but has not successfully engaged in services or is AWOL, Medi-Cal was termed	10 days <u>before</u> termination

ASSESSMENT

INITIAL ASSESSMENT

The mental health assessment serves as the foundation for the client's plan of care. The assessment reinforces eligibility to receive outpatient specialty mental health services, drives the treatment planning process, and provides the basis for ongoing changes in treatment delivery and discharge planning.

BCDBH requires that the initial assessment is completed within the first 60 calendar days of the Informed Consent Signature date

ASSESSMENT REQUIREMENTS

DHCS and BCDBH requires that every SMHS assessment document/form contain 11 required elements. These required elements are:

1. **Presenting Problem:** Describe the client's presenting complaint and history. This must include the current level of functioning and symptoms. Also address any relevant family history and current family information.
 - This will support the required DSM criteria for each diagnosis (including severity, frequency, duration, etc.)
 - Include a detailed description of the client's functional impairment(s)
2. **Relevant Mental Health Conditions and Psychosocial Factors:** Describe the factors that affect the client's physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma.
 - A description of the client's cultural/spiritual/linguistic factors which may include: ethnicity, gender, spiritual beliefs, beliefs around birth/death, family traditions, healing rituals, view of authority figures, family structure/dynamics, roles, how conflict is handled, military service.
3. **Mental Health History:** Describe the client's prior treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports.
4. **Medical History:** Describe the relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal

and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.

5. **Medications:** Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications.
6. **Substance Exposure/Substance Use:** Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.
 - If a substance-related diagnosis is indicated, it must be included on the Substance Use classification.
7. **Client Strengths:** Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
 - Abilities and accomplishments
 - Interests and aspirations
 - Recovery resources and assets
 - Unique individual attributes
8. **Risks:** Situations that present a risk to the beneficiary and/or others, including past or current trauma
 - History of Danger to Self (DTS) or Danger to Others (DTO);
 - Previous inpatient hospitalizations for DTS or DTO;
 - Prior suicide attempts; family history of suicide;
 - Lack of family or other support systems;
 - Arrest history, if any;
 - Probation status;
 - History of alcohol/drug abuse;
 - History of trauma or victimization;
 - History of self-harm behaviors (e.g., cutting);
 - History of assaultive behavior;
 - Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the client vulnerable to others; and,
 - Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

9. **A Mental Status Examination:** An MSE is a structured way of observing and describing a person’s psychological functioning at a given point in time, under the domains of appearance, attitude, behavior, mood, and affect, speech, thought process, thought content, perception, cognition, insight and judgment.
10. **A Complete Diagnosis:** A diagnosis from the current DSM and the corresponding ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
 - The Diagnosis must include the following classifications: Mental Health, Substance Use, Medical, and Environmental
11. **Additional clarifying formulation information, as needed:** Additional clarifying formulation (clinical/diagnostic formulation) information, as needed.

If Substance Use Diagnosis is the client’s primary diagnosis the client does not qualify for specialty mental health services and the client should be provided a referral to Substance Use Services.

CONTENT

The initial assessment must be completed for all long-term clients. Additionally the following forms are required:

- Release of Information (as needed)
- CANS (for Children)
- PCS 35 (for Children)
- MORS (for Adults)
- Progress Note documenting completion of assessment

ASSESSMENT TIMELINE

1. INITIAL ASSESSMENT

- The initial mental health assessment is required for all clients meeting medical necessity who are not currently opened or are new to the outpatient mental health system (or are returning for services after being discharged from all outpatient services for more than 30 days). This assessment shall be completed within 60 calendar days of the client’s signature on the informed consent to treatment form or that of the legal guardian or adult.



Assessments are considered valid when signed by a LPHA and finalized in the EHR (the date of validation appears by the LPHA staff signature).

2. UPDATED/ANNUAL ASSESSMENT (CONTINUED MEDICAL NECESSITY DETERMINATION)

- An updated assessment must be completed annually on or before the expiration date of the previous assessment.
 - This is done by completing the Medical Necessity Determination (MND) Form
- Updated assessments are required to be comprehensive and complete. In other words, the updated assessment must “stand alone” and not simply be the same as the initial assessment or initial medical necessity determination form. When completing an updated or annual assessment the clinician must complete a new Medical Necessity Determination form.
- Updated assessments must contain a summary of the treatment provided in the past year and the response to that treatment. This should include the type and frequency of treatment provided, i.e. what interventions and modalities were provided and the client’s response to those.
- Updated assessments must reflect the client’s current functioning and needs for continued treatment. (i.e. this is what establishes continued medical necessity)

Staff must be able to justify why treatment shall continue, for example: If a client has received individual therapy each week for a year and has not made significant progress why should treatment continue at the same frequency, duration, and type of treatment?

3. ASSESSMENTS (MEDICAL NECESSITY DETERMINATION) WHEN CLIENT TRANSFERS TO OR ARE OPENED TO A NEW PROGRAM

- If an open client transfers to a new program or is added to a new program, the clinician may use one of the following options:
 - a. Complete a new Assessment or Medical Necessity Determination within 30 calendar days of opening in the new program, if indicated which would include if the prior assessment was incomplete or did not meet the documentation standards.

OR

 - b. Accept the prior Assessment/Medical Necessity Determination, if satisfactory, as long as it was completed within the past year and attest that they have pulled the document forward and not made any changes. This assessment must be updated within a year of the existing annual assessment date.

4. ASSESSMENT (MEDICAL NECESSITY DERTMINATION) WHEN A CLIENT RETURNS WITHIN 30 DAYS OF DISCHARGE

- *A client is discharged from all open programs and returns for services within 30 days or less can be re-opened without having to re-do all opening paperwork, with the exception of the Informed Consent. Assessments, treatment plans, etc. can be pulled forward and updated from a previous program as long as the information is current and was completed less than one year ago.*

Table – Assessment/Medical Necessity Determination Timeliness

Type of Service	Opening Assessment	Subsequent Assessment (MND)
Outpatient *	Within 60 days of Informed Consent Signature Date (or prior to first planned service—whichever comes first)	Annually, prior to the expiration of the initial assessment or MND
TBS	Within 30 days of referral to TBS	Not Applicable: Length of stay is less than 12mos
Adult Residential	Within 3 full days of Informed Consent Signature Date	Annual assessment within 30 days of prior to the expiration of the initial assessment
Crisis Residential	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Crisis Stabilization	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Medication Treatment- Urgent Meds	The finalized MD progress note documents the medical necessity for the urgent medication service	Not Applicable: Length of stay is less than 12mos
* This will include the Initial Assessment and the Medical Necessity Determination		

PROVISION OF SERVICES PRIOR TO THE COMPLETION OF ASSESSMENT

In the gap of time that may exist between the assessment's completion, and while the Treatment Plan is being developed, some mental health services may be provided as long as the medical necessity for services is clearly identified in the Assessment. These services may include

- Assessment;
- Plan Development;
- Crisis Intervention;
- Crisis Stabilization;
- Urgent Medication Support Service (for an urgent need which must be documented);
- Targeted Case Management (for the completion of the treatment plan); and
- Intensive Care Coordination for assessment, plan development, and referral/linkage to help a client obtain needed services.

If a clinical issue arises that is not identified in the Assessment, each Progress Note addressing that issue must demonstrate and document medical necessity.

DIAGNOSIS

"By history", "Rule Out" and "Provisional" diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a client may have a "by history", "rule out", or "provisional" diagnosis in addition to at least one current included diagnosis.

DUAL DIAGNOSIS

If a substance-related diagnosis appears prevalent, the clinician needs to complete the full Substance Use Disorder Assessment and the Substance –related diagnosis is listed in the Substance Use classification.

Section 4: Assessment

Included / Excluded Diagnoses:

Categories of Included Diagnoses for Outpatient (Non-Hospital) Services	Excluded Diagnoses for Outpatient (Non-Hospital) Services
<ul style="list-style-type: none"> • Pervasive Developmental Disorders except Autistic Disorder • Disruptive Behavior and Attention Deficit Disorders • Feeding and Eating Disorders • Elimination Disorders • Somatoform Disorders • Adjustment Disorders • Personality Disorders (excluding antisocial personality disorder) • Dissociative Disorders • Schizophrenia Spectrum and Other Psychotic Disorders* • Mood Disorders (except due to a general medical condition) • Anxiety Disorders (except due to a general medical condition) • Factitious Disorders • Paraphilias • Gender Identity Disorders • Impulsive Control Disorders not elsewhere classified • Medication-Induced Movement Disorders related to other included diagnoses 	<ul style="list-style-type: none"> • Provisional Diagnosis (x vs. y) • “Z” codes • Intellectual Disability • Learning Disorders • Motor Skills Disorder • Communication Disorders • Delirium • Dementia • Amnesic Disorders • Sleep Disorders • Mental Disorders due to a general medical condition • Autistic Disorder • Tic Disorders • Cognitive Disorders – dementia with depressed mood or delusions • Substance Induced Disorders with psychotic, mood or anxiety disorders • Anti-Social Personality Disorders • Other conditions that may be the focus of clinical attention
<p>A full list of included diagnoses is located in Appendix B</p>	

OUTCOME MEASURES

The use of outcome measures is an evidence based practice that supports the agency's commitment to the recovery model and client driven services. Outcome Data is used to identify potentially high-risk clients who may need intensive behavioral health services or is used to identify those clients that are prepared to transition to a less restrictive level of care.

Child and Adolescent Needs and Strengths (CANS)

All clients age 6 to 20 years old participating in youth treatment programs shall have a clinician complete the CANS.

TIMELINES

Initial – within 60 days of intake

Unless the client is determined to not meet program eligibility (requiring the episode to be closed within 60 days of intake) and there is not sufficient information available to complete the CANS.

Updates – The CANS will be completed every six months

Transfer – CANS will be completed prior to transfer to another BCDBH Clinic or provider.

Discharge – The CANS is to be completed at the close of service unless a CANS has been completed within 30 days prior to discharge and there are no additional changes in the scores.

Pediatric Symptom Checklist (PSC)-35

All clients age 4 to 18 years old participating in youth treatment programs shall have a completed PSC-35 by their parent/guardian.

TIMELINES

Initial – within 60 days of intake

Unless the client is determined to not meet program eligibility (requiring the episode to be closed within 60 days of intake) and there is not sufficient information available to complete the PSC-35.

Updates – The PSC-35 will be completed every six months

Transfer – PSC-35 will be completed prior to transfer to another BCDBH Clinic

Section 5: Outcome Measures

Discharge – The PSC-35 is to be completed at the close of service unless a PSC-35 has been completed within 30 days of discharge and there are no additional changes in the scores.

Milestones of Recovery Scale (MORS)

All clients age 21 years old or older participating in youth and adult treatment programs shall have a completed MORS.

TIMELINES

Initial – within 60 days of intake

Unless the client is determined to not meet program eligibility (requiring the episode to be closed within 60 days of intake) and there is not sufficient information available to complete the MORS.

Updates – The MORS will be completed every six months

Transfer – MORS will be completed prior to transfer to another BCDBH Clinic

Discharge – The MORS is to be completed at the close of service unless a MORS has been completed within 30 days of discharge and there are no additional changes in the score.

TREATMENT PLAN

Whereas the assessment documents the current mental health condition and functional impairments of the client, the Treatment Plan is the guiding force behind the delivery of care. The plan helps the client and the clinical staff to collaborate on the client’s recovery goals. Ultimately, treatment should result in services provided at the lowest level of care needed or discharged to the community.

TREATMENT PLAN BASICS

- The Treatment Plan is an agreement between the client and the clinician that states which mental health problem(s) will be the focus of treatment. The Treatment Plan consists of specific goals, objectives, and the treatment interventions and modalities (type of service) that will be provided (See *“Signatures”* –Section 1).
- There needs to be a clear connection and flow from the DSM diagnosis and functional impairments in the assessment to the problem, goal, objectives, and interventions in the treatment plan. BCDBH calls this flow **“The Golden Thread.”**
- A client receiving both general mental health and medication support services will show how medication assists the client to improve function or reduce symptoms as appropriate. (Avatar users—please do not use the “integrated treatment” button, but make a separate intervention for Medical Support).
- BCDBH requires a minimum of two objectives with two unique interventions with the appropriate modalities, per objective on each Treatment Plan.
- A Treatment Plan is required to be completed with all required signatures in each outpatient mental health episode. The Treatment Plan shall be used for all service activities. If the client signature cannot be obtained please see the documentation example for clarity.
- The Treatment Plan is effective once it has been signed (and co-signed, if required) and dated by the required staff member(s). In the event of a new diagnosis or significant change, a new Treatment Plan may be needed if clinically appropriate.

**At BCDBH only
Clinicians are
permitted to
complete treatment
plans, but it is
recommended that
feedback on
objectives, goals and
interventions is
sought from all
members of the
treatment team.**

TREATMENT PLAN TIMELINE

The completion of the Treatment Plan is subject to specific deadlines and signature requirements, as described below:

1. INITIAL

An initial plan can occur in two primary instances: new to services or transferring to a new program.

- **New to Services:** The initial Treatment Plan shall be completed within 60 days of the client's first face to face service or entry to a program. This deadline applies to clients who are new to BCDBH or are re-entering services after previously being discharged for more than 30 days.
- **Transfer:** For existing clients who enter a new program or if the client transfers to a different program, the plan if still appropriate can be pulled forward and utilized in the new program. In order to bill for services in a new program, each client must have a valid treatment plan within that treatment episode.

When pulling the Treatment Plan forward, the person pulling it forward will attest that they have pulled it forward and have/have not made any changes



DOCUMENTATION TIP

Check the content and the dates of the Treatment Plan to be sure the services that are delivered are covered in the plan. If a different Treatment Plan is needed, update the plan with the client!

2. PLAN UPDATE/ANNUAL

Each Treatment Plan can be authorized for up to one year, however many clients achieve their goals or have significant changes prior to the year ending. Plans shall be updated prior to a year based on goal achievement or significant change in a client's life. ***A plan should not be the same year after year.*** If the current plan did not help the client achieve their goals, the plan must change. If the current plan did work, update to reflect the changes.

It is sometimes hard to define a "significant change" in a client's condition. Examples may include; a client who has never been suicidal suddenly making a suicide attempt; or, a client who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the client's condition include, but are not limited to: job loss, birth of a child, death of a family member or

Section 6: Treatment Plans

significant other, change in relationship status (such as divorce), change in residence/living situation.

An annual treatment plan must be completed on or before the plan end date of the previous treatment plan.

- For example, the initial treatment plan is completed and signed by the LPHA on 6/30/18; the annual treatment plan will be due on or before 6/29/19.
- Subsequent treatment plans will be due prior to the expiration of the most recent treatment plan.

For a complete list of all documentation timelines please see the Chart Documentation Timelines in [SECTION 3](#).

Type of Outpatient Service	Initial Treatment Plan	Subsequent Treatment Plan
Outpatient	Within 60 days of first face to face service (or prior to first planned service— whichever comes first)	Annually, prior to the expiration of the previous plan
TBS	Within 30 days of referral to TBS	Not Applicable: Length of stay is less than 12mos. Note the requirement to “review” every 30 days.
Adult Residential	Within 3 full days of Episode Opening/Admission	Annually, within 30 days of Anniversary of Episode Opening
Crisis Residential	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Crisis Stabilization	At the time of admission to the program	Not Applicable: Length of stay is less than 12mos
Medication Treatment-Meds Only	Within 60 days of first face to face service (or prior to first planned service— whichever comes first)	Annually, prior to the expiration of the previous plan

3. LATE PLAN UPDATE/ANNUAL

If the treatment plan has expired/lapsed and the next Treatment Plan is completed late, *services provided during the lapse will not be billable*, the exception being certain services which are listed in the next section.

Example: The Plan update due date is July 1st, but the Plan is completed on July 7th. Any/all services provided July 1st through 6th would be not be billable.

Planned and Unplanned Services Prior to the Completion of the Treatment Plan

The table below shows the services and service activities that may be delivered while the Treatment Plan is being developed or has been finalized. This information was recently clarified by **DHCS in Information Notice 17-040**.

Unplanned Services/Activities	Planned Services/Activities
<ul style="list-style-type: none"> • Assessment • Plan Development • Crisis Intervention • Crisis Stabilization • Specified <i>activities</i> within Targeted Case Management (TCM)/Intensive Care Coordination (ICC): <ul style="list-style-type: none"> ○ Assessment, Plan Development and Referral/Linkage to obtain needed services • Specified <i>activities</i> within Medication Support Services: <ul style="list-style-type: none"> ○ Assessment, Evaluation and Plan Development 	<ul style="list-style-type: none"> • Collateral • Rehabilitation • Therapy • Therapeutic Behavioral Services (TBS) • Intensive Home Based Services (IHBS) • Therapeutic Foster Care (TFC) • Specified <i>activities</i> within TCM/ICC: <ul style="list-style-type: none"> ○ Monitoring and Follow-up Activities • Specified activities within Medication Support Services: <ul style="list-style-type: none"> ○ Direct Treatment and Monitoring • Adult Residential Services • Crisis Residential Services • Day Treatment Rehabilitation and Intensive

TREATMENT PLAN REQUIREMENTS

DHCS requires that 11 required elements appear in every Treatment Plan document. These 11 requirements are enumerated in the contract between DHCS and the County Mental Health Plan:

1. **Initial Treatment Plan & Treatment Plan Updates:** The Initial Treatment Plan is finalized within 60 days of the first face to face service. The Treatment Plan is updated at least annually and/or when there are significant changes in the beneficiary's condition.
2. **Specific Objectives:** Treatment Plan objectives must be specific, observable, and measurable. Objectives must be related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
3. **Proposed Interventions/Modality & Detailed Description:** The Treatment Plan contains the proposed type(s) of interventions/modalities. There must be a detailed description of the intervention to be provided.
4. **Frequency of Interventions/Modality:** The Treatment Plan includes the proposed frequency of the intervention(s)/Modality.
5. **Duration of Interventions/Modality:** The Treatment Plan includes the proposed duration of the intervention(s)/Modality.
6. **Focus of Interventions/Modality:** The Treatment Plan interventions/modalities focus on and address the identified functional impairments as a result of the mental illness or emotional disturbance.
7. **Consistency of Interventions/Modalities with Objectives & Diagnosis:** The Treatment Plan interventions/modalities are consistent with both: (1) Treatment Plan goal(s)/treatment objective(s) and (2) the qualifying diagnosis.
8. **Staff Signatures (for LPHA) and Co-Signatures (for non-LPHA):** The Treatment Plan is signed by: (1) person providing the service(s) or (2) person representing a team or program providing the service(s) or, (3) a person representing the MHP providing the service(s) or (4) co-signed by a [LPHA] if the Treatment Plan is used to establish that services are provided under the direction of [non-LPHA].
9. **Client Participation In & Agreement With Treatment Plan:** The client's participation in and agreement with the Treatment Plan is documented by one of the following: (1) reference to the client's participation in/agreement written within the body of the Treatment Plan, (2) the client's signature* on the treatment plan or (3) a description of the client's participation in/agreement documented in the medical record.

*If the client refuses or is unavailable to sign the Treatment Plan, a progress note must include a written explanation of the refusal/unavailability to sign the plan. The progress note date shall be notated on the treatment plan. Document efforts made to re-negotiate goals if the client refuses to sign.



DOCUMENTATION TIP

If the client has functional impairments such as anger, aggression, or threatening behaviors that when listed as goals on the treatment plan may preclude the client from wanting to sign the plan, meet with clinical supervisor to review plan, and document in progress notes attempts to assist client to formulate goals that address client needs and incorporate clinical judgement of appropriate interventions.

10. **Evidence of Offering Copy of Treatment Plan to Client:** The Treatment Plan will include documentation that the client was offered a copy of the plan. By signing the Treatment Plan the client acknowledges they were offered a copy of the plan. If a client refuses to sign, a copy of the plan must still be offered and this should be documented in the progress note.
11. **Dates & Staff Degree/Title on the Treatment Plan:** The Treatment Plan must include all of the following (1) the date of service; (2) the staff's signature, professional degree and title of job/licensure; and (3) the date the documentation was entered into the medical record.

TREATMENT PLAN COMPONENTS

The Treatment Plan contains the following components to identify the needs and services of the client: Problems, Goals, Strengths, and Barriers to Treatment, Objectives, Interventions/Modalities, and Signatures.

PROBLEMS

The problem is the focus of treatment based on the mental health diagnosis, which includes symptoms, behaviors, and functional impairments. Each Treatment Plan is required to have a minimum of two Problem Statements.

- Example: A client diagnosed with Schizophrenia – may have symptoms such as auditory hallucinations, delusions, disorganized thinking, poor hygiene, social withdrawal, or

other issues that may interfere with securing stable housing and/or maintaining positive family relations or otherwise impact his/her life functioning.

- Example: A client diagnosed with Oppositional Defiant Disorder – may have symptoms such as arguing with adults, yelling and screaming, temper tantrums, blaming others, or not taking responsibility which impacts their functioning at school.
- Example: A client diagnosed with Generalized Anxiety Disorder - uses Cannabis when he feels anxious and often drives while under the influence of this substance.

In some cases, there may be two diagnoses that are the focus of treatment (e.g. Bipolar Disorder & Post-Traumatic Stress Disorder).

PERFECTING THE “PROBLEM” STATEMENT

The problem section will include the client’s functional impairment that is related to the diagnosis, i.e. maintaining housing.

- Example: Client has depressive symptoms of insomnia, isolation, social withdrawal, decreased appetite, suicidal ideation, and poor concentration, which interferes with client’s ability to achieve daily activities such as work or school.
- Example: Client’s psychiatric symptoms of schizophrenia are evidenced by disorganized thoughts, irritability, and paranoid ideations, auditory and visual hallucinations which lead to difficulties maintaining housing.
- Poorly Written Example: Client has symptoms of major depressive disorder (specific symptoms/functional impairments are missing).

GOALS

Each plan is required to have a minimum of one goal for each problem statement.

The goal is the client’s desired outcome associated with their problem. This is where the clinician can help the client articulate what life could be like without the problem, or assist the client in identifying the improved coping skills that would assist the client in better management of the problem.

The goals should be stated in the client’s words whenever possible.

- Example: Billy would like to have more friends. Or “I would like more friends.”
- Example: Diane desires to live independently. Or “I would like to live in my own apartment.”
- Example: Jack wants to stop using prescription opioids. Or “I need to stop using pills because it’s causing problems at home and I have been missing work.”

STRENGTHS

Environmental and personal factors that will increase the likelihood of success such as:

- Community supports, family/relationships, support/involvement, work, etc. may be unique to racial, ethnic, linguistic and cultural (including lesbian, gay, bisexual and transgender) communities
- Identifying the person's best qualities/motivation
- Strategies already utilized to help (what worked in the past)
- Competencies/accomplishments interests and activities, i.e. sports, art identified by the consumer and/or the provider
- Motivated to change
- Has a support system – friends, family
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has knowledge of their disease
- Values medication as a recovery tool
- Has a religious/spiritual program and/or connected to a religious/spiritual organization
- Good physical health
- Adaptive coping skills/ help-seeking behaviors
- Capable of independent living

Use the information on strengths (including cultural or spiritual strengths) to identify the individual/family attributes and skills. Identify resources that will be particularly significant to supporting the client in achieving their goals.

When considering strengths, it is beneficial to explore other areas not traditionally considered “strengths,” Such examples include: an individual's most significant or most valued accomplishment, what motivates them, educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.

OBJECTIVES

Each plan is required to have one objective per problem statement.

An objective is a description of what the client will do to show progress toward a goal.

An objective will:

1. Address the problem statement (behavior or functional impairment)
2. Be specific, observable, measurable and achievable based on the client's perspective

3. Have baseline (what behavior/activity is like currently) and target levels (what is the goal)

Objectives should not be absolutes, that is, it should not be expected that a person exhibiting a behavior 8 times per day at baseline to go to 0 times per day to achieve the objective. With the exception of physical assault or sexual perpetration on others, which should always have a goal of 0 times per day. Smaller and more reasonable steps can assist in successes in the client's life and motivate towards goal achievement.

- Remember, the plan can always be updated when a goal is achieved, so a movement from 8 times per day to 5 times per day, for example, can be updated once achieved to assist that movement from 5 times per day to be 2 times per day etc. Success breeds success.

It is important to track client progress on objectives closely. This should be addressed in the progress notes as it documents the treatment plan progress and the continued establishment of medical necessity. Update the treatment plan as needed or begin transitioning the client to a lower level of treatment or discharge when objectives have been met or functioning has been restored.



DOCUMENTATION TIP

OBJECTIVE TEMPLATE:

Client Name will Increase/Decrease Functional Impairment
from Baseline to Target

EXAMPLES OF A GOOD OBJECTIVE:

- Tom will decrease contacts with law enforcement for disturbing the peace from 5 times a week to 2 times a week or less.
- Sally will increase attendance at school from 0 days to 3 days per week.
- James will decrease cannabis use from 3 times per day to one time per day.

EXAMPLES OF A POOR OBJECTIVE:

- "Decrease psychiatric symptoms." - The objective lacks specificity, frequency (baseline to target), and is too vague to measure.
- "Improve coping skills 0 times daily to 3 times daily." – This objective lacks specificity related to specific symptoms and is too vague to measure the specific skill that is being used.

 DOCUMENTATION TIP

Do NOT use *percentages* (%) or *feelings* in the objective as they are difficult to track or measure.

INTERVENTIONS

Interventions are the therapeutic activities provided by staff to assist the client in attaining the objective in each goal. In other words, how can staff provide a clinical service/modality to assist the client to meet their goals? There must be at least two interventions per measurable objective provided by staff members.

Interventions are the services/modalities a provider anticipates delivering to a client when preparing the client’s treatment plan. All planned services/modalities must be included as an intervention/modality on the Treatment Plan. If there is an intervention included on the Treatment Plan that is not the initial/current focus of treatment, the progress notes must include the clinical justification for retaining those interventions on the Treatment Plan.

Interventions may also include what the client or client’s support person is going to do to work towards the goal (i.e. therapeutic homework, attending a social skills group, wellness group, etc.).

The intervention should directly relate to the functional impairment and will describe how the services/modalities provided will help the client.

What + Why = How this will help

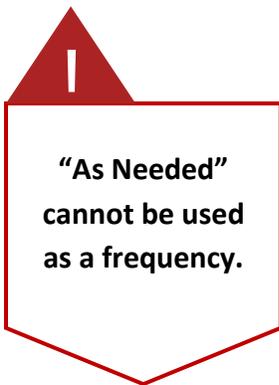
Interventions must address the objectives and must include duration and frequency. Frequency must be stated specifically (e.g. daily, weekly) or as a frequency range (e.g. 1-4x weekly).

Example: Frequency of service: weekly (1x weekly)

Duration of Service: one year

One way to capture the required elements of an intervention is to utilize the following intervention template:

Type of Service/Modality + Purpose = Helping/Action Word + Functional Impairment



Section 6: Treatment Plans

EXAMPLES OF A GOOD INTERVENTION USING THE TEMPLATE:

- Individual therapy to help client identify triggering situations and feelings to increase awareness and lessen self-deprecating thoughts and suicide ideation (weekly for one year).
- Rehabilitation services to teach/model relaxation techniques and coping skills to assist client with reducing anxiety in social situations (twice weekly for 6 months).
- Brokerage services to link client to dual diagnosis group or other needed community resources as needed to reinforce his efforts in stopping the use of cannabis (1 time monthly for one year).
- Medication support and education (side effects, medication efficacy) to promote adherence to medications assisting client with symptom reduction (1 time every 3 months for one year).

These interventions are good when the client wants to have interventions that they want to do in the treatment plan. These interventions would be documented when growth/stagnation is noted in whatever modality is used when monitoring progress.

EXAMPLES OF A CLIENT INTERVENTION:

- Client will attend social skills group to improve social skills by interacting with same aged peers to reduce age-inappropriate behavior (Frequency of service: weekly for Duration of Service: one year).

EXAMPLES OF A SUPPORT PERSON INTERVENTION:

- Mom will play/engage with Johnny to increase his abilities to gain positive attention and encourage bonding to help control impulsive and aggressive behavior for at least 20 minutes a day for the next six months.
- Client's daughter will drive him to bingo to assist him in increasing socialization and decrease isolation 1x/week for the next 6 months.



DOCUMENTATION TIP

Interventions not included in the treatment plan are subject to disallowance; i.e., group therapy being provided without listing it as an intervention. Also interventions that are addressed in the treatment plan and then never utilized may also be reviewed and should periodically be addressed in a progress note as to why the intervention is not being provided, if this continues it may indicate needing to update the treatment plan.

Treatment Plans for Dual Diagnosis Clients

Dual-diagnosis services may be provided for clients with both a mental health diagnosis and substance-related diagnosis, when the primary focus of treatment is on the mental health diagnosis. Primary focus means more than 50% of services provided address the mental health diagnosis. The primary goal on the treatment plan must address the mental health condition

FOCUS OF SERVICE

Dual-diagnosis services provided by the mental health clinics BCDBH **must** focus on the mental/behavioral health needs of the client. The goal to address the use of substances (to cope, or reduce mental health symptoms) must be the secondary or tertiary goal on the treatment plan. While dual diagnosis can be treated, a majority (50% or more) of the services provided to the client must be focused on the *mental health condition*, rather than on the substance use condition. Deal with mental/behavioral health concepts and needs, including how the client recognizes and attempts to meet needs, handles emotions, and makes plans and follow-through, carries out responsibilities, etc.



DOCUMENTATION TIP

Remember if services provided primarily focus on sobriety or dealing with aspects of the client's substance use/dependence (whether to use, how much to use, how to quit, etc.), the services may be subject to audit disallowance.

DISCHARGE/TRANSITION OF CARE

The Care Coordinator will implement a Transition of Care/Discharge strategy in the treatment plan for changes in the level of care of the client. This will include the following, as appropriate:

1. Referral to additional providers.
2. Obtain a ROI for any new providers.
3. Communicate to the client that if they decompensate or have an increased risk of hospitalization, services would be reinstated or made available as needed.
4. This must be documented in the client's progress note.

SIGNATURES

- The “[Signatures](#)” section indicates the client’s participation and agreement with the Treatment Plan (CCR Title 9 Division 1, §1810.440).
- Treatment planning sessions are typically documented in a progress note as plan development.
 - The progress note should contain information about the client and the client’s significant support person’s participation in the treatment planning process and/or signing the plan.
- The client must be offered a copy of the Treatment Plan.
 - The client acknowledges the offer of the copy by signing the plan as the signature states: “Client helped develop, understands, agrees with the goals, and has been offered a copy of this client plan.”
- Signatures are **required** by the [LPHA](#) and the client and/or legal guardian.
 - If the client does not or cannot sign the plan, the progress note shall document the reason for the missing signature.
 - Ongoing efforts to obtain client’s missing signature must be made and documented in additional progress notes.
 - Exception – If the client refuses to sign:
 - Ascertain the reason.
 - Renegotiate the goal, if that is the reason.
 - If the client agrees with the goal and the treatment proposed but still refuses to sign the Treatment Plan then document that in the progress note.
- The client plan is a collaborative process between the client and the provider. The client should understand what they are signing based on their participation in that process.
- A Treatment Plan without required signatures or dates is subject to disallowance. ***Don’t be late!***



CARE COORDINATION

Coordination, collaboration, and communication are vital components when multiple providers and various agencies are serving the same client. To achieve this, it is dependent upon the identification of one person to take the lead in providing general oversight and coordination of all necessary service components and to ensure clients are aware of how services are planned and added when needs are identified. This coordination creates the best opportunity to ensure positive outcome while avoiding the pitfalls of unnecessary or wasteful duplication of services, or worse, providers working at cross purposes.

ROIs will be in place
for ALL ongoing
coordination efforts

DEFINITION

Care Coordinator (CC) – the designated person to oversee and appropriately manage a client’s behavioral health service needs. This may be a Licensed/Waivered Mental Health Professional (LMHP) or a Behavioral Health Counselor in conjunction with an LMHP monitor, as appropriate to the Program. Individuals working for contracted organizational providers may also serve as the CC.

The Care Coordinator will oversee services between current treatment providers, other managed care organizations, and other human service agencies including community and social support providers, *as appropriate*. This will include all BCDBH clients—both in children’s and adult services. The Care Coordinator may or may not be the lead clinician, depending on program needs. The Care Coordinator will facilitate the team approach to communicate and collaborate between service providers to ensure quality of care without duplication of services. ROIs must be in place for ongoing coordination of care.

The Case Coordinator will be established by the completion of the treatment plan, or no later than 60 days. This will be true whether the provider is BCDBH staff or staff with a contracted organization provider.

The overall point of establishing a Care Coordinator is to ensure clients are aware of the name of the person to call in who is in charge of their primary treatment and how services are planned for/added when needs are identified.

Care Coordination Activities

The Care Coordinator will monitor services between settings of care and other managed care organizations and other human services agencies including community and social support providers—*as appropriate*. Examples:

1. Between settings of mental health care (including Fee-For-Service Providers)
2. Physical Health Organizations (e.g. Medi-Cal Managed Care Plan, Ampla)
3. Department of Children’s Services (DESS)
4. Other Human Service Agencies (e.g. Public Health)
5. Community And Social Support Providers
6. Education Programs
7. Housing
8. Rehabilitative Services

The Care Coordinator will ensure that, in the course of coordinating care, each beneficiary's *privacy is protected* in accordance with all federal and state privacy laws.

The CC will communicate and coordinate with all mental health providers on a routine basis to establish and monitor mutual client goals. At a *minimum*, the CC will document at least monthly contacts with all individuals providing direct mental health services, and incorporate these other service and coordination into the “interventions” section of their client plan. More frequent contacts/communication with the treatment team to coordinate care may be necessary when a client is receiving more intensive services (i.e. TBS, WRAP, ICC, IHBS or SEARCH or when multiple providers are involved in the treatment).

There is a *Care Coordination* brochure that you may give to your client when the CC is established. The brochure is translated into both Spanish and Hmong.

Example of Progress note CC Established (I of DIRT):

Clinician informed client that (insert name) is their Care Coordinator and may be collaborating with additional service providers for their treatment when appropriate.

SPECIAL NOTE: The Care Coordinator is NOT liable for the failure of other agencies responsible for non-mental health services to provide those services or to ensure the agency participates in coordination efforts. However, any breakdown in participation must be documented in progress notes.

References: Contract with DHCS citing WIC 14683, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) and the Child Health and Disability Prevention Program (Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

For AVATAR users:

Outpatient Progress Notes (CC)

Interventions Related to Objective

- Anger management skill building
- Art Therapy
- Assertive Communication Skills
- Assertiveness training group
- Assessment
- Avoided Hospitalization
- Behavior Modification
- Case Management
- Child Family Team (CFT) meeting
- Client-Centered Therapy
- Cognitive Behavior therapy
- Collateral
- Communication skill-building
- Conflict Resolution
- Crisis Intervention/de-escalation
- Day Treatment
- DBT
- Discharge
- EMDR
- Established Care Coordinator
- Family Therapy
- First Attempted Contact
- Group Counseling
- Homeless Prevention
- Hospital Discharge Planning
- Housing Intervention
- Info Note
- Insight-oriented therapy re: Behavior
- Intensive Care Coordination (ICC)
- Intensive Home Based Services (IHBS)
- Left Voicemail
- Life Review
- Limit Setting
- Medication Support Services
- MET
- Motivational Interviewing
- Multi-Disciplinary Team (MDT)
- No Show
- Other

Interim Svcs Education

Was Service Provided in Language other than English?
 Yes No

Service Provided In
[Dropdown]

Language Service Provided By
[Dropdown]

BCDBH Interpreter
[Text Field]

Where was this service provided?
 School Hospital Housing/Shelter
 None of these

School
[Dropdown]

Hospital
[Dropdown]

Housing/Shelter
[Dropdown]

Client is identified as a human trafficking survivor
 Yes No

If Other, Please Describe
[Text Field]

Care Coordinator
[Text Field]

When the CC is established with the client, please check this box for tracking purposes and any time the CC changes and a new CC is established.

For NON AVATAR users:

Client Charge Input

Psychotherapy Add-On Duration: [Text Field]

Add-On Notes: [Text Area]

Submit

Online Documentation

Service Start Time: [Dropdown] [Current] [H] [M] [AM/PM]

Service End Time: [Dropdown] [Current] [H] [M] [AM/PM]

Evidence-Based Practices / Service Strategies (CS):

- Age-Specific Service Strategy
- Assertive Community Treatment
- Delivered in Partnership with Health Care
- Delivered in Partnership with Law Enforcement
- Delivered in Partnership with Social Services
- Delivered in Partnership with Substance Abuse Services
- Ethnic-Specific Service Strategy
- Family Reconciliation

Interventions Related to Objective

- Child Family Team (CFT) meeting
- Established Care Coordinator
- First Attempted Contact
- Multi-Disciplinary Team (MDT)
- Wellness Recovery Action Plan (WRAP)

Care Coordinator
[Text Field]

Children's Community Charter
Citrus Avenue Elementary
Come Back Butte Charter
Concow Elementary
CORE Butte Charter
Durham Elementary
Durham High
Durham Intermediate
Emma Wilson Elementary
Esperanza High
Fair View High
Feather Falls Elementary
Forest Ranch Charter
Golden Feather Community Day
Golden Hills Elementary
Gridley High
Head Start/Preschool
Heritage Community Day
Homestead Charter
Honcut School
Honey Run Academy Elementary
Honey Run Academy Secondary
Hooker Oak Elementary
Inspire School of Arts and Sciences
Ipakanni Early College Charter
Ishi Hills Middle
K-7 Palermo Union Community Day
Las Plumas High
Learning Community Charter
Little Chico Creek Elementary
Loma Vista School
Manzanita Elementary
Marigold Elementary
Marsh Junior High
McKinley Elementary
McManus Elementary
Neal Dow Elementary
Nelson Avenue Middle
Nord Country School
Notre Dame
Oakdale Heights Elementary
Oakdale K-7

My Care Coordination:

Care Coordinator:

Phone Number:

My Primary Clinic:

Clinic Phone Number:



Butte County Department of
Behavioral Health

Care Coordination

Using a Team Approach for
Quality, Client-Centered,
Appropriate and
Effective Care





Why Coordination?

Coordination, collaboration, and communication are vital when there are other mental health providers and agencies involved in your care. Services are better and wellness can be achieved when using a team approach—everyone communicates and coordinates services towards a mutually agreed upon goal. YOU are part of this team!

But to make this coordination happen, it is important to identify one person to take the lead in providing general oversight and coordination of all necessary services. Also we want to ensure you are aware of how services are planned and added when needs are identified.

If you ever have a change in your coordinator, you will be given the new information as soon as it happens.

What is Included?

Examples of care coordination include:

- Establishing accountability and agreeing on who has responsibility for each service coordinated
- Communicating/sharing knowledge
- Helping with transitions of care
- Assessing client's needs and goals
- Creating a proactive care plan
- Referring and linking to community resources
- Working with other team members to align resources with client's needs
- Monitoring and follow-up, including responding to changes in client's needs
- Supporting client's self-management goals



The Care Coordinator will communicate and coordinate services between settings of care—other health agencies, human service agencies, and community and social support providers.

Sharing Information

In order for a team approach, we will ask you to sign Releases of Information for those providers and agencies involved in your care. This is important as we will not release any information without this! However, if you choose not to sign a release of information for the coordination of services, it will not stop us from serving you—it just stops us from talking to other agencies and providers! We would like to be able to coordinate services effectively and this requires frequent communication between service providers.

Using a Team Approach

A Team Approach combines you with a group of talented and resourceful people that can better help you reach your wellness goals. It increases the quality of your treatment—providing communication and collaboration—for safe and effective treatment.



Kev Tu Tswjkav Tus Kheej:

Tus Tu Tswjkav:

Xovtooj:

Kuv lub Tsev Khomob:

Tsev Khomob Tus Xovtooj:



Butte County Cajmeem Saib
Kev Kajsiab

Kev Tu Kev Tswjkav:

Siv ibpab neeg los sibpab kom
ua tau zoo, nyob nruabnrab,
zoo sivtau thiab pabtau zoo.





Yog Vimlicas Thiaj Muaj Kev Tswjkav?

Kev tswjkav, kev Sibkoom, thiab kev haislus yog tseemceeb rau lubneej txojhia thaum muaj lwm cov kev kajsia cov neeg pab thiab cov koomhaum koom nrog uake rau koj txojkev koj tuskheej. Kev pab zoo dua thiab kevzoo yuav caumcuag thaum siv ibpab los pab-txuas kev haislus thiab tswjkav pab mus rau lawm tomntej yog ib qhov kev pomzoo los ntawm lub homphiaj. KOJ yog ibtug ntawm pabno!

Tabis yuav tswj kom qhov no tshwmsim, nws tseemceeb heev yuav tsum muab ibtug los ua tus coj ua pab tso mkwm thiab tswjkav txhuayam kev pab uas yuav tsum tau pab. Ibyam peb xav kom koj rastxog haistias cov kev pab yog npaj lica thiab yuav ntxiv lica thaum pom haistias muaj qhov yuav tau ntxiv rau.

Yog haistias koj tau muaj kev pavhloov rau tus kheej rau kev tswjkav, koj yuav tau txais kevqhia yamtsiab sai sai thaum nws tshwmsim.

Abtsi nyob nrog rau hauv?

Pivtxwv kev khomob muaj xwvli:

- Tsim kom muaj kev tso mkwm thiab leejtwg saib txoj haujlwm twg los tswjkav rau ib qhov kev pab.
- Kev cev lus haislus/sibpauv tswvyim
- Pab rau txoj kev hloov kev tu
- Ntsuam xyuas tus mob kev xav tau thiab homphiaj
- Tsim kom muaj kev npaj los kho
- Xa mus nrhiav kev pab hauv zejzrog
- Ua haujlwm nrog lwm pawgneeg nrhiav kev pab rau tus tau txais kev pab qhov nws xav tau
- Tso mkwm thiab taugqab, qhia txog kev hloov thiab tus tautxais kev pab kev xav tau
- Kev txhawb nqa rau tus tautxais kev pab kom nws tuskheej txawj tswjkav nws cov homphiaj



Tus Tswj kev Tu yuav cev lus thiab Tswjkav kev pab rau txoj kev tu – rau lwm lub tsev khomob, cov koomhaum pab tibneeg, thiab lub zejzrog thiab cov neeg muaj kev pab pab rau tibneeg.

Kev Sibpauv Lus Ntaubntawv

Kev los sibkoom ua ibpab sibqhia yuav mus tau, peb hais kom koj los kosnpe tso cai rau daimntawv (Releases of Information) cov neeg muab kev pab thiab cov koomhaum uas koomtes nrog rau koj txoj kev tu.. Qhov no nws tseemceeb heev peb yuav tsis tso cov ntaubntawv los tham tawm yog tsis tau kev tso cai! Txawm haistias, yog koj hos tsis kam kosnpe rau daimntawv (release of information) rau txoj kev tswjkav rau txoj kev pab, nws yeej tsis nres peb rau txoj kev pab pub rau koj - nws tsuas yog nres tsis pub peb tham nrog lwm lub koomhaum, thiab cov neeg pab xwb! Peb xav kom txoj kev tswjkav pab no mus tau zoo thiab qhov no yuav tsum sibtham tasli losntawm cov neeg muaj kev pab.

Kev Siv Ibpab Neeg Sibkoom Uake Komze

Kev siv ibpab neeg sibkoom komze yog kev sibkoom losntawm koj nrog rau ib pabneeg muaj peevxwm thiab muaj kev pab zoo uas yuav pab tau koj lub homphiaj kev nojqab nyobzoo. Nws pab tau koj txoj kev khomob - pab kev cev lus thiab sibkoom uake - rau txoj kev khomob tsis phomsij kho tau zoo.



Mi Coordinación de Cuidado:

Mi Coordinador de Cuidado:

Número de teléfono del
Coordinador:

Mi Clínica Primaria:

Número de teléfono de la
clínica:



Condado de Butte
Departamento de Salud
Conductiva

Translation Completed By: BMW – QM 02/22/19
Reviewed By: LC 02/25/19

Coordinación de Cuidado

Usando un enfoque de equipo
para asegurar que su cuidado es
de calidad, apropiado al cliente, y
efectivo.





¿Por qué la coordinación?

Coordinación, colaboración, y comunicación son importantes cuando hay otros proveedores de salud mental y agencias involucradas en su cuidado. Los servicios son más efectivos y se puede lograr el bienestar con un enfoque de equipo—todos se comunican y pueden coordinar servicios hacia la meta mutua. ¡USTED es parte de este equipo!

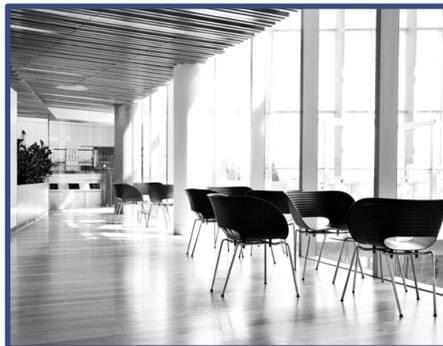
Pero para que esta coordinación pueda suceder, es importante identificar una persona que va dirigir previendo la atención general y la coordinación de todos los servicios necesarios. También queremos asegurar que usted esté al tanto de como los servicios están planeados y poder añadir cuando hay necesidades que requieren atención.

Si llegará a haber un cambio en su coordinador, usted recibirá nueva información en el momento que un cambio sucede.

¿Qué es incluido?

Ejemplos de la coordinación de su cuidado incluye:

- Estableciendo responsabilidad y llegando a un acuerdo de quien tiene la responsabilidad de cada servicio coordinado.
- Comunicando/compartiendo conocimiento de su cuidado.
- Ayudando con cualquier transición de su cuidado
- Evaluando las necesidades y las metas del cliente.
- Creando un plan de cuidado que sea proactivo.
- Dando referencias y obteniendo recursos de la comunidad.
- Trabajando con otros miembros del equipo para juntar recursos que ayudarán a lograr las metas del cliente.
- Dando seguimiento y estando al tanto de su cuidado, que incluye respondiendo a cualquier cambio en sus necesidades.
- Apoyando que los clientes puedan manejar su propio tratamiento.



El Coordinador de Cuidado se comunicará y coordinará servicios entre los sitios de su cuidado—como otras agencias de salud, agencias de servicios humanos, y proveedores de apoyo comunitario y social.

Compartiendo Información

Para lograr un enfoque de equipo, le vamos a pedir que firme un permiso para la divulgación de información a los proveedores y las agencias involucradas en su cuidado. ¡Esto es importante porque no compartiremos su información sin su permiso por escrito! Sin embargo, si usted decide no firmar el permiso para la coordinación de los servicios, esto no va a detenernos para darle los servicios—solo nos detendrá en hablar con otras agencias y proveedores. Quisiéramos poder coordinar sus servicios de una manera efectiva y esto requiere comunicación frecuente entre los proveedores de sus servicios.

Usando un Enfoque de Equipo

Un Enfoque de Equipo lo/la conecta con un grupo de proveedores talentosos e ingeniosos que pueden ayudarle a alcanzar sus metas de bienestar. Aumenta la calidad de su tratamiento—proporcionando comunicación y colaboración— para un tratamiento que es seguro y efectivo.

CULTURAL AND LINGUISTIC SERVICES

The following Cultural and Linguistic Services requirements must be met and documented in the client medical record on every occasion:

1. Clients whose primary language is not English must be made aware of the availability of and offered or linked to oral language interpreter services in their primary language;
2. Clients who are hearing impaired must be made aware of the availability of and offered or linked to sign language interpreter services; and
3. Clients who are visually or hearing impaired must be provided treatment specific information in alternative formats (e.g. braille, audio, or large print formats).

There must be documentation in the client medical record of the client's response to the offer of interpretive services. There also must be documentation in the client's medical record that services were provided in the client's preferred language.

If the need for language assistance is identified in the client assessment, there must be documentation in the client medical record where clients were linked to culture-specific and/or linguistic services such as referrals to community-based organizations or other community resources.

Finally, linkages to interpreter services also must be documented in the client medical record. Interpreter services includes both oral and sign language interpreter services.

[Language Line Solutions \(BCDBH Policy 089B\)](#)

When an individual calls or has a service at a BCDBH clinic and an interpreter is required during that call/service, BCDBH will first try to identify the language being spoken. This can be done using the BCDBH Determining Language Preference sheet posted in most clinic lobbies. The staff will attempt to locate a BCDBH staff on site that may be available to provide language services over the phone or in person. If there is no staff available, then BCDBH Staff can utilize the Language Line Solutions for alternative translation assistance for clients.

DIRECTIONS FOR ACCESSING LANGUAGE LINE SOLUTIONS

When receiving a call from a Limited English Proficiency (LEP) client:

- First, **identify the language being spoken**: If you are in person with the client, use the Determining Language Preference form available at each site.
- Next, quickly **check if there are any staff on site who speak the identified language of the client calling**: Each site should have a current list posted of each Butte County Department of Behavioral Health (BCDBH) bilingual certified staff person. In the circumstance that no staff is available who speak the given language, proceed to the next steps below.

***Note:** If speaking to client over the telephone, you can ask for assistance from the Language Line Solutions representative for assistance in identifying client's preferred language.*

To connect to Language Line Solutions, **press the FLASH button** to place the LEP client on hold:

- **Dial Routine: 1-800-523-1786**
- **Give Information:**
 - Client I. D. Number: 201723
 - Language needed: (as determined)
 - Personal Code: Your employee ID #
- **Add** LEP client to the line by pressing **the FLASH button**
- **Wait** for the Language Line Solutions representative to add the Interpreter onto the line.
- **Record** the interpreters name and ID number. Introduce yourself and the interpreter, and define the role of the interpreter in the conversation. Quickly summarize what you wish to accomplish and give any special instructions.
- **Say "end of call"** to the interpreter when the call is completed.

***Not all phones are the same!** Please be familiar with how to transfer calls and connect three-way callers on the phone you are using.

Section 8: Cultural and Linguistic Services

HELPFUL HINTS:

- Be familiar with this process, staff linguistic capabilities, phone mechanisms, etc., to ensure that the caller receives services in his/her language as quickly and smoothly as possible.
- To facilitate interpretation, avoid using slang, jargon, acronyms, or technical terms that may not interpret well into another language.
- You can also use Language Line Solutions services to place outgoing calls to LEP clients, to set up appointments, convey important treatment information, etc. Please note to primarily use bilingual staff or interpreters in non-emergency situations in order to increase cost efficiency.
- If you would like to watch a live demonstration on how the system works, please visit the Language Line Solutions web site at: <http://www.language.com>

Important Note:

As the following lists are updated/changed, replacement lists will be sent out to replace these attachments. If replaced as they come in, your manual will always be up-to-date.



Determining Language Preference

This is a tool to use in determining language being spoken and/or read.

English	If you speak another language, language assistance services, free of charge, are available to you
Español (Spanish)	Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Tiếng Việt (Vietnamese)	Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Tagalog (Tagalog–Filipino)	Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
한국어 (Korean)	한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다
繁體中文 (Chinese)	如果您使用繁體中文，您可以免費獲得語言援助服務
Հայերեն (Armenian)	Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ
Русский (Russian)	Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
رسی (Farsi)	اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما



Determining Language Preference

This is a tool to use in determining language being spoken and/or read.

日本語 (Japanese)	日本語を話される場合、無料の言語支援をご利用いただけます。
Hmoob (Hmong)	Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
ਪੰਜਾਬੀ (Punjabi)	ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਮੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
عربية (Arabic)	إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
हिंदी (Hindi)	यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध
ภาษาไทย (Thai)	ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี
ខ្មែរ (Cambodian)	អ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែរ , រសវាជំនួយមននកភាសា ងាយមិនគិត ្ន ្ន គឺអាចមានសំរា ំ ំអ អុើ នក។ ចូ
ພາສາລາວ (Lao)	ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.

BCDBH Bilingual Certified Staff List

FY 2018-2019 4th Quarter



Last Name	First Name	Language	Classification	Site
Amaya	Sotero	Spanish	BH Counselor II	Gridley
Anaya	Norma	Spanish	BH Worker	PHF
Barba-Gonzalez	Fabiola	Spanish	BH Counselor I	CCCC
Bonner	Graciela	ASL	MRT Senior	CCCC
Calderon	Angel	Spanish	BH Counselor II	Gridley
Cervantes	Aurora	Spanish	BH Counselor II	Mobile Crisis
Chavez-Lee	Liberty	Hmong	MRT	SUD
Coronel	Griselda	Spanish	Accountant	Admin
Flores	Nicolas	Spanish	BH Clinician I	CCCC
Gomez	Roberto	Spanish	BH Worker	PHF
Hernandez	Cristina	Spanish	BH Clinician I	CCCC
Hinojosa	Ivette	Spanish	BH Counselor I	Gridley
Jimenez Vargas	Eric	Spanish	BH Clinician I	Gridley
Lee	Daone	Hmong	Psych Tech	PHF
Lo	Lee	Hmong	BH Clinician I	OOP
Lopez	Victor	Spanish	BH Counselor II	CAS
Lopez Leon	Geisha	Spanish	BH Clinician I	OCC
Martinez	Jennifer	Spanish	MRT	CAS
Martinez	Pablo	Spanish	BH Counselor II	CCCC
Medina	Jesus	Spanish	BH Counselor II	CCCC
Moua	Amy	Hmong	MRT	OCC
Muniz	Emilio	Spanish	BH Counselor II	SEARCH
Saechao	Kae	Mien	BH Counselor I	OCC
Thao	Chang	Hmong	BH Clinician II	PHF
Thao-Lee	Chia	Hmong	Supervisor, BH Clinician	OCC
Torres-Carrillo	Minerva	Spanish	BH Clinician I	CCCC
Towner-Caro	Karin	Spanish	Supervisor, BH Clinician	CAS

Last Name	First Name	Language	Classification	Site
Vang	Teng	Hmong	BH Counselor II	OCC
Vang	Chao	Hmong	BH Counselor II	OOP
Vang	Pai	Hmong	BH Clinician I	OOP
Vang Thao	Valerie	Hmong	BH Clinician I	Gridley
Weinrich	Debra	Spanish	BH Clinician II	CAS
Wilson	Bianca	Spanish	BH Clinician III	QM
Yang	Dia	Hmong	BH Clinician I	CAS
Yang	Dale	Hmong	BH Clinician I	OOP

The latest and updated version of this list can be found at DBH Info under [Language Access/BCDBH Bilingual Certified Staff List](#)

**Butte County Department of Behavioral Health
FY 18-19 Contracted Translators/Interpreters**

**Bold and underlined indicates current contract with BCDBH*



Translator/ Interpreter	Phone/Email	Availability	Notes
American Sign Language (ASL)			
NorCal Center for Deaf and Hard of Hearing	(916) 349-7525 info@norcalcenter.org	By Appointment	Use request form; Spoken English to ASL, vice versa
Alternative Language			
Language Line Solutions	(800) 523-1786	24/7	Phone translation services multiple languages
TDD/TTY Telephone Service*	(800) 735-2929 (800) 735-2922 (voice call)	24/7	Statewide access
Hmong			
Hmong Cultural Center Seng Yang	(530) 534-7474 info@hmongculturalcenter.com	By Appointment	Translate documents/ Hmong to English/ English to Hmong
Mien			
Khae Shelly Tern	(530) 282-3515 (530) 532-5890	Mon-Fri 3 pm – 5 pm *With Extended hours during Summer break	Oroville preferred; Evenings
Spanish			
Alicia Cuevas	(530) 370-3369 5acuevas@att.net	Mon.-Sun Oroville, Chico, Paradise, Gridley	Written and oral translation
Martha Martinez	(530) 228-9762 mmartinez189@mail.csuchico.edu	By Appointment (Evenings/Weekends)	Document translation preferred
Washington Quezada	(530) 624-3496 (cell) washo466@gmail.com	As assigned by BCDBH QM	Document translation

***TDD/TTY: Assistance for Hearing Impaired Individuals via Telephone**

Send questions or comments to DBHQM@buttecounty.net (530) 891-2456 Updated 05/21/19

The latest and updated version of this list can be found at DBH Info under

[Language Access/Translator List](#)



TIPS FOR WORKING WITH TELEPHONE INTERPRETERS

BEFORE YOU START:

• Identify the target language using language identification form (in-person) or by requesting assistance from Language Line Solutions representative.

- Watch a live demonstration:

<https://youtu.be/LQoCRen--M4>

- Explore the vendor's website:

www.language.com

- Know how to use your conference call or three-way calling features
- If your meeting is longer than 30 minutes, try to schedule an in-person interpreter

If you have line quality problems before reaching an interpreter, ask the representative to stay on the line to check for sound quality.

If you have problems connecting to an interpreter, call Language Line Solutions Customer Service:

[1-800-752-6096](tel:1-800-752-6096)

PLACING THE CALL:

Call: [[1-800-523-1786](tel:1-800-523-1786)]
(Client ID/Access Code: [201723](#) **)**
 The number and Client ID should not be shared with outside entities.

AN INTERPRETATION MAY NOT BE GOING SMOOTHLY IF:

- The interpretation is too long or too short compared to the length of the material being interpreted;
- The interpreter repeatedly asks for clarification;
- It sounds like the interpreter is having a side conversation with the Limited English Proficient (LEP) individual;
- The LEP caller corrects or appears to disagree with the interpreter;
- The LEP caller begins to speak in halting and incorrect English;
- The interpreter or the LEP caller is becoming increasingly impatient;
- It sounds like the interpreter is using many English terms to convey the meaning of your conversation; or
- The interpreter does not conduct himself or herself in a professional manner.

AT THE START OF THE CALL:

Record the interpreter's ID number, introduce yourself and the interpreter, and define the role of the interpreter in the conversation. Be sure to let all parties know that they may be asked to stop, rephrase, or clarify throughout the call.

- ✓ **Talk directly to the LEP individual**, not the interpreter. For example, "What is your name?" and not "Please ask the caller for their name."
- ✓ If the LEP individual is willing to share, **obtain the caller's phone number** in case of accidental disconnection.
- ✓ **Pause after one or two sentences** to allow for interpretation
- ✓ **Ask one question at a time.**
- ✓ **Speak clearly** at a normal pace and refrain from technical language.

If you think something is wrong with the interpretation, feel free to ask the LEP individual:

"Would you mind repeating back to me what I said, so that I can make sure I am communicating clearly?"

If you believe that your communication with the LEP individual has been compromised by the quality of interpretation, END THE CALL.

Call the telephone interpretation service to obtain a new interpreter. Once you have successfully completed your call with a new interpreter, please provide feedback as noted.

Say **"END OF CALL"** to the interpreter when the call is completed.

PROVIDING FEEDBACK: If you encounter technical problems or have questions, contact your section's Language Access Point of Contact: Bianca Wilson, LMFT - BCDBH QM (530) 879-3931.

PROGRESS NOTES

Progress notes are a summary description of what was clinically accomplished or attempted at the time the service activity was delivered that assisted the client to make progress towards goals. Progress notes need to demonstrate how the intervention reduced symptoms or functional impairment, or prevented deterioration in an area of life functions. The key word is “progress.” In general, progress means “to advance or make steady increases towards a goal.”

FREQUENCY OF PROGRESS NOTE DOCUMENTATION

The frequency of documentation depends on the type of service, as indicated below:

Type of Non-Hospital Service	Time Claimed In	Progress Note Standard
Outpatient	Exact Minutes	Every contact is documented in progress note
TBS	Exact Minutes	Every contact is documented in progress note
Adult Residential	Calendar Days	Weekly Summary
Crisis Residential	Calendar Days	Daily Note
Crisis Stabilization	Exact Minutes	Progress note (4 hour blocks)
Medication Treatment - Urgent Meds	Exact Minutes	The contact is documented at the time of service in a progress note
Medication Treatment-Meds Only	Exact Minutes	Every contact

REQUIRED ELEMENTS FOR PROGRESS NOTES

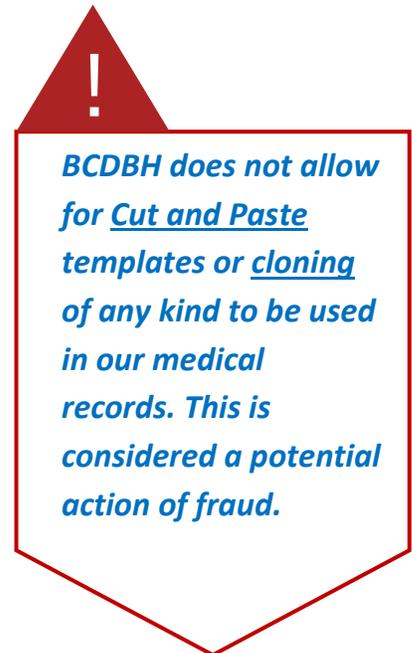
1. **Relevant Aspects of Client Care:** Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2. **Details of the Encounter:** Documentation of client encounters, including relevant clinical decisions, when decisions are made, and alternative approaches for future interventions, and the client’s response to the intervention.

Section 9: Progress Notes

3. **Interventions and Details:** Interventions applied, client's response to the interventions, [how services provided reduced impairment/restored functioning/prevented deterioration in an important area of life functioning out lined in the Treatment Plan], and the location of the interventions.
4. **Date of Service:** The date the services were provided.
5. **Referrals:** Documentation of referrals to community resources and other agencies, when appropriate.
6. **Follow-Up Care or Discharge Summary:** Documentation of follow-up care or, as appropriate, a discharge summary. Record any therapeutic assignments (homework) for the time between sessions.
7. **Service Time:** The amount of time taken to provide services (exact minutes, not estimated or rounded).
8. **Signature, Degree & Licensure/Title:** The signature of the person providing the service (or electronic equivalent); the person's type of professional degree and licensure, or job title.
9. **Date of Documentation:** The date the documentation was entered in the medical record. *Non-EHR Contractors must sign and date each note with professional title for the date the note was written (no back-dating).
10. **Timeliness, Frequency & Legibility:** The standard for Butte County Behavioral Health is Within 7 (seven) days. All staff are encouraged, but not required, to use concurrent documentation (write the note with the client present) to write notes in real time, eliminate post service documentation time, and increase the client's involvement in the clinical record. All documentation must be legible. Same day/Next day documentation is encouraged.
11. **Multi-Provider Notes:** When services are being provided to, or on behalf of, a client by two or more persons at one point in time, the progress notes must include:
 - The documentation of each person's involvement in the context of the mental health needs of the client;
 - The exact number of minutes used by persons providing the service;
 - The signature(s) of person(s) providing the services.

GENERAL RULES FOR PROGRESS NOTES

1. Every service activity must have a separate, corresponding note (i.e. if two different services are provided to the same client in the same day, each service requires a separate note; repeated service/code on the same day may be combined into one note).
2. Progress notes documenting the use of evidence-based practices such as motivational interviewing, and techniques such as unconditional positive regard, and empathetic listening should describe how the technique used during the intervention assisted to reduce impairment, restore functioning, allow developmental progress as appropriate, or prevent significant deterioration in an important area of life functioning outlined in the client plan, and then document the client's response to the *intervention*.
3. When more than one staff member participates in a service for the same client, each staff must write a note for the time they were present and bill for the service. For example: if two staff participate in a plan development meeting with a client, each staff member writes their own note to represent their contribution to the meeting.
4. Progress notes should be written objectively. Use behavioral language rather than jargon (not they were confused; rather they used the same phrase repetitively when asked different questions). Refrain from using negative language about clients. Remember that a client can request their chart at any time, or a court may subpoena a chart.
5. Documentation should demonstrate how the intervention allows the clients to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention.
6. Documentation should show that clients are being served in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency.
7. **At no time** shall any documentation appear cloned. This includes assessment, treatment/client plans, and progress notes. **Medical Record Cloning occurs:**



Section 9: Progress Notes

- a. When documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation.
 - b. Whether the cloned documentation is handwritten, the result of pre-printed template, or use of Electronic Health Records, cloning of documentation will be considered **misrepresentation of the medical necessity requirement** for coverage of services.
 - c. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
8. BCDBH requires the use of the **D.I.R.T.** format for the following service types:
- Assessment; Rehabilitation; Therapy; Collateral; Crisis Intervention; Intensive Care Coordination; Intensive Home Based Services; and Therapeutic Behavioral Services.

DESCRIBE	The presenting problem, how the client presents him/herself, or the reason for the service activity.
INTERVENTION	What treatment plan service was provided by the clinician?
RESPONSE	What was the client's clinical response to the intervention?
TREATMENT PLAN	What is the next step for the recovery process?

The hardest part of the **D.I.R.T.** note can be the *intervention statement*. Below is a simple formula to assist with writing the intervention segment of a progress note. This is NOT the complete note or even the complete intervention portion! It is important that all interventions are documented, including referrals provided, documents reviewed and signed, etc.

PROGRESS NOTE MENTAL HEALTH INTERVENTION STATEMENT

An *Intervention Statement* has four components:

ACTION WORD CLINICAL TECHNIQUE USED TO ADDRESS FUNCTIONAL IMPAIRMENT

ACTION WORD (what was done)

CLINICAL TECHNIQUE (mental health technique/strategy used)

Used TO ADDRESS (purpose of intervention— what's the goal for this intervention)

FUNCTIONAL IMPAIRMENT (focus of intervention)

Functional Impairment:

- a. Inability to meet basic needs (e.g. community, family, social, legal, housing)
- b. Clinical Risks (suicide, assault, grave disability)
- c. Daily Living Skills (e.g. hygiene, fiscal management, shopping, medication compliance)
- d. Behaviors associated with diagnosis/symptoms that cause life difficulties

Progress Note Intervention Criteria (all must apply):

- a. Focus of the intervention is to address the functional impairment identified.
 - b. It is expected the individual will benefit from the intervention by significantly diminishing the impairment, or preventing deterioration in an important life function (for children: it is probable that the child will progress developmentally as individually appropriate, be corrected or ameliorated/improved), and
 - c. The condition would not be responsive to physical healthcare based treatment.
9. Refer to the specific *Service Type Section* for examples of notes that contain all the required elements. View [APPENDIX H.3](#) for other Progress Note Help.



DOCUMENTATION TIP

If client has a recent history of suicidal or homicidal ideation and/or hospitalization, document potential risk in each progress note.

Primary Reasons for Recoupment or Disallow a Progress Note:

1. The progress note was written during a time period that treatment plan or the assessment had expired.
2. The progress note is missing one of the following:
 - a. Missing date of service
 - b. Missing the Treatment Plan objective being charted to
 - c. Note does not address the functional impairment
 - d. Missing the clinical intervention(s)
 - e. Missing the Client's clinical response to the intervention
 - f. Note is not readable (illegible or coherent)
3. Service is not billable
4. No progress note found or note service code does not match the intervention used.

Multiple Provider Notes- Individual and Group Services

When more than one staff member participates in a service for the same client, each staff must write a note for the time they were present and bill for the service.

For example: if two staff participate in a plan development meeting with a client, each staff member writes their own note to represent their contribution to the meeting.

Each group facilitator must write their own notes per client stating their facilitation/role and participation in the service.

Each staff participating in the service writes a progress note on every client in a group, should indicate the total number of clients in the group and the service time should match the time that specific client spent in that group (start/end time).

The documentation/travel time should reflect what was provided that is specific to that client. They should each have a service for the group (their session time) and the number in the group listed in the progress note.



Staff cannot write notes that simply state “See other staff’s progress note” delivered.

DOCUMENTING LOCKOUT SITUATIONS

When a mental health service is provided to a client in a lockout situation (when Medi-Cal is suspended or when a client is in a facility that provides “bundled” mental health services), a Progress Note for that service should still be written and noted to be “non-billable” so that the clinical record documents all services provided.

These will be accomplished with either an informational note or for those programs with authorization, a non-Medi-Cal code. Refer to [SECTION 13](#) (Lockouts) for examples.



DOCUMENTATION TIP

If a minor client is residing in Juvenile Hall, services are not billable to Medi-Cal unless the client has been adjudicated (client is only awaiting placement in a STRTP or other setting). Due to risk of disallowance, evidence of a placement order must be obtained and filed in the clinical record prior to providing services. A copy of the court ordered placement, or another document indicating the date of adjudication, will serve as proof. If that proof is not available prior to providing necessary services, the clinician may use a Progress Note to document a client’s adjudication status as reported by a reliable source that is identified in the Note. “Best practice” is to make ongoing efforts to obtain paper evidence of adjudication.

FORMAT FOR PROGRESS NOTES

Progress Note Elements	
<p>D</p> <p>Describe</p> <p><i>The presenting problem, how the client presents him/herself, or the reason for the service activity</i></p>	<ol style="list-style-type: none"> 1. WHAT WAS THE REASON OR PURPOSE OF THE ENCOUNTER? <ul style="list-style-type: none"> ○ Start by describing the type of service e.g. individual, collateral, crisis, etc. 2. WHAT WAS THE CONTENT OR TOPICS DISCUSSED? <ul style="list-style-type: none"> ○ Factual, brief, and relevant to the goals and objectives if possible 3. WHAT CLINICAL OBSERVATIONS WERE MADE? <ul style="list-style-type: none"> ○ Should be objective, factual, and non-judgmental 4. WHAT IS THE CURRENT MEDICAL NECESSITY FOR SERVICES? <ul style="list-style-type: none"> ○ Please remember we need to demonstrate continued medical and service necessity for the level of services that are provided ○ Was the service provided appropriate to address the client's service need? 5. WHAT WAS SAID, DONE OR REQUESTED BY THE CLIENT? <ul style="list-style-type: none"> ○ This is a good place to address requests for linguistic services
<p>I</p> <p>Intervention</p> <p><i>What treatment plan service was provided by the staff?</i></p>	<ol style="list-style-type: none"> 1. WHAT WAS DONE IN THE CONTEXT OF THE ENCOUNTER? <ul style="list-style-type: none"> ○ Example: Address what was done about the request for linguistic services cited above ○ Crisis: Clearly state how the crisis was addressed 2. WHAT THERAPEUTIC INTERVENTIONS OR TECHNIQUES WERE EMPLOYED? <ul style="list-style-type: none"> ○ These should reflect the ones listed in the treatment plan, if not address why there was a deviation from the plan 3. WHAT PROGRESS OR SETBACKS OCCURRED? <ul style="list-style-type: none"> ○ Describe in measurable, behavioral terms progress toward the goal and address possible reason for lack of progress 4. WHAT REFERRALS WERE MADE? <ul style="list-style-type: none"> ○ If any referrals were made, please address them here

R

Response

What was the client's clinical response to the intervention?

1. WHAT WAS THE CLIENT'S RESPONSE TO THE INTERVENTION?

- o Address this in specific terms based on behavior or client report
- o Crisis: Has the crisis been resolved?

2. HOW WAS THE INTERVENTION EFFECTIVE OR INEFFECTIVE?

- o Describe in terms of measurable or observable changes in behavior whenever possible

3. WHAT SIGNS OR SYMPTOMS OF THE DIAGNOSIS ARE PRESENT OR NO LONGER PRESENT?

- o This goes to medical necessity and accuracy of current treatment

4. WHAT WAS DONE OUTSIDE THE SESSION?

- o If homework was given at the previous session, this is a good place to address what the client did or did not accomplish
- o If the client self-initiated any interventions, report them as well (e.g. joining a self-help group)

5. WHAT ARE THE CLIENT'S CURRENT IMPAIRMENTS AND STRENGTHS?

- o Again, this addresses medical and service necessity and should describe current levels of functional impairments and strengths to overcome them

T

Treatment Plan

What is the next step for the recovery process?

1. HOW DID THE SESSION ADDRESS TREATMENT PLAN OBJECTIVES?

- o Describe how this helped the client's recovery process
- o Crisis: Should a new Outpatient Treatment Plan be developed to address behavior/situation (is it repeated behavior)?

2. WHAT WILL BE DONE OUTSIDE THE SESSION?

- o Describe any activities that will occur before the next contact, e.g. planned, referrals, etc.

3. WAS THERE HOMEWORK ASSIGNED?

- o Was the client taught a new coping skill? Practiced by the next session?

4. WHAT TYPE OF FOLLOW UP WILL BE MADE?

- o Similar to above, could consist of planned collateral contacts. State the planned time for the next contact with the client

SERVICE TYPES

Mental Health Services are services recommended by a physician or other LPHA within the scope of his or her practice under State law both to reduce mental disorders and emotional disturbances and to restore, improve, and/or maintain a client's functional level.

These are the generally used categories of Specialty Mental Health Services:

- 1.** Mental Health Services including:
 - i. Assessment
 - ii. Plan Development
 - iii. Collateral
 - iv. Rehabilitation
 - v. Therapy
- 2.** Medication Support Services
- 3.** Targeted Case Management/Brokerage
- 4.** Therapeutic Behavioral Services (TBS)
- 5.** Intensive Care Coordination (ICC)
- 6.** Intensive Home Based Services
- 7.** Crisis Intervention
- 8.** Crisis Stabilization
- 9.** Adult Residential Treatment Services
- 10.** Crisis Residential Treatment Services

The following sections provide guidance on how to document for each service type in a progress note. It is organized with an overview of the function of the service type then shows the billable activities associated with that service type. Examples are included along with tips for writing a progress note to capture each service type.

SERVICE CODE DEFINITIONS

DIRECT SERVICES

Billing Code	Modality	Definition
3030	BROKERAGE/ TARGETED CASE MANAGEMENT	Services that assist a client to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.
3110	COLLATERAL	Services to one or more significant support persons in the life of the client for the purpose of improving or maintaining the mental health of the client. Progress notes must address the goals and interventions on the treatment plan.
3112	GROUP COLLATERAL	Services provided to a group of 'significant support persons' of client's receiving direct mental health services. Client is not present. Used primarily in relation to youth (clients under 18) - though not exclusively. The group activity is education and interventions that help the significant support people improve the client's functional impairments and/or assist in minimizing the impact of mental illness on client functional impairments. The primary focus cannot be support for the parent, significant other, etc. Progress notes should include the number of clients represented - not the number of significant support people who are present. Example: there are 7 significant support people present in the group, but they represent 5 clients. The note would reflect 5 clients were benefitting from the group. Progress notes must address the goals and interventions on the treatment plan.

Billing Code	Modality	Definition
3310	ASSESSMENT AND EVALUATION	Service activity with a client that formulates a clinical analysis of the history and current status of the client’s mental, emotional, or behavioral disorder, including relevant cultural issues. Assessment may include diagnosis and testing procedures (includes performance outcome measures).
3410	INDIVIDUAL THERAPY	Face-to-face (F2F) service time (client is present) is from 1 - 37 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the treatment plan.
3412	INDIVIDUAL THERAPY	F2F service time (client is present) is from 38 -52 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the treatment plan.
3414	INDIVIDUAL THERAPY	F2F service time (client is present) is from 53 - 480 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the treatment plan.
3415	INDIVIDUAL THERAPY	A “non face-to-face” direct service activity (the client is not physically present – perhaps telephone, etc.). Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the treatment plan.
3450	REHABILITATION SERVICES	Counseling and other services with a client which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must address the goals and interventions on the treatment plan.

Billing Code	Modality	Definition
3510	GROUP THERAPY	Services provided to a group of clients that focus on symptom reduction as a means to improve functional impairment. Progress notes must include the number of clients in the group and address the goals and interventions on the treatment plan.
3570	GROUP REHABILITATION SERVICES	Services provided to a group of clients which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must include the number of clients present and address the goals and interventions on the treatment plan.
3710	CRISIS INTERVENTION	“Face-to-face” (F2F) service time (client physically present) is between 1-44 minutes. Unplanned services that require a more timely response than a regularly scheduled visit. Progress notes need not address the treatment plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.
3715	CRISIS INTERVENTION	A “non face-to-face” direct service activity (the client is not physically present - perhaps telephone, etc.). Unplanned services that require a more timely response than a regularly scheduled visit. Progress notes need not address the treatment plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.
3910	PLAN DEVELOPMENT	Service activity, which consists of the development of treatment plans, the approval of treatment plans, and/or monitoring of a client’s progress. Progress notes should state that the treatment plan goals and interventions were developed, updated, progress toward the goals, or how the interventions will be implemented.

PROCEDURE CODES FOR INTENSIVE YOUTH SERVICES

Billing Code	Modality	Definition
3230	THERAPEUTIC BEHAVIORAL SERVICES (TBS)	This includes all services relating to TBS including direct service, plan development, and collateral contacts with the family. Progress notes must address the goals and interventions on the TBS treatment plan. One note per shift. This code is used primarily by contractors providing TBS and should not be used by clinicians who are responsible for delivering the mandatory co-occurring mental health services (therapy, rehab, etc.).
3040	INTENSIVE CARE COORDINATION (ICC)	ICC is a targeted case management service that facilitates assessment of, care planning for and coordination of services (see Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services & Therapeutic Foster Care Appendix D in the Manual for a more detailed description of ICC.)
3420	INTENSIVE HOME BASED SERVICES (IHBS)	IHBS are mental health rehabilitation services provided to high need youth. IHBS are individualized, strength-based interventions designed to improve and restore mental health conditions that interfere with a youth's functioning and are aimed at helping the youth build skills necessary for successful functioning in the home and community and improving the youth's family ability to help the youth successfully function in the home and community.
3060	AB403 CFT PARTICIPATION	Child/Family Team meeting participation that occurs prior to the youth being opened to services. In this instance, the presence of BCDBH staff is critical in the continuing process of engagement with the family and/or caregivers about client strengths and needs, ensuring services are coordinated, and providing a process for communication. (see Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services & Therapeutic Foster Care Appendix D [pgs 5 and 21] in the Manual for a more detailed description of CFTs)

Billing Code	Modality	Definition
3316	AB403 STRTP ASSESSMENT	Assessment completed by a licensed mental health professional prior to placement in an STRTP/Short-Term Residential Therapeutic Programs (up to 60 calendar days), or within five calendar days of placement (see Short-Term Residential Therapeutic Program Regulations, §Section 9).



[Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home-based Services \(IHBS\) & Therapeutic Foster Care \(TFC\) for Medi-Cal Beneficiaries](#)

PROCEDURE CODES FOR MEDICAL STAFF

Billing Code	Modality	Definition
3610	MEDICATION SUPPORT	A “non face-to-face” direct service activity (the client is not present). This code is used primarily for two Medi-Cal claimable activities: developing and writing a medication treatment plan (med support Plan Development); or medication monitoring services including review of recent lab reports, medication renewal orders, etc.
3630	MEDICATION SUPPORT- MENTAL HEALTH SERVICE	F2F service time (client physically present) This code is to be used by none-prescribing medical staff for ongoing assessment, administration of medications, etc. non-prescriber code
90792	ASSESSMENT MHS SERVICES W/MEDICAL SERVICES	Face-to-face” (F2F) service time (client physically present) Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. – The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. Diagnostic Evaluation/Assessment MH Svc w/ Medical Services (old = 90801).

Billing Code	Modality	Definition
99213	MEDICATION SUPPORT-MENTAL HEALTH SERVICE Evaluation/ Management	F2F service time (client physically present). This code is to be used by psychiatrists and Family Nurse Practitioners (individuals who have prescriptive authority) for ongoing assessment, prescription, administration of medications, etc. for Established Patients – Detail History/Examination for mild to moderate complexity (primary care level or stable mentally ill)(old 90804, 90806, 90808).
99214	MEDICATION SUPPORT-MENTAL HEALTH SERVICE Evaluation/ Management	F2F service time (client physically present). This code is to be used by psychiatrists and Family Nurse Practitioners (individuals who have prescriptive authority) for ongoing assessment, prescription, administration of medications, etc. for Established Patients – Comprehensive History/Examination for moderate to severe complexity (unstable chronically mentally ill) (old 90804, 90806, 90808; otherwise, the same as 99213).
M0064	MEDICATION SUPPORT Brief (1-15 minutes)	F2F service time (client physically present) is between 1-15 minutes. This code is to be used by any licensed medical staff (MD, FNP, RN, LVN, LPT) where the primary purpose includes ongoing assessment, prescription, administration of medications, etc.

PROCEDURE CODES FOR DIRECT SERVICES – “LOCK OUT” SETTINGS

The following service codes capture direct service activity delivered in settings that do not allow conventional funding stream billing (Medi-Cal, etc.) including Juvenile Hall, Jail, Psychiatric Inpatient Hospitals, etc. Staff should use these codes only after approval and consultation with their Program Manager /Clinical Supervisor.

Billing Code	Modality	Definition
6030	(NO MCAL) BROKERAGE/ TARGETED CASE MANAGEMENT	Services that assist a client to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client's progress; placement services; and plan development.
6110	(NO MCAL) COLLATERAL	Services to one or more significant support persons in the life of the client for the purpose of improving or maintaining the mental health of the client. Progress notes must address the goals and interventions on the treatment plan.
6300	(NO MCAL) ASSESSMENT AND EVALUATION	Service activity with a client that formulates a clinical analysis of the history and current status of the client's mental, emotional, or behavioral disorder, including relevant cultural issues. Assessment may include diagnosis and testing procedures (includes performance outcome measures).
6410	(NO MCAL) INDIVIDUAL THERAPY	(1-37 MINUTES F2F): Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the treatment plan.
6412	(NO MCAL) INDIVIDUAL THERAPY	(38-52 MINUTES F2F): Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the treatment plan.

Billing Code	Modality	Definition
6414	(NO MCAL) INDIVIDUAL THERAPY	(53+ MINUTES F2F): Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the treatment plan.
6415	(NO MCAL) INDIVIDUAL THERAPY	(NON FACE-TO-FACE): Therapeutic interventions with a client not physically present (telephone, etc.) that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy when client not present. Progress notes must address the goals and interventions on the treatment plan.
6450	(NO MCAL) REHABILITATION SERVICES	Counseling and other services with a client which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must address the goals and interventions on the treatment plan.
6510	(NO MCAL) GROUP THERAPY	Services provided to a group of clients that focus on symptom reduction as a means to improve functional impairment. Progress notes must include the number of clients in the group and address the goals and interventions on the treatment plan.
6570	(NO MCAL) GROUP REHABILITATION SERVICES	Services provided to a group of clients which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must include the number of clients present and address the goals and interventions on the treatment plan

Billing Code	Modality	Definition
6630	(NO MCAL) MEDICATION SUPPORT	A “non face-to-face” direct service activity (the client is not present). This code is used primarily for two Medi-Cal claimable activities: developing and writing a medication treatment plan (med support Plan Development); or medication monitoring services including review of recent lab reports, medication renewal orders, etc.
6710	(NO MCAL) CRISIS INTERVENTION	(1-74 MINUTES F2F): Unplanned services that require a more timely response than a regularly scheduled visit. Progress notes need not address the treatment plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.
6715	(NO MCAL) CRISIS INTERVENTION (NON FACE-TO- FACE)	Unplanned services that require a more timely response than a regularly scheduled visit but the client is not physically present (telephone, etc.) Progress notes need not address the treatment plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.
6910	(NO MCAL) PLAN DEVELOPMENT	Service activity, which consists of the development of treatment plans and the approval of treatment plans. Progress notes should state that the treatment plan goals and interventions were developed, updated, progress toward the goals, or how the interventions will be implemented.

PROCEDURE CODES DEFINITIONS – INDIRECT SERVICES

Billing Code	Modality	Definition
4000	NO SHOW	To be used when a client is scheduled and does not show up at the appointment time. Essentially an “information note” attached to a client record. Staff may use up to 15 minutes to account for this incident.
4010	INFORMATIONAL NOTE	Documentation of a client interaction or activity that cannot be accounted for as a direct service, but needs to be included in the client record.
4060	CLIENT SUPPORT	An activity or contact not eligible to be reported as treatment or outreach. Support may include housing support, recreation, respite care or social support that does not fall under 2410 Day Treatment Socialization. This code is used when other available codes have been ruled out.
4110	MH PROMOTION	Any activity that informs, educates, clarifies, etc. mental health services to the general public or to other agencies. Not to be used instead of 4780.
4210	COMMUNITY CLIENT SERVICE (NON-OPENED CASES)	Activities directed toward: 1) assisting clients and families for whom there is no open case record to achieve a more adaptive level of function through single contact or occasional contact, or 2) enhancing or expanding the knowledge and skills of human service agency staff in meeting the needs of mental health clients.
4250	CRISIS “ON DUTY”	Used to record time spent on the crisis line and as backup counselor when no other activity code can be used to capture this time.
4270	CRISIS STABILIZATION INFO NOTE	Documentation of a client interaction or activity that cannot be accounted for as a direct service, but needs to be included in the client record. No specific staff time is included.
4421	SUPERVISION OF STUDENT INTERNS	To be used by clinical line staff for direct time spent in oversight of student intern activity.

Billing Code	Modality	Definition
4560	PHF ON DUTY	Used to account for staff time when they have been temporarily assigned to work a shift on the PHF.
4580	CSU ON DUTY	Used to account for staff time when they have been temporarily assigned to work a shift on the CSU.
4770	SAMHSA ACTIVITIES	SAMHSA related activities not eligible to be reported as treatment or outreach which are provided by staff supported by the general SAMHSA grant. This code identifies staff time that should be billed to the grant.
4780	GENERAL ADMINISTRATIVE ACTIVITIES	Used to record any non-client billable activity that is not captured in any other indirect code.
4790	TIME OFF	Any time off, whether paid or Leave Without Pay.
4890	MEDI-CAL QUALITY MANAGEMENT	Used to record time directly related to the Utilization Review activities in association with, and under the direction of, Quality Management (QM)/Quality Improvement (QI) programs (e.g. participation in monthly QI Committees, inpatient & outpatient authorizations, audits, and assigned QA activities).

THE FOLLOWING SERVICE CODES ARE FOR IDENTIFIED MHSA PLANNING PERSONNEL - USE IS LIMITED/RESTRICTED TO DESIGNATED STAFF ONLY

Billing Code	Modality	Definition
4970	MHSA Community Support Services (CSS)	Activities, non-direct Mental Health Service, within approved MHSA programs.
4971	MHSA Workforce Education Training (WET)	Activities, non-direct Mental Health Service, within approved MHSA programs.
4972	MHSA Prevention & Early Intervention (PEI)	Activities, non-direct Mental Health Service, within approved MHSA programs.
4973	MHSA Capitol Information Technology (CapIT)	Activities, non-direct Mental Health Service, within approved MHSA programs.
4974	MHSA Housing	Activities, non-direct Mental Health Service, within approved MHSA programs.

SPECIALTY MENTAL HEALTH SERVICES – ASSESSMENT (3310)

“Assessment” means a service activity designed to evaluate the current status of a client’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the client’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures (CCR Title 9 Division 1, §1810.204) (For information on how to complete an assessment document or option, please refer to the Assessment section).



ACTIVITIES

- Assessment activities are usually face-to-face or by telephone with or without the client or significant support persons and may be provided in the office or in the community. An assessment may also include gathering information from other professionals.
- Examples include the following:
 - Interviewing the client and/or significant support persons to obtain information to assist in providing focused treatment.
 - Administering, scoring, and analyzing psychological tests and outcome measures such as CANS and the MORS.
 - In some instances, gathering information from other professionals (e.g., teachers, previous providers, etc.) and reviewing/analyzing clinical documents/ other relevant documents may be justified as contributing toward the assessment.
 - Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.

PROGRESS NOTE- ASSESSMENT

- Each assessment activity requires a progress note. The note should contain a brief summary of what was completed during the assessment interview/session, who was present/participated in the service delivery, and record the exact time the assessment service lasted.

Section 10.1: Assessment

- The final assessment progress note date should match the date the assessment is finalized in the EHR. An additional progress note shall be written if an assessment is appended or updated.

It is best practice that the assessment progress note include the review of mandated reporting requirements, confidentiality of services, and the completion of any required paperwork (i.e. the informed consent, Release of Information, financial paperwork).

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
<p>Youth Client referred for chronic depressive symptoms</p>	<p>Describe</p>	<p>Met with parent and client at school, separately, to complete assessment. Client referred for chronic depressive symptoms. Client is a 10yo Caucasian female of appropriate height, overweight for age. Made good eye-contact and appeared groomed.</p>
	<p>Intervention</p>	<p>Discussed consent for services, confidentiality, scope of practice and HIPAA. Reviewed and signed all relevant paperwork. Parent declined copies. Therapist began gathering information for presenting problems and bio/psycho/social history from parent and client. Assessed for lethality issues (0 HI; current/past SI with no intent, means, or plan at this time; no history of past attempts or impulse-control issues). Therapist provided empathetic and reflective listening to encourage client to express needs. Provided client and parent with crisis numbers. Developed a safety plan and recommended securing any potentially lethal items, including medications or sharp objects. Discussed potential med. referral.</p>
	<p>Response</p>	<p>Client reported depressive symptoms such as excessive sleep, high levels of irritability, low mood, lasting for over a year, with increasing severity beginning in May with an unclear presenting issue at that time. Episodes may last for a few hours to a couple days, days are not always consecutive, and episodes are recurrent. Parent reported they struggle with anxiety/panic disorder and this may possibly impact client. Parent is open to the possibility of medication, requested to begin with therapy first and make other consistent, positive adjustments before considering a med referral. Parent will take therapist’s recommendation if these methods do not appear to help or if symptoms are revealed to be more severe/elevated SI risk. For a full bio/psycho/social history, please refer to assessment.</p>
	<p>Treatment Plan</p>	<p>Primary Diagnosis of Persistent Depressive Disorder, moderate (F34.1). Medical conditions are being ruled out at this time. Therapist will begin developing rapport with client and discuss treatment plan goals.</p>

Clinical Scenario	Progress Note Elements	
Referral for anxiety related to family trauma impacting functioning	Describe	Met with father and client separately at school for an assessment to address a referral for anxiety related to family trauma impacting functioning. Client is a 9yo American Indian female, tall for age and slightly overweight. Client smiled and seemed comfortable throughout assessment. Diagnosed with primary of PTSD and secondary of Major Depressive Episode, single, moderate.
	Intervention	<p>Discussed consent for services, confidentiality, scope of practice and HIPAA. Reviewed and signed all relevant paperwork. Offered copies. Therapist began gathering information for the assessment including bio/psycho/social history, presenting problems and symptoms. Assessed for lethality issues (0 HI). Client reports SI with no intent, or current plan. "Sometimes I wish I wasn't here." Refer to assessment for additional info. Created a safety plan and provided a copy, notified parent of SI risk and safety plan. Therapist provided empathetic and reflective listening with crisis numbers. Discussed potential for including rehab services and recommended referring for medication. Safety Plan:</p> <ol style="list-style-type: none"> 1. Identify Triggers – What am I feeling? 2. Communication – Find a safe person to talk with – Client has chosen Mrs. Smith (teacher); Contact Crisis when needed. 3. Coping Skills – Play favorite game, listen to music, breathing balloon (deep breathing). 4. Parent Support - Parent will increase monitoring/checking in, play favorite game with client.
	Response	Client/parent reported daily symptoms consistent with PTSD beginning after a major car accident in which client and family almost died last fall. Client is reporting sleep issues (i.e. nightmares – 3x weekly min.), hypervigilance when getting into vehicles, recurrent flashbacks of accident. Client also reported daily major depressive symptoms beginning four months ago, including appearing/feeling depressed/sad, significantly irritable, difficulty concentrating, poor self-esteem/worthlessness, SI, overeating, and sleep disturbances. Refer to assessment for full bio/ psycho/social history. Client asked to complete client plan separately from parent with therapist. Parent agreed to this and both gave consent for a med referral. Parent understood safety plan and will increase monitoring/checking in.
Treatment Plan	Therapist will begin gathering info for client plan with client next week and also complete a medication referral to address sleep issues and difficulty with strong emotions. Therapist will also include a case manager to begin providing rehab support.	

Clinical Scenario	Progress Note Elements	
<p>Referred to outpatient services after being discharged from a 24 hour stay on the PHF.</p>	Describe	<p>Met with client for assessment. Client is a tall, slender, middle aged man. He wore a heavy jacket, over several other shirts and sweaters, despite the 90 degree weather outside. Client clothing was dirty and stained. Client’s hair was uncombed, he is unshaven and has a strong body odor. Client fingernails are long and dirty. Affect is constricted. Client indicated he has trouble with keeping appointments due to forgetting, and is in jeopardy of losing his housing due to his apartment being dirty. Client was recently discharged from psychiatric hospital. Client reported hearing voices for years, has difficulty with maintaining housing, and feels as though he is being watched and becomes angry with neighbors regarding this. Client meets criteria for Schizophrenia (F20.9), which was also the diagnosis from recent hospitalization.</p>
	Intervention	<p>Discussed consent for services, confidentiality, scope of practice and HIPAA. Reviewed and signed all relevant paperwork. Offered copies. Therapist began gathering information for the assessment: history and social/ educational/ employment/mental health tx history. Refer to assessment for full bio/ psycho/social hx. Assessed HI/ SI risk. Provided active listening and explored potential coping strategies for client when angered by neighbor.</p>
	Response	<p>Client stated the reason for recent admission to the hospital was due to “my neighbor watching me all the time.” Client reported that he has not been able to work since he was “fired over 20 years ago.” Client indicated “watching TV” calms him down.</p>
	Treatment Plan	<p>Client is in need of services to assist with ongoing case management, skills training, and medication services. He would also benefit from increased socialization. Will make a referral for medication services. Explore options for increasing socialization, wellness and continued stabilization.</p>

SPECIALTY MENTAL HEALTH SERVICES – PLAN DEVELOPMENT (3910)

“Plan Development” means a service activity which consists of development of treatment plans, approval of treatment plans, and/or monitoring of a client’s progress related to the treatment plan. (CCR Title 9 Division 1, §1810.232) Treatment plans drive services and are based on the assessment recommendations.

ACTIVITIES

Plan Development activities may be face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. Plan Development may also include contact with other professionals.

Plan development activities can be conducted with or without the client, and include the five following items:

- Development of the treatment plan
- Approval of the treatment plan
- Updating of the treatment plan
- Monitoring the client’s progress in relation to the treatment plan
- Discharge planning

PROGRESS NOTE- PLAN DEVELOPMENT

- Plan Development progress notes are expected to refer to the treatment plan (i.e. development, approval, updating, or monitoring client progress)
 - At BCDBH only Clinicians are permitted to complete a treatment plan, however other clinical staff input and assistance in the development is highly valued! Ultimately, a clinician must develop the treatment plan.
- Discharge summaries document the termination and/or transition of services, and provide closure for a service episode and referrals as appropriate

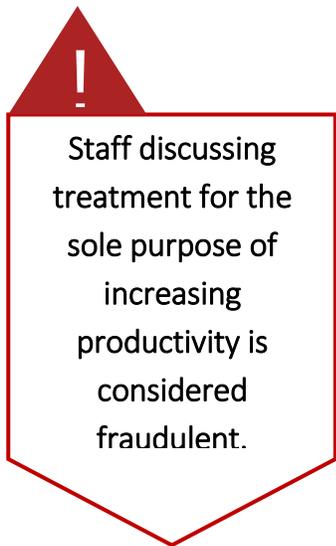


DOCUMENTATION TIP

When discharge planning administrative tasks such as discharge, copying or filing cannot be claimed as a billable service.

MISCELLANEOUS

- Plan Development may be provided during the development/approval of the initial Treatment Plan and subsequent Treatment Plans. However, Plan Development can be provided at other times, as clinically indicated.
 - For example, the client’s status changes (i.e. significant improvement or decline) and there may be a need to update the Treatment Plan. The monitoring of the treatment plan without updating the plan should be specified in the treatment plan as ongoing.
- Plan Development may include activities without the client’s presence, such as collaborating with other professionals in the development, monitoring progress or updating the Treatment Plan.
- Multiple Plan Development service activities for one event are at risk of disallowance, **if** inappropriately documented. For example, if several staff members are present at a treatment team meeting in which a client’s Treatment Plan is discussed, the only staff that can bill are those who are actively involved in that client’s treatment, i.e. client’s doctor and therapist.



Staff discussing treatment for the sole purpose of increasing productivity is considered fraudulent.



DOCUMENTATION TIP

Supervision, individual or group, is never a billable activity.

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
Youth – develop treatment plan	Describe	Met with client for a plan development session. Client presented with varying affect and was open and engaged in session.
	Intervention	Engaged client in plan development session to assist client in creating treatment plan goals. Engaged client in discussion regarding his being easily distracted in class, disruptive, defiant. Struggles with same-aged peers. Inquired about current skills to calm down and focus in class and relate to peers. Inquired about areas of focus for treatment and preferred goals. Treatment plan was developed during session.
	Response	Client engaged in discussing his behaviors at school. “Class is boring, nobody like me.” Client struggles to verbalize feelings related to behaviors. Client stated he use to have more friends, but doesn’t any more, wishes he did. Client reported wanting to work on doing better in class and not getting into trouble, and acquiring friendships. Client approved and signed treatment plan.
	Treatment Plan	Will meet with client next week to begin therapy sessions.

Clinical Scenario	Progress Note Elements	
Phone call- Plan development	Describe	Phone call with client to update treatment plan. Client agreed to discuss treatment plan updates and treatment options.
	Intervention	Engaged client in plan development session to assist client in updating treatment plan goals. Inquired about areas of focus for treatment and preferred goals. Processed with client his goal to reduce anxiety related to recent work issues with peers. Client has missed 3 works days in the past month due to conflict with peer at bike shop. Therapist discussed with client the potential loss of social security benefit, if he continues to miss work. Client is open to meeting with Dr. Smith to discuss medication to address anxiety. Added goal to treatment plan regarding medication support and will make referral to Dr. Smith.
	Response	Client was open and engaged during phone call. Client engaged in discussing recent significant increase in anxiety which has resulted in missed work and impacted peer relationships. Client reported wanting to continue to work at his job. Client reports he enjoys his job and is now willing to explore the possibility of medication to assist with his symptoms.
	Treatment Plan	Will meet with client next week to review and sign treatment plan.

Clinical Scenario	Progress Note Elements	
<p>Client refuses to sign treatment plan</p>	<p>Describe</p>	<p>Met with client for a plan development. Client presented with constricted affect but was direct and engaged in session.</p>
	<p>Intervention</p>	<p>Engaged client in plan development session to assist client in creating treatment plan goals. Client stated he wanted his treatment goal to be “getting a girlfriend.”</p> <p>Engaged client in discussion regarding his anger and recent contact with local law enforcement and contact with program manager due to verballing threatening clinic staff when at an appointment last week. Discussed that the possibility that one of the consequences of anger outbursts is a lack social connection and continued negative interactions with staff, and possibly law enforcement. Inquired about current skills to manage anger and the usefulness of deep breaths and other mindful skills. Processed how treatment focus on how about how his mental illness impacts his social life can help towards an eventual goal of “getting a girlfriend, but for now therapist is concerned about anger outbursts and frequency of law informant or clinic management interaction. Discussed that his outburst at the clinic last week frightened other clients and staff. Treatment plan was developed during session around helping client to develop social skills and emotional management.</p>
	<p>Response</p>	<p>Client engaged in processing his behaviors when not on medication and reported needed medication stating “you do not want to see me without my meds.” Client reported getting angrier when others point out his anger and tell him to calm down “which happens a lot when I have a girlfriend.” Client reported not wanting to work on his anger but “I just want a girlfriend.” Client was unable to demonstrate empathy for scaring other clients in the lobby during his outburst last week and stated “well, if they are scared it’s not my fault”. Client would not approve plan based on needing emotional management and social skills (clinical reasons for treatment). Client refused to signed treatment plan but was willing to participate in treatment.</p>
	<p>Treatment Plan</p>	<p>Will follow-up with client in coming months in hopes he will sign treatment plan. Will continue to work with client regarding emotional management and increasing social skills.</p>

SPECIALTY MENTAL HEALTH SERVICES – COLLATERAL (3110)

“Collateral” means a service activity to a significant support person in a client’s life for the purpose of meeting the needs of the client in terms of achieving the goals of the client’s treatment plan. Collateral may include but is not limited to: consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity (CCR Title 9 Division 1, 1810.206).

SIGNIFICANT SUPPORT PERSONS

Significant support persons are individuals who, in the opinion of the client or the person providing services, have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a client who is a minor, the legal representative of a client who is not a minor, a person living in the same household as the client, the client's spouse, and relatives of the client (Source: 9 CCR §1810.246.1).

ACTIVITIES

Collateral activities are usually face-to-face or by telephone with the significant support person, and may be provided in the office or in the community. The client may or may not be present.

Examples include the following:

- Educating the support person about the client’s mental illness
- Training the support person to better support or work with the client

PROGRESS NOTE- COLLATERAL

- Collateral progress notes must include the staff intervention(s) identified on the treatment plan (e.g., educating, training, etc.) and must demonstrate how they benefit the client.
- Collateral progress notes should include the role of the significant support person (e.g. parent, guardian, etc.).
- Documentation should substantiate that the support person is significant in the client’s life.

Section 10.3: SMHS – Collateral

- An excellent collateral progress note should document the changes that occurred as a result of educating and training the significant other, e.g., show how parents learned and demonstrated new ways of dealing with their child's symptoms or behaviors.
- If working with a significant other as a collateral service, documentation must include how the clinician educated or trained the significant other to better understand or support the client.
- Collateral groups (e.g. parenting groups) are billable with or without the client. The note must reflect how the interventions benefit the client.

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
<p>Caregiver reports client struggles with following adult directions and is defiant towards adults at home and at school</p>	<p>Describe</p>	<p>Contacted client’s foster parent via phone for a collateral session to assist with skills/communication techniques to increase mental health of client. Foster parent was open and engaged in session.</p>
	<p>Intervention</p>	<p>Reported overview of information given regarding clients’ most recent suspension. Engaged foster parent in discussion regarding regulation techniques to assist in regulating client. Encouraged foster parent to create calendar for client to assist in client’s regulation/planning skills to expect upcoming events. Suggested use of stickers or small treats to reward client for meeting daily goals of listening to directions at home and school. Actively listened to foster parent’s responses and asked clarifying questions.</p>
	<p>Response</p>	<p>Foster parent was open and engaged in session. Foster parent reported the day before suspension spending 3 hours individually with client and enjoying time together. Foster parent was puzzled/not sure what triggered recent acting out behaviors. Foster parent reported being open to trying a behavior calendar to assist with meeting this goal. Stated that client really loves scratch and sniff stickers and foster parent plans to take client to pick out some out.</p>
	<p>Treatment Plan</p>	<p>Will follow up with client and foster parent regarding skills suggested in session. Will meet with client in 1 week to offer ongoing support and intervention as needed to improve functioning and wellbeing and to assist client in making progress toward treatment goals.</p>

Clinical Scenario	Progress Note Elements	
<p>Client’s parents report client engages in oppositional behavior in the home setting</p>	<p>Describe</p>	<p>Met with client’s mother and step mother to provide collateral session. Both parents appeared engaged and willing to participate in the session.</p>
	<p>Intervention</p>	<p>Engaged in collateral contact with client’s parents (mother and step mother) to help develop strategies to improve client’s functioning in the home setting. Encouraged parents to assist client in engaging in coping strategies and/or using a reset during times parents notice frustration level rising, before anger outburst occur. Also discussed use of positive reinforcement when client displays positive behaviors.</p>
	<p>Response</p>	<p>Parents reported client has shared some information regarding her learned coping skills, but client appears to struggle with engaging in coping skills when not getting her way. Both parents discussed client is defiant towards each of them most days of the week in the home setting and refuses to follow their directions and then engages in anger outbursts when consequence of timeout/going to her room are provided. Both parents accepted information regarding encouraging client to use coping skills prior to anger outburst occurring.</p>
	<p>Treatment Plan</p>	<p>Will continue to meet with parents for collateral sessions on a weekly basis offering education and support to assist parents in providing supportive environment that facilitates opportunity for client’s growth/progress.</p>

SPECIALTY MENTAL HEALTH SERVICES – REHABILITATION (3450)

“Rehabilitation” means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a client’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. (CCR Title 9 Division 1, 1810.243) It is important to distinguish “rehabilitation” versus “personal care activities.” Personal care activities are not reimbursable activities. The following Table shows the distinction between rehabilitation and personal care activities:

REHABILITATION	VS	PERSONAL CARE ACTIVITIES
<i>Enable client to overcome limitations due to mental disorder</i>		Performing activities for the client who is unable to do for themselves
	EXAMPLE	
<i>Teaching client to prepare meals</i>		Feeding client; preparing meals for client; general care

 **DOCUMENTATION TIP**

Rehabilitative Activities are designed to enable the client to overcome the limitations due to the mental disorder and to teach the client to function in an age appropriate manner without the need for redirection or intervention.

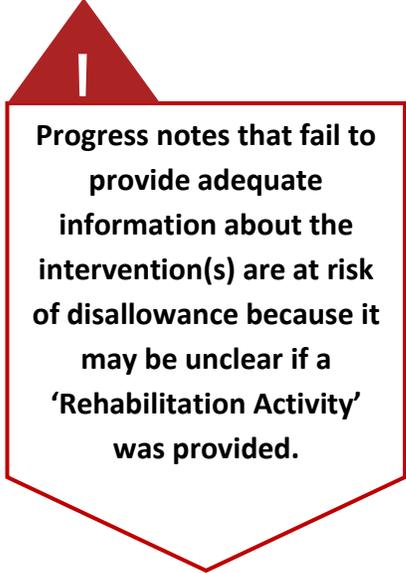
Action words may include: teaching, training, modeling, coaching, collaborating, educated, mentoring, redirected, reinforced, practiced, and validated.

Rehabilitation services include eight main areas:

- **Psychiatric** (symptom management; social skills training, relaxation, meditation and massage; support groups and in-home assistance)
- **Health and Medical** (maintaining consistency of care; family physician and mental health counseling)
- **Housing** (safe environments; supported housing; community residential services; group homes; independent/apartment living)

Section 10.4: SMHS – Rehabilitation

- **Basic Living Skills** (personal hygiene or personal care, preparing and sharing meals, home and travel safety and skills, goal and life planning, chores and group decision-making, shopping and appointments)
- **Social** (relationships, psychological support to clients and their families, recreational and hobby, family and friends, housemates and boundaries, communications, network enhancement & community integration)
- **Vocational and/or Educational** (vocational planning, transportation assistance to employment, preparation programs (e.g., calculators), GED classes, televised education, coping skills, motivation)
- **Financial** (personal budget), planning for own apartment (startup funds, security deposit), household grocery; social security disability; banking accounts (savings or travel)
- **Community and Legal** (resources; health insurance, community recreation, memberships, legal aid society, homeownership agencies, community colleges, houses of worship, ethnic activities and clubs; employment presentations; hobby clubs; special interest stores; summer city schedules)



Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if a 'Rehabilitation Activity' was provided.

The main difference between rehabilitation services (teaching/training) and targeted case management/ brokerage is in the referral process, accessing community services, and monitoring the client plan.

The main difference between rehabilitation services (teaching/training) and therapy is the scope of practice. Rehab Services are basically skills training/education. Therapy involves understanding and processing emotions, as well as implementing therapeutic interventions designed to help clients challenged by a range of circumstances including: trauma, depression, anxiety, stress, unanticipated life events, interpersonal discord, social injustice, worksite disruption and career issues.

ACTIVITIES

Rehabilitation activities are usually face-to-face or by telephone with the client and may be provided in the office or in the community. Rehabilitation can be done as:

- Individual Rehabilitation
- Group Rehabilitation –Code 3570 (for two or more clients)

Section 10.4: SMHS – Rehabilitation

- Education, skills training, and counseling to the client in relation to the four following functional skills:
 1. Health – medication education and compliance, grooming and personal hygiene skills, meal preparation skills
 2. Daily Activities – money management, leisure skills
 3. Social Relationships – social skills, developing and maintaining a support system
 4. Living Arrangement – maintaining current housing situation

PROGRESS NOTE- Group Rehabilitation

When providing Group Rehabilitation (i.e. two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

1. Type or name of group
2. Total group time, which is the time spent in group plus documentation time and may also include travel time
 - Duration of service in exact minutes
 - Start and Stop times of the direct service
 - Documentation/Travel time
3. Number of clients
4. Number of clinical staff and their names (if there is more than one staff member) with appropriate credentials
5. Each staff providing services will complete their own group progress note documenting the service they provided.



DOCUMENTATION TIP

If there are two clinical staff co-facilitating a group, EACH facilitator must document the need for more than one staff facilitating the group.

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
Individual skill building session for client: managing money	Describe	Client present for scheduled visit with this writer to address goal of money management skill-building to reduce ongoing impairment in activities of daily living (ADL) such as running out of money to buy food at end of month. Due to client symptoms of mental health including disorganized thinking, poor judgement, and internal preoccupation, client continues to struggle in paying monthly rent on time versus using monthly income to buy junk food.
	Intervention	Met with client at current housing placement and helped client to develop a list of expenses and current income. Helped client identify necessary vs. discretionary purchases and highlighted practical choices based on client’s overall goal, i.e. maintaining current housing placement.
	Response	Client was collaborative and able to identify areas where he can reduce discretionary purchases without negatively impacting his quality of life. Client reports he is aware that he has very little “fun” money but going hungry isn’t a better alternative for him.
	Treatment Plan	Provider will follow up with client next week to discuss progress with money management goals and to discuss how to maximize food purchases on a limited budget.

Clinical Scenario	Progress Note Elements	
Social Skills group note	Describe	Client arrived on time for social skills group. Dressed appropriately. Group Topic: Effective Communication (start time: 1:30; end time: 2:30) Treatment Goal addressed: to assist with social anxiety
	Intervention	Intervention of effective communication practice: group had handout of sets of general questions to ask each other. Broke up into small rotating groups of 2 and 3 persons for 20 minute intervals (including feedback). Counselor modeled effective communication skills to group when answering questions.
	Response	Client had difficulty accepting feedback at first until he realized how these skills can be applied to his own social interactions. Also assisted individual with giving constructive feedback of his own to the group. Client stated he enjoyed the group “once I got the hang of it.”
	Treatment Plan	Client will attend social skills group next week.

SPECIALTY MENTAL HEALTH SERVICES – THERAPY (3410, 3412, 3414, 3415)

“Therapy” means a service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the client is present. (CCR Title 9 Division 1, 1810.250)



For documentation of a therapy note, the interventions must focus on amelioration or reduction of mental health symptoms. Review of previous records are permitted.

Family Therapy

Family therapy is not a specifically defined service under Medi-Cal; however, these services may be provided, when medically necessary, and claimed as Therapy. Progress notes for each family therapy session must clearly document how the session focused primarily on reducing each client’s symptoms as a means to improve his or her functional impairments or to prevent deterioration and to assist the client in meeting the goals of their client plan.

ACTIVITIES

Therapy can be face-to-face, or over the telephone, or via telemedicine with the client(s) or family, and may be provided in the office or in the community.

- Individual Therapy
- Group Therapy—Code-3510 (for two or more clients)
- Family Therapy with the client present



DOCUMENTATION TIP

Therapy can only be provided by an LPHA or a trainee supervised by an LPHA. See the Scope of Practice section for more information.



PROGRESS NOTE - GROUP THERAPY

When providing Group Therapy (i.e., two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

1. Type or name of group

Section 10.5: Therapy

2. Total group time, which is the time spent in group plus documentation time and may also include travel time
 - Duration of service in exact minutes
 - Start and Stop times of the direct service
 - Documentation/Travel time
3. Number of clients
4. Each staff providing services will complete their own group progress note documenting the service they provided.



DOCUMENTATION TIP

If there are two clinical staff co-facilitating a group, EACH facilitator must document the need for more than one staff facilitating the group.

Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the Therapy activity was provided; i.e., each note must have the problem area/clinical focus, staff intervention and the client's response. Each note must be unique to the client as well as to an intervention on their treatment plan.

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
Individual Therapy – Coping skills	Describe	Client arrives 10 min late for scheduled therapy session with therapist at outpatient clinic. Client states that she had an argument with her mother this morning and reports feeling “pissed off” today. Client denies any increased suicidal thoughts this week but reports feeling “frustrated” and “can’t do my deep breathing like I usually can.”
	Intervention	Therapist listened empathically to client’s current experiences, providing safe space for client to process thoughts & feelings related to recent argument with her mother. Roleplayed with client various techniques, such as thought stopping and focusing on positive interactions with mother, as a way to cope with increased feelings of frustration. Modeled the use of grounding exercise with client and encouraged her to utilize new techniques at least once this week.
	Response	Client continues to be engaged and talkative in session with therapist. She shares openly about issues with mother and states that mother “knows what to say to push my buttons.” Client responds well to offering of new techniques and states “Yeah I already do that sometimes when I feel mad.” Client enjoyed practicing grounding technique in session and agreed to utilize new technique at least once this upcoming week.
	Treatment Plan	Scheduled to meet with client again next week and continue assessing client’s needs, her increased MH symptoms and impairments, and continue working towards client stated goal of decreased anger & frustration.

Clinical Scenario	Progress Note Elements	
Family Therapy– Client communication	Describe	Client and mother arrived on time for family therapy session. Client wore sweatshirt hood covering most of her face. Client was quiet and sat far away from mother in room.
	Intervention	Processed the previous week activities and any ongoing unresolved issues within family. Assisted mother with reframing “demands” to “negotiations” for better dialogue about expectations with client. Supported client in expressing feelings of frustration to avoid blaming and generalizing (always/never). Client and mother came to some compromises on behaviors through the process.
	Response	Client was unresponsive (head down) while mother discussed what had been happening this week (client not doing her chores, sitting alone in her room). When client did speak, she spoke softly because “I just don’t want to argue anymore. She knows she’s always pushing my buttons.” Client was willing to listen while mother was assisted with reframing expectations, and was agreeable to compromise on small issues (e.g. removing the hood while indoors). Client was able to express feelings and was willing to have counselor count every time she used the words “always” and “never”. Client stated “I didn’t realize I did that so much.”
	Treatment Plan	Client is amenable to be mindful of the amount of times she uses always/never statements. Mother will work on negotiations vs demands and report next week.

Clinical Scenario	Progress Note Elements	
Group Therapy– Youth	Describe	Client arrived on time for processing group. Dressed appropriately. Group Topic: Effective Communication (start time: 1:30; end time: 2:30) Treatment Goal addressed: to assist with social anxiety
	Intervention	Intervention of processing thoughts and feelings while learning to communicate: group participated in “Talking, Feeling, Doing” Game to assist in identifying feelings related to social anxiety. Allowed time for feedback and processing.
	Response	Client appeared to enjoy being able to ask his peers questions during game play and was responsive to feedback. During game play client drew card saying “What does it feel like to make a new friend?” Client was able to effectively identify his feelings of anxiousness regarding this scenario.
	Treatment Plan	Client will attend social therapy group next week.

SPECIALTY MENTAL HEALTH SERVICES – TARGETED CASE MANAGEMENT (3030)

Targeted Case Management (TCM) – Linkage and Brokerage services include a broad array of services designed to assist and support clients, including life areas that fall outside of the mental health system.

Definition of TCM – Linkage and Brokerage services are services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service and the service delivery system; monitoring of the client’s progress; placement services; and plan development (CCR Title 9 Division 1, 1810.249).

- Linkage and Brokerage – Assist clients to access and maintain needed services such as psychiatric, medical, educational, social, prevocational, vocational, rehabilitative, or other community services
- Placement – Assist clients to obtain and maintain adequate and appropriate living arrangements

ACTIVITIES

TCM - Linkage and Brokerage activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services may also include contact with other professionals.

- Communicating, consulting, coordinating and corresponding with the client and/or others to establish the need for services and a plan for accessing these services
- Establishing and making referrals
- Monitoring the client’s access to services
- Monitoring the client’s progress once access to services has been established
- Locating and securing an appropriate living arrangement, including linkage to resources; i.e., Board and Care, Section 8 Housing, or transitional living
- Arranging and conducting pre-placement visits, including negotiating housing or placement contracts

Section 10.6: SMHS – Targeted Case Management



DOCUMENTATION TIP

Case management does not include transportation solely for the purpose of transportation or waiting with client for a doctor’s appointment, waiting at SSI office, or completing SSI paperwork.

PROGRESS NOTE- TARGETED CASE MANAGEMENT

A TCM Linkage and Brokerage progress note includes the focus of the assistance/intervention provided to the client (e.g., accessing medical services) and justifies the need for this service based on mental health symptoms/issues; i.e. who was spoken to, what was discussed with professional, what is the plan, is there a referral to an outside service and what is the next step needed to assist the client.

MISCELLANEOUS

See Lock-Outs—[Section 13](#)

Section 10.6: SMHS – Targeted Case Management

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
Client needing assistance to access Community Resources	Describe	Client arrives on time for case management session with counselor to work on client’s stated goals of increasing his independent living skills. Client continues to complain about difficulty locating appropriate food bank in the community and thus feeling “more anxious and frustrated.”
	Intervention	Counselor and client called local food bank to determine drop-in hours and intake process. Counselor encouraged client to write information provided by food pantry staff in notebook. Counselor reviewed client’s previously stated transportation plan to/from food pantry on designated days.
	Response	Client expresses relief after receiving assistance in calling food bank, less anxiety, and willingness to follow through with plan of visiting food bank independently. Client denies any increased thoughts of paranoia or anxiety related to visiting food bank and states he is willing to “give it another shot.”
	Treatment Plan	Counselor scheduled to meet with client next week after his food pantry visit to discuss his ability to follow plan and connect with local food bank. Counselor will continue to assist client in connecting with services & resources in community that are in line with client’s stated goal of increased independence.

Clinical Scenario	Progress Note Elements	
Client struggling to attend med appointment	Describe	Unscheduled phone call from client who states he cannot come in for his injection appointment later this week because he does not have a ride.
	Intervention	Commended client for expressing concerns, rather than just not showing up for appointment. Explored possibility of getting client a bus pass. Offered to meet with client at client’s home to look at bus schedules. Discussed options of other transportation modes as well.
	Response	Client initially agitated when called and expressed feelings of being overwhelm at the lack of transportation. Client reported feeling less agitated when given options and chose to accept bus pass and will meet to review bus schedules to be on time to next appointment.
	Treatment Plan	Meet with client to review bus schedules and provide bus pass, client will maintain appointments as scheduled.

SPECIALTY MENTAL HEALTH SERVICES – YOUTH INTENSIVE SERVICES (ICC, IHBS, TBS)

INTENSIVE CARE COORDINATION (3040)

Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for EPSDT beneficiaries with intensive needs. Clients need not be a member of the Katie A. class to receive ICC. ICC services are intended to link clients to services provided by other child serving systems, to facilitate teaming, and to coordinate mental health care. If a client is involved with two or more providers, ICC is used to facilitate cross-system communication and planning.

ACTIVITIES

1. *Assessing*

- Assessing client's and family's needs and strengths
- Assessing the adequacy and availability of resources
- Reviewing information from family and other sources
- Evaluating effectiveness of previous interventions and activities

2. *Service Planning and Implementation*

- Developing a plan with specific goals, activities, and objectives
- Ensuring the active participation of client and individuals involved and clarifying the roles of individuals involved
- Identifying the interventions/course of action targeted at the client's and family's assessed goals

3. *Monitoring and Adapting*

- Monitoring to ensure that identified services and activities are progressing appropriately
- Changing and redirecting actions targeted at the client's and family's assessed needs, not less than every 90 days or 6 months depending on class or subclass

4. *Transition*

- Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

Section 10.7: Intensive Services (ICC, IHBS, TBS)

INTENSIVE HOME-BASED SERVICES (3420)

Intensive Home-Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of a child/youth and significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the client plan. IHBS are not traditional therapeutic services. This service is targeted to the Katie A. Subclass and their significant support persons, though it is not a requirement. Services are expected to be of significant intensity to address the intensive mental health needs of the child/youth, consistent with the client plan and the Core Practice Model. Services may be delivered in the community, school, home or office settings. IHBS services includes, but not limited to:

ACTIVITIES

- Medically necessary, skills-based interventions for the remediation of behaviors or improvement of symptoms, including but not limited to the implementation of a positive behavioral plan and/or modeling interventions for the client's family and/or significant others to assist them in implementing the strategies;
- Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks or the avoidance of exploitation by others;
- Development of skills or replacement behaviors that allow the client to fully participate in the Child and Family Team (CFT) and service plans, including, but not limited to, the plan and/or child welfare service plan;
- Improvement of self-management of symptoms, including self-administration of medications as appropriate;
- Education of the client and/or their family or caregiver(s) about, and how to manage the client's mental health disorder or symptoms;
- Support of the development, maintenance and use of social networks including the use of natural and community resources;
- Support to address behaviors that interfere with the achievement of a stable and permanent family life;
- Support to address behaviors that interfere with seeking and maintaining a job;
- Support to address behaviors that interfere with a client's success in achieving educational objectives in an academic program in the community;
- Support to address behaviors that interfere with transitional independent living objectives such as seeking and maintaining housing and living independently.

Section 10.7: Intensive Services (ICC, IHBS, TBS)

THERAPEUTIC BEHAVIORAL SERVICES/TBS (3230)

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with Serious Emotional Disturbances (SED) who are experiencing a stressful transition or life crisis that is placing the individual at risk of an out of home placement in a RCL 12 or higher or are at risk of a psychiatric emergency. TBS is also used to help a client transition from this high level of care (STRTP or psychiatric hospital to a lower level of care).

All providers of Therapeutic Behavioral Services (TBS) must comply with:

- The documentation standards noted in the “TBS Documentation Manual” published by the Department of Health Care Services (DHCS); and

ASSESSMENT

Initial Assessments: Initial Assessments for TBS are due within 30 days of the TBS episode opening date.

- a. If it is not possible to complete the Assessment within 30 days, the need for more time must be documented in a progress note and the deadline may be extended to 60 days.
- b. In addition to TBS Documentation Manual description, TBS Initial Assessments must address the following communication needs:

Communication needs are assessed for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.). If required, indicate whether it was/will be provided, and document any linkage of the client to culture-specific and/or linguistic services in the community. Providers are required to offer linguistic services and document the offer was made; if the client prefers a family member as interpreter, document that preference. Service-related correspondence with the client must be in their preferred language/format. (DHCS contract)

TREATMENT PLANS

- a. Initial Treatment Plans for TBS are due within 60 days of the date of the initial assessment appointment, and must be completed and reviewed before services are authorized.
- b. Monthly Summaries of the Treatment Plan are required (functions as Treatment Plan Updates).

Section 10.7: Intensive Services (ICC, IHBS, TBS)

ACTIVITIES

TBS activities are usually face-to-face with the client and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals.

- One-to-one therapeutic contact typically models/teaches, trains or supports appropriate behavioral changes
- TBS activities may also include assessment, collateral, and plan development, which are coded as TBS
- TBS is provided only by qualified providers (see [Scope of Practice](#))



Section 10.7: Intensive Services (ICC, IHBS, TBS)

For additional information please see the external links below:



[DHCS Therapeutic Behavioral Services Website](#)



[Pathways to Mental Health Services – Overview](#)



[Medi-Cal Manual for Intensive Care Coordination \(ICC\), Intensive Home-based Services \(IHBS\) & Therapeutic Foster Care \(TFC\) for Medi-Cal](#)



[Pathways to Mental Health Services – Core Practice Model \(CPM\) Guide](#)

DOCUMENTATION EXAMPLES - ICC/CFT Meeting

Clinical Scenario	Progress Note Elements	
<p>Client has difficulty managing depressive and anxiety symptoms including difficulty concentrating, difficulty expressing emotions thoughts and needs appropriately</p>	<p>Describe</p>	<p>Child and Family team (CFT) intensive care coordination session with client, caregivers, primary clinician and IHBS Team. Session was to determine progress towards client’s treatment goals and create action steps/ goals. Clinician was present to act as member of the team, providing information and help create goals. IHBS team was present due to the introduction of IHBS services.</p>
	<p>Intervention</p>	<p>Facilitated ICC-CFT meeting in order to develop goals and help monitor/promote progress towards treatment goals. MHRS engaged group in discussion about “what is going well” to develop foundation for meeting and to celebrate progress. Discussed team/client resources including informal and community to develop client and family support system. Reviewed concerns and created goals using strengths to address concerns with the team.</p>
	<p>Response</p>	<p>Client shared throughout the session openly. Caregivers, client and group shared information about what was going well, including client’s new school, new teachers and friends. Client shared a list of her strengths including her positive energy, love of animals and her artwork. When concerns about her struggles with routine, refusal to follow directions and disrespectful responses came up in session, client shut down and would not respond.</p>
	<p>Treatment Plan</p>	<p>Goals included improving communication skills and improve following directions. Action steps included introducing a high/low check-in, a share journal, a selected chore (laundry), safe place and introducing art work. Will follow up with clinician about future CFTs and progress towards goals.</p>

DOCUMENTATION EXAMPLES - ICC for IHBS

Clinical Scenario	Progress Note Elements	
<p>Client has difficulty managing depressive and anxiety symptoms including difficulty concentrating, difficulty expressing emotions thoughts and needs appropriately</p>	Describe	<p>Met with foster parent, BCDBH clinician, BCDBH Katie A Coordinator, and CSD worker for a CFT/ICC meeting to begin IHBS services. Per clinician and team feedback client ability to maintain focus and behavior would be impacted by attending the meeting in its entirety. He joined at an end point to receive information, provide input and convey understanding.</p>
	Intervention	<p>Engaged in a CFT/ ICC meeting in order to gather information from team members regarding what is going well in the client and family system, the needs and concerns that are present, the supports (formal and informal) that are available, and the goals and roles moving forward generally and with IHBS services. Identified the need to address client aggression toward others and client’s difficulty maintaining appropriate behavioral in the school setting – primarily in the afternoon when appearing to be overwhelmed/ overstimulated. Planned with team regarding how to best implement services to meet client needs. Met with client briefly to review the positive input provided by the team about him.</p>
	Response	<p>Team informed that client responds well to structure and redirection and is responsive to praise and being a “helper” to others. Client’s input for a positive was that he is going to school and learning. Team informed that client has difficulty focusing with extraneous stimuli and lacks frustration tolerance for continued activities. Primary concerns were client aggression toward himself, peers and siblings and blaming others for wrongdoing or harming himself. As well as going off task in the classroom. Foster parent informed there are a lot of informal and formal supports available to the client and family. And team and client were agreeable to start of IHBS this week.</p>
	Treatment Plan	<p>Plan to begin IHBS this week.</p>

DOCUMENTATION EXAMPLES - IHBS

Clinical Scenario	Progress Note Elements	
Client having difficulty managing depressive and anxiety symptoms	Describe	Traveled to client’s home to meet with client and family for an IHBS session. Client, mother, and father were present and engaged in today’s session. Client presented as asleep upon arrival to the home but woke up shortly after arrival and engaged appropriately during session.
	Intervention	Provided IHBS to increase client skills and to foster successful functioning in the home setting as well as to build parent capacity to assist client in this endeavor. Was informed of client intentional behavior this morning to miss school bus. Praised parents for decision to walk away from client/ignore negative behaviors to assist client with self-regulation. Directed mother/father to focus on engaging with client when she is displaying positive behaviors and discussed client’s plan to apologize for earlier behavior. Engaged client in creative activity to reinforce practice and use of deep breathing and mindfulness to improve self-regulation.
	Response	Mother reported that client intentionally missed school bus this morning and refused to go to school. Mother and father reported feeling extremely frustrated, called clinician, and then chose to walk away from client to cool off. Parents agreed to work on engaging with client when she displays positive behaviors (follow directions, respectful, etc.). Client woke up and immediately began to complete chores without prompting. Mother and father responded with praise in thanking client for doing so without being told to. Client shared that she was doing this because she felt sorry for her behavior this morning and stated plan to apologize to parents. Client apologized to each parent individually. Client actively engaged in creative activity and demonstrated practice of deep breathing and mindfulness.
	Treatment Plan	Will continue to provide IHBS with a focus on engaging parents in client’s behavioral intervention plan, encouraging client’s use of self-regulation techniques, and following plan to apologize to parents when engages in negative behaviors.

DOCUMENTATION EXAMPLES - TBS

Clinical Scenario	Progress Note Elements	
<p>Client engages in argumentative and violent/aggressive behaviors with authority figures and shows poor decision-making skills</p>	Describe	<p>Traveled to client’s home for scheduled TBS session. Client presented in a variety of moods evidenced by client’s behavior and facial expression throughout. Client’s father reports that client continues to present as self-harming when does not get his way, “banging head against wall and hitting siblings” to which client rolls eyes.</p>
	Intervention	<p>Engaged client and family in TBS services in order to reduce client’s self-harming and aggressive/violent behaviors. Discussed client’s behaviors with client’s father in order to update client’s behavior chart. Engaged client in replacement activity (bike riding) in order to reduce client’s target behaviors and encouraged family to participate as well. Attempted to redirect client during times of increased frustration towards siblings to help reduce client’s argumentative behaviors. Used proximity and an if/when statement to help improve client’s decision making during activity. Praised caregiver for interaction with client in order to reinforce caregiver parenting skills. Modeled proper home behavior in order to reduce client’s negative decisions.</p>
	Response	<p>Client’s father shared that client has been doing well except a few arguments last week. Father shared that they had also gotten new bikes and have been bike riding as a family lately which client seems to enjoy. Client then asked if we could all go bike riding. Client is observed to engage in bike riding but becomes increasingly agitated at siblings for “cutting me off.” Client rode off alone and did not follow father redirection to stay out of school lot. Client returned home and started asking if he could return to school lot. Client did not listen to redirection attempts made by father and began to threaten that he was going to school lot anyway. Parent and siblings were in argument with client but stopped after instruction. Client rode off and headed to school. Client did not want to listen to any discussion regarding consequences and began to argue stating that he wanted to counselor to leave. Client continued to argue when informed that counselor would not leave until client left school parking lot. Client became increasingly agitated by proximity but eventually joined counselor on his way back to house. Client reported feeling “pissed off” because he lost tablet privileges last week. Client was able to acknowledge having lost tablet after hitting sibling, states he felt bad for hitting. Client then followed modeling for rest of session evidenced by client following rules of house and using proper language.</p>
	Treatment Plan	<p>Will continue weekly TBS services, engaging client’s caregivers and reinforcing their use of limit-setting and consequences to client’s negative behaviors.</p>

DOCUMENTATION EXAMPLES - TBS

Clinical Scenario	Progress Note Elements	
<p>Client engages in self-harm by thrashing on the floor and making suicidal statements</p>	Describe	<p>TBA traveled from office to client’s home for scheduled TBS session. Client was combative and argumentative for about half the session and for the other half was calm based on his demeanor.</p>
	Intervention	<p>TBS engaged client and family in TBS services in order to reduce self-harm and client hitting family members. TBA discussed client’s behavior with client’s father in order to update behavioral charts. TBA provided suggestions for a replacement activities for going to the school in order to reduce occurrence of target behaviors. TBA attempted redirection with client in order to reduce client’s hitting of family members. TBA suggested to client’s father to give client space in order to reduce target behavior and provided praise to client for calming down in order to reinforce that behavior in the future.</p> <p>Target Behavior 1 Reported: 1 Observed: 0 Target Behavior 2 Reported: 2 Observed: 6</p>
	Response	<p>Father shared that client struggled over the weekend. Client was hitting and screaming, but explained he was doing okay right now. Client was currently playing with some friends on their trampoline in the backyard. Client was doing well until his friends wanted to go to school where client is not allowed. Client became upset when father said he could not go to the school. Client began to hit his father and became more agitated. Client would leave the room and then return and hit is father some more. Client would not listen to redirection, but eventually headed to his room. Client stayed in his room for about 20 minutes. Client returned in a calm manner and was able to sit down and have dinner. Client accepted praise and did not display any more target behaviors.</p>
	Treatment Plan	<p>TBA will continue TBS services.</p>

SPECIALTY MENTAL HEALTH SERVICES – CRISIS INTERVENTION

Crisis Intervention is an immediate emergency response that is intended to help the client cope with a crisis (e.g. potential danger to self or others; potentially life altering event; severe reaction that is above the client’s normal baseline, etc.).

Definition

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a client for a condition that requires more timely response than a regularly scheduled visit. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348. (CCR Title 9 Division 1, 1810.209)

ACTIVITIES

Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These include:

- Assessment of the client’s mental status, acuity of symptoms and current need
- Therapeutic services for the client
- Education, training, counseling, or therapy for significant support persons involved

PROGRESS NOTE- CRISIS

An excellent Crisis Intervention progress note contains a clear description of the “crisis” in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client. A crisis is an unplanned situation that deviates from repetitive client behavior. If a client has a “behavior” that happens frequently, it no longer is a crisis and may need to be addressed on the treatment plan.

All services provided (i.e., Crisis Assessment, safety plan, Collateral, Individual/Family Therapy, TCM - Linkage and Brokerage) will be billed as Crisis Intervention.

- **Once the crisis is resolved**, any follow-up cannot be billed as Crisis
- The maximum amount claimable to Medi-Cal for crisis intervention in a 24-hour period is 8 hours (480 minutes) per client

 DOCUMENTATION TIP

Two people cannot bill crisis simultaneously on one client when the purpose of the presence of the other staff member is purely for reasons of staff safety.

DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
<p>Youth had SI while at school</p>	<p>Describe</p>	<p>Oroville High School counselor called on this day requesting risk assessment for youth presenting with suicidal ideation. Clinician to assess client for current risk and to determine appropriate level of care for client.</p>
	<p>Intervention</p>	<p>Met with client at school to further assess client’s risk of harm to self, plan for client safety, and provide needed resources & supports to minimize risk. Spoke with client regarding her ability to contract for safety and discussed use of coping skills. Supported client in developing safety plan to have mother meet at school with counselor to address current needs and the use of crisis hotline when needed.</p>
	<p>Response</p>	<p>Client reported cutting on this day due to stressors surrounding relationship with boyfriend and stated “I just want to end it all.” Client denied any history of suicidal ideation and expressed remorse for cutting incident. Client denied needing medical attention for cuts “I didn’t draw blood” and denied current thoughts of suicide or self-harm. Client confirms that she is able to use coping skills highlighted today and reported feeling “better” after meeting with clinician.</p>
	<p>Treatment Plan</p>	<p>Client agreed to safety plan of having mother meet at the school with counselor to address client’s current needs. School counselor will schedule meeting with client and mother. Client has been provided crisis hotline and encouraged use, as needed.</p>

Clinical Scenario	Progress Note Elements	
Adult had missed appts	Describe	<p>Clinician has made multiple attempts to contact client as he has missed several individual therapy sessions in office. Clinician received phone call from client’s brother who lives in the apartment complex reporting “I haven’t seen my brother come out of his apartment in a few days but I’ve heard him blasting his music late at night.” Client has history of Bipolar I Disorder with symptoms that include mania, paranoia, and risk of harm to self and others. Client also has history of medication non-compliance putting him at increased risk for MH decompensation (ROI on file).</p>
	Intervention	<p>Clinician consulted on client’s case with Unit Supervisor and formed plan to conduct welfare check to client’s home along with second provider for further assessment of client’s needs. Clinician traveled to client’s home. Once client peered through window, clinician attempted to coax client out of his apartment and made several attempts to talk with client in his home. Client appeared upset and yelled at a “person” behind clinician. Clinician further assessed client’s mental status, current MH presentation, second clinician called for Mobile Crisis Support while this clinician and attempted to de-escalate client. Once Mobile Crisis arrived, clinicians were able to collaborate with providers on assessing client’s needs and determining his need for emergency psychiatric care.</p>
	Response	<p>Client presents today with increased psychomotor agitation, delusional thoughts that “people are after me, that’s why I have to play my music loud, to distract them.” Client reports having stopped his medications “two weeks ago” out of fear that medications were “made of metal and being used to track me.” Client became calm while second clinician contacted Mobile Crisis. Once Mobile Crisis arrived to client’s home, he was agreeable to their assessing of his needs and agreed to plan of visiting Crisis Stabilization Unit if it meant “I’d be safer there.” Clinicians provided Mobile Crisis Team with collateral information from client’s brother and historical information regarding client’s MH symptoms and treatment.</p>
	Treatment Plan	<p>Clinician will follow up with client’s brother (ROI on file) and inform him of today’s safety plan. Clinician will collaborate with CSU staff as needed and provide any needed d/c planning assistance to ensure continuity of client’s care.</p>

SPECIALTY MENTAL HEALTH SERVICES – CRISIS STABILIZATION

Crisis Stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

Definition

“Crisis Stabilization” means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in 9 CCR §1840.338 and 9 CCR §1840.348.

ACTIVITIES

Crisis Stabilization activities can only take place when the client is admitted to the Crisis Stabilization Unit (CSU). These include:

- Assessment of the client’s mental status, acuity of symptoms and current need.
- Assessment of the client’s medical needs via a nursing assessment.
- Therapeutic services for the client.
- Education, training, counseling, or therapy for significant support persons involved.

ASSESSMENT

CSU staff, acting within their scope of practice, will review the crisis assessment or complete a new one if the client does not have one to determine medical necessity for CSU services.

TREATMENT PLAN

CSU staff, acting within their scope of practice, will complete a treatment plan to address the specific crisis episode the client is experiencing. The treatment plan will include: Problem Statement, Unit Goal, Objective, Interventions, Overall Goal, and Clinical Comments.

PROGRESS NOTES

Admission Notes include:

- Addresses how client came to need crisis services, client identifying information, including whether client has current suicidal or homicidal ideation, and whether hospitalization is being considered and information regarding safety plan (if known).
- All interventions and documents completed by client and Clinician including brochures offered, Release of Information, 5150 content and updated 5150 status, the client's Mental Status Exam information and treatment plan.
- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions.

Treatment Planning Notes include:

- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions. The Crisis Assessment goal may be used as appropriate when the client is in the CSU for stabilization services. Otherwise, the CSU will develop at least one clinical goal to assist client while he/she is receiving intensive crisis stabilization services.
- Treatment Planning notes will also include reassessments and show efforts to either pursue hospitalization or safety planning.

Discharge Notes include:

- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions.
- Safety plan in its entirety, or hospitalization information with updates of date/time, accepting hospital/doctor, who was notified of discharge from CSU and transportation disposition
- An excellent Crisis Stabilization progress note contains a clear description of the "crisis," in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client. It will also continue to monitor the client's reason for admission to include assessment of danger to self, danger to others, grave disability or other factors that may contribute to a need to assess for hospitalization.
- All services provided (i.e., Crisis Assessment, safety plan, Collateral, Individual/Family Therapy, TCM - Linkage and Brokerage) shall be billed as Crisis Stabilization.
 - The maximum amount claimable to Medi-Cal for crisis stabilization in a 24-hour period is 20 hours (1200 minutes) per client.

DOCUMENTATION EXAMPLE

Clinical Scenario	Progress Note Elements	
<p>Client came to CSU with SI/HI</p>	<p>Describe</p>	<p>Client is a 38 year old female, on CSU under voluntary status, with previous BCDBH Diagnosis of Bipolar disorder, unspecified. Client was dropped off at CSU by Chico PD by client request. Client reports that police were called to the Torres Shelter after multiple complaints were made by staff that client was yelling “I’m gonna kill myself!”</p> <p>Client’s treatment plan goals include increasing coping skills for anxiety, increasing coping skills for depression symptoms, and discharging to lower level of care in the community.</p>
	<p>Intervention</p>	<p>Engaged with client to provide supportive counseling and to assess mental health status, symptoms, progress towards treatment plan goals, and current HI and SI. Spoke with client about SI and suicidal statements. Client stated she had a recent fight with boyfriend which had increased her anxiety and anger. Educated client on use of coping skills such as deep breathing and journaling during times of increased anxiety. Encouraged client to utilize outpatient resources to help maintain mental health stability. Discussed community resources and provided brokerage services to help client connect with Torres Shelter upon discharge.</p>
	<p>Response</p>	<p>Client presented with a flat affect while discussing coping skills, but was engaged in dialogue. Client acknowledged clinician’s discussion about staffs’ concerns with her suicidal statements. Client stated that journaling has worked for her in the past and plans to try this skill again. Client agreed to follow up with her outpatient clinician but stated that she was anxious about returning to the Torres Shelter. Client shared that she would utilizing deep breathing techniques that this staff shared to attempt to alleviate the anxiety.</p>
	<p>Treatment Plan</p>	<p>Continue to work on safety plan goals and developing a discharge plan.</p>

SPECIALTY MENTAL HEALTH SERVICES – CRISIS STABILIZATION

Crisis Stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others, or substantially increase the risk of the beneficiary becoming gravely disabled.

Definition

“Crisis Stabilization” means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in 9 CCR §1840.338 and 9 CCR §1840.348.

ACTIVITIES

Crisis Stabilization activities can only take place when the client is admitted to the Crisis Stabilization Unit (CSU). These include:

- Assessment of the client’s mental status, acuity of symptoms and current need.
- Assessment of the client’s medical needs via a nursing assessment.
- Therapeutic services for the client.
- Education, training, counseling, or therapy for significant support persons involved.

ASSESSMENT

CSU staff, acting within their scope of practice, will review the crisis assessment or complete a new one if the client does not have one to determine medical necessity for CSU services.

TREATMENT PLAN

CSU staff, acting within their scope of practice, will complete a treatment plan to address the specific crisis episode the client is experiencing. The treatment plan will include: Problem Statement, Unit Goal, Objective, Interventions, Overall Goal, and Clinical Comments.

PROGRESS NOTES

Admission Notes include:

- Addresses how client came to need crisis services, client identifying information, including whether client has current suicidal or homicidal ideation, and whether hospitalization is being considered and information regarding safety plan (if known).
- All interventions and documents completed by client and Clinician including brochures offered, Release of Information, 5150 content and updated 5150 status, the client's Mental Status Exam information and treatment plan.
- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions.

Treatment Planning Notes include:

- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions. The Crisis Assessment goal may be used as appropriate when the client is in the CSU for stabilization services. Otherwise, the CSU will develop at least one clinical goal to assist client while he/she is receiving intensive crisis stabilization services.
- Treatment Planning notes will also include reassessments and show efforts to either pursue hospitalization or safety planning.

Discharge Notes include:

- Clinical interventions provided by staff to support goals and treatment plan, as well as client response to interventions.
- Safety plan in its entirety, or hospitalization information with updates of date/time, accepting hospital/doctor, who was notified of discharge from CSU and transportation disposition
- An excellent Crisis Stabilization progress note contains a clear description of the "crisis," in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client. It will also continue to monitor the client's reason for admission to include assessment of danger to self, danger to others, grave disability or other factors that may contribute to a need to assess for hospitalization.
- All services provided (i.e., Crisis Assessment, safety plan, Collateral, Individual/Family Therapy, TCM - Linkage and Brokerage) shall be billed as Crisis Stabilization.
 - The maximum amount claimable to Medi-Cal for crisis stabilization in a 24-hour period is 20 hours (1200 minutes) per client.

DOCUMENTATION EXAMPLE

Clinical Scenario	Progress Note Elements	
<p>Client came to CSU with SI/HI</p>	<p>Describe</p>	<p>Client is a 38 year old female, on CSU under voluntary status, with previous BCDBH Diagnosis of Bipolar disorder, unspecified. Client was dropped off at CSU by Chico PD by client request. Client reports that police were called to the Torres Shelter after multiple complaints were made by staff that client was yelling “I’m gonna kill myself!”</p> <p>Client’s treatment plan goals include increasing coping skills for anxiety, increasing coping skills for depression symptoms, and discharging to lower level of care in the community.</p>
	<p>Intervention</p>	<p>Engaged with client to provide supportive counseling and to assess mental health status, symptoms, progress towards treatment plan goals, and current HI and SI. Spoke with client about SI and suicidal statements. Client stated she had a recent fight with boyfriend which had increased her anxiety and anger. Educated client on use of coping skills such as deep breathing and journaling during times of increased anxiety. Encouraged client to utilize outpatient resources to help maintain mental health stability. Discussed community resources and provided brokerage services to help client connect with Torres Shelter upon discharge.</p>
	<p>Response</p>	<p>Client presented with a flat affect while discussing coping skills, but was engaged in dialogue. Client acknowledged clinician’s discussion about staffs’ concerns with her suicidal statements. Client stated that journaling has worked for her in the past and plans to try this skill again. Client agreed to follow up with her outpatient clinician but stated that she was anxious about returning to the Torres Shelter. Client shared that she would utilizing deep breathing techniques that this staff shared to attempt to alleviate the anxiety.</p>
	<p>Treatment Plan</p>	<p>Continue to work on safety plan goals and developing a discharge plan.</p>

COMMUNITY RESIDENTIAL TREATMENT SETTINGS (CRTS)

It is important to note that the organizations providing Adult Residential Treatment and Crisis Residential services have additional requirements based on their status as a Social Rehabilitation Program. Below is a summary of information that relates to Social Rehabilitation Programs:

Care, Supervision & Physical Building—Licensing by CDSS

The California Department of Social Services' (CDSS) Community Care Licensing (CCL) is responsible for inspecting and licensing the care/supervision program and the physical building for Residential Facilities that include: Small Family Home; Crisis Nursery; Temporary Shelter; Transitional Care for Children; Transitional Housing Placement Program; Community Treatment Facility; Group Home; Adult Residential Care Facility for Persons with Special Health Care Needs; Adult Residential Facility and Social Rehabilitation.

Mental Health Treatment Program Provider—Certification by DHCS

The California Department of Health Care Services (DHCS) is responsible for certifying residential programs as a Mental Health Treatment Program Provider. CRTS offer different types of Residential treatment:

- Short-Term Crisis Residential: Offers alternatives to acute hospitalization; provides stabilization and diagnostic services for no longer than three months.
- Transitional Residential: Provides an activity based program that encourages utilization of community resources for no longer than 18 months.
- Long-Term Residential: Provides rehabilitation services for the chronically mentally ill who need long-term support and care for up to two to three years, in order to develop independent living skills (DHCS Certification).

The regulations over Specialty Mental Health Services appear in CCR, Title 9, Division 1, Chapter 11. Every provider who bills Mental Health Medi-Cal must follow these regulations, as well as County MHP requirements. The regulations over Social Rehabilitation Programs appear in a completely different Chapter of CCR Title 9 (Source: Chapter 3, Article 3.5, Standards for the Certification of Social Rehabilitation Programs). Programs that are certified by DHCS as Social Rehabilitation Programs must follow these additional regulations.

Section 10.10: Community Residential Treatment Settings

ADULT RESIDENTIAL TREATMENT SERVICES

Adult Residential Treatment Service means “rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.” The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

ASSESSMENT

Providers must complete the SMHS Assessment as described under the Assessment Section of this manual.

Timeliness of the Assessment

- (1) Initial Assessment: must be completed and finalized by the Residential Facility Director or a trained staff at the residential facility upon the first face to face appointment at the residential facility.
- (2) Annual Assessment: within 30 days before the Episode Opening Anniversary.

Additional Required Content from Social Rehabilitation Program Certification Standards (CCR, Title 9, Chapter 3, Article 3.5, §532.2):

At the admission to program, there must be a written assessment of each client on admission that includes (at least):

- (1) Health and psychiatric histories
- (2) Psychosocial skills
- (3) Social support skills
- (4) Current psychological, educational, vocational and other functional limitations
- (5) Medical needs, as reported
- (6) Meal planning, shopping and budgeting skills

TREATMENT PLAN

The residential facility and client shall together develop a written treatment/rehabilitation plan specifying goals and objectives and the residential facility staff and client's responsibilities for their achievement. Clients shall be involved in an on-going review of progress towards reaching

Section 10.10: Community Residential Treatment Settings

established goals and be involved in the planning and evaluation of their treatment goals. It must be signed by the client, residential facility program director or a residential facility staff member.

The treatment plan shall include, but not be limited to, the following:

- Specific goals and measurable objectives, and the staff and client's responsibilities for their achievements.

The objective shall be measurable with time frames;

- Plans for meeting the objective.
- Identification of any individuals or agencies responsible for implementing and evaluating each part of the plan.
- If needs are identified in the treatment plan that cannot be met by the facility, but can be met in the community, the facility shall arrange for clients to attend these identified community programs.
- A method of evaluating progress.
- Anticipated length of stay for the client in the residential facility needed to accomplish identified goals.

Timeliness of the Treatment Plan

- (1) Initial Treatment Plan: must be fully completed and finalized by the Residential Facility Director or a trained staff at the residential facility upon the first face to face appointment at the residential facility.
- (2) Monthly Review of Treatment Plan: Clients shall be involved in an on-going review of progress towards goal attainment and in the planning and evaluation of their treatment/rehabilitation goals every thirty (30) days.

PROGRESS NOTES

All progress notes must include the following elements at a minimum, unless not applicable for the Weekly Summary:

- A. The Dates of Service
- B. Activities in which the client participated
- C. Client's behaviors and staff intervention
- D. Progress toward objectives/goals or documentation of lack of progress
- E. Contact with other programs/agencies/treatment personnel involved with the client's treatment

Section 10.10: Community Residential Treatment Settings

SERVICES DISCHARGE AND CLOSING SUMMARY

Adult Residential Treatment Services providers must complete a written discharge summary prepared by staff and the client that includes at a minimum an outline of services provided, goals accomplished, reason and plan for discharge and referral follow-up plans. This information must be included on the Closing Summary form for every client discharged.

CRISIS RESIDENTIAL TREATMENT SERVICES

“Crisis Residential Treatment Service” means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

ASSESSMENT

Providers must complete the SMHS Assessment as described under the Assessment Section of this manual.

Timeliness of the Assessment

- (1) Initial Assessment: must be completed and finalized by the Residential Facility Director or a trained staff at the residential facility upon the first face to face appointment at the residential facility.
- (2) Annual Assessment: within 30 days before the Episode Opening Anniversary.

Additional Required Content from Social Rehabilitation Program Certification Standards (CCR, Title 9, Chapter 3, Article 3.5, §532.2):

At the admission to program, there must be a written assessment of each client on admission that includes (at least):

- (1) Health and psychiatric histories
- (2) Psychosocial skills
- (3) Social support skills
- (4) Current psychological, educational, vocational and other functional limitations
- (5) Medical needs, as reported
- (6) Meal planning, shopping and budgeting skills

Section 10.10: Community Residential Treatment Settings

TREATMENT PLAN

The residential facility and client shall together develop a written treatment/rehabilitation plan specifying goals and objectives and the residential facility staff and client's responsibilities for their achievement. Clients shall be involved in an on-going review of progress towards reaching established goals and be involved in the planning and evaluation of their treatment goals. It must be signed by the client, residential facility program director or a residential facility staff member.

- A. The treatment plan shall include, but not be limited to, the following:
 - Specific goals and measurable objectives, and the staff and client's responsibilities for their achievements.
- B. The objective shall be measurable with time frames;
 - Plans for meeting the objective.
 - Identification of any individuals or agencies responsible for implementing and evaluating each part of the plan.
 - If needs are identified in the treatment plan that cannot be met by the facility, but can be met in the community, the facility shall arrange for clients to attend these identified community programs.
 - A method of evaluating progress.
 - Anticipated length of stay for the client in the residential facility needed to accomplish identified goals.

Timeliness of the Treatment Plan

- (1) Initial Treatment Plan: must be fully completed and finalized by the Residential Facility Director or a trained staff at the residential facility upon the first face to face appointment at the residential facility.
- (2) Weekly Review of Treatment Plan: Clients shall be involved in an on-going review of progress towards goal attainment and in the planning and evaluation of their treatment/rehabilitation goals every seven (7) days.

PROGRESS NOTES

All progress notes must include the following elements at a minimum, unless not applicable for the Daily Summary:

- A. The Dates of Service
- B. Activities in which the client participated
- C. Client's behaviors and staff intervention
- D. Progress toward objectives/goals or documentation of lack of progress

Section 10.10: Community Residential Treatment Settings

- E. Contact with other programs/agencies/treatment personnel involved with the client's treatment

SERVICES DISCHARGE AND CLOSING SUMMARY

Prior to discharge, there shall be a written discharge summary prepared by the staff which shall include an outline of services provided, goals accomplished, reason and plan for discharge and referral follow-up plans.

Any of the following criteria are sufficient for discharge from this level of care:

- The individual's documented treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged at an alternate level of care.
- The individual no longer meets admission criteria or meets criteria for a less or more intensive level of care.
- Consent for treatment is withdrawn, and it is determined that the individual has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.
- Support systems that allow the individual to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured.

The individual is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.

Section 10.10: Community Residential Treatment Settings

DOCUMENTATION EXAMPLES – Transitional Residential Treatment

Clinical Scenario	Progress Note Elements	
Transitional Residential – Daily Summary	Describe	Client is a 48-year-old English speaking Hispanic male admitted to Trinity Pines on 6/7/17. Client has a primary diagnosis of F25.9 Schizoaffective Disorder. Time spent summarizing staffs' interactions with client today and client's status. Client continues to present with irritability and anger outbursts. He did see a county psychiatrist recently who made medication changes – it does appear that client has made some mild improvement as a result (decreased severity with anger outbursts and less internal stimuli).
	Intervention	<p>Client's current CSP goals are:</p> <ol style="list-style-type: none"> 1) Client will increase coping skills for managing anger outbursts from 1, currently, to 5 within 30 days. 2) Client will increase socialization from 2 hours a day, currently, to 4 hours a day within 30 days. 3) Client will increase ability to manage hygiene/ADLs from occurring 2 days/week, currently, to occurring 4 days/week within 30 days. <p>Client appeared to make some mild progress with CSP goals today in terms of managing anger outbursts and managing hygiene</p>
	Response	Client became irritable during medication self-administration this morning. Staff intervened letting him know understanding of frustration and that we want to support him with management for success. Reinforced we are here to support him with his progress and reminded him that we need to talk to each other respectfully. Asked about coping skills that client has been using to help when he is frustrated - client talked about how playing cards helps him when he is "hot under the collar." Also discussed how it has been helpful for him to "take 5" when upset and then come back to process with staff. We agreed that client would take a few minutes and take some deep breaths - client re-approached this staff about 10 minutes later, apologized and stated "I don't know why I let the little things bother me." Staff spent time reinforcing the positive nature of his efforts and encouraged him to continue to build on the strides that he has made. Later in the morning another staff prompted client to take a shower - this writer observed that client initially balked, but then did take a shower upon his second prompt when he was reminded of the reward system that he has in place with the House Manager.
	Treatment Plan	<p>TP staff need to continue to provide firm, but supportive boundaries with client and support him with the progress with his goals that he is making. It is helpful to remind client of the agreement that he has with the House Manager.</p> <p>Other pertinent information on client: Client has a 10:00 am appointment with Dr. Silver at BCDBH tomorrow, 1/15/18. Client's Case manager will be here to pick him up at 9:30 am.</p>

Section 10.10: Community Residential Treatment Settings

Clinical Scenario	Progress Note Elements	
Transitional Residential – Weekly Summary	Describe	<p>Client is a 32-year-old English speaking African American male admitted to Trinity Pines on 4/4/17. Client has a primary diagnosis of F20.0 Paranoid Schizophrenia. Time spent reviewing and documenting client's progress for the past week.</p> <p>Client continues to display Sx of schizophrenia, including paranoia and some disorganization. Client also continues to display negative symptoms of schizophrenia including apathy, lack of emotion and poor social functioning - he has made some recent progress in this area.</p>
	Intervention	<p>Current CSP goals include:</p> <ol style="list-style-type: none"> 1) Increase ability to manage ADLs from 3 times/week, to 4 times/week within 30 days. 2) Decrease anxiety due to OCD and learn 2 new coping skills, from 0, within 30 days. 3) Increase ability to manage time by arriving to groups and meals on time with 2 or less prompts from staff, improving from the current 3 or more prompts within 30 days. <p>Client has made marked progress with his goals this past week - he is coming to groups and meals on time, doing better with his ADLs and showing some progress with coping skills for OCD anxiety.</p> <p>Client appears to have a renewed sense of motivation and staff are providing positive feedback. Client reports having a good week!</p>
	Response	<p>Trinity Pines staff have provided group and individual counseling, as well as support with self-administration with his medications and linkage to community resources. Staff have also encouraged client to increase his bathing/ADLs and have continued to attempt to support client with increasing coping skills for managing Sx of OCD and to increase his time management skills. Overall, client has had a very positive week in terms of progress. Client continues to demonstrate impairments in life functioning in terms of impacted ability to utilize social support, manage ADLs and is unable to engage in employment or live on his own at this. Client continues to be conserved through BCPG.</p>
	Treatment Plan	<p>TP staff will continue to provide group and individual counseling as well as support with medication self-administration and linkage to community resources.</p>

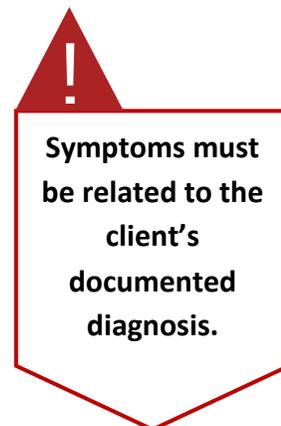
Section 10.10: Community Residential Treatment Settings

DOCUMENTATION EXAMPLES – Crisis Residential Treatment

Clinical Scenario	Progress Note Elements	
Crisis Residential Daily Summary	Describe	Client is a 48-year-old English speaking Hispanic male admitted to Iris House on 1/9/18 as an alternative to hospitalization. Client “stepped-down” from the BCDBH PHF. Client has a primary diagnosis of F25.9 Schizoaffective Disorder. Time spent summarizing staff’s interactions with client today and client’s status. Client continues to present with psychosis, irritability and anger outbursts. He had medication changes 2 days ago (see Physician’s Orders) – it does appear that client has made some mild improvement as a result (decreased severity with anger outbursts and less internal stimuli).
	Intervention	Client’s current CSP goals are 1) Client will increase coping skills for managing anger outbursts from 1, currently, to 5 within 7 days. 2) Client will increase socialization from 2 hours a day, currently, to 4 hours a day within 7 days. 3) Client will increase ability to manage hygiene/ADLs from occurring 3 days/week, currently, to occurring 5 days/week within 7 days. Client appeared to make some mild progress with CSP goals today in terms of managing anger outbursts and managing hygiene. He continues to respond to internal stimuli on a consistent basis.
	Response	Client became irritable during medication self-administration this morning and staff intervened by letting him know that I understand that he is frustrated and that we want to support him with managing his frustration. It was reinforced that we are here to support him with his progress and reminded him that we need to work together regarding his frustrations. I then asked about coping skills that client has been using to help when he is frustrated – client talked about how playing cards helps him when he is “hot under the collar.” We also discussed how it has been helpful for him to “take 5” when upset and then come back to process with staff. We agreed that client would take a few minutes and take some deep breaths – client re-approached this staff about 10 minutes later, apologized and stated “I don’t know why I let the little things bother me.” Staff spent time reinforcing the positive nature of his efforts and encouraged him to continue to build on the strides that he has made. Later in the morning another staff prompted client to take a shower – this writer observed that client initially balked, but then did take a shower upon his second prompt. Staff have attempted to engage client in the milieu throughout the shift in order to reduce isolation.
	Treatment Plan	Staff need to continue to provide firm, but supportive boundaries with client and support him with the progress with his goals that he is making. It is helpful to remind client of the agreement that he has with the House Manager. Client has a 10:00 am appointment with Dr. Silver at BCDBH tomorrow, 1/15/18. Client’s Case manager will be here to pick him up at 9:30 am.

MEDICATION SUPPORT SERVICES

“Medication Support Services” means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to review of records, evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and/or assessment of the client (CCR Title 9 Division 1, 1810.225).



Symptoms must be related to the client's documented diagnosis.

ACTIVITIES

Medication Support Services activities are face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services include:

- Evaluation of the need for psychiatric medication
- Evaluation of clinical effectiveness and side effects of psychiatric medication
- Medication education, including discussing risks, benefits and alternatives with the client or support persons
- Ongoing monitoring of the client's progress in relation to the psychiatric medication
- Prescribing, dispensing, and administering of psychiatric medications
- The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client

SERVICES & DESCRIPTIONS PERTAINING TO MEDICAL STAFF

1. MEDICATION EVALUATION

For Prescribers only:

- This service is used when a psychiatric assessment is performed by a Prescriber

2. MEDICATION MANAGEMENT

For Prescribers only:

- Includes clinic visits, refilling prescriptions, face-to-face or telephone consults with other Medical Prescribers

3. MEDICATION SUPPORT NON- PRESCRIBERS

For Medical Staff Non- Prescribers (Registered Nurses, Licensed Vocational Nurses & Licensed Psychiatric Technicians)

- Administering of medication per Prescriber’s orders
- Evaluation of clinical effectiveness and side effects of psychiatric medication
- Ongoing monitoring of the client’s progress in relation to the psychiatric medication
- Medication education, including discussing risks, benefits and alternatives with the client or support persons

4. ALL MEDICAL STAFF (PSYCHIATRIST, PRESCRIBERS, REGISTERED NURSES, LICENSED VOCATIONAL NURSES & LICENSED PSYCHIATRIC TECHNICIANS) CAN ALSO PROVIDE:

- Medication Injection
- Prep report other Physicians/Agency (Preparation of report for other physicians/agencies)Review Hospital Records/Reports/Labs (Review of hospital records, reports and labs)



DOCUMENTATION EXAMPLES

Clinical Scenario	Progress Note Elements	
Nurse Note - Client has a question about meds	Describe	Client calls to report possible adverse effects of Bupropion. Complains of dry mouth with onset 2 weeks after starting Bupropion. Takes Bupropion for major depression with symptoms of depressed mood and a severe loss of the ability to feel pleasure/happiness that caused him to lose his job.
	Intervention	Provided medication management services to client via phone. Informed the client that dry mouth is relatively common with Bupropion (incidence 15-30%). Recommend that he increase fluids, and to discuss possible change in medication with psychiatrist at his next visit. Assessed medication adherence (client states he adheres to med regimen) and mental status (client denies SI and HI; thought processes are linear and goal-directed).
	Response	Client expresses understanding of the information provided, and wishes to continue with Bupropion for now. States meds help him deal with recent bedbug outbreak at his hotel.
	Treatment Plan	Client agrees to take meds as prescribed and to try recommendations for dry mouth. Follow-up with MD on Wed 8/4/18 at 10:00 a.m.

Clinical Scenario	Progress Note Elements	
Medication Administration Client has an appointment to receive a medication injection	Describe	Client receives medication to improve her impairments in life functioning (homelessness; work). She comes to the clinic stating “I need my shot.”
	Intervention	Confirmed current med orders and last administration (last dose given 7/15/16). Praised the client for presenting on time this month considering her past history of frequently showing up days late for injection. Administered Haloperidol Decanoate 100mg to left deltoid. Multi-dose vial lot F67456. Assessed side effects (client states that she doesn’t have any problems related to meds). Provided med education to the client on possible adverse effects. Mental status exam conducted-- Client presents as disheveled and tangential.
	Response	Client expresses understanding of the information provided, but seems suspicious. Client tolerated procedure well. No bleeding from site noted.
	Treatment Plan	Client agrees to return Fri 9/9/16 9:00 a.m. for next shot at injection clinic. She will meet with her therapist Tue 8/30/16 2 p.m., and her psychiatrist on the same day at 3 p.m.

Section 10.11: SMHS – Medication Support

Clinical Scenario	Progress Note Elements	
<p>Medication Box Fill</p> <p>Client has appt to receive oral medication (client’s meds stored in clinic med room)</p>	Describe	Client comes to clinic and states “I need my meds.” Client has dx of major depression and medication helps prevent a significant decline in his self-care functioning and a reoccurrence of distress/suffering from his symptoms
	Intervention	Confirmed that client takes medication as prescribed (sertraline 100mg po every morning) and assessed side effects (occasional upset stomach). Assisted client in filling a medication box for one week of sertraline 100mg po every morning. Reinforced importance of med adherence. Assessed for acute risk factors and side effects of medications, none identified. Evaluated client’s mental status—his mood is “good” and his affect is congruent.
	Response	Client accepts medications. Client agreed to monitor his insomnia (primary symptom) and make sure to eat food before he takes his meds. Client was able to identify that sertraline prevents the recurrence of depressed mood and insomnia.
	Treatment Plan	Client agrees to take meds as prescribed. He will return next Monday for med distribution, and will f/u with psychiatrist on Monday 8/9/18 at 9:00am. Client is being considered for step-down to primary care, and has apt to talk to primary care provider on Friday.

Clinical Scenario	Progress Note Elements	
<p>Medication Box Fill</p> <p>Order-Connect refill for an existing client who is known to provider and clinically stable</p>	Describe	Patient calls requesting med refill.
	Intervention	Chart/orders reviewed. Reports adherence with treatment, good symptom control, no adverse effects. Med refilled per order so that treatment not interrupted, to prevent decompensation. RTC: 1 month
	Response	
	Treatment Plan	

DISCHARGE

Discharge documentation describes the termination and/or transition of services. It provides closure for a service episode with referrals, as appropriate.



Discharge occurs:

- When a client has either met their goals and can transition to a lower level of care or out of services.
- Lack of contact and lack of medication refills for over 180 days will be reviewed for closure.
- For Crisis Stabilization clients, when a client discharges from the facility, staff must close the case and complete a Closing Summary.
- For Crisis Residential Treatment Services clients, when a client discharges from the facility, staff must close the case and complete a Closing Summary.
- For Adult Residential Treatment Services clients, when a client discharges from the facility, staff must close the case and complete a Closing Summary.

Exceptions:

- For “Meds Only” clients (“medication services”), case closure is required after six months of inactivity, i.e. lack of contact and lack of medication refills, from the last service date.

Discharge/Transition of Care

The [Care Coordinator](#) will implement a Transition of Care/Discharge strategy in the treatment plan for changes in the level of care of the client. This will include the following, as appropriate:

1. Referral to additional providers.
2. Obtain a ROI for any new providers.
3. Communicate to the client that if they decompensate or have an increased risk of hospitalization, services would be reinstated or made available as needed.
4. This must be documented in the client’s progress note.

Example of Transition of Care/Discharge Strategy

When the need for SMHS decreases:

1. Referral
 - a. to MCP (w/ROI) or
 - b. provider that takes Medi-Cal for Mild/Moderate clients
2. Continuity of Care requirement—
 - a. Make certain there is an appointment with transportation
 - b. One follow-up to make certain the client is engaged with new provider
3. Close client

Discharge Summaries

A Discharge Summary must be completed upon discharge of each client based on the standards below. In every instance, the disposition of the case must be documented in a progress note.

This will include:

- Date of discharge;
- Reason for discharge;
- Brief summary of treatment provided and progress toward goals; and
- Referral(s) for community services, if needed.
- The appropriate Outcome Measure is to be completed at the close of service unless it has been completed within 30 days of discharge and there are no additional changes in the score.

NON-REIMBURSABLE SERVICES

For Medi-Cal, some services are not eligible for reimbursement, even though they may be provided on behalf (and to the benefit) of the client. These non-reimbursable services include, but are not limited to, the following:

- Academic educational services
- Vocational services where the purpose is actual work or work training
- Socialization - if it consists of generalized group activities which do not provide systematic individualized feedback to the specific target behaviors of the clients involved
- Recreation
- Personal care services provided to clients (e.g. grooming, personal hygiene, assisting with medication, preparation of meals, etc.)
- Transportation of a client
- Preparation for a service activity, such as collecting materials for a group session
- Service provided that are solely payee related
- Translation/interpretation services
- Missed appointments
- Travel time when no face-to-face contact with the client or significant support person was provided, including leaving a note on the door for the client
- Leaving and/or listening to telephone messages
- Communication via e-mail unless clinically appropriate (e.g., therapeutic communication for deaf and hard-of-hearing clients)
- Completing mandatory reports: Suspected Child Abuse Report, Suspected Elder/Dependent Adult Abuse Report, Tarasoff, etc., including making associated phone calls
- Completing Social Security reports
- Clerical tasks: faxing, copying, mailing, etc.
- After the death of a client, no services are billable

LOCK-OUTS

A “lockout” means that a service activity is not reimbursable through Medi-Cal because the client resides in and/or receives mental health services in one of the settings listed below:

- Jail/Prison
- Juvenile Hall (not adjudicated)
- Institute of Mental Disease (IMD)

A clinician may provide the service (e.g. targeted case management for a client residing in an IMD), but it would be reimbursable only under certain circumstances – See Lock-Out Grid at the end of this Section.

Inpatient Services

No service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Psychiatric Inpatient
- Psychiatric Nursing Facility

Exception: Medication Support Services or TCM-Linkage and Brokerage (for placement purposes only within 30 days of discharge) are reimbursable.

Outpatient Services

No other service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Crisis Stabilization

Exception: Targeted Case Management for placement purposes only is reimbursable while client is at the Crisis Stabilization Unit.

Residential Services

No other service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Crisis Residential
- Adult Residential

Exception: Medication Support Services or TCM-Linkage and Brokerage is reimbursable. Crisis Intervention for Adult Residential only.



DOCUMENTATION TIP

Standard Skilled Nursing Facility (SNF) is NOT a lock-out environment; only a Skilled Psychiatric Nursing Facility (SPNF) would be a lock-out. A Skilled Nursing Psych Facility requirement of more than 50% of the beds to be “psych” beds.

SPECIAL NOTE FOR YOUTH SERVICES

Intensive Care Coordination

For members of the target group who are transitioning to a community setting ICC services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days 25 or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in an IMD or individuals who are inmates of public institutions. ICC may be provided solely for the purpose of coordinating placement of the child/youth on discharge from the hospital, psychiatric health facility, group home or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

Intensive Home-Based Services

Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided. IHBS may not be provided to children/youth in Group Homes. IHBS can be provided to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits outside the Group Home setting. Certain services may be part of the child/youth’s course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child/youth. These services include:

- Day Treatment Rehabilitative or Day Treatment Intensive
- Group Therapy
- Therapeutic Behavioral Services (TBS)
- Targeted Case Management (TCM)

BILLING LOCK-OUT GRID

Service Site or During the Hours of Operation	Lock-out Mental Health Service	Lock-out Medication Support Services	Lock-out Targeted Case Management Services
Adult Residential	Yes	No	No
Crisis Residential	Yes ¹	No	No
Crisis Stabilization (CSU)	Yes ²	Yes	No
Day Programs (Intensive and Rehabilitation)	No ³	Yes	No
Juvenile Hall, Jail, or Similar Detention (not adjudicated for Placement)	Yes ⁴	Yes ³	Yes ³
Psychiatric Inpatient Hospital	Yes ^{1,4}	Yes	Yes ⁴
Psychiatric Health Facility (PHF)	Yes ¹	Yes	Yes ⁵
Psychiatric Nursing Facility	Yes ¹	Yes	Yes ⁵
Physical Health Care Hospital	No	No	No

1. Except on the day of admission.
2. No other Specialty Mental Health Service is reimbursable during the same time period the service is reimbursed.
3. Except by the same Day Treatment Program Staff.
4. Except on the day of admission, and 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement.
5. Except on the day of admission, and 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement.

*Adapted from CIMH EPSDT Manual Lock-Out Crosswalk (Lisa Scott-Lee, 2007)

Documentation Manual GLOSSARY

Term	Definition
LPHA	“Licensed Practitioner of the Healing Arts (LPHA)” – In Butte County the following are considered LPHA’s: physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, and licensed psychiatric nurse practitioner.
PRESCRIBER	A prescriber is someone who holds a license that allows them to prescribe medication. Butte County has MD’s, DO’s, and NP’s who are prescribers. In situations where a client is receiving mental health and medication services a prescriber’s signature must be on the treatment plan.
PULLED FORWARD	In the EHR, documents have been designed so that when a client is opened to a new program staff can “pull forward” information from a previous program, rather than having to manually enter the information. “Pulled Forward” essentially means to “copy” information into the new program. This should only be done when a client is transferring from one program to another and the documentation remains valid. If a document is pulled forward, the person pulling the document forward must attest that they are pulling it forward and not making any changes. If changes are needed to a document, the provider must complete a new document. It is important to pay attention to dates of expiration when pulling forward to ensure the document (assessment or treatment plan) has the appropriate end date in the new episode. Failure to put the correct dates can cause issues with disallowances if a treatment plan or assessment expires and services are delivered after an expiration date.
SCOPE OF PRACTICE	The definition of scope of practice provided by law delineates what the profession does and places limits upon or confines the breadth of functions persons within a profession may lawfully perform. Scope of practice in Butte County’s Mental Health Plan also incorporates job classification. For example, a staff member in a Behavioral Health Counselor (BHC) position may hold a Master’s Degree in Psychology or Social Work, which technically allows them to diagnose a client; however, diagnosing is not a function within the BHC job classification and therefore is not within the scope of practice for a BHC.
VALID	In the context of this documentation manual, valid refers to the date all of the required information and appropriate signatures have been finalized on an option. For example, an assessment may be started on 5/11/17; however, this

	assessment isn't finalized until 6/12/17. In this example the valid date of the assessment is 6/12/17.
LONG TERM CLIENT	BCDBH has defined a long-term client as one who receives services for more than 60 days.
SPECIALTY MENTAL HEALTH SERVICES (SMHS)	<p>Medi-Cal services is the broad array services available to meet the mental health needs of Medi-Cal beneficiaries. Specialty Mental Health Services (SMHS) include the smaller array of Mental Health Services.</p> <ul style="list-style-type: none"> • <u>Mental Health Services</u>: assessment; evaluation; plan development; therapy; rehabilitation services; and collateral services. • <u>Case Management/Brokerage</u>: coordination and referral; placement services; and plan development. • <u>Medication Support Services</u>: assessment; prescribing, administering, dispensing, monitoring drug interactions and contraindications of psychiatric medications or biologicals; evaluation; obtaining informed consent; medication education; and plan development. • <u>EPSDT Supplemental Specialty Mental Health Services</u>: assessment, plan development, and treatment through mental health services; medication support services; crisis intervention services. • <u>Therapeutic Behavioral Services (TBS)</u>: an EPSDT supplemental service; assessment; plan development; behavioral interventions • <u>Intensive Care Coordination (ICC)</u>: Services delivered using a Child and Family Team, intended for children and youth with more intensive needs and/or whose treatment requires cross-agency collaboration. ICC Services components/activities include: assessment; service planning and implementation; monitoring and adapting; and transition. • <u>Intensive Home-Based Services (IHBS)</u>: Services expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the plan and the Core Practice Model, and are predominantly delivered outside an office setting, and in the home, school, or community. Services include medically necessary, skill-based interventions; development of functional skills; development of skills or replacement behaviors that allow the child or youth to participate in the CFT; improvement of self-management of symptoms; education of the child, youth and/or caregiver(s) on how to manage the mental health disorder or symptoms; support the use of social networks; and support to address behaviors that interfere with the achievement of a stable and

permanent family life, achieve educational objectives, and behaviors to support independent living skills. Services are typically (but not only) provided by paraprofessionals under clinical supervision.

- Therapeutic Foster Care (TFC): TFC service activities are provided through the TFC service model and include collateral, rehabilitation, and plan development as it relates to the TFC. It is delivered in the home or other community setting by a trained and qualified TFC parent.
- Day Treatment Intensive and Day Rehabilitation: assessment; evaluation; plan development; therapy; rehabilitation services; and collateral.
- Crisis Intervention: assessment; evaluation; therapy; and collateral.
- Crisis Stabilization: assessment; evaluation; medication support; crisis intervention; therapy; and collateral.

PSYCHOLOGICAL GLOSSARY

Term	Definition
Addiction	A condition in which the body requires a drug in order to function without physical and psychological reactions to its absence; often the outcome of tolerance and dependence.
Anhedonia	An inability to feel pleasure.
Anticipatory coping	Efforts made in advance of a potentially stressful event to overcome, reduce, or tolerate the imbalance between perceived demands and available resources.
Apathetic	Showing lack of interest, or indifference; lacking feeling.
Aphasia	Has difficulty saying words, even when he/she knows what he/she wants to say.
Apraxia	Has difficulty doing things with his/her hands or taking a step, even when he/she knows what he/she wants to do.
Avolition	A lack of motivation.
Blocking	A phenomenon in which a previously-learned thought process prevents or delays the learning and conditioning of new behavior. It may also be a process wherein the flow of thought is obstructed or interrupted. Also called thought obstruction.
Blunted	A decrease (reduction) in amplitude of emotional expression.
Catharsis	The process of expressing strongly felt but usually repressed emotions; an emotional release.
Chronic stress	A continuous state of arousal in which an individual perceives demands as greater than the inner and outer resources available for dealing with them.
Circumstantial	Organized but over inclusive, eventually gets to the point in a painstakingly slow manner; often gets lost in a lot of detail that has very little to do with the main point he's/she's trying to get across.
Clang Association	Associations that are governed by rhyming sounds, rather than meaning, e.g., "This what I thought, bought, knot, caught, rot, sought."

Section 15: Psychological Glossary

Term	Definition
Comorbidity	The experience of more than one disorder at the same time (Co-Occurring).
Compulsion	An insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person's ordinary conscious wishes or standards. A defensive substitute for hidden and still more unacceptable ideas and wishes. Anxiety results from failure to perform the compulsive act.
Confabulation	Generating material (lying) to replace gaps in story; defensive "filling in" of actual experiences recounted in a detailed and plausible way as though they were factual.
Constricted	Normal amplitude but restricted range.
Conversion	A mental condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained; condition in which you show psychological stress in physical ways
Deductive Reasoning	A form of thinking in which one draws a conclusion that is intended to follow logically from two or more statements or premises.
Delusion	Persistent false beliefs not in keeping with the person's culture or education (e.g. grandeur, persecution); firmly believes something that almost nobody else believes, even after being shown proof that it's not true.
Depersonalization	The sense of feeling disconnected or detached from one's body and thoughts.
De-realization	A vague sense of unreality in one's perception of the external world.
Dissociation	A psychological separation or splitting off; an intrapsychic defensive process which operates automatically and unconsciously. Through its operation, emotional significance and affect are separated and detached from an idea, situation, or object. Dissociation may, unconsciously, defer or postpone experiencing the emotional impact, as for example, in selective amnesia.

Section 15: Psychological Glossary

Term	Definition
Dual Diagnosis	The term used to describe patients with both severe mental illness and problematic drug and/or alcohol use.
Echolalia	Meaningless repetition of words.
Egosyntonic	Referring to behaviors, values, and feelings that are in harmony with or acceptable to the needs and goals of the ego, or consistent with one's ideal self-image.
Emotion	A complex pattern of changes, including physiological arousal, feelings, cognitive processes, and behavioral reactions, made in response to a situation perceived to be personally significant.
Emotional intelligence	Type of intelligence defined as the abilities to perceive, appraise, and express emotions accurately and appropriately, to use emotions to facilitate thinking, to understand and analyze emotions, to use emotional knowledge effectively, and to regulate one's emotions to promote both emotional and intellectual growth.
Euphoric	Feeling great (as if one just won the lottery); Elated, Ecstatic, Exhilarated.
Exaggerated Startle Response	Often overreacts to things that happen suddenly, as if those things are going to hurt him/her
Fixation	A state in which a person remains attached to objects or activities more appropriate for an earlier stage of psychosexual development
Flat Affect	Virtually complete absence of affective expression.
Flight of Ideas	Flow of thoughts is extremely rapid but connections remain intact.
Flooding	A therapy for phobias in which clients are exposed, with their permission, to the stimuli most frightening to them.
Grandiose	Unrealistic exaggeration of own importance.
Group Polarization	The tendency for groups to make decisions that are more extreme than the decisions that would be made by the members acting alone.
Groupthink	The tendency of a decision-making group to filter out undesirable input so that a consensus may be reached, especially if it is in line with the leader's viewpoint.

Section 15: Psychological Glossary

Term	Definition
Hallucinations	<p>An experience involving the apparent perception of something not present that seems indistinguishable from such an experience in reality.</p> <ul style="list-style-type: none"> • Auditory Hears sounds when no sound is being made. • Gustatory Tastes things even when nothing has been put in his/her mouth. • Kinesthetic Feels parts of his/her body moving when they're not. • Olfactory Smells things that other people don't smell. • Tactile Feels things moving on his/her skin when they're not. • Visual Sees things that aren't there.
Hyper-Responsive	Often has a strong overreaction to sounds or lights.
Hyper-Vigilance	Often looks around for threats in a way that takes attention away from other things.
Hypochondriasis	Worries a lot about his/her health, even when he/she is healthy.
Ideas of Influence	Tends to assume that he/she is causing another person to have the thoughts they are having, or to do the things that they are doing, but is not absolutely sure.
Ideas of Reference	Incorrect interpretation of casual incidents and external events as being directed toward the self.
Illusions	Misinterpretation of events or often hears or sees things differently than the way they really sound or look (e.g., misperceiving billowing curtains in a darkened room to be an intruder).
Inappropriate	Emotions expressed are not congruent with content of patient's thoughts (Occasional nervous smiling or laughter is not sufficient).
Labile	Quick and unpredictable shifts in emotional state.
Lacks Insight	Not aware of having problems that a lot of other people have noticed.
Learned helplessness	When people become conditioned to believe that a situation is unchangeable or inescapable.

Section 15: Psychological Glossary

Term	Definition
Limited Insight	Not aware of problems being as serious as many other people think they are.
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Magical Thinking	To think that he/she can make things happen simply by thinking about them.
Malingering	Exaggerated or feigned illness in order to escape duty or work.
Mutism	Refusal to speak.
Neologisms	Words that are created by the patient and have their own idiosyncratic meaning.
Nihilistic	Rejecting all religious and moral principles in the belief that life is meaningless.
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Persecutory	A belief that one is being singled out for attack or harassment.
Perseveration	An involuntary repetition of the answer to a previous question in response to a new question.
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Section 15: Psychological Glossary

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Poor Judgment	Doesn't clearly understand the consequences of acting on impulses (developmentally appropriate).
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Psychomotor retardation	A significant slowing of speech and body movements, lack of usual fidgetiness.
Reasoning	The process of thinking in which conclusions are drawn from a set of facts; thinking directed toward a given goal or objective.
Recall	A method of retrieval in which an individual is required to reproduce the information previously presented.
Repression	The basic defense mechanism by which painful or guilt-producing thoughts, feelings, or memories are excluded from conscious awareness.
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Self-awareness	The top level of consciousness; cognizance of the autobiographical character of personally experienced events.
Self-concept	A person's mental model of his or her abilities and attributes.
Self-efficacy	The set of beliefs that one can perform adequately in a particular situation.
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APPROVED ABBREVIATION / ACRONYM DICTIONARY

From PnP 169

Abbreviated Symbol	Term
@	at
↑	increase
↓	decrease
1°	Primary
2°	Secondary
Å	present, positive for
x3	times 3
q, O	not present, absent
>	more, greater, larger
<	less, lesser, smaller
#	number
\»	therefore
ā	before

A	
AA	Alcoholics Anonymous
abbr	abbreviation
a.c.	before meals
ADHD	Attention Deficit Hyperactivity Disorder
ADL	activities of daily living
ad. lib.	as desired
admit/adm	admission

Section 16: Approved Abbreviations/Acronym Dictionary

Adol.	adolescent
ADM	antidepressant medication
ADS	Alcohol Drug Service
ACSW	Academy of Certified Social Workers
AH, A/H	auditory hallucination(s)
AIDS	Acquired Immune Deficiency Syndrome
Anx	Anxiety
APRN	Advanced Practice Registered Nurse
Aka	also known as
a.m.	morning
AMA	against medical advice
AOD	alcohol and other drugs
APA	American Psychiatric Association
ApoA	American Psychological Association
amt.	amount
appro.	appropriate
approx.	approximately
apt	apartment
appt	appointment
ARC	Area Regional Center
as tol.	as tolerated
ASA	aspirin
ASAP	as soon as possible
Ax	assessment
A/W	associated with
AWOL	away without leave

Section 16: Approved Abbreviations/Acronym Dictionary

B	
B/bro	brother
BC	board certified
B&C	Board and Care
BCP	birth control pills
bf	boyfriend
BCDBH	Butte County Department of Behavioral Health
b.i.d.	twice daily
bil	brother-in-law
BM	bowel movement
BP	blood pressure
BSW	Bachelors in Social Work
BPD	borderline personality disorder

C	
CA	California
cal	calorie
cap	capsule
cau	Caucasian
CBC	complete blood count
CAC	Certified Alcoholism Counselor
cc	chief complaint
c/o	complains of
CHI	closed head injury
ClI/CI/Ct	client
Clin.	clinician
cm	centimeter
CNS	Clinical Nurse Advanced Training

Section 16: Approved Abbreviations/Acronym Dictionary

Cnty.	County
Coll	Collateral
COPD	Chronic Obstructive Pulmonary Disease
cp	chest pain
CRNP	Certified Registered Nurse Practitioner
C&S	culture and sensitivity

D	
D:	describe
dau/dtr/D	daughter
Day Tx/TX	Day Treatment
<u>Dep/dep</u>	depression
D+A	drug and alcohol
d/c	discontinue/ed
D'cd, d/c	discharge/ed
DESS	Department of Employment & Social Services
DEV	development
dl	deciliter
DM	Diabetes Mellitus
DNKA	did not keep appointment
DOB	date of birth
d/o-DO	disorder
DOD	date of death
DSM 5	Diagnostic and Statistical Manual of Mental Disorders—5 th Edition
d/t	due to
D/W	discussed with
Dx	diagnosis

Section 16: Approved Abbreviations/Acronym Dictionary

E	
EDD	Employment Development Department
ED	Emotionally Disturbed
EPSDT	Early and Periodic Screening Diagnostic and Treatment
ER	emergency room
ETOH/E-OH	alcohol

F	
Fa	father
FNP	Family Nurse Practitioner
FNRC	Far Northern Regional Center
FT	full-time
f/u	follow-up
f/v	field visit
FY	fiscal year

G	
GAD	Generalized Anxiety Disorder
gf	girlfriend
GP	grandparent
GSW	gunshot wound

H	
H	husband
h/a	headache
HBP	Hypertension/high blood pressure
HI	Homicidal ideation

Section 16: Approved Abbreviations/Acronym Dictionary

HIPAA	Health Insurance Portability & Accountability Act
Ht.	height
h/o	history of
h.s.	at night/bedtime
h/v	home visit
Hx	history

I	
I:	Intervention
I/C	intercourse
ID	intra dermal
IEP	Individual Education Plan or Program
IM	Intramuscular (injection)
Ind, Indiv	Individual Therapy
IVDU	intravenous drug user
IQ	Intelligence quotient

J & K	
Jt	muscle joint

L	
L, lt.	left
lab	laboratory
lb.	pound
LBP	low back pain
LCSW	Licensed Clinical Social Worker
LFT	liver function test

Section 16: Approved Abbreviations/Acronym Dictionary

Li*	Lithium
Liq	liquid
LLE	left lower extremity
Li2Co3	Lithium Carbonate
LLQ	left lower quadrant
LMD	local medical doctor
LMP	last menstrual period
LOA	leave of absence
LOS	length of stay
LPHA	Licensed Practitioner of the Healing Arts
LPS	Lanterman-Petris Short
LPT	Licensed Psychiatric Tech.
LUE	left upper extremity
LUQ	left upper quadrant
LVN	Licensed Vocational Nurse

M	
M	male
MA	Master of Arts
MS	Master of Science
MSW	Master of Social Work
Max	maximum
M/Cal	Medi-Cal
M/Care	Medi-Care
M/N, Med-Nec	medical necessity
Mcg.	microgram
M.D.	Medical Doctor
MDD	Major Depressive Disorder

Section 16: Approved Abbreviations/Acronym Dictionary

MDT	Multidisciplinary Team
med(s).	medication(s)
med suppt	medication support
M.F.T., MFT	Marriage and Family Therapist
mg.	milligram
MHC	Mental Health Clinician
MHW	Mental Health Worker
Min.	minute
misc.	miscellaneous
MMPI	Minnesota Multiphasic Personality Inventory
MN	Masters Nursing
Mo	mother
mo.	month
mod.	moderate
MR	Mental Retardation
MRT	Medical Record Technician
MS	Multiple Sclerosis
MSE	Mental Status Exam
msg	message
MSW	Master Social Worker
mtg.	meeting
MVA	motor vehicle accident
MVP	Mitral Valve prolapse

N	
N.A.	Narcotics Anonymous
N/A	not applicable
neg.	negative

Section 16: Approved Abbreviations/Acronym Dictionary

Neuro	neurological
NKA	no known allergies
noc.; noct	night, nocturnal
NOS	not otherwise specified
NS	no show
N&V	nausea and vomiting

O	
O2	oxygen
OB	obstetrics
o.d.	right eye
o.m.	every morning
OP	Out patient
o.s.	left eye
OSHPD	Office of Statewide Health Planning & Develop.
OSDS	Other Service Delivery Staff
OT	Occupational Therapy
ov	office visit
oz.	ounce

P	
p⁻	After [letter p with a bar over it]
p.c.	after eating
PCP	Primary Care Physician
pcp	drug
P/D	Personality Disorder
PD	Police Department
PDR	Physician Desk Reference

Section 16: Approved Abbreviations/Acronym Dictionary

PE	physical exam
PERRLA	pupils, equal, round & reactive to light and
Ph.D.	Doctor of Psychology
PsyD	Doctor of Psychology
PHF	Psychiatric Health Facility
PHN	Public Health Nurse
p.m.	noon - midnight
PMD	Primary Care Doctor
PMH	past medical history
p.o.	by mouth
P.O.	Probation Officer
POM	Performance Outcome Measures
PPD	purified protein derivative(TB test)
Prep.	preparation (for)
prn	as needed
Psych	Psychology
Psy tech/ Psych tech	Psychiatric Technician
y	Psychiatrist
pt.	patient
PTA	prior to admission
p/t	part time
PTSD	Post-Traumatic Stress Disorder
Pub Guard/PG	Public Guardian
Px	prognosis

Section 16: Approved Abbreviations/Acronym Dictionary

Q	
Q or ?	question
q 2 hr	every 2 hrs
q 3 hr	every 3 hrs
QA	Quality Assurance
qam	every morning
qd	every day
qh	every hour
QI	Quality Improvement
q.i.d.	four times daily
QM	Quality Management
QMPH	Quality Medical Health Professional
qod	every other day
q.q.h.	every 4 hours
qn	every night
q.s.	quantity sufficient/as much as required
qw	every week
PI	Paranoid ideation

R	
R:	response
RDA	recommended daily allowance
Re:	with regard to
rec	recommendations
ref	referral
Rehab	rehabilitation
REM	rapid eye movement
RLE	right lower extremity

Section 16: Approved Abbreviations/Acronym Dictionary

RLQ	right lower quadrant
rm	room
RN	Registered Nurse
R/O	rule out
RoI, ROI	release of information
RS	reschedule
Rt, rt.	right
RT	Recreation Therapy
RTC	return to clinic
RTW	return to work
RUE	right upper extremity
RUQ	right upper quadrant
Rx	therapy or prescription

S	
sis	sister
S+S	signs and symptoms
S/A	suicide attempts
satis.	satisfactory
Schiz.	Schizophrenia
S/D	Short Doyle
SD/MC, SDMC	Short Doyle / Medi-Cal
SED	severely emotionally disturbed
SI	suicide ideation
sib	sibling(s)
Sig.	signature; to write
sil	sister-in-law
sm	small

Section 16: Approved Abbreviations/Acronym Dictionary

SNF	Skilled Nursing Facility
SO	significant other
SOB	sobriety maintenance
S.S.; Soc. Sec.	Social Security
spec.	specimen
S & R	Seclusion & Restraint
SSI	Social Security Income
STAT	immediately
SQ	subcutaneous
SUD	Substance Use Disorder
s/v	school visit
sx	symptom(s)
sz	seizures

T	
Ⓣ	treatment (circled)
TAR	treatment authorization request
TBS	Therapeutic Behavioral Services
Tbs.	tablespoon
T/Con	temporary conservatorship
Temp	temperature
t.i.d.	three times a day
Th	therapist
T.O.	telephone orders
TPR	temperature, pulse, respiration
tsp	teaspoon
TSH	thyroid stimulating hormone
Tx., tx.	treatment

Section 16: Approved Abbreviations/Acronym Dictionary

U	
U/A	urinalysis
Unauth.	unauthorized
unk.	unknown

V	
VD	Venereal Disease
VH, V/H	visual hallucination (s)
V.O.	verbal orders
VOC; voc	vocational
Vol	volunteer
vol	volume
V.S.	vital signs
vs.	versus

W, X, Y & Z	
W	wife
w/	with
w/d	withdrawal/withdrew
w/in	within
w/out-w/o	without
WAIS-R	Wechsler Adult Intelligence
WD, WN	well developed, well nourished
wk.	week
WNL	within normal limits
wt.	weight
x	times
y.o, y/o	year(s) old
Yr	year

YOUTH SERVICES AUTHORIZATIONS

AUTHORIZATION PROCESS

All specialty mental health services will be authorized for organizational providers using the BCDBH Managed care Authorization Form (MCA) Form. Most services are authorized for a period of one year. BCDBH QMAC is the main point of authorization for services performed by contract providers.

It is the responsibility of the Clinical Coordinator (CC) to complete the MCA for services performed by contract providers. The MCA and the required supplemental documentation must be reviewed and approved by the Clinical Supervisor or Program Manager of the clinic site.

Completed MCAs and the required supplemental documentation (as listed below) will be submitted to BCDBH QMAC for authorization through fax, email or inter-office mail. When QMAC authorizes services, the treatment plan is reviewed to make certain the plan allows for these services to be billed.

Determination of Eligibility

Each service authorization guarantees the full-scope Medi-Cal beneficiary eligibility only for the date the authorization was given. It does not guarantee ongoing Medi-Cal eligibility. It is the clinic's responsibility to ensure that services are provided to eligible full-scope Medi-Cal beneficiaries.

BCDBH has implemented a county-wide standardization with completing MCAs. All BCDBH Clinical staff and contract providers are expected to adhere to standards listed below.

MCA Completion Standards (how to complete the MCA)

When completing the MCA please include the following:

Clinical rationale for services requested. Describe specific medical necessity related to the Diagnosis: (One MCA per service authorized—e.g. WRAP has different rationale than Medication Support)

- Diagnosis (based on what symptoms?)
- Functional Impairment that will be worked on with this treatment
- Why is this service needed?
- What specifically would you like to see happen? (i.e. treatment goals)
- Was Treatment Plan included? (If so, was service written into care plan?)

MCA-Annual Rationale for Services:

Clinical rationale for services requested. Describe specific Medical Necessity related to the Diagnosis and Program: (One MCA per service authorized—e.g. WRAP has a different rationale than Med Support)

The **GOLDEN THREAD**:

- A. Diagnosis (based on current/maintained symptoms)?
- B. What Functional Impairment/behavior was the focus of treatment?
- C. Progress toward treatment goal(s) this service ameliorated (improved, lessened, supported, risk of deterioration if services ceased)
- D. Clinical reason for continued treatment and/or any changes in treatment approach to support success?
- E. Has the Client/Family has agreed to this continued service?
- F. Is there a termination/transition plan for this service?

Clinical documentation should be included as it provides the support for the clinical rationale.

Adjunctive Services

BCDBH considers adjunctive services to be any requests for additional therapeutic services in “adjunction” with clients’ currently provided Specialty Mental Health Services.

The Treatment Plan must identify what modality (billing code) will be used for this service. If the Treatment Plan already has this billing code included for the specific functional impairment, an update would not be necessary.

- Individual Therapy or Individual/Family Therapy
- Rehabilitation Services
- Brokerage/Targeted Case Management
- Plan Development
- Collateral
- Group Rehabilitation

Request for New Services (MCA Referral)

The case is already open and adjunctive services are needed. All paperwork for opening a client is required.

A Managed Care Authorization (MCA) for **each** service requested with Clinical Rationale for the specific service requested and functional impairment that will be addressed.

Section 17: Youth Service Authorizations

The following documents are required to be submitted with the Referral MCA:

- Medical Necessary Determination
- Initial Assessment
- Treatment Plan (Include intervention for adjunct service)
- Diagnosis with valid Signature
- MH Admission Packet
- Payor Financial Information (PFI)
- CANS (most current)
- Informed Consent for Services which should include (or documented individually):
 - Acknowledgement of Receipt of Guide to Medi-Cal Mental Health Services
 - Acknowledgement of Receipt of Privacy Practices
 - Acknowledgement of Receipt of BCDBH Provider List
- Authorization for Use and Disclosure of PHI
 - Release of information for all parties involved

12-Month Re-Authorization (ANNUAL)

Managed Care Authorization (MCA) for each service requested with Clinical Rationale for the specific service requested and functional impairment that will be addressed on the treatment plan (and progress for each objective on Client Plan).

The following documents are required to be submitted with the 12-month re-authorization MCAs:

The following documentation must be fully completed:

- Medical Necessary Determination
- Initial Assessment
- Treatment Plan (Include intervention for adjunct service)
- Diagnosis with valid Signature
- MH Admission Packet
- Payor Financial Information (PFI)
- CANS (most current)
- Informed Consent for Services which should include (or documented individually):
 - Acknowledgement of Receipt of Guide to Medi-Cal Mental Health Services
 - Acknowledgement of Receipt of Privacy Practices
 - Acknowledgement of Receipt of BCDBH Provider List
- Authorization for Use and Disclosure of PHI
 - Release of information for all parties involved

Section 17: Youth Service Authorizations

For the MCA and templates/examples, see [Appendix F – Managed Care Authorizations](#)

For Agency Resource help see [Appendix G – Contract Agency Resources](#)

DOCUMENTATION FAQs

SCOPE OF PRACTICE

1. **Who can formulate a diagnosis?**

Formulation of a diagnosis requires a provider, working within his/her scope of practice, to be licensed, waived and/or under the direction of a licensed provider in accordance with California State law. Diagnosis is in the scope of practice for the following provider types:

- (A) Physicians;
- (B) Psychologists;
- (C) Licensed Clinical Social Workers;
- (D) Licensed Professional Clinical Counselors;
- (E) Licensed Marriage and Family Therapists; and,
- (F) Advanced Practice Nurses, in accordance with the Board of Registered Nursing.

2. **Can a non-LMHP complete parts of the assessment? Can a diagnosis made by an LMHP be added to an assessment performed by a non-LMHP with a reference note, “as diagnosed by...”?**

The diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary’s physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, waived, and/or under the direction of a LMHP.

However, the MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary’s mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (Cal. Code Regs., tit.9, § 1840.344; State Plan, Section 3, Supplement 3 to Attachment 3.1-A, pg. 2m-p). At BCDBH, the only time an assessment can be completed by anyone other than a clinician is in our crisis services, however, an LPHA must diagnose.

ASSESSMENT

3. What is a “One Shot”?

A “One Shot” is when a client is seen one time, usually for an assessment. It is a “One Shot” because it is clear by the conclusion of the initial service that the client will not be returning for further services. Yes, It is billable.

4. Can a beneficiary’s diagnosis determined during a recent inpatient stay be used as the diagnosis for an outpatient assessment?

The assessment, which includes diagnosis, is designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. The status of the beneficiary’s mental, emotional, or behavioral health may change as a beneficiary transitions from inpatient to outpatient services. As such, the MHP and its providers should not rely on an inpatient diagnosis when performing an assessment for outpatient services. However, the outpatient provider should review the inpatient assessment documentation to inform the outpatient assessment and verify that the diagnosis reflects the beneficiary’s current mental, emotional, or behavioral health status.

5. Can “By history”, “Rule out”, or “Provisional” diagnoses be used in meeting Medical Necessity?

“By history”, “Rule Out” and “Provisional” diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a beneficiary may have a “by history”, “rule out”, or “provisional” diagnosis as long as there is also at least one included diagnosis.

For Psychiatric Inpatient Hospital Services, a beneficiary must have one of the included diagnoses listed and meet the other medical necessity criteria in California Code of Regulations, title 9, section 1820.205.

For outpatient SMHS, a beneficiary must have one of the included diagnoses listed and meet the other medical necessity criteria in California Code of Regulations, title 9, sections 1830.205 or 1830.210.

6. If a beneficiary receives services from LMHPs in different programs, can the diagnosis made by an LMHP in one program be used in the other program(s), or must each program independently diagnose the beneficiary?

The diagnosis of a beneficiary may be used by multiple providers if the diagnosis reflects the current status of the beneficiary's mental, emotional, or behavioral health.

A re-assessment may be required when a client has experienced a significant medical or clinical change, or where a significant amount of time has elapsed since a prior assessment and diagnosis. Determination of whether and when a re-assessment and diagnosis are necessary depends on the MHP's policies and guidelines and on the community standard of care. The interventions applied by each provider must be appropriate to address the beneficiary's included diagnosis and associated functional impairments. Best practices would indicate that a re-assessment should be done on at least an annual basis or when there is a significant change in the beneficiary's condition.

TREATMENT PLAN

7. When is a treatment plan effective?

A Treatment plan is effective once it has been signed (and co-signed, if required) and dated by the required staff member(s). (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(1)).

At BCDBH, the treatment plan is finalized and becomes valid the date the LPHA signs the plan. The plan is only valid for the date of the LPHA signature +364 days.

8. Is there a minimum age for a minor (under 18 y/o) to independently sign his/her treatment plan?

There is no minimum age for a minor to independently sign a treatment plan, assuming the treatment plan is not used to obtain the minor's consent to treatment. The treatment plan is a collaborative process between the beneficiary and the provider. The beneficiary should understand what they are signing based on their participation in that process.

9. What if a beneficiary refuses to sign their treatment plan?

Each time a beneficiary's signature or the signature of the beneficiary's legal representative is required on a treatment plan or an updated treatment plan "and the beneficiary refuses or is unavailable for signature, the treatment plan [or updated plan]

Appendix A: Frequently Asked Questions

shall include a written explanation of the refusal or unavailability.” The written explanation may be on the plan itself or in a progress note. Although not required, it is best practice to make additional attempts to obtain the beneficiary’s signature and document the attempts in the client record. (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(2)(B))

At BCDBH, we have a line on our treatment plans that states “see progress note dated” in which the clinician shall enter the date the client was offered the ability to sign his or her treatment plan. The progress note shall include the reasons the client did not sign the plan and a continued effort shall be made to attempt to obtain the signature of the client. If there is no documented attempts to try and obtain the client signature, the plan may be subject to disallowance along with any services provided under the time frame of that plan.

10. What is the difference between a “proposed intervention” on a treatment plan and an “actual intervention”?

Proposed interventions are the services a provider anticipates delivering to a beneficiary when preparing the beneficiary’s treatment plan. MHPs are required to ensure that treatment plans “identify the proposed type(s) of intervention/modality...to be provided” to the beneficiary. The actual interventions are those that are actually delivered to a beneficiary. The actual interventions are documented in progress notes.

SERVICES PRIOR TO A TREATMENT PLAN BEING IN PLACE

11. What services will be disallowed if, at the time the services were provided, the beneficiary being treated did not have an approved treatment plan?

The State Plan requires SMHS to be provided based on medical necessity criteria, in accordance with an individualized treatment plan, and approved and authorized according to State of California requirements. An approved treatment plan must be in place prior to service delivery for the following SMHS:

- a. Mental Health Services (except assessment, plan development)
- b. Intensive Home Based Services (IHBS)
- c. Specific component of TCM and ICC: Monitoring and follow up activities to ensure the beneficiary’s treatment plan is being implemented and that it adequately addresses the beneficiary’s individual needs
- d. Therapeutic Behavioral Services (TBS)

Appendix A: Frequently Asked Questions

- e. Day Treatment Intensive
 - f. Day Rehabilitation
 - g. Adult Residential Treatment Services
 - h. Crisis Residential Treatment Services
 - i. Medication Support (non-emergency)
 - j. Psychiatric Health Facility Services (Cal. Code Regs., tit. 22, § 77073.)
 - k. Psychiatric Inpatient Services (Code Fed. Regs., tit. 42, § 456.180(a); Cal. Code Regs tit. 9 §§ 1820.230 (b), 1820.220 (l)(i))
- 12. What services are reimbursable during the time that there is a “gap” between treatment plans?**

A “gap” between treatment plans results when a treatment plan has expired and there is an amount of time that passes before the updated treatment plan is in effect. When there is a gap between treatment plans those services that can be provided prior to a treatment plan being approved can be provided and are reimbursable. However, services provided in the “gap” that are services that cannot be provided prior to a treatment plan being in effect are not reimbursable and will be disallowed.

For TCM, ICC, and Medication Support Services provided prior to a treatment plan being in place, the progress notes must clearly reflect that the service activity provided was a component of a service that is reimbursable prior to an approved treatment plan being in place, and not a component of a service that cannot be provided prior to an approved treatment plan being in place.

PROGRESS NOTES

- 13. Can I have an example of the correct way to bill for plan development session for contact between two/three BH staff members that are both associated w/the client’s care?**

D) Met with SEARCH Behavioral Health Counselor, Sally Jones and Dr. Jones, client's psychiatrist to identify steps the team could take to assist client in staying out of the PHF as he seems to be show increased aggression.

I) BHC discussed concerns of recent visits with client have been met with resistance from client opening the door and on the few occasions he has allowed her to come in, his appearance and the condition of his home have significantly deteriorated. Discussed

Appendix A: Frequently Asked Questions

client missing multiple appointments and hasn't attended the social groups. Dr. Jones discussed client's resistance to taking medications that may be helpful; however, there are other medications that can be tried.

*T) Plan is to go meet with client to address current concerns and reasons for attending individual and group appointments. Will also let client know that Dr. Jones is willing to meet with client to discuss his concerns about medication. Note was written concurrently and each staff participated for the full amount of time. *NOTE (R) No response is needed as client was not present.*

14. What are the main reasons for recoupment of a progress note?

The primary reasons for recoupment or the need to 'void' progress notes:

1. Documentation does not establish the expectation that the proposed intervention will:
 - a) Significantly diminish the impairment;
 - b) Prevent significant deterioration in an important area of life functioning;
 - c) Allow the child to progress developmentally as individually appropriate; or
 - d) For full-scope Medi-Cal beneficiaries under the age of 21 years, correct or ameliorate the condition.
2. No progress note/wrong billing code used
3. No documentation of the beneficiary's participation in and agreement with the treatment plan
4. Treatment plan is expired
5. Annual Assessment is expired
6. Progress note does not demonstrate a medically necessary services was provided (i.e. note is clerical in nature)
7. Progress note appears to be cloned from another chart, or from a previous week of service. Using "templates" or cookie cutter notes are often red flags to auditors and may lead to disallowances and/or to investigation of documentation practices. BCDBH prohibits cloning or cut and pasted notes.

Also, progress note indicates that the service provided was solely for the purpose of:

- a. Academic educational service
- b. Vocational service that has work or work training as its actual purpose
- c. Recreation or Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors
- d. Transportation
- e. Clerical
- f. Payee Related

- 15. Should a clinician repeat the medical necessity statement on each and every progress note? Not the description of the client's current continued needs, but a repeat of the one in the original assessment paperwork.**

Repeated phrases often look very 'cookie cutter' and so can count against us as not being 'individualized.' A progress note should occasionally include a description of the ongoing reason for treatment - which should look something like the medical necessity. It must be descriptive enough to capture specific individualized information regarding how the intervention reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the treatment plan, and the beneficiary's response to the intervention.

LOCATION OF SERVICES

- 16. Can a provider claim Medi-Cal reimbursement for services provided in a vehicle or while the provider is driving if the intervention is therapeutic, included in the treatment plan, benefits the client, and documentation meets progress note requirements?**

These services may be claimed as long as the medical necessity criteria are met for the provision of SMHS, the intervention is on the treatment plan when a treatment plan is required, and all progress note requirements are met.

It is not necessary to document the reason for providing services in a location other than a clinic setting, e.g., at a beneficiary's home, in a park setting, in a vehicle. Services should be provided in the least restrictive setting.

CASE CONFERENCES

- 17. What is the definition of "case conference"? Can a provider bill Medi-Cal for time in a case conference?**

Although the term "case conference" is not specifically defined in the State Plan, MHP contract, or applicable regulations, it may refer to a discussion between direct service providers and other significant support persons or entities involved in the care of the beneficiary. It may be similar or comparable to a multi-disciplinary team meeting. If the case conference concerns the development of a treatment plan for a beneficiary, the conference could be claimed as Plan Development. Similarly, if the term refers to a discussion between multiple providers concerning the assessment of a beneficiary, the conference could be claimed as Assessment. If the discussion between multiple

Appendix A: Frequently Asked Questions

providers concerns coordination of services and linkage or referrals, etc., the conference could be claimed as TCM. (See question #13)

Individual participants claiming for their participation in these types of services (e.g., plan development, assessment, or TCM) must describe their role and involvement in the service. Any participation time claimed, which may include active listening time, must be supported by documentation showing what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the treatment plan).

CLAIMING FOR SERVICE FUNCTIONS BASED ON MINUTES OF TIME

18. Which services are billed based on minutes of time? What requirements apply to claims for those services?

For the following services, the billing unit is the time of the person delivering the service in minutes of time:

- (1) Mental Health Services
- (2) Medication Support Services
- (3) Crisis Intervention
- (4) Targeted Case Management
- (5) Therapeutic Behavioral Services (TBS)
- (6) Intensive Care Coordination (ICC)
- (7) Intensive Home Based Services (IHBS)

The following requirements apply for claiming of services based on minutes of time:

- (1) The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one-hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.
- (2) When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield

Appendix A: Frequently Asked Questions

the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

- (3) The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity. (Cal. Code Regs., tit. 9 §1840.316)

For example:

- a. A Licensed Clinical Social Worker (LCSW) provides individual therapy (mental health services) in the Medi-Cal office to a beneficiary for 45 minutes. She spends 12 minutes following the therapy session documenting the interventions provided in a progress note that demonstrates that the interventions address the beneficiary's diagnosis, impairments, and client goals as indicated in the treatment plan. This documentation time is reimbursable as mental health services. The total time for this service would be 57 minutes (45 for the individual therapy plus 12 minutes for the related documentation).
- b. An LCSW drives 23 minutes from the MHP clinic or a contract provider site to a beneficiary's home to provide individual therapy (mental health services) for 48 minutes to a beneficiary. Following the intervention, the clinician drives 24 minutes back to the clinic and spends 13 minutes documenting the intervention provided in a progress note in the beneficiary's client record. The travel and documentation time are reimbursable as they are directly linked to providing the mental health service. (i.e.: 48-minute session, plus 47 minutes of travel time, plus 13 minutes of documentation time for a total of 108 minutes).
- c. A clinician or other staff member drives 15 minutes from their primary office to a beneficiary's school to provide 50 minutes of collateral services (mental health services) to a parent and teacher. Following the intervention, the Marriage and Family Therapist Intern (MFTI) travels 30 minutes to their next community based client. At the end of the day, the MFTI spends 16 minutes documenting the collateral intervention to the client's significant support persons (collateral resources). The travel time to the school (15 minutes), the 50-minute session and the 16-minute documentation time can be claimed as a collateral service to the first beneficiary for a total of 81 minutes. The 30-minute travel time to the next community-based client would be included in the claim for the service provided to the next beneficiary, including travel time back to the office and documentation time.

- 19. Should the amount of time a provider claims for performing an assessment of a beneficiary be estimated? For example, if a provider conducts a face-to-face assessment of a beneficiary, but does not prepare the written assessment until a later day, should the provider estimate the time it would take to write the assessment and include it in the time claimed for the face-to-face assessment?**

Providers should not estimate the amount of time they spend assessing a beneficiary. Time performing an assessment can either be claimed piece by piece or the time can be totaled and submitted as one claim (e.g., separate claims can be submitted for conducting the face-to-face assessment; for reviewing the beneficiary's records to obtain history, and for writing up the assessment; or, a single claim can be submitted detailing all of these activities).

CLAIMING FOR GROUP THERAPY

- 20. How should providers bill for Group Therapy sessions?**

In the past, DHCS allowed for multiple staff to claim for services provided in group in one note, however recent changes in Information Notice 18-002 changed the ability to capture more than one provider in each note. Therefore, if more than one facilitator leads a group, each must write a note to capture his or her time providing services. When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of the mental health needs of the client. The progress note should include the total number of group participants (Medi-Cal and non-Medi-Cal participants) and clearly indicate length of group session with documentation time included (or documentation time clearly recorded separately). In addition, when multiple providers render a covered service to more than one participant, the total number of minutes of the session must be distributed evenly among the group participants (regardless of payer source), and prorated among the providers at the group session." (Cal. Code Regs., Tit. 9 § 1840.314(c); Medi-Cal Billing Manual Chapter 7, section 7.5.5)

EXAMPLE:

Each staff leading the group writes a progress note on every client in the group, indicates the total number of clients in the group and the service time should match the time that specific client spent in that group (start/end time). Each staff will also bill for their documentation time for each of those client notes.

CLAIMING FOR TRAVEL TIME

21. Is travel time reimbursable?

The time required for documentation and travel is reimbursable when the documentation or travel is a component of the reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity, as follows:

- Travel time from a provider site to an off-site location(s) where Medi-Cal SMHS are delivered is claimable. The travel time must be directly linked or related to the services provided which should be clearly documented in the progress note. In addition, the amounts of travel time and service time should each be reflected in the progress note.
- Travel time between provider sites or from a staff member's residence to a provider site may not be claimed. (A "provider site" is defined as a site with a provider number. This includes affiliated satellite sites and school sites.)
- Travel time between a staff's home and a beneficiary's home may be claimed as long as the MHP permits such activity and MHP travel guidelines are followed. (Cal. Code Regs., tit. 9, § 1840.316(b)(3); Medi-Cal Billing Manual)

CLAIMING FOR CHART REVIEW

22. Is time spent reviewing a beneficiary's chart reimbursable? For which SMHS and under what circumstances is it reimbursable?

Record review is reimbursable when performed as part of the following direct services and service activities:

- Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
- Targeted Case Management
- Medication Support Services, and
- Crisis Intervention

(NOTE: If on the progress note the provider documents that they conducted chart review in preparation for a service and documents that the client was a no-show for the service, the time spent to review the chart in preparation for the client's appointment is reimbursable as plan development. –FY1718-Reasons for recoupment)

- 23. If a provider reviews a beneficiary's chart, in preparation for a session with a beneficiary, and the beneficiary no-shows, is the time for chart review claimable? If so, can the provider submit a subsequent claim for chart review in preparation of the beneficiary's next appointment?**

Yes, as long as the provider documents the circumstances of the beneficiary no-show, the time spent to review the chart in preparation for the beneficiary's appointment is reimbursable. The provider may submit another claim for chart review prior to the beneficiary's next appointment, as long as the time claimed is reasonable and in preparation for the beneficiary's appointment.

Consecutive no shows is a sign that the client may not be engaging in treatment as anticipated. Multiple chart reviews billings when the client is not engaging in treatment are subject to disallowance.

If this occurs, the client should be contacted and the treatment plan adapted if client is no longer able to participate in care as originally determined in the treatment planning process.

MODALITIES ON Tx PLAN VS. CLINICAL/THERAPEUTIC MODALITIES

- 24. Why are we required to put modalities on treatment plans as service codes and not the type of therapy that will be used?**

DHCS requires that the service type/modality (individual therapy, targeted case management, rehab) to be used as an intervention to treat the client's functional impairment be listed on every treatment plan. Many clinicians are familiar with the definition of "modality" as being the type of therapeutic technique or procedure such as: Cognitive Behavioral Therapy, Brief Solution Focused Therapy, Dialectical Behavioral Therapy, etc. However, in working with Medi-Cal regulation and treatment plans, the "service type/modality" must be included as the means of the intervention. BCDBH QMAC encourages the use of best practice methods in treatment too, but the only required modality per the Medi-Cal regulations is the service code or billing type on each intervention

Legal/Minor Consent Frequently Asked Questions

Q. What is minor consent for mental health service?

A. California has two laws that allow youth who are ages 12 and older to consent to certain types of treatment. Please reference the law for what type of mental health, Medi-Cal and or substance abuse treatment is allowed per minor consent. Neither of these laws authorize minors to consent to inpatient psychiatric care, convulsive therapy, psychosurgery, or psychotropic medications; parents or guardians must consent to those types of treatment.

- 1.) Family Code § 6924: “A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied:
 - a. The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services.
 - b. AND the minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse.”
- 2.) Health & Safety Code § 124260 became effective January 1, 2011 and states “[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services.”

Q. What are some online resources to learn more about California’s Minor Consent laws?

- http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=FAM§ionNum=6924.
- http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=124260.
- www.teenhealthlaw.org,
- <http://www.teenhealthlaw.org/fileadmin/teenhealth/teenhealthrights/ca/CaMCCConfMentalHealthChart12-10.pdf>

Q. Why are there two laws? What is the difference between the two laws?

A. Family Code § 6924 was created to allow vulnerable youth to consent to their own treatment in situations in which guardians refused or were unable to consent for services, or in which seeking consent from a youths' guardian would place the child in potential danger. The law was enacted to help reduce incidences of suicide, homicide, and youth being unable to access services due to their age and inability to consent to treatment.

Health & Safety Code § 124260 was created after many professionals reported that while the Family Code § 6924 was helpful, the second criteria in Family Code § 6924 was too restrictive. Professionals argued that many youth would not immediately report to health care professionals that they were in danger of serious physical or mental harm or were victims of incest or child abuse. Professionals argued that time was needed to build rapport with clients and to properly assess them and determine their needs. As a result, this H&S Code was adopted and allows health professionals to see children 12 and older if it is determined that they are mature enough to participate intelligently in treatment.

Q. May I provide services to youth 12 and older that meets either minor consent criteria?

A. Ethically and legally you may as long as you document how and why it is appropriate to do so in the client's record and if you document in your professional opinion that the child is mature enough to participate intelligently in mental health treatment. Care and caution must be taken in determining which minor consent law will be used. Both have advantages and drawbacks. Both Family Code 6924 and Health and Safety Code 124260 REQUIRE that the parent or guardian be "involved" in the mental health treatment or counseling UNLESS it would be inappropriate, and there must be charting explaining whether and when the therapist attempted to contact the parent or guardian, whether the attempt to contact the parent or guardian was or was not successful, or why the therapist chose not to attempt to contact the parent or guardian.

Q. Are there any financial limitations for providing services under minor consent Medi-Cal?

A. Yes. The least restrictive H&S Code § 124260 law has a provision that states, "this bill would provide that the above mental health services will not apply to the receipt of benefits under the Medi-Cal program." Because of this, providers are not able to bill Medi-Cal if the client only meets criteria for H&S Code §124260 minor consent. If services are provided pursuant to H&S 124260, NO Medi-Cal billing should be done at all.

Appendix A: Frequently Asked Questions

The more restrictive Family Code §6924 does not have funding restrictions and Medi-Cal can be billed. If the provider intends to bill the parent's Medi-Cal account, written authorization must first be obtained from the minor so that there is no confidentiality breach. If the minor does not want the parent's Medi-Cal account billed, then the minor should be enrolled in "minor consent Medi-Cal" and any billing would be to the minor's own account. NOTE: for minor consent services the child gets "minor consent Medi-Cal " (their own separate coverage) and nothing is ever sent to their home address (minor consent Medi-Cal does not ask for their address); also, if child does not get their own Medi-Cal staff should direct them to myhealthmyinfo.org so that they can instruct Medi-Cal to NOT send anything to their home and to instead direct all mail to them at an alternative address or by alternative means.

Q. Will billing Medi-Cal for mental health services cause a client's guardian(s) to find out that the minor is in treatment?

A. Possibly. Because Medi-Cal is insurance, bills/summaries of services received by someone other than the primary insured, on the primary insured's account may be sent to the primary insured's address of residence. This is done in part to reduce waste, abuse, and fraud. For this reason it is essential that one of the following happen:

- 1) The minor's written authorization be obtained allowing billing their parent's Medi-Cal account, or
- 2) The minor be directed to myhealthmyinfo.org and be assisted in directing Medi-Cal to send nothing to the parent's address, or
- 3) The minor be enrolled in "Minor Consent Medi-Cal" and his/her own Medi-Cal number be billed, or
- 4) Alternative arrangements are made to assure confidentiality.

A client's parent could learn that a client is in treatment by reading such correspondence if the steps outlined above are not taken. BCDBH does not send correspondence to minors receiving mental health treatment, however we cannot guarantee that other parts of the Medi-Cal system follow these same policies. Additionally, a minor's guardian could contact Medi-Cal and inquire about claims made to their dependents. However, they are not entitled to access records of the treatment.

Regardless of all of the precautions taken to ensure confidentiality of minors the limits of confidentiality should be discussed with clients.

Appendix A: Frequently Asked Questions

Q. Is there another way to obtain funding for seeing a minor that wants to consent to their own treatment without billing Medi-Cal?

A. Possibly. Funds allocated in your agency's contract may be used for minors consenting under H&S Code §124260. Anytime minors will be consenting under the H&S Code, Providers must request authorization from their Program Manager. Please document the following information: Beneficiary's, age, current MH diagnosis including signs and symptoms, current presentation, reason for minor consent, and risk factors (DTS, DTO, risk from others, etc.). (See PnP 308 for more information).

Q. If our agency provides services at a school site and it is difficult to get a guardian/parent (due to logistical reasons) to sign informed consent, may the youth who meets criteria for minor consent, consent to their own treatment?

A. Yes, however, involving parents in treatment is required under both laws, unless the provider deems it inappropriate. "Involvement" in treatment does not mean that the parent is asked to consent to treatment; you never need parental consent to treat the minor under Family Code 6924 or Health and Safety Code 124260—that is the point of minor consent. Only the minor provides consent to treatment. However, difficulty in contacting a minor's guardian cannot be a determining factor for choosing to see a minor under minor consent.

Q. What should we do if we obtain guardian/parental consent at a later time?

A. If the parent becomes aware of the treatment, AND consents to services being billed to their Medi-Cal account, you should inform the billing department as soon as this happens so that Medi-Cal benefits can be used instead of general funds. Note: the minor's parent/guardian is not liable for payment for mental health treatment or counseling services provided pursuant to either minor consent for outpatient mental health services law unless the parent/guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.

Legal/Minor Consent: Treatment Plans

Q. When the parent/caretaker is involved in the treatment; must the child/youth and the legal representative sign the Treatment Plan?

A: BCDBH requires the child/youth (12+) to sign the Treatment Plan.

The client signatures must be obtained as an indication of their participation in the treatment plan. (DHCS has no other way to “know” that collaboration was key to the treatment process.)

The caveat is that if you decide, based on your clinical expertise, that the client does not qualify for minor consent, i.e., is not mature enough to participate intelligently in the services, then the parent or legal guardian must consent to the treatment and sign the treatment plan.

In that case, do the following.

- On the Treatment Plan, give a date that references a Progress Note which states the reason why the minor did not qualify for minor consent services, and that the parent's Medi-Cal will be billed instead as it would for any other non-minor consent service.
- You are permitted to bill for services if you document these types of situations well.
- Until the Treatment Plan is signed, document in each and every Progress Note your intention to obtain a signature from the appropriate party and the reason why you are unable to obtain a signature from the client/legal representative.
- Lastly, if the client signature line is blank and there is no documentation in the Progress Notes as to why the Treatment Plan has not been signed, it will be considered invalid and all services under that Client Plan will be subject to disallowances.

Legal/Minor Consent: Release of Information

BCDBH Policy and Procedure 308:

V. Medi-Cal Records

- A.** The minor controls the Medi-Cal record under Minor consent for SMHS services regardless of parental/guardian involvement, provided that minor could have or did consent for services.
- B.** The minor must sign a written authorization for any Medi-Cal record release to a third party that requires authorization, including release of chart information to the parent.

Appendix A: Frequently Asked Questions

Note from QM: Confidentiality and Minor consent

California, Senate Bill (SB) 138—enacted in 2015—states that “HIPAA explicitly protects the confidentiality of medical care (including mental health treatment) obtained by dependents insured under a health insurance policy held by another person.” Whether or not a parent (or parent’s insurance) is paying for the care, the medical record belongs to the client. Note that a parent can refuse to pay and is not liable for minor consent services (except to the extent that they are involved in and are themselves receiving services), and that would make the youth a fiscal minor consent case.

If a parent has already signed consent before the minor turn 12, and they continue with treatment, it is fine to keep treating because we have implied consent from the minor who keeps showing up. However, we will need something in writing from the client when they are 12+ regarding informed consent and should get a signature as soon as possible. That said, a parent's signature is NEVER required in cases where a minor qualifies for minor consent (and in fact has no legal authority). And when it comes to the record, if the minor consented or could have consented to the treatment, Health and Safety Code 123115 says the minor alone has the right to access the record and is the only one who can release the record to third parties.

For the Release of information, it then becomes a matter of age 12 being mature enough to understand treatment. This can be very arbitrary, so BCDBH has chosen to have every youth 12+ sign any release of information to lessen confusion. With all the codes and regulation, BCDBH’s understanding is the child 12+ is the owner of the chart, thus needing a signed release of information (ROI) in order to release information—even to the parent. However, it is important to remember the “minimum necessary” rule even when you have a signed ROI. It is best practice to discuss with your client that you don’t intend on sharing all information with their parents, and what you plan on discussing with them before you disclose any information.

Side note: if a parent is in the session without a written ROI and the child is fine with it, it is implied consent for *that* time. A release of information is required for *any* time there is communication without the client (12+) present (e.g. collateral with the parent/guardian without an ROI). When these incidents are identified, a Privacy Incident Report (PIR) is required.

APPROVED DIAGNOSIS LIST

Approved Mental Health Diagnoses

Z04.9 Condition Not Found Z78.9 No Known Health Problems (medical classification only)
 R69 Diagnosis Deferred Z71 Medical condition not demonstrated

Diagnosis with specifiers not listed are billable as long as they share the same ICD 10 code

Diagnostic Code	DSM Diagnostic Description
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, W/out Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.89	Other Specified Depressive Episodes
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.240	Claustrophobia
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F40.9	Phobic Anxiety Disorder, Unspecified
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
F41.1	Generalized Anxiety Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder with Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder With Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder With Related Psychological Factors
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.8	Other Eating Disorders
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis (postpartum psychosis)
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.0	Pathological Gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania (hair pulling disorder)
F63.81	Intermittent Explosive Disorder
F63.89	Other Impulse Disorders
F63.9	Impulse Disorder, Unspecified
F64.2	Gender Identity Disorder of Childhood
F64.8	Other Gender Identity Disorders
F64.9	Gender Identity Disorder, Unspecified
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.81	Frotteurism
F65.89	Other Paraphilias
F65.9	Paraphilia, Unspecified
F68.10	Factitious Disorder Imposed on Self, Unspecified
F68.11	Factitious Disorder With Predominantly Psychological Signs and Symptoms
F68.12	Factitious Disorder With Predominantly Physical Signs and Symptoms
F68.13	Factitious Disorder With Combined Psychological and Physical Signs and Sxs
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F84.8	Other Pervasive Developmental Disorders
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactive Disorder, Other Type
F90.9	Attention Deficit/Hyperactivity Disorder, Unspecified Type
F91.0	Conduct Disorder Confined to Family Context
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Social Engagement Disorder
F94.8	Other Childhood Disorders of Social Functioning
F94.9	Childhood Disorder of Social Functioning, Unspecified
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
F98.8	Other Behavioral/Emotional Disorders With Onset in Childhood/Adolescence
F98.9	Unspecified Behavioral/Emotional Disorders w/ Onset in Childhood/Adolescence

Outpatient MH Excluded Primary Diagnostic Categories

- Autistic Spectrum Disorders
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Other conditions that may be a focus of clinical attention, except Medication-
- Induced Movement Disorders
- Mental Retardation
- Antisocial Personality Disorder

Appendix B: Approved Diagnosis List

Approved Substance Use Disorder Diagnoses

Z04.9 Condition Not Found Z78.9 No Known Health Problems (medical classification only)
R69 Diagnosis Deferred Z71 Medical condition not demonstrated

Diagnosis with specifiers not listed are billable as long as they share the same ICD 10 code

Diagnostic Code	DSM Diagnostic Description
F10.10	Alcohol use disorder, Mild
F10.129	Alcohol intoxication with mild use disorder
F10.20	Alcohol use disorder, Moderate or Severe
F10.229	Alcohol intoxication with moderate or severe use disorder
F10.239	Alcohol withdrawal without perceptual disturbances
F10.929	Alcohol intoxication without use disorder
F11.10	Opioid use disorder, Mild
F11.129	Opioid intoxication without perceptual disturbances with mild use disorder
F11.20	Opioid use disorder, Moderate or Severe
F11.229	Opioid intoxication without perceptual disturbances with moderate/severe use disorder
F11.23	Opioid withdrawal delirium
F11.23	Opioid withdrawal
F11.929	Opioid intoxication without perceptual disturbances without use disorder
F12.10	Cannabis use disorder, Mild
F12.129	Cannabis intoxication without perceptual disturbances with mild use disorder
F12.20	Cannabis use disorder, Moderate or Severe
F13.10	Sedative, hypnotic, or anxiolytic use disorder, Mild
F13.129	Sedative, hypnotic, or anxiolytic intoxication with mild use disorder
F13.20	Sedative, hypnotic, or anxiolytic use disorder, Moderate or Severe
F13.229	Sedative, hypnotic, or anxiolytic intoxication with moderate/severe use disorder
F13.239	Sedative, hypnotic, or anxiolytic withdrawal without perceptual disturbances
F13.921	Sedative, hypnotic, or anxiolytic intoxication delirium without use disorder
F13.929	Sedative, hypnotic, or anxiolytic intoxication without use disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F14.10	Cocaine use disorder, Mild
F14.129	Cocaine intoxication without perceptual disturbances with mild use disorder
F14.20	Cocaine use disorder, Moderate or Severe
F14.229	Cocaine intoxication without perceptual disturbances with moderate or severe use disorder
F14.23	Cocaine withdrawal
F14.929	Cocaine intoxication without perceptual disturbances without use disorder
F15.10	Amphetamine-type substance use disorder, Mild
F15.10	Other or unspecified stimulant use disorder, Mild
F15.129	Amphetamine or other stimulant intoxication, without perceptual disturbances, with mild use disorder
F15.20	Amphetamine-type substance use disorder, Moderate or Severe
F15.20	Other or unspecified stimulant use disorder, Moderate or Severe
F15.229	Amphetamine or other stimulant intoxication, w/out perceptual disturbances, with moderate/severe use disorder
F15.23	Amphetamine or other stimulant withdrawal
F15.90	Stimulant use disorder
F15.929	Amphetamine or other stimulant intoxication, w/out perceptual disturbances, without use disorder
F15.93	Caffeine withdrawal
F16.10	Other hallucinogen use disorder, Mild
F16.10	Phencyclidine use disorder, Mild
F16.129	Phencyclidine intoxication with mild use disorder
F16.20	Other hallucinogen use disorder, Moderate or Severe
F16.20	Phencyclidine use disorder, Moderate or Severe
F16.229	Other hallucinogen intoxication, with moderate or severe use disorder
F16.929	Phencyclidine intoxication without use disorder
F18.10	Inhalant use disorder, Mild
F18.129	Inhalant intoxication with mild use disorder
F18.20	Inhalant use disorder, Moderate or Severe
F18.229	Inhalant intoxication with moderate or severe use disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F18.929	Inhalant intoxication without use disorder
F19.10	Other (or unknown) substance use disorder, Mild
F19.129	Other (or unknown) substance intoxication, with mild use disorder
F19.20	Other (or unknown) substance use disorder, Moderate or Severe
F19.229	Other (or unknown) substance intoxication, with moderate or severe use disorder
F19.239	Other (or unknown) substance withdrawal
F19.929	Other (or unknown) substance intoxication, without use disorder

APPROVED DIAGNOSIS LIST

Approved Mental Health Diagnoses

Z04.9 Condition Not Found Z78.9 No Known Health Problems (medical classification only)
 R69 Diagnosis Deferred Z71 Medical condition not demonstrated

Diagnosis with specifiers not listed are billable as long as they share the same ICD 10 code

Diagnostic Code	DSM Diagnostic Description
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F20.9	Schizophrenia, Unspecified
F21	Schizotypal Disorder
F22	Delusional Disorder
F23	Brief Psychotic Disorder
F24	Shared Psychotic Disorder
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, Unspecified
F28	Other Psychotic Disorder Not Due to a Substance or Known Physiological Condition
F29	Unspecified Psychosis Not Due to a Substance or Known Physiological Condition
F30.10	Manic Episode Without Psychotic Symptoms, Unspecified
F30.11	Manic Episode Without Psychotic Symptoms, Mild
F30.12	Manic Episode Without Psychotic Symptoms, Moderate
F30.13	Manic Episode, Severe, Without Psychotic Symptoms

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F30.2	Manic Episode, Severe, With Psychotic Symptoms
F30.3	Manic Episode in Partial Remission
F30.8	Other Manic Episodes
F30.9	Manic Episode, Unspecified
F31.0	Bipolar Disorder, Current Episode Hypomanic
F31.12	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Moderate
F31.13	Bipolar Disorder, Current Episode Manic, Without Psychotic Features, Severe
F31.2	Bipolar Disorder, Current Episode Manic, Severe, With Psychotic Features
F31.30	Bipolar Disorder, Current Episode Depressed, Mild or Moderate Severity, Unspecified
F31.31	Bipolar Disorder, Current Episode Depressed, Mild
F31.32	Bipolar Disorder, Current Episode Depressed, Moderate
F31.4	Bipolar Disorder, Current Episode Depressed, Severe, W/out Psychotic Features
F31.5	Bipolar Disorder, Current Episode Depressed, Severe, With Psychotic Features
F31.60	Bipolar Disorder, Current Episode Mixed, Unspecified
F31.62	Bipolar Disorder, Current Episode Mixed, Moderate
F31.63	Bipolar Disorder, Current Episode Mixed, Severe, Without Psychotic Features
F31.64	Bipolar Disorder, Current Episode Mixed, Severe, With Psychotic Features
F31.71	Bipolar Disorder, in Partial Remission, Most Recent Episode Hypomanic
F31.73	Bipolar Disorder, in Partial Remission, Most Recent Episode Manic
F31.75	Bipolar Disorder, in Partial Remission, Most Recent Episode Depressed
F31.77	Bipolar Disorder, in Partial Remission, Most Recent Episode Mixed
F31.81	Bipolar II Disorder
F31.89	Other Bipolar Disorder
F31.9	Bipolar Disorder, Unspecified
F32.0	Major Depressive Disorder, Single Episode, Mild
F32.1	Major Depressive Disorder, Single Episode, Moderate
F32.2	Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F32.3	Major Depressive Disorder, Single Episode, Severe, With Psychotic Features
F32.4	Major Depressive Disorder, Single Episode, in Partial Remission
F32.89	Other Specified Depressive Episodes
F32.9	Major Depressive Disorder, Single Episode, Unspecified
F33.0	Major Depressive Disorder, Recurrent, Mild
F33.1	Major Depressive Disorder, Recurrent, Moderate
F33.2	Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
F33.3	Major Depressive Disorder, Recurrent, Severe, With Psychotic Symptoms
F33.41	Major Depressive Disorder, Recurrent, in Partial Remission
F33.8	Other Recurrent Depressive Disorders
F33.9	Major Depressive Disorder, Recurrent, Unspecified
F34.0	Cyclothymic Disorder
F34.1	Dysthymic Disorder
F34.81	Disruptive Mood Dysregulation Disorder
F34.89	Other Specified Persistent Mood Disorder
F34.9	Persistent Mood [Affective] Disorder, Unspecified
F39	Unspecified Mood [Affective] Disorder
F40.00	Agoraphobia, Unspecified
F40.02	Agoraphobia Without Panic Disorder
F40.10	Social Phobia, Unspecified
F40.11	Social Phobia, Generalized
F40.240	Claustrophobia
F40.248	Other Situational Type Phobia
F40.290	Androphobia
F40.298	Other Specified Phobia
F40.8	Other Phobic Anxiety Disorders
F40.9	Phobic Anxiety Disorder, Unspecified
F41.0	Panic Disorder [Episodic Paroxysmal Anxiety Disorder]
F41.1	Generalized Anxiety Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F41.3	Other Mixed Anxiety Disorders
F41.8	Other Specified Anxiety Disorders
F41.9	Anxiety Disorder, Unspecified
F42.2	Mixed Obsessional Thoughts and Acts
F42.3	Hoarding Disorder
F42.4	Excoriation Disorder
F42.8	Other Obsessive-Compulsive Disorder
F42.9	Obsessive-Compulsive Disorder, Unspecified
F43.0	Acute Stress Reaction
F43.10	Post-Traumatic Stress Disorder, Unspecified
F43.11	Post-Traumatic Stress Disorder, Acute
F43.12	Post-Traumatic Stress Disorder, Chronic
F43.20	Adjustment Disorder, Unspecified
F43.21	Adjustment Disorder With Depressed Mood
F43.22	Adjustment Disorder With Anxiety
F43.23	Adjustment Disorder With Mixed Anxiety and Depressed Mood
F43.24	Adjustment Disorder with Disturbance of Conduct
F43.25	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
F43.29	Adjustment Disorder With Other Symptoms
F43.8	Other Reactions to Severe Stress
F43.9	Reaction to Severe Stress, Unspecified
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.4	Conversion Disorder With Motor Symptom or Deficit
F44.5	Conversion Disorder With Seizures or Convulsions
F44.6	Conversion Disorder With Sensory Symptom or Deficit
F44.7	Conversion Disorder With Mixed Symptom Presentation
F44.81	Dissociative Identity Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F44.89	Other Dissociative and Conversion Disorders
F44.9	Dissociative and Conversion Disorder, Unspecified
F45.0	Somatization Disorder
F45.1	Undifferentiated Somatoform Disorder
F45.21	Hypochondriasis
F45.22	Body Dysmorphic Disorder
F45.29	Other Hypochondriacal Disorders
F45.41	Pain Disorder Exclusively Related to Psychological Factors
F45.42	Pain Disorder With Related Psychological Factors
F45.8	Other Somatoform Disorders
F45.9	Somatoform Disorder, Unspecified
F48.1	Depersonalization-Derealization Syndrome
F50.00	Anorexia Nervosa, Unspecified
F50.01	Anorexia Nervosa, Restricting Type
F50.02	Anorexia Nervosa, Binge Eating/Purging Type
F50.2	Bulimia Nervosa
F50.8	Other Eating Disorders
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder, Unspecified
F53.0	Postpartum Depression
F53.1	Puerperal Psychosis (postpartum psychosis)
F60.0	Paranoid Personality Disorder
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder
F60.4	Histrionic Personality Disorder
F60.5	Obsessive-Compulsive Personality Disorder
F60.6	Avoidant Personality Disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F60.7	Dependent Personality Disorder
F60.81	Narcissistic Personality Disorder
F60.9	Personality Disorder, Unspecified
F63.0	Pathological Gambling
F63.1	Pyromania
F63.2	Kleptomania
F63.3	Trichotillomania (hair pulling disorder)
F63.81	Intermittent Explosive Disorder
F63.89	Other Impulse Disorders
F63.9	Impulse Disorder, Unspecified
F64.2	Gender Identity Disorder of Childhood
F64.8	Other Gender Identity Disorders
F64.9	Gender Identity Disorder, Unspecified
F65.2	Exhibitionism
F65.3	Voyeurism
F65.4	Pedophilia
F65.81	Frotteurism
F65.89	Other Paraphilias
F65.9	Paraphilia, Unspecified
F68.10	Factitious Disorder Imposed on Self, Unspecified
F68.11	Factitious Disorder With Predominantly Psychological Signs and Symptoms
F68.12	Factitious Disorder With Predominantly Physical Signs and Symptoms
F68.13	Factitious Disorder With Combined Psychological and Physical Signs and Sxs
F68.A	Factitious Disorder Imposed on Another
F80.82	Social (Pragmatic) Communication Disorder
F80.9	Developmental Disorder of Speech and Language, Unspecified
F84.2	Rett's Syndrome
F84.3	Other Childhood Disintegrative Disorder
F84.5	Asperger's Syndrome

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F84.8	Other Pervasive Developmental Disorders
F84.9	Pervasive Developmental Disorder, Unspecified
F90.0	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
F90.1	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive Type
F90.2	Attention-Deficit/Hyperactivity Disorder, Combined Type
F90.8	Attention-Deficit/Hyperactive Disorder, Other Type
F90.9	Attention Deficit/Hyperactivity Disorder, Unspecified Type
F91.0	Conduct Disorder Confined to Family Context
F91.1	Conduct Disorder, Childhood-Onset Type
F91.2	Conduct Disorder, Adolescent-Onset Type
F91.3	Oppositional Defiant Disorder
F91.9	Conduct Disorder, Unspecified
F93.0	Separation Anxiety Disorder of Childhood
F93.8	Other Childhood Emotional Disorders
F93.9	Childhood Emotional Disorder, Unspecified
F94.0	Selective Mutism
F94.1	Reactive Attachment Disorder of Childhood
F94.2	Disinhibited Social Engagement Disorder
F94.8	Other Childhood Disorders of Social Functioning
F94.9	Childhood Disorder of Social Functioning, Unspecified
F95.0	Transient Tic Disorder
F95.1	Chronic Motor or Vocal Tic Disorder
F95.2	Tourette's Disorder
F95.8	Other Tic Disorders
F95.9	Tic Disorder, Unspecified
F98.3	Pica of Infancy and Childhood
F98.4	Stereotyped Movement Disorders
F98.8	Other Behavioral/Emotional Disorders With Onset in Childhood/Adolescence
F98.9	Unspecified Behavioral/Emotional Disorders w/ Onset in Childhood/Adolescence

Outpatient MH Excluded Primary Diagnostic Categories

- Autistic Spectrum Disorders
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Other conditions that may be a focus of clinical attention, except Medication-
- Induced Movement Disorders
- Mental Retardation
- Antisocial Personality Disorder

Appendix B: Approved Diagnosis List

Approved Substance Use Disorder Diagnoses

Z04.9 Condition Not Found Z78.9 No Known Health Problems (medical classification only)
 R69 Diagnosis Deferred Z71 Medical condition not demonstrated

Diagnosis with specifiers not listed are billable as long as they share the same ICD 10 code

Diagnostic Code	DSM Diagnostic Description
F10.10	Alcohol use disorder, Mild
F10.129	Alcohol intoxication with mild use disorder
F10.20	Alcohol use disorder, Moderate or Severe
F10.229	Alcohol intoxication with moderate or severe use disorder
F10.239	Alcohol withdrawal without perceptual disturbances
F10.929	Alcohol intoxication without use disorder
F11.10	Opioid use disorder, Mild
F11.129	Opioid intoxication without perceptual disturbances with mild use disorder
F11.20	Opioid use disorder, Moderate or Severe
F11.229	Opioid intoxication without perceptual disturbances with moderate/severe use disorder
F11.23	Opioid withdrawal delirium
F11.23	Opioid withdrawal
F11.929	Opioid intoxication without perceptual disturbances without use disorder
F12.10	Cannabis use disorder, Mild
F12.129	Cannabis intoxication without perceptual disturbances with mild use disorder
F12.20	Cannabis use disorder, Moderate or Severe
F13.10	Sedative, hypnotic, or anxiolytic use disorder, Mild
F13.129	Sedative, hypnotic, or anxiolytic intoxication with mild use disorder
F13.20	Sedative, hypnotic, or anxiolytic use disorder, Moderate or Severe
F13.229	Sedative, hypnotic, or anxiolytic intoxication with moderate/severe use disorder
F13.239	Sedative, hypnotic, or anxiolytic withdrawal without perceptual disturbances
F13.921	Sedative, hypnotic, or anxiolytic intoxication delirium without use disorder
F13.929	Sedative, hypnotic, or anxiolytic intoxication without use disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F14.10	Cocaine use disorder, Mild
F14.129	Cocaine intoxication without perceptual disturbances with mild use disorder
F14.20	Cocaine use disorder, Moderate or Severe
F14.229	Cocaine intoxication without perceptual disturbances with moderate or severe use disorder
F14.23	Cocaine withdrawal
F14.929	Cocaine intoxication without perceptual disturbances without use disorder
F15.10	Amphetamine-type substance use disorder, Mild
F15.10	Other or unspecified stimulant use disorder, Mild
F15.129	Amphetamine or other stimulant intoxication, without perceptual disturbances, with mild use disorder
F15.20	Amphetamine-type substance use disorder, Moderate or Severe
F15.20	Other or unspecified stimulant use disorder, Moderate or Severe
F15.229	Amphetamine or other stimulant intoxication, w/out perceptual disturbances, with moderate/severe use disorder
F15.23	Amphetamine or other stimulant withdrawal
F15.90	Stimulant use disorder
F15.929	Amphetamine or other stimulant intoxication, w/out perceptual disturbances, without use disorder
F15.93	Caffeine withdrawal
F16.10	Other hallucinogen use disorder, Mild
F16.10	Phencyclidine use disorder, Mild
F16.129	Phencyclidine intoxication with mild use disorder
F16.20	Other hallucinogen use disorder, Moderate or Severe
F16.20	Phencyclidine use disorder, Moderate or Severe
F16.229	Other hallucinogen intoxication, with moderate or severe use disorder
F16.929	Phencyclidine intoxication without use disorder
F18.10	Inhalant use disorder, Mild
F18.129	Inhalant intoxication with mild use disorder
F18.20	Inhalant use disorder, Moderate or Severe
F18.229	Inhalant intoxication with moderate or severe use disorder

Appendix B: Approved Diagnosis List

Diagnostic Code	DSM Diagnostic Description
F18.929	Inhalant intoxication without use disorder
F19.10	Other (or unknown) substance use disorder, Mild
F19.129	Other (or unknown) substance intoxication, with mild use disorder
F19.20	Other (or unknown) substance use disorder, Moderate or Severe
F19.229	Other (or unknown) substance intoxication, with moderate or severe use disorder
F19.239	Other (or unknown) substance withdrawal
F19.929	Other (or unknown) substance intoxication, without use disorder

FUNCTIONAL IMPAIRMENT Z-CODES

There are many Z-Codes available for use. The list below are some of the more commonly used in Behavioral Health. Here are some examples:

Key: Functional Impairment (ICD Z Code) Classification

Living Arrangements/Housing (Mental Health or Environmental)

Housing, food and clothing must be provided by or arranged for by others

Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization

- Z590: Homelessness
- Z591: Inadequate housing (e.g. unsatisfactory surroundings, not having heat, etc.)
- Z592: Discord/Problems with neighbors, lodgers, landlord
- Z594: Inadequate food/drinking water supply
- Z593: Problems related to living in residential institution
- Z599: Problems related to housing
- Z602: Problems related to living alone

Activities of Daily Living (Mental Health)

Needs assistance caring for themselves (hygiene, nutrition, health care)

Unable to care for themselves in a safe and sanitary manner

Severe disruption of daily life due to frequent thoughts of death, suicide or self-harm often with behavioral intent and/or plan

Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

- Z602: Problems related to living alone
- Z74.1 Need for assistance with personal care
- Z74.3 Need for continuous supervision

Appendix C: Functional Impairment Z-Codes

Primary Support Group (Mental Health or Environmental)

Inability to maintain (role, e.g. parental) responsibilities with reliability and follow-through

Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization

Inability to establish or maintain satisfactory relationships with peers and/or adults

Children and teens exhibit problem in their capacity for shared attention, engagement, initiation of effective two way conversations, and shared social problem solving

Pattern of disruptive behaviors such as repeated and/or unprovoked violence towards family members or caretakers

Disregard for the safety and welfare of self and family members

In children, major impairments undermine the developmental foundation of healthy functioning exhibited by:

Rarely seeking comfort in distress

Limited positive affect and excessive sadness, irritability, or fear

Disruptions of feeding and sleeping

Willingness to go with unfamiliar adults

Regression of previously learned skills

- Z60.4: Social exclusion and rejection
- Z60.5: Target of (perceived) adverse discrimination and persecution
- Z60.8: Other problems related to social environment
- Z60.9: Problem related to social environment, unspecified
- Z62.0: Inadequate parental supervision and control
- Z62.21: Child in welfare custody
- Z62.810: Personal history of physical/sexual abuse in childhood
- Z62.811: Personal history of psychological abuse in childhood
- Z62.82: Parent-child conflict
- Z62.898: Other specified problems related to upbringing
- Z63.72: Alcoholism and drug addiction in family
- Z63.79: Other stressful life events affecting family and household
- Z63.8: Other specified problems related to primary support group
- Z63.9: Problem related to primary support group, unspecified
- Z65.3: Problems related to other legal circumstances
- Z65.4: Victim of crime and terrorism

Appendix C: Functional Impairment Z-Codes

- Z65.8: Other specified problems related to psychosocial circumstances
- Z65.9: Problem related to unspecified psychosocial circumstances

Education (Mental Health or Environmental)

Performance is significant below expectations for cognitive/behavioral level

Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

Inability to pursue educational goals in a normal time frame due to failing grades, repeated absence or truancy, expulsion, suspension

- Z550: Illiteracy and low-level literacy
- Z551: Schooling unavailable and unattainable
- Z552: Failed school examinations
- Z553: Underachievement in school
- Z554: Educational maladjustment and discord with teachers and classmates
- Z558: Other problems related to education and literacy
- Z559: Problems related to education and literacy, unspecified

Financial Economical Issues (Mental Health, Substance Use, or Environmental)

Frequent termination from work

Requires structured or supervised work

Performance is significant below expectations for cognitive/behavioral level

Inability to pursue vocational goals in a normal time frame due to repeated absence or termination

Inability to secure or maintain employment at a self-sustaining level (for example inability to conform to work/school schedule, poor relationships at work/schools, hostile behaviors on the job)

- Z560: Unemployment, unspecified
- Z562: Threat of job loss
- Z562: Threat of job loss
- Z563: Stressful work schedule
- Z564: Discord with boss and workmates
- Z565: Uncongenial work environment
- Z5689: Other problems related to employment
- Z569: Unspecified problems related to employment

Appendix C: Functional Impairment Z-Codes

Access to Health Care Services (Medical)

Unable to seek care of necessary medical/dental care for serious conditions

Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

- Z758: Other problems related to medical facilities and other health care
- Z759: Unspecified problem related to medical facilities and other health care

Social Relationships/Environmental/Community (MH, SUD or Environmental)

Seriously disruptive to family and/or community

Regularly involved in assaultive behavior

Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization

Dangerous to self or others physical safety

Impairment in community functioning due to a lack of ability/reliability to maintain structured time for sustainable social/relational activities

Impairment in community functioning due to a consistent lack of age appropriate behavioral controls, decision making, judgments which result in potential need for out of home care or placement

Impairment in community functioning due to a no reliability in problem solving skills

Impairment in community functioning due to an inability to maintain safety without assistance

- Z595: Extreme poverty
- Z603: Acculturation difficulty
- Z604: Social exclusion and rejection
- Z605: Target of (perceived) adverse discrimination and persecution
- Z608: Other problems related to social environment
- Z609: Problem related to social environment, unspecified (e.g. maladjustment)
- Z620: Inadequate parental supervision and control
- Z6221: Child in welfare custody
- Z6222: Institutional upbringing
- Z6229: Other upbringing away from parents
- Z62810: Personal history of physical/sexual abuse in childhood
- Z62811: Personal history of psychological abuse in childhood

Appendix C: Functional Impairment Z-Codes

- Z6282: Parent-child conflict
- Z62898: Other specified problems related to upbringing
- Z6372: Alcoholism and drug addiction in family
- Z6379: Other stressful life events affecting family and household
- Z638: Other specified problems related to primary support group
- Z639: Problem related to primary support group, unspecified
- Z653: Problems related to other legal circumstances
- Z654: Victim of crime and terrorism
- Z658: Other specified problems related to psychosocial circumstances
- Z659: Problem related to unspecified psychosocial circumstances
- Z703: Counseling related to combined concerns regarding sexual attitude, behavior, orientation
- Z709: Sex counseling, unspecified
- Z73.4 Inadequate social skills, not elsewhere classified
- Z73.5 Social role conflict, not elsewhere classified
- Z73.6 Limitation of activities due to disability
- Z73.8 Other problems related to life management difficulty
- Z73.89 Other problems related to life management difficulty
- Z73.9 Problem related to life management difficulty, unspecified

School Situation (Mental Health or Environmental)

Frequent trouble at school

Frequently suspended from school

Performance is significant below expectations for cognitive/behavioral level

Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

Inability to pursue educational goals in a normal time frame due to failing grades, repeated absence or truancy, expulsion, suspension

- Z550: Illiteracy and low-level literacy
- Z551: Schooling unavailable and unattainable
- Z552: Failed school examinations
- Z553: Underachievement in school
- Z554: Educational maladjustment and discord with teachers and classmates
- Z558: Other problems related to education and literacy
- Z559: Problems related to education and literacy, unspecified

MANDATORY REPORTING

CHILD ABUSE REPORTING

Under the law, when the victim is a child (a person under the age of 18) and the perpetrator is any person (including a child), the Physical abuse (PC 11165.6) is defined as physical injury inflicted by other than accidental means on a child, or intentionally injuring a child. Any of these types of abuse or neglect occurring in out-of-home care must also be reported (PC 11165.5).

Child sexual abuse (PC 11165.1) includes sexual assault or sexual exploitation of anyone under the age of 18. Sexual assault includes sex acts with children, intentional masturbation in the presence of children, and child molestation. Sexual exploitation includes preparing, selling, or distributing pornographic materials involving children; performances involving obscene sexual conduct; and child prostitution (Exploitation below).

Willful cruelty or unjustified punishment (PC 11165.3) includes inflicting or permitting unjustifiable physical pain or mental suffering, or the endangerment of the child's person or health. "Mental suffering" in and of itself is not required to be reported; however, it may be reported. Penal Code 11166.05 states: "Any mandated reporter who has knowledge of or who reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way may report the known or suspected instance of child abuse or neglect to an agency specified in Section 11165.9". (The specified agencies include any police department, sheriff's department, county probation department, if designated by the county to receive mandated reports, or the county welfare department.)

Unlawful corporal punishment or injury (PC 11165.4), willfully inflicted, resulting in a traumatic condition.

Neglect (PC 11165.2) of a child, whether "severe" or "general," must also be reported if the perpetrator is a person responsible for the child's welfare. It includes both acts and omissions that harm or threaten to harm the child's health or welfare.

General neglect means the failure of a caregiver of a child to provide adequate food, clothing, shelter, medical care, or supervision, where no physical injury to the child has occurred.

Severe neglect means the intentional failure of a caregiver to provide adequate food, clothing, shelter, or medical care where injury has occurred or is likely to occur. Severe neglect also includes those situations of neglect where any person having the care or

Appendix D: Mandated Reporting

custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered.

Exploitation – 1/1/15 (AB1775) – includes a person who depicts a child in, or knowingly develops, duplicates, prints, downloads, streams, accesses through electronic or digital media, or exchanges, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct ... DOES NOT EXCLUDE SEXTING BETWEEN TEENS REGARDLESS OF WHETHER IT IS

- consensual or
- harmful

This makes sexting between teens a reportable event (child pornography). The only exception is unknowingly/accidentally opening a text message with images.

AB 3189 – Minor Consent

Family Code 6930 (added) –Minors 12 and older who state that they are injured as a result of intimate partner violence may consent to medical care related to the dx or tx of the injury and the collection of medical evidence with regard to the alleged intimate partner violence.

“Intimate Partner Violence” means:

- Intentional or reckless infliction of bodily harm,
- Perpetrated by a person with whom the minor has or has had a sexual or dating relationship.

Family Code §6930 does not apply (is not needed) when the minor is an alleged victim of rape or sexual assault because minor consent is already established by existing law:

- Family Code §6927 (rape)
- Family Code §6928 (sexual assault)

Note: All three are reportable as child abuse

WHEN DO YOU REPORT?

Child abuse must be reported when a legally mandated reporter “...has knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse or neglect...” (PC 11166[a]). “Reasonable suspicion” occurs when “it is objectively reasonable for a person to entertain such a suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse” (PC 11166[a][1]). Although wordy, the intent of this definition is clear: if you suspect, report.

Appendix D: Mandated Reporting

Reports must be made immediately, or as soon as practically possible, by phone. A written report must be forwarded within 36 hours of receiving the information regarding the incident (PC 11166[a]). The written report must be submitted on a Department of Justice form (SS 8572). If needed, forms can be printed from http://caag.state.ca.us/childabuse/pdf/ss_8572.pdf.

TO WHOM DO YOU REPORT?

The report must be made to a county welfare department, probation department (if designated by the county to receive mandated reports), or to a police or sheriff's department, not including a school district police or security department (PC 11165.9). Reports by commercial print and photographic print processors are to be made to the law enforcement agency having jurisdiction over the case (PC 11166[e]).

JOINT KNOWLEDGE – WHO REPORTS?

When two or more mandated reporters jointly have knowledge of suspected child abuse or neglect, a single report may be made by the selected member of the reporting team. Any member of the reporting team who has knowledge that the designated person has failed to report must do so him or herself (PC 11166[h]).

SAFEGUARDS FOR MANDATED REPORTERS

In order to protect mandated reporters from repercussions for reporting as required, CANRA includes specific safeguards as follows:

- § Those persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required, even if the knowledge or reasonable suspicion of the abuse or neglect was acquired outside of their professional capacity or scope of employment. Mandated reporters and others acting at their direction are not liable civilly or criminally for photographing the victim and disseminating the photograph with the report. (P.C. 11172(a))
- § No supervisor or administrator may impede or inhibit a report or subject the reporting person to any sanction (PC 11166[f]).
- § The identity of the reporting party and the contents of the child abuse report are confidential and may only be disclosed to specified persons and agencies (PC 11167[d][1]; PC 11167).
- § In the event a civil action is brought against a mandated reporter as a result of a required or authorized report, he or she may present a claim to the State Board of Control for reasonable attorney's fees incurred in the action if he or she prevails in the action or the court dismisses the action (PC 11172 [c].)

Appendix D: Mandated Reporting

DOCTOR-CLIENT PRIVILEGE

In any court proceeding or administrative hearing, the physician-client and psychotherapist privileges do not apply to the information required to be reported.

PENALTY FOR NOT REPORTING CHILD ABUSE

Penal Code §11166(c), §11166.01

Any mandated reported who fails to report an incident of known or reasonable suspected child abuse or neglect is guilty of a misdemeanor punishable by up to 6 months in jail or by a fine of \$1000, or both.

If a mandated reporter conceals his/her failure to report an incident known by the mandated reporter to be abuse or severe neglect, the failure to report is a continuous offense until an agency specified in §11165.9 discovers the offence.

Any supervisor or administrator who violates §11166(1) [that prohibits impeding others from making a report], shall be punished by not more than 6 months in jail or by a fine of not more than \$1000, or both.

Any mandated reporter who willfully fails to report abuse or neglect, or a person who impedes or inhibits a report of abuse or neglect, where that abuse or neglect results in death or great bodily harm, shall be punished by not more than 1 year in jail or by a fine of not more than \$5000, or both.

Mental health professionals risk both criminal and civil liability for failure to report (see §11166(c), §11166.01). If a professional fails to report suspected abuse and a child is abused or killed as a result, the professional can be sued for malpractice. In addition, administrative action may be taken, resulting in suspension or revocation of a practitioner's license.

FEEDBACK TO REPORTER

After the investigation has been completed or the matter reaches a final disposition, the investigating agency shall inform the mandated reporter of the results of the investigation and any action the agency is taking (P.C. 11170(b)(2)).

MEDICAL RECORDS

The Suspected Child Abuse Report is kept in a file in the clinic's chart room. Please ask our supervisor or program manager.

CONCLUSIONS

It is crucial that mandated reporters become familiar with reporting laws and procedures and not let denial, fear, or ignorance interfere with providing help to families in which abuse is suspected.

Appendix D: Mandated Reporting

Therapists are advised to familiarize themselves with social services, the legal system, and helping agencies in their community. Frequently, coordinating therapy with other helping services will result in enhanced treatments for the family. Training and consultation are also highly encouraged for any professional working with child abuse. In addition to local expertise, there are many excellent written materials, training programs, seminars and/or conferences which can be consulted when questions regarding specific cases arise.

ELDER AND DEPENDENT ABUSE REPORTING

Everyone should report all observed, known or suspected incidents of adult abuse, but the following persons are required by law to report: W&IC 15630(a)

Any person who provides Health or Social Services to elderly or dependent adults (whether or not they are paid) is a MANDATED REPORTER. W&IC 15630(b)(1)

Any mandated reporter, who in his/her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be abuse, abandonment, isolation, financial abuse or neglect, or is told by an elder or dependent adult that he/she has experienced behavior constituting abuse, shall report the known or suspected abuse by telephone immediately.

DEFINITIONS

ELDER: An Elder is any person 65 years of age or older. PC 368(b); W&IC 15610.27

DEPENDENT ADULT: Any person between the ages of 18-64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. PC 368 (h) and W&IC 15610.23(a)

CARETAKER: Any person who has the care, custody or control of, or who stands in a position of trust with an elder or dependent adult (whether paid or not) PC368(i)

TYPES OF ABUSE AND NEGLECT: (As Denied in: Elder Abuse & Dependent Adult Civil Protection Act – W&IC, Division 9, Part 3, Chapters 11-13)

- **Physical:** The infliction or threat of physical pain or injury to an elder or dependent adult by any person, unreasonable physical constraint or prolonged or continued deprivation of food or water, use of physical or chemical restraint of psychotropic medication for punishment (over or under medicating), unauthorized purposes or use beyond that which the medication was ordered. Includes: assault, battery, non-consensual sexual contact with, or exploitation of, an elder or dependent adult. PC 243.4, 261, 264.1, 262, 285, 286, 288a, 289
- **Financial:** (Including Consumer Fraud by a Business) Taking, hiding or using the money or property of an elder or dependent adult wrongfully or with intent to defraud. i.e. using undue influence to get a victim to sign documents such as will, trust, property transfer, etc., with or without a Financial Power of Attorney.
- **Neglect:** Failure to provide needed care, custody or control of an elder or dependent adult to exercise a degree of care that a reasonable person in a like position would exercise, i.e.: care of basic body hygiene, clean, safe housing, adequate food and liquid, clean appropriate clothing, medical aids such as glasses and walkers or supervision for demented or developmentally delayed individuals.

Appendix D: Mandated Reporting

- **Self-Neglect:** Failure of an elder or dependent adult to provide themselves appropriate personal hygiene, medical care or protection from hazards or to prevent malnutrition or dehydration due to ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health.
- **Abandonment:** Desertion or willful forsaking of an elder or dependent adult by anyone having the care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
- **Psychological/Mental Suffering:** Fear, agitation, confusion, severe depression, or other forms of serious emotional distress brought on by intimidating behavior, threats, harassment, or by deceptive acts, or by false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of an elder or dependent adult.
- **Isolation:** Purposeful prevention of communication between the elder or dependent adult and others (excluding activities pursuant to the instruction of a licensed physician or activities that are a reasonable response to a threat or danger to property or physical safety.) i.e. person of trust being violent, aggressive, controlling, uncaring or threatening withdrawal of care or nursing home placement. This abuse may also include isolating the victim from friends and family.
- **Abduction:** Removal from the state or restraining from returning to the state of California of any elder or dependent adult who does not have the capacity to consent to the removal/restraint (including any conservatee removed from the state or restrained from returning without the consent of the conservator or court.)

In instances of physical abuse, (W&IC Code: 15630, 15631, and 15610.67) requires the following:

- Serious bodily Injury (as defined in W&I 15610.67): Report Immediately to Law Enforcement and within 2 hours provide a written report (SOC 341) to Long-Term Care (LTC) Ombudsman, and Law Enforcement and Licensing Agency.
- No Serious bodily injury (as defined in W&I 15610.67): Report within 24 hours by telephone to Law Enforcement and within 24 hours provide a written report (SOC 341) to LTC Ombudsman and Law Enforcement and Licensing Agency.
- Physical Abuse caused by resident diagnosed with dementia by physician with no serious bodily injury: Report immediately, or as soon as practicably possible by telephone to LTC Ombudsman or Law Enforcement and within 24 hours provide a written report (SOC 341) to LTC Ombudsman or Law Enforcement.

After you report, APS may:

- Cross report to law enforcement if a crime occurred or is alleged
- Determine if a response is warranted and how quickly to dispatch a Social Worker (immediately, urgently, or within 10 days)
- Conduct a private face-to-face interview
- Investigate protective issues
- Conduct a strength and needs assessment
- Provide linkage to community resources
- Establish an action plan and follow up where needed

However APS May Not Impose Services

Any victim of Elder/Dependent adult abuse may refuse or withdraw consent at any time to an investigation or provision of services. APS shall act only with consent UNLESS a violation of a penal code is believed to have occurred. W&I 15636(A)

Legally Competent Victims Retain Their Civil Rights Including the Right to Refuse Services

There are several considerations for determining legal capacity; which can ONLY be assessed by a licensed professional and declared by a judge.

APS CANNOT

- Force clients to accept services
- Remove someone from their home without their consent
- Force someone in to placement
- Share results of their investigative report

TO WHOM DO YOU REPORT?

The report must be made to a county welfare department, probation department (if designated by the county to receive mandated reports), or to a police or sheriff's department, not including a school district police or security department (PC 11165.9). Reports by commercial print and photographic print processors are to be made to the law enforcement agency having jurisdiction over the case (PC 11166[e]).

JOINT KNOWLEDGE – WHO REPORTS?

When two or more mandated reporters jointly have knowledge of suspected child abuse or neglect, a single report may be made by the selected member of the reporting team. Any member of the reporting team who has knowledge that the designated person has failed to report must do so him or herself (PC 11166[h]).

SAFEGUARDS FOR MANDATED REPORTERS

In order to protect mandated reporters from repercussions for reporting as required, CANRA includes specific safeguards as follows:

- § Those persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required, even if the knowledge or reasonable suspicion of the abuse or neglect was acquired outside of their professional capacity or scope of employment. Mandated reporters and others acting at their direction are not liable civilly or criminally for photographing the victim and disseminating the photograph with the report. (PC 11172(a))
- § No supervisor or administrator may impede or inhibit a report or subject the reporting person to any sanction (PC 11166[f]).
- § The identity of the reporting party and the contents of the child abuse report are confidential and may only be disclosed to specified persons and agencies (PC 11167[d][1]; PC 11167).
- § In the event a civil action is brought against a mandated reporter as a result of a required or authorized report, he or she may present a claim to the State Board of Control for reasonable attorney's fees incurred in the action if he or she prevails in the action or the court dismisses the action (PC 11172 [c].)

DOCTOR-CLIENT PRIVILEGE

In any court proceeding or administrative hearing, the physician-client and psychotherapist privileges do not apply to the information required to be reported.

PENALTY FOR NOT REPORTING ELDER/DEPENDENT ABUSE

PC 368

(a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health

Appendix D: Mandated Reporting

of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars (\$6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(2) If in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older.

(3) If in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars (\$2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars (\$2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars (\$10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and

Appendix D: Mandated Reporting

imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars (\$950).

- (2) By a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars (\$950).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable as follows:

- (1) By a fine not exceeding two thousand five hundred dollars (\$2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars (\$10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars (\$950).
- (2) By a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars (\$950).

(f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

SUGGESTED REPORTING PROCEDURE

After assessing and interviewing a client, if the provider determines that a report must be filed according to the reporting law, the provider may report according to the following procedure:

- Inform the client of staff's duty to report (as appropriate).
- Inform client of likely response(s) by law enforcement/DESS and what will happen regarding the report (as appropriate).
- Make a telephone report immediately, or as soon as is practically possible.

DESS:1-800-400-0902; APS:1-800-664-9774

- Complete the **Suspected Child Abuse Report** form and fax or send within 36 hours to DESS (ask for the fax number). If none at clinic, these can be found at:
http://caag.state.ca.us/childabuse/pdf/ss_8572.pdf
- Complete the **Suspected Child Abuse Report** form and fax or send within 36 hours (ask for the fax number). If none at clinic, these can be found at:
<https://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC341.pdf>
- Provide all the information **required by law**.
- Include any special instructions for safely contacting the client, and address special needs, i.e. language needs, in the report.
- **ALL** providers involved are equally responsible to see that the report is made according to State requirements. When two or more providers have knowledge of a known or suspected instance of child abuse required to be reported, only one person is required to submit the report. ALL providers must know when the report was filed (Do not just expect the other person to report—communicate!).
- File a copy of the report in your program's designated place.
- Maximize role of client's input; advocate for the client's needs with authorities as appropriate.
- Keep the report **confidential**; it cannot be accessed by friends, family or other third parties without the client's consent.

‡ **PLEASE NOTE:** This document is just a summary and does not include all provisions of the law. Information presented herein should not be construed as legal advice. Specific questions regarding interpretation of the law should be referred to your Program Manager, Supervisor, or Quality Management.

Frequently Asked Questions on Mandatory Reporting Requirements

This information is intended to be a general reference guide for questions about mandatory reporting. Information presented herein should not be construed as legal advice. Specific questions regarding interpretation of the law(s) should be referred to your program manager or Quality Management.

1) What is a mandated reporter?

Mandated reporters are individuals who are mandated by law to report known or suspected child maltreatment. They are primarily people who have contact with children through their employment. Mandated reporters are required by the state of California to report any known or suspected instances of child abuse or neglect to the county child welfare department or to a local law enforcement agency (local police/sheriff's department).

2) How much proof do I need to provide that abuse or neglect has occurred?

No proof of abuse or neglect is needed, only "reasonable suspicion" that child abuse or neglect may have occurred. If you are at all concerned about the possibility of abuse or neglect, you should report. Investigations will be conducted by law enforcement and/or the county child welfare department to determine if abuse or neglect has occurred. Delayed reporting while awaiting further information may hinder investigation by the appropriate agencies.

3) How do I report?

Mandated reporters must report to DESS or to local law enforcement (police or sheriff's department) immediately by phone. A written report must then be sent within 36 hours by fax, or it may be sent by electronic submission, if a secure system has been made available for that purpose in your county. Written reports must be submitted on the California Suspected Child Abuse Report Form 8572.

4) Can I report the abuse or neglect anonymously?

No. Mandated reporters must identify themselves to the county child welfare department when making child abuse or neglect reports. However, persons who are not legally mandated may make anonymous reports.

5) Do I need to tell the parents or client that I made a report?

No. You are not legally required to notify the parents that you are making a report. However, it may be beneficial to let the parents know you are reporting for the benefit of a future relationship.

6) If I tell my supervisor about my concerns of abuse or neglect, have I met the obligation for mandated reporting?

You must still make a report to the county child welfare department, adult protective services, or local law enforcement. If the supervisor disagrees, the individual with the original suspicion must report.

7) What if my supervisor tells me not to report my concerns because they are not sufficient?

You must still make a report to county child welfare department, adult protective services, or local law enforcement. If the supervisor disagrees, the individual with the original suspicion must report.

8) What happens if I am concerned about abuse or neglect and I do not make a report??

Legally mandated reporters can be criminally liable for failing to report suspected abuse or neglect. The penalty for this misdemeanor is up to six months in jail and/or up to a \$1,000 fine. Mandated reporters can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child/victim is further victimized because of the failure to report.

9) If my client was injured in another county, do I report to the respective law enforcement agency in which the health facility jurisdiction lies, or to the law enforcement agency in the county in which the client was injured?

The law states that a report must be made to “a local law enforcement agency.” However, it is generally recommended that the report be made in the jurisdiction where the client was injured. It would be helpful to discuss this issue with your program manager or Quality Management.

10) What happens after the report is filed?

After a report is filed, the county child welfare department, adult protective service, or local law enforcement agency investigates the allegations. These agencies are also required to cross report suspected child abuse or neglect cases to each other. The county child welfare department, adult protective services, or local law enforcement agency investigation will result in one of three outcomes.

- A. Unfounded report – the report is false, or does not involve abuse, such as an accidental injury
- B. Substantiated report – it is determined that child abuse has occurred
- C. Inconclusive report – there is insufficient evidence to determine whether or not abuse has occurred

Appendix D: Mandated Reporting

Only substantiated reports of child abuse and severe neglect must be forwarded to the Department of Justice. The county child welfare department will determine if children need to be removed from the home or if services need to be offered to the parents or caregivers. APS will determine if law enforcement needs to be notified. Law enforcement agencies may also pursue criminal prosecution.

11) If the client does not want a report to be made, must I make a report?

Yes. Mental health providers are required to report if the terms of the law are met, whether or not the client consents to a report. However, mental health providers should find out why the client does not want a report made, and advocate on behalf of the client's needs and concerns with the authorities.

12) If the incident I report turns out not to be the result of abuse or neglect, can I be sued?

For mandated reporters, Penal Code 11172(a) provides absolute immunity from state criminal or civil liability for reporting as required. This immunity applies even if the mandated reporter acquired the knowledge or reasonable suspicion of abuse or neglect outside of his or her professional capacity or scope of employment. However, mandated reporters will only have immunity under federal claims if the report was made in good faith.

13) What if I learn of abuse, but have been told that it has already been reported?

As a mandated reporter, you are responsible for reporting suspicions of abuse when you become aware of them. Assuming that someone else, including another professional, has had the opportunity to report does not satisfy your reporting requirement. Keep in mind that cumulative reports are factored into the child protection assessment, and the information you provide may or may not have been included in previous reports.

FAQs ABOUT CHILD ABUSE

a) At what age is a child most at risk for abuse?

Children of any age may be abused or neglected. However, infants and toddlers are most likely to sustain serious injuries due to their fragility. Adolescents who are abused may not receive needed help due to a belief that they provoked their abuse or should have been able to protect themselves from abusive situations. Despite their age and size, it is important to remember that adolescents are often just as vulnerable as younger children to physical, sexual and emotional abuse and neglect.

b) In cases of domestic violence when there is a child in the home, is it reportable as child abuse?

While each county handles this issue differently, domestic violence is being reported in some counties as emotional abuse (Penal Code 11166.05). When a child is in the home, medical personnel, law enforcement, or domestic violence units generally report to Child Welfare Services. In addition, a judge can order an emergency protective order if a child is determined to be in “immediate and present danger of abuse by a family or household member, based on an allegation of a recent incident of abuse or threat of abuse by the family or household member” (California Family Code Section 6250). If you encounter a situation of domestic violence where there is concern about the safety and well-being of a child, contact your local child welfare agency and/or law enforcement agency.

c) What is the fine line between physical abuse and discipline?

Under California Welfare and Institutions Code Section 300(a), reasonable and age appropriate spanking to the buttocks where there is no evidence of serious physical injury does not constitute abuse. However, if the discipline is excessive or forceful enough to leave injuries, physical abuse has occurred. The use of instruments increases the likelihood of injuries as does the excessive punishment of young children. The intent of the reporting law is not to interfere with appropriate parental discipline, but to respond to extreme or inappropriate discipline which is abusive. If you have reasonable suspicion of abuse, even with no visible signs, you are required to report.

d) What is the difference between children’s “normal” sex play and sexual abuse?

The lack of contemporary normative data regarding sexual activity among young children makes differentiating between normal sex play and sexual abuse difficult. It is clear, however, that very young children without exposure or experience do not usually have substantial or detailed knowledge about sexual activity and that the child who exhibits developmentally inappropriate behaviors has probably either been exposed to that behavior or has experienced it. Exposure may have occurred directly (by observing people engaged in sexual activities) or indirectly (through media such as television or movies). Factors to be considered in addition to developmental appropriateness include the dynamics of the situation. Was coercion, threat, intimidation or force involved? Were age and size of the children involved similar? Even in cases involving children of similar age and size it is possible that the activity is abusive if threats, force, or coercion is present. Differences in emotional maturity and status must also be evaluated. For example, a child who has been delegated the authority of “babysitter” by parents has a distinct status or power advantage over other children, even if the age differential is not large. Many assessment questions must be considered when professionals are presented with situations

Appendix D: Mandated Reporting

in which children are engaging in sexual activity. It is important to understand not only the child's knowledge base but also the sources of that knowledge. In most cases of this type, consultation is very helpful. See [Sexual Abuse Reporting](#) for a chart summarizing the reporting requirements based on the age difference between the partner and the minor.



When Sexual Intercourse* with a Minor Must Be Reported as Child Abuse by Mandated Reporters: California Law

The California Child Abuse and Neglect Reporting Act requires certain professionals (“mandated reporters”), like teachers and health care providers, to report to child protection or law enforcement when they know or reasonably suspect child abuse. Sexual intercourse with a minor (a person younger than age 18) is reportable as child abuse in three circumstances:

1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report if they have a reasonable suspicion that intercourse with a minor was coerced or in any other way not voluntary. As one example, sexual activity is not voluntary when the victim is unconscious or so intoxicated that he or she cannot resist. *See* Penal Code sections 261 and 11165.1 for more examples.

2. WHEN IT INVOLVES SEXUAL EXPLOITATION OR TRAFFICKING

Mandated reporters must report if they have a reasonable suspicion that a minor has been sexually trafficked or is being sexually exploited. See www.teenhealthlaw.org for more information on this requirement.

3. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND MINOR IN A FEW SITUATIONS

Mandated reporters also must report intercourse with a minor in a few situations based solely on the age difference between the minor and their partner, according to the following chart:

KEY: M = Mandated. A report is mandated based solely on age difference between partner and minor.

J = Use judgment. A report is not mandated based solely on age difference; however, a reporter must report if he or she has a reasonable suspicion that the intercourse was coerced, involved trafficking or exploitation, or was in any other way not voluntary, as described above, irrespective of age..

Age of Partner ⇒ Age of Youth ↓	12	13	14	15	16	17	18	19	20	21	22 & older
11	J	J	M	M	M	M	M	M	M	M	M ⇒
12	J	J	M	M	M	M	M	M	M	M	M ⇒
13	J	J	M	M	M	M	M	M	M	M	M ⇒
14	M	M	J	J	J	J	J	J	J	M	M ⇒
15	M	M	J	J	J	J	J	J	J	M	M ⇒
16	M	M	J	J	J	J	J	J	J	J	J ⇒
17	M	M	J	J	J	J	J	J	J	J	J ⇒
18	M	M	J	J	J	J	Chart design by David Knopf, LCSW, UCSF. (The legal sources for this chart are: Penal Code §§ 261.5, 261, 11165.1, 11165.6, 11166; 249 Cal. Rptr. 762, 769 (3 rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1 st Dist. Ct. App. 1986).				
19	M	M	J	J	J	J					
20	M	M	J	J	J	J					
21 & older	M	M	M	M	J	J					

Do I have a duty to ascertain the age of a minor’s sexual partner for the purpose of child abuse reporting?

No statute or case obligates mandated reporters to ask youth about the age of their sexual partners for the purpose of reporting child abuse. *See* 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988).

Do I report pregnancy as child abuse?

The Child Abuse and Neglect Reporting Act states that “the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of child abuse.” Penal Code section 11166(a)(1).

What do I do if I am not sure whether I should report something?

When you aren’t sure whether a report is required or warranted, you may consult with legal counsel and Child Protective Services to ask about the necessity or appropriateness of a referral.

* This worksheet addresses mandated reporting of vaginal intercourse between non-family members. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California, check www.teenhealthlaw.org. Legal information, not legal advice. © National Center for Youth Law. June 2017.

CONFIDENTIALITY

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996 (federal law). The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared. This applies to all forms of PHI, including paper, oral, and electronic, etc. In this section you will also see Code of Federal Regulations (CFR) that mental health rules fall under.

BCDBH's Notice of Privacy Practices (NPP) describes how client information may be used, disclosed, and how they may access their information.

There are California laws and regulations (California Medical Information Act—CMIA, Welfare and Institution Codes (W&I), Health and Safety Codes (H&S), the Lanterman–Petris–Short Act (LPS), California Family Code, Civil Codes, and Penal Codes) that also govern confidentiality that can be stricter than and pre-empt the federal laws. Our job is to keep the more stringent (limiting) laws, codes, and regulations to protect our clients. The following guidelines are to help you understand the difference between what we “**must**” or what we “**may**” disclose and whether an authorization to release information is needed (an ROI).

Please do not throw PHI in the trash can (like client's phone numbers) or leave unattended charts on your desk!

However, a Basic Rule for confidentiality is:

**The Minimum Necessary Rule –
Just the tiniest amount necessary to get the job done!**

How does Pre-emption and Minimum Necessary Rules work in real life?

1. Look at HIPAA for an exception to privacy (applies to ALL records)
2. Look at California or SUD laws that apply (i.e., what KIND of record are you being asked to disclose?)
3. If there is a conflict, follow HIPAA (e.g., the rule that says you **MUST** disclose to the Secretary of DHHS investigating HIPAA; California law might not specifically list this disclosure as an exception to privacy)

Appendix E: Confidentiality

4. If no conflict exists, follow the most stringent privacy law or provision that allows no disclosure, or most limited, disclosure of PHI

Examples—applying pre-emption rule to disclosures:

- **NO CONFLICT:** the HIPAA rule that says you “may” disclose to law enforcement officer looking for the perpetrator of a crime; California mental health law that says you “must” disclose to officer who lodges with an inpatient psych facility an arrest warrant for a serious or violent felony; W&I 5328(t) –**there is no conflict, so follow California law**
- **CONFLICT:** HIPAA says you MUST disclose to the Secretary of DHHS investigating HIPAA problem, California law does not specifically list this exception –**follow HIPAA**; California law says you *may* share with certain MDTs (Multi-Disciplinary Teams), but if HIPAA has no similar exception, follow HIPAA (you must get authorization)
- **NO CONFLICT, MOST STRINGENT:** HIPAA says you “may” disclose to law enforcement; California mental health law does not include exception for missing person inquiry and is therefore more stringent –**follow California law**

What **MUST** be disclose (is required):

1. Secretary of DHHS, if asked (e.g., HIPAA-related investigation)
2. Patient, if seeking “access” to own record (unless it will cause death or serious physical harm if released)

What **MAY** be disclose (is permitted, clinical discretion))

1. For **Treatment, Payment, Operations** (45 CFR 164.506)
 - this exception would not likely apply to law enforcement disclosures unless the officers are EMTs or paramedics performing duties as “healthcare providers”
 - if it applies, CMIA (treatment or diagnosis), LPS (provider with medical or psychological responsibility for patient) and SUD law (medical emergency and consent is not able to be obtained for “emergency” reason) would permit a disclosure to first responder through this “treatment purpose” gate

Appendix E: Confidentiality

Examples

- CMIA—ok to disclose physical health information to other healthcare professionals for “diagnosis and treatment of the patient” (Civ. Code 56.10(c)(1))
 - LPS—ok to disclose mental health information to other healthcare professionals (including those outside your facility) if they have “medical or psychological responsibility” for the patient’s care (W&I Code 5328(a)(1))
 - 42 CFR Part 2—SUD information may be disclosed w/o consent for treatment or operations purposes only in communication within a program or between a program and the entity that has direct administrative control over the program (42 CFR 2.12(c)(3))
2. With **WRITTEN AUTHORIZATION** (with permission) from the client (45 CFR 164.508)
- The elements of written authorization form:
- what?
 - to whom?
 - from whom?
 - purpose?
 - right of revocation
 - expiration date or event
 - right to copy of form
 - other rights and warning about possible re-disclosure

California State Law

- CMIA—Civil Code 56.10(a) –physical health records -“no disclosures without first obtaining written authorization....”
- Civil Code 56.11 –authorization form requirements –handwritten or in 14-point font, and includes “date” of expiration (more stringent?)
- LPS—W&I Code 5328 (b) –mental health records –ok to disclose to third parties with permission of client AND approval of provider (does not specify that it be written authorization in all cases)
- HIV—H&S Code 120980(a) –HIV test results –no disclosure to third parties except with written authorization as provided in subsection (g)disclosure only to subject of test or his/her providers of health care for purposes of diagnosis, care or treatment (not including health plan)

Appendix E: Confidentiality

Federal Law (SUD)

- 42 CFR Part 2, section 2.1(b)(1): **SUD** treatment program records are confidential (subject to certain limited exceptions) but “may be disclosed in accordance with the prior written consent of the patient...”
- 42 CFR section 2.31 –written consent form: Remember: the “to whom” section (under new regulation) even more specific as of March 21, 2017 -if the third party is not a health provider with a “treating provider relationship” then he/she must be specifically named by name

Examples

- DUI test results (forensic labs) –patient authorizes the release of lab work to the officer (or to DA or to the Courts)
- Police investigating assault and battery case, and victim provides written authorization for release of ED records outlining extent of injuries.

3. With **VERBAL AUTHORIZATION** (with permission) from the client (45 CFR 164.510)

HIPAA—45 CFR 164.510

- a) hospital directory (patient must be given opportunity to verbally “opt out” or ask for a restriction or limitation on who will know their location)
 - only includes name, location in facility, condition (in general terms), and religious affiliation (only given to members of the clergy, if patient doesn’t opt out and NPP tells patient about this disclosure)
 - emergency situation –if patient cannot be presented with an opportunity to opt out (e.g., patient is unconscious) then provider may use or disclose directory information if it is consistent with known prior expressed preference, if any, and in the individual’s best interest
- b) limited disclosure for “involvement in the client’s care and notification purposes”
 - to family members, relatives, close friends, or others identified by client
 - info must be directly relevant and limited to the person’s involvement in the client’s care or payment for care
 - to notify or assist in notifying the person of the client’s location (hospital), general condition or death
 - if client is present → verbal agreement/opportunity to object, or reasonably infer that patient does not object
 - if patient not present or cannot provide verbal permission or assent:

Appendix E: Confidentiality

- provider may still disclose if in patient's best interest and directly relevant to involvement of person (e.g., to pick up Rx, medical supplies, x-rays, etc.); or
- to disaster relief entity; or
- to notify person of patient's death

Examples

- CMIA—physical health information —disclosure ok with verbal permission because HIPAA “authorizes” it (Civil Code 56.10 (c)(14) —disclosures are ok if authorized by law)
- LPS—W&I Code 5328 (b) —mental health records —ok to disclose to third parties with permission of client AND approval of provider (does not specify that it be a written authorization)
- **HIV**—H&S Code 120980 —HIV test results —**get it in writing!** (more stringent)
- **SUD** -42 CFR Part 2 —**get it in writing!** (more stringent)
- Patient wishes to file a police report because his car was broken into in the clinic parking lot and asks you to confirm info to the officer about the date and circumstances to provide information about what your security guard saw when called to investigate the break-in
- Law enforcement officer helped save life of grateful motorist and wants to stop by and say “hi” (ask client first)
- Client is “in the field” and requests that your staff talk on phone to law enforcement re: probable cause to “write a 5150 hold” (W&I 5150.05 encourages this in establishing basis for “probable cause”)

PROACTIVE STEP

When the law permits you to release information to law enforcement, it improves relationships if you do so in a helpful way that protects privacy while still helping “in the interests of justice”

It is always better to tell the patient (and to get permission) when it is a “MAY” — if possible.

4. **WITHOUT AUTHORIZATION** (no permission) from the client (45 CFR 164.512)
45 CFR 164.512 —**categories** of disclosures permitted without authorization
 - a. Required by law (e.g., child abuse reporting)

Appendix E: Confidentiality

- b. For public health activities (e.g., Ebola)
- c. About adult victims of abuse, neglect or domestic violence (e.g., call to APS)
- d. Health oversight activities
- e. Judicial and administrative proceedings (e.g., certification hearing for 5250)
- f. Law enforcement purposes (e.g., crime, victim or suspect)
- g. Decedents (e.g., to coroner or medical examiner)
- h. Organ or tissue donation
- i. Research
- j. To avert threat to health or safety (e.g., Tarasoff warning)
- k. Specialized government functions (e.g., to protect the President)
- l. Workers compensation

NOTE: California law requires that we DO NOT allow ICE agents into non-public areas of our buildings without a warrant (ICE = Immigration and Custom Enforcement).

Non-Consent “Rule”

- The one who says “yes” can say “no”
- This can be frustrating for the provider when clients refuse the offered care that the provider thinks is appropriate or necessary
- The more dangerous circumstances of the “no” the more likely it is that the provider will rethink the client’s mental capacity

5150 Exception –Safety Always Tops the Right to Say “No”

- This is a conflict between **personal rights vs. society’s concerns about dangerousness** (complex legal framework dealing with refusal of necessary mental health care)
- Takes away patient’s right to say “No” in a very narrow set of circumstances: danger to self, danger to others, or gravely disabled *due to* a mental health disorder
- Use with caution!

All of the following disclosures to law enforcement are “permitted” by HIPAA

(NOT “required” disclosures to law enforcement)

- Child abuse report (see MANDATED REPORTING section)
- Tarasoff (duty to warn)
- 911 call placed by hospital ED for help with violent visitor

Crime on Premises –ok to disclose limited PHI as follows

- HIPAA -45 CFR 164.512(f)(5) to report a crime on the premises

Appendix E: Confidentiality

- CMIA –Civil Code 56.10(b)(9) and (c)(14)
- LPS –ok to call 911 for help –be careful about disclosing PHI
- 42 CFR 2.12 –ok to report crimes committed on the premises, or threats against staff or facility

45 CFR 164.512(f)(6) to report a crime NOT on the premises but in the course of providing emergency medical care (not disclosing MH or SUD)

- CMIA –Civil Code 56.10(b)(9) and (c)(14)
- LPS –ok to call 911 for help for yourself if you are first responder –be careful about disclosing PHI
- SUD –not permitted by federal law (42CFR Part 2)

TARASOFF -SERIOUS & IMMINENT THREATS

- **45 CFR 164.512(j)** –*avert a serious threat to health or safety* -to law enforcement as necessary to prevent or lessen serious and imminent threat to the health or safety of a person or the public or to identify or apprehend an individual
- **CMIA –Civil Code 56.10(b)(9)** (if another law requires a disclosure) and (c)(14) (if another law authorizes a disclosure)
- **LPS –W&I Code 5328(g)**-To governmental law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families
- **LPS –W&I Code 5328(r)** When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this subdivision, “psychotherapist” means anyone so defined within Sec. 1010 of the Evidence Code.
- **SUD**–Tarasoff warning without linking patient to SUD treatment program

Appendix E: Confidentiality

MINORS AND CONFIDENTIALITY

Status of Minor = Treat as Adult

Emancipated –treat as adult

- Married (or divorced/annulled)
- Active duty U.S. military
- Court order (14 and older)

“Self-sufficient minor” -treat as adult, but ok to notify/bill the parent

- 15 or older,
- Living separate and apart from parent, and
- Managing own finances (having sufficient finances to manage)

Sensitive Services (Minors Can Consent, But Only to Certain Care)

Any age

- Sexual assault, intimate domestic violence, or rape
- Prevention or treatment of pregnancy

12 and older: Client 12+ owns the clinical mental health record

- Diagnosis and treatment of infectious reportable conditions
- Prevention, diagnosis and treatment of sexually-transmitted diseases
- Outpatient mental health/substance use disorder counseling (Family Code 6924 and H&S 124260; Family Code 6929)
 - Involve parent unless inappropriate (CA Fam. Code 6924; 45CFR 164.502(g)(3)(ii))
 - Does not include medications or inpatient care
 - **Client 12+ MUST sign the ROIs**
 - The youth “did or could have” given consent for Informed Consent and Treatment Plan but didn’t sign (in other words, if the youth continues to come and participates in treatment, it is okay for the parent to sign in place of the youth)

MENTAL HEALTH TREATMENT FOR MINORS:

The health care provider is required to involve a parent or guardian in the minor’s treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor’s record. For services provided under Health and Safety Code § 124260(a), providers must consult with the minor before deciding whether to involve parents.

While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor’s authorization. The provider can only share the minor’s medical records with

Appendix E: Confidentiality

parents with a signed authorization from the minor (CA H&S Code §§ 123110(a), 123115(a)(1); CA Civil Code §§ 56.10, 56.11, 56.30; CA W&I Code §5328).

AB 2088—Minors Records

Minors 12+ have the right to provide an addendum to their record if he/she believes their records are incomplete or incorrect, with no limit to the words (Adult clients have always had this option).

Multi-Disciplinary Teams (MDTs, CFTs, and IEP/504s)

This can be a very sticky area in treatment, as there are times when—as mental health specialists—we are required to be at meetings, but there may be no Release of Information for all the people/agencies in the room.

There are ways to handle these situations without breaching confidentiality:

1. Don't talk, only listen.
2. If asked questions, speak in VERY general terms about treatment options.
3. Give any client information beforehand to appropriate (and authorized) people/agencies.

However, these are not ideal circumstances and can place a mental health specialist in a very awkward position. Let your supervisor or program manager know when these situation occurs—there might be other options available.

Crisis Services and SUD Treatment

It can be easy to breach confidentiality during crisis situations without prior Releases of Information in place. 42CFR Part 2 (the Federal SUD Confidentiality regulations), does not allow for the release of confidential information about substance abuse treatment without authorization except in VERY limited circumstances.

The State deems specialty Crisis Services to be mental health outpatient services (as they are not inpatient services and these are the only two billing options). As such, Crisis Service Teams should attempt to get an ROI for SUD clients using crisis services, if appropriate (e.g. clients in Suboxone or methadone treatment). However, clients self-disclosing treatment would not need an ROI or if medication services are not required.

Any questions should be addressed to your supervisor, program manager or Quality Management.

Appendix E: Confidentiality

An Important Reminder for Releasing Records

The US Department of Health and Human Services has published guidelines for individuals' right under HIPAA to access their health information (45 CFR §164.24). These regulations and guidelines are to provide individuals with **easy access** to their health information and to empower them to be more in control of decisions regarding their health and well-being. This will allow individuals to better monitor their conditions, adhere to treatment plans, find and fix errors in their health records, and to track progress. The goal is to put individuals in the driver's seat with respect to their health as we move toward a more patient-centered health care system.

The bottom line is that individuals have a right to review and obtain copies of their records. "Records" means any item, collection or grouping of information that includes protected health information (PHI) and is maintained, collected, used, or disseminated by or for a covered entity.

The regulations **ONLY** allow a MHP to withhold information under the following circumstances:

- If any portion of the requested record is **reasonably likely to endanger the life or physical safety of the individual or another person**. This ground for denial does not extend to concerns about psychological or emotional harm (e.g., concerns that the individual will not be able to understand the information or may be upset by it).
- If any portion of the requested record is reasonably likely to cause substantial harm to a person (other than a health care provider) referenced in the PHI.
- If a personal representative (i.e. parent) has requested access and any portion of the requested record is reasonably likely to cause substantial harm to the individual (i.e. child) or another person (i.e. the other parent).

When the record is reviewed by clinical staff it **MUST** be documented why **ANY** portion of the chart is being withheld. If you are withholding any part of the record the *Denial of Request* form must be filled out and given to the client, see attached policy. If they disagree, they can submit a *Request for Review of Denial* form. It would be important for that risk to be evident from the face of the records themselves in the event a complaint were filed with a state licensing board or the Office of Civil Rights.

Many MHPs have shared their sincere concern about allowing a parent to access his or her child's records on the belief that it will destroy the child's trust in the therapist and for all future therapists. Based on the regulations and guidelines now in place that will NOT constitute a basis for withholding the information from the parent unless the MHP can make a valid connection to endangerment to life or physical safety (please be aware of the ROI status for children over age 12 whether or not they are consenting to their own services).

Appendix E: Confidentiality

All requests for information must follow our departments Record Request Policy 128B.

BCDBH Policy and Procedures regarding Confidentiality:

- BCDBH policy #128 –covers Client Access to PHI
- BCDBH policy #139 –covers Minimum Necessary Rule
- BCDBH policy #140 –covers Use/Disclosures which an ROI is Required
- BCDBH policy #184 –covers Transmitting PHI via Email
- BCDBH policy #189 –covers Transmitting PHI via Fax
- BCDBH policy #226 –covers Minor Consent for SUD
- BCDBH policy #274 –covers Confidentiality of SUD Clients
- BCDBH policy #299 –covers PHI Protection
- BCDBH policy #308 –covers Minor Consent for SMHS
- BCDBH policy #316 –covers Client Consent to Photograph

Authorization to Release information (ROIs)

Introduction

Authorizations for the Use and Disclosure of Protected Health Information are legal documents that are essential for the exchange of protected health information between different parties.

With this information you should be able to:

- Explain when Authorization is needed
- Identify the different components of an Authorization
- Accurately describe the correct way to complete an authorization
- Understand how an authorization is revoked

Completing the County Form

AUTHORIZATION DETAILS	
Records Coming From (Disclosed by): Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), <u>including us</u> , who are authorized to make use of and/or disclose the information described in this form.	
<u>BCDBH</u>	<u>BCDBH-James Rogers</u>
<u>Enloe Hospital</u>	<u>BCDBH – SUD</u>
<u>Michelle Jones</u>	<u>Quest Diagnostics</u>
Records Going To (Received by): Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), <u>including us</u> , who are authorized to receive the information described in this form.	
<u>BCDBH-MH</u>	<u>BCDBH-James Rogers</u>
<u>Enloe Hospital</u>	<u>BCDBH – SUD</u>
<u>Michelle Jones</u>	<u>Quest Diagnostics</u>

Who will be disclosing the records?

Who will be receiving the records?

If a class of persons/organizations is given, it must be specific enough to understand who has/gets the information, and that the client meant for that person to release/receive the information.

CAUTION: **SUD** client's need to be VERY specific with who will receive the information (names) if the agency is not in the SUD provider network of care (e.g. need probation officer's name, not just Probation Department).

Persons or Class of Persons	Organizations or Class of Organizations
Too General - my doctor; all doctors; treating physician	Too General - all hospitals; the clinic; laboratories, life insurance company
Specific - Dr. G. Brown; Butte County Behavioral Health; Chico High School	Specific - Enloe Hospital; BH Outpatient Clinics, Quest Diagnostic; Aetna Life Rep.

Appendix E: Confidentiality

PURPOSE OF DISCLOSURE OF PHI

At the request of the individual/client At the request of an authorized representative

County has limited its form to address only requests by the individual or the individual's representative

SERVICE DATES

The information to be used or disclosed includes only those items checked above, with respect to services provided on or around: _____ (insert dates of service). **NOTE:** If this section is left blank, the treatment dates covered by this authorization are from the most recent date of service (to discharge) and claims resolution.

EXPIRATION OF AUTHORIZATION

THIS AUTHORIZATION SHALL BECOME VALID IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR THE FOLLOWING PERIOD: *(The Client/Patient MUST INITIAL one of the following for the authorization to become valid.)*

- JS This authorization expires one year from the signature date below.
- This authorization expires as specified: *Not greater than 1 year*
- This authorization expires once information is disclosed. This is a one-time authorization.

Insert date range for information. If blank only last course of treatment (episode) should be disclosed, unless SUD program, in that case must put service dates

County of Butte (Countywide Form) Authorization for Use or Disclosure of Protected Health Information (PHI)	Client Name: _____ Client Number: _____
--	--

How long will the authorization be good for?

Client Name and Number needs to be on ALL 3 pages

TYPE OF INFORMATION TO BE USED OR DISCLOSED

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for mental illness and/or alcohol/drug abuse. The information to be used or disclosed includes: *(The client MUST INITIAL items to be disclosed)*

- JS Discharge Summary JS Alcohol/Drug Records (MUST INITIAL FOR SUD RECORDS)
- JS Psychiatric Evaluation/MSE () Attendance Only
- JS Medication Records JS Lab Reports
- () Inpatient Records JS Intake/Admission Summary () Medical Finding
- JS Progress Notes: SPECIFY Medical or Doctor's Notes
- () Billing Records () Financial Records
- () Public Social Services Records (Welfare and Related Social Programs Information)
- JS OTHER (please specify): *BE SPECIFIC - Program Participation; Treatment Engagement; Progress Reports related to Treatment Goals; Treatment Recommendations. (Cannot say "All Records")*

The heart of the authorization. What information should be disclosed. If it isn't initialed, don't disclose!

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release the County of Butte from all legal responsibilities or liability that may arise from the use or disclosure of information in reliance on this authorization.

Clients should be clear about the type of information that is going to be disclosed. Don't just shotgun.

Appendix E: Confidentiality

IMPORTANT!! The Signature Line

Client's Signature & Date. If minor has the right to consent to services (12+), they sign first and the parent signs below.

REVOCATION OF AUTHORIZATION

As of this date, _____ I hereby revoke this authorization.

Name of Client

Signature of Client Revoking Authorization

If Applicable:

Name of Parent/Guardian

Signature of Parent/Guardian Revoking Authorization

STAFF VERIFICATION

(FOR INTERNAL USE ONLY)

TO BE COMPLETED BY BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH COUNSELOR OR CLINICIAN

- I have verified the client's signature against the medical record.
 I have received _____ as documentation that verifies the relationship with the client and the authority to request/receive health information on behalf of the client.

Must check one of the boxes above. It is okay to verify signature to signature in chart.

Staff Signature: _____ *Super Counselor* Date: _____ *xx/xx/xxxx*

Print Staff Name: _____ *Super Counselor*

.....
COPY: () DELIVERED ON _____ () FAXED ON _____ () MAILED ON _____
() RETAINED IN FILE ONLY () GIVEN TO CLIENT ON _____

Revocation Section – The form can be used as the “writing” required to revoke the authorization. Once revoked, a single diagonal line on the front page stating “Revoked” will immediately inform staff.

Staff Verification and Documentation Sections are where staff verify the authenticity of the person requesting records and also documenting if and how the requestor received a copy. Staff may state “client known to me” for well-established clients.

Butte County Department of Behavioral Health Policy

- BCDBH policy #140 – B covers Use and Disclosure of PHI for Which an Authorization is Required
- Ask your Supervisor, Program Manager, Custodian of Records, or Quality Management any questions you may have about the ROI/Authorization procedure.

Frequently Asked Questions

- **I need to add another agency to the Authorization (ROI). Can I write it in and have the client initial and date the addition?**
 - No. Nothing can be added to the document once the client has signed it. Another ROI needs to be completed.
- **Do I have to give the client a copy?**
 - You must offer the client a copy.
- **Can I make changes to the form to fit the needs of our specific program?**
 - No changes can be made to the form. This is a countywide form approved by County Counsel.
- **Is the authorization valid if the client signs but forgets to date it?**
 - No, it is not valid without a date or if any of the other required elements are missing.
- **Does a minor need to sign the ROI?**
 - Yes, if they are 12 or older.
 - **The minor's signature is the most important (12+).**
 - The parent or legal guardian may sign as well (12+), but a parent (or representative) **MUST** sign if they are under the age of 12.
 - A parent's or legal guardian's signature is not needed if the client meets the requirement for minor consent.
- **If the client is conserved, do they sign the release?**
 - Yes, a conserved client still maintains their privacy rights.
 - The public guardian can consent as well if the authorization pertains to mental health treatment affecting their grave disability.
 - The public guardian cannot supersede the client's right to revoke authorization for release of information to family members.

MANAGED CARE AUTHORIZATIONS and REFERRAL FOR ADJUNCT SERVICES for the Child/Youth System of Care

The following form is the *only* form to be used for referrals to network providers. This form can be found on BCDDBH Quality Management web page under **Forms** and can be downloaded or added to *Favorites* for convenience: <http://www.buttecounty.net/behavioralhealth/qualitymanagementdivision>

(The Request for Service form is used by schools and other outside agencies to request/begin services.)

The form is then emailed to DBHQM@buttecounty.net for authorization and monitoring.

BCDBH CHILD/YOUTH SYSTEM OF CARE REFERRAL/MANAGED CARE AUTHORIZATION (MCA)

Referral Other:

Date of Referral/MCA: Client Name: Client ID:

Agency/Program: Clinician Name/ID:

Parent/Guardian Name: Parent/Guardian Phone Number:

Parent/Guardian Address:

Referring Party Name: Referring Party Phone:

Current Service(s) (Check all services client is currently receiving):

<input type="checkbox"/> HAP	<input type="checkbox"/> IHP	<input type="checkbox"/> SMHS/SBC	<input type="checkbox"/> TFC	<input type="checkbox"/> YES	<input type="checkbox"/> None
<input type="checkbox"/> HEART	<input type="checkbox"/> Med Support	<input type="checkbox"/> Strong Starts	<input type="checkbox"/> VOCS	<input type="checkbox"/> YIP	
<input type="checkbox"/> IHBS	<input type="checkbox"/> PCIT	<input type="checkbox"/> TBS	<input type="checkbox"/> WRAP	<input type="checkbox"/> 6th Street	

Requested Service(s) (Choose only ONE program per form):

<input type="checkbox"/> HAP	<input type="checkbox"/> Med Support	<input type="checkbox"/> Strong Starts	<input type="checkbox"/> YES	Services requiring prior authorization: <input type="checkbox"/> IHBS <input type="checkbox"/> TBS <input type="checkbox"/> TFC
<input type="checkbox"/> HEART	<input type="checkbox"/> PCIT	<input type="checkbox"/> VOCS	<input type="checkbox"/> 6th Street	
<input type="checkbox"/> IHP	<input type="checkbox"/> SMHS/SBC	<input type="checkbox"/> WRAP		

Please provide clinical rationale for service request:

I have reviewed this referral/MCA with my supervisor (Name of Supervisor)

Provider of Services (Name & Credentials): Date:

For Quality Management Use Only

<p>For IHBS, TBS, TFC services only:</p> Service Authorized From: <input style="width: 100px;" type="text"/> To: <input style="width: 100px;" type="text"/>	<p>For Referrals:</p> Referral Approved: <input style="width: 100px;" type="text"/> Assigned To: <input style="width: 100px;" type="text"/>
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Quality Management Clinician Signature: _____

Appendix F: Managed Care Authorizations



BCDBH CHILD/YOUTH SYSTEM OF CARE REFERRAL/MANAGED CARE AUTHORIZATION (MCA)

Referral Other:

Date of Referral/MCA:

Client Name:

Client ID:

Agency/Program:

Clinician Name/ID:

Parent/Guardian Name:

Parent/Guardian Phone Number:

Parent/Guardian Address:

Referring Party Name:

Referring Party Phone:

Current Service(s) (Check all services client is currently receiving):

<input type="checkbox"/> HAP	<input type="checkbox"/> IHP	<input type="checkbox"/> SMHS/SBC	<input type="checkbox"/> TFC	<input type="checkbox"/> YES	<input type="checkbox"/> None
<input type="checkbox"/> HEART	<input type="checkbox"/> Med Support	<input type="checkbox"/> Strong Starts	<input type="checkbox"/> VOCS	<input type="checkbox"/> YIP	
<input type="checkbox"/> IHBS	<input type="checkbox"/> PCIT	<input type="checkbox"/> TBS	<input type="checkbox"/> WRAP	<input type="checkbox"/> 6th Street	

Requested Service(s) (Choose only ONE program per form):

<input type="checkbox"/> HAP	<input type="checkbox"/> Med Support	<input type="checkbox"/> Strong Starts	<input type="checkbox"/> YES	Services requiring prior authorization: <input type="checkbox"/> IHBS <input type="checkbox"/> TBS <input type="checkbox"/> TFC
<input type="checkbox"/> HEART	<input type="checkbox"/> PCIT	<input type="checkbox"/> VOCS	<input type="checkbox"/> 6th Street	
<input type="checkbox"/> IHP	<input type="checkbox"/> SMHS/SBC	<input type="checkbox"/> WRAP		

Please provide clinical rationale for service request:

I have reviewed this referral/MCA with my supervisor

(Name of Supervisor)

Provider of Services (Name & Credentials):

Date:

For Quality Management Use Only

For IHBS, TBS, TFC services only:

Service Authorized From:

To:

Quality Management Clinician Signature: _____

For Referrals:

Referral Approved:

Assigned To:

Treatment Plan Intervention Examples

When there is a youth that will benefit from adjunctive services, a referral is sent to QM for review. At that time, the treatment plan is referenced to see if the service requested is in the treatment plan. Please utilize these examples as template ideas when you create your treatment plans. Please do not copy and paste these directly into your treatment plans as each intervention should be specific to your client.

Intervention Modality	Examples
Medication Support Services	<ul style="list-style-type: none"> Medical staff will provide medication support and education to promote adherence to medications assisting client with symptom reduction Staff will provide ongoing psychiatric and medication support services to continue to support client's progress towards mitigation of client's symptoms
Intensive Care Coordination (ICC)/ Child Family Team (CFT) Meeting	<ul style="list-style-type: none"> Provide CFT/ICC meetings to focus on strengths, identified struggles and help family develop plan of action to reduce symptoms Staff to work in collaboration and utilize ICC services with family, school staff, co-workers, and other agencies/ programs involved in clients care to assist, support, and monitor client's goals progress
Group Rehabilitation (e.g. YES groups; summer activities)	<ul style="list-style-type: none"> Provide group rehabilitation services to teach, model, rehearse positive communication skills to address anger and aggressive behavior and to encourage pro-social interactions in appropriate social settings Provide group rehabilitation services to teach, model, reinforce age appropriate social skills and to provide a setting where client can learn skills to decrease symptomatic behavior
Intensive Home Based Services (IHBS)	<ul style="list-style-type: none"> Provide IHBS at home and/or school to provide structure, enhance limit setting, improve appropriate communication, and model positive interactions Provide IHBS services to increase appropriate expression of emotions/needs and ability to cope with daily stressors
Therapeutic Behavior Support (TBS)	<ul style="list-style-type: none"> Staff will provide TBS to provide structure, teach positive parenting, improve appropriate communication, reduce outbursts, and create safety in order to support child to reduce symptoms and learn to cope with stressors
In Home Parenting (IHP)	<ul style="list-style-type: none"> In home parenting to stabilize the parent-child relationship. Teach, coach, and practice skills and positive parenting to reduce and redirect emotional outbursts, give more positive attention to appropriate behaviors and set boundaries.
Parent Child Interaction Therapy (PCIT)	<p>*** A separate intervention for PCIT is not needed, as long as individual and family therapy interventions are included on your treatment plan***</p>

MCA DOCUMENTATION EXAMPLES

Annual Update:

Primary Diagnosis: DSM 5	Functional Impairment <i>(Service will assist to ameliorate)</i>
F34.1 Persistent Depressive Disorder with anxious distress, moderate	Impaired ability to manage feelings cause conflict in parental relationships.
Clinical Rationale for Service Requested	
<p>Over the past 1½ to 2 years, client has experienced depressive symptoms including depressed mood most days, insomnia most nights, low self-esteem, low energy, difficulty concentrating (most school days), difficulty completing tasks, irritability and anger (4-5x weekly), feelings of hopelessness (monthly), anxiousness and stress related to school and peer settings (weekly) and reports difficulty maintaining control when feeling worried or overwhelmed (weekly). Client goal #1 to reduce anger outbursts from 6x weekly to 3x weekly. Client and mother report client continues to engage in anger outbursts at least 4x weekly, but client has improved insight to feelings associated with anger and increased ability to recognize behaviors associated to outbursts. Client goal #2 to improve communication skills. Client reports desire to discontinue goal in order to focus more on emotional regulation and coping skills to decrease depressive symptoms. Client continues to experience impaired ability to identify and manage emotions, impaired ability to complete tasks, impaired ability to communicate thoughts and feelings, impaired ability to earn minimum grades and impaired ability to manage negative behaviors related to anger in the home setting.</p> <p>Client has again refused referral to Med Support services, stating “pills make me feel even worse.” Mother and client requested continued WRAP to address depressive symptoms.</p>	

Appendix F: Managed Care Authorizations

Referral to Med Support:

Primary Diagnosis: DSM 5	Functional Impairment <i>(Service will assist to ameliorate)</i>
F43.20 Adjustment Disorder, unspecified	Lack of concentration and angry outbursts are causing impairment at home, school, and social settings.
Clinical Rationale for Service Requested	
<p>Client experiences both emotional and behavioral impairments in the home, social, and school settings including impaired ability to earn minimum grades/meet age appropriate education level, impaired ability to maintain focus for age appropriate length of time, impaired ability to follow teacher and parent instructions, impaired ability to complete tasks requested by mother without antagonistic behavior, impaired ability to build and manage meaningful friendships, impaired ability to engage in positive behaviors for age appropriate length of time, and impaired ability to manage negative behaviors and emotions appropriately. Mother has requested, and client's school has encouraged client to obtain psychiatric medication evaluation.</p>	

Referral to YES:

Primary Diagnosis: DSM 5	Functional Impairment <i>(Service will assist to ameliorate)</i>
F90.9 ADHD, Combined Type; F41.1 Anxiety Disorder, unspecified	Poor social skills and angry outbursts cause impairment in multiple settings, but especially at school.
Clinical Rationale for Service Requested	
<p>Client began stimulant medication shortly after starting counseling (with primary MD) and, with the help of clinician and parent, has developed improved time-management strategies. He has shown sustained, moderate progress on his goal to increase on-task behavior. He now completes approx. 6 of 10 tasks relative to his previous 3 of 10 tasks (report of low to failing grade in one school subject). Client showed moderate progress on his goal to increase self-soothing and reduce angry outbursts (yelling, profanity in interactions with parents and school staff), which last year led to suspensions and risk of expulsion. Yelling episodes decreased from 3x daily to 1x daily over the majority of the last 6 months. However, there was one school suspension last month for yelling and low cooperation.</p> <p>Requesting services for increased social engagement (YES) to give opportunity for immediate rehab intervention when frustration level increases/cooperation level decreases to sustain progress toward goals.</p>	

CONTRACT AGENCY RESOURCES

Counseling Solutions

- **Counseling** for Children-therapeutic services to children in Butte County who have Medi-Cal
- **Victim Witness:** After Butte County Victim Witness Program (**530-538-7340**) assesses, the Victim Witness Program provides an array of services to the victim and others who were impacted by the crime and Counseling Solutions specifically serves victims and is a resource for trauma.

Northern Valley Catholic Social Services

- **Iversen Wellness & Recovery Center** offers an environment of inclusiveness, recovery, and wellness to adults living with persistent mental illness
- **Northern Valley Talk Line** based on the Recovery Model, the Northern Valley Talk Line (NVTL) provides non-crisis peer to peer telephone service to the community 7 days a week from 4:30 pm—9:30 pm. 1-855-582-5554
- **Promotores Program** enhances the quality of life for families by promoting mental health and well-being by using a strength-based approach to empower families when delivering services. Services are available to Latino and Hmong residents of Chico, Gridley and Biggs
- **School-Based Counseling** at elementary schools in Chico, Oroville, Durham, Palermo, and other ridge communities. Services include therapy, case management, family support, and can be provided in a team approach to support families with greater need.
- The **Wraparound** process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.

Valley Oaks Children's Services

- Observation and **counseling** for children; support for parents (children 0-5 years old)

Victor Community Counseling Services

- **Home and school based counseling** family-based mental health treatment and case management services. This service focuses on children and youth who are at risk of out-of-home placement, in foster care, involved with the Juvenile Justice system, and with more serious emotional disorders for which traditional services are insufficient
- **Success 1st early Wraparound** an early wraparound program to capture those seriously emotionally disturbed, unserved, underserved children/adolescents, age 0-15 years, to provide services, keeping them in the lowest level of care possible
- **School aged treatment** highly individualized, family- focused and community-based specialty mental health treatment
- **Therapeutic Behavioral Services (TBS)** provides critical, short-term support and is designed to provide one-on-one therapeutic aid to children/youth
- **Transitional Age Youth** services (TAY) coordinated and comprehensive array of services for TAY clients who meet the focal population criteria and allow clients to selectively utilize services needed to maximize their individual potentials (Resiliency/Recovery Model) and successfully transition into adulthood
- **Wraparound** is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams.

Youth for Change

- **6th Street Center** provides day time services to homeless and runaway youth with a nurturing and supportive environment where they can begin to rebuild their lives. Services include meals, showers, mental health services, and much more.
- **H.E.A.R.T.** (Homeless Emergency Action Response Team) offers 24 hours services to homeless and runaway youth (under the age of 18) and their caregivers in Butte County
- **Hospital Alternatives Program** (HAP) provide comprehensive response and support services to youth who are in need of intensive services as an alternative to being hospitalized following a 5150 screening.
- **In Home Parenting** is an in home parenting education program offered to Butte County families. Parents who want to improve their parenting skills can work with an in-home

Appendix G: Contract Agency Resources

parent educator to improve their relationship with their child(ren) and enhance their family support system

- **Medication Support Services** offered to all children, adolescents, and their families who are enrolled in a variety of Youth for Change programs, up to the age of 18. Services include: consultation, diagnostic assessment, psychotropic medication treatment and psychotherapy, delivered by our Child and Adolescent Psychiatrist (tele-psychiatry) and our Medication Support nurse.
- **School Based Counseling** program provides counseling services to students and their families who are referred by Paradise Unified School District. Therapists also provide psycho-education to classroom teachers to help them interact more effectively with their students.
- **Strong Starts Program** provides individual, family, and group therapy for youth ages infant to 18. Strong Starts staff are specifically trained in Parent Child Interaction Therapy (PCIT), Sand Tray, and Play Therapy.
- **Therapeutic Behavioral Services (TBS)** provide additional short term support to youth under the age of 21. TBS staff will assist children/youth in their transition to lower levels of care (including home or home like setting) or avoid moving to a higher level of care (to reduce psychiatric hospitalization or group home placement).
- **Youth Empowerment Services (YES)** offers weekly skill building groups to youth from ages 8 - 24 with the intent of enhancing self-confidence, communication skills, social skills and community development through engagement in outdoor and recreational activities. Referrals come from Butte County Department of Behavioral Health.

ASSESSMENT HELPS

SPIRITUAL ASSESSMENT: HOPE

HOPE Approach to a Spiritual Assessment	
H Spiritual Resources	<ul style="list-style-type: none"> ○ What are your sources of hope or comfort? ○ What helps you during difficult times?
O Organized Religion	<ul style="list-style-type: none"> ○ Are you a member of an organized religion? ○ What religious practices are important to you?
P Personal Spirituality	<ul style="list-style-type: none"> ○ Do you have a personal spiritual belief separate from organized religion? ○ What spiritual practices are most helpful to you?
E Effects on Care	<ul style="list-style-type: none"> ○ Is there any conflict between your beliefs and the care you will be receiving? ○ Do you hold beliefs or follow practices that you believe may affect your care?
<small>Source: Anandarajah, G. & Hight, E. (2000). Spirituality and medical practice: Using HOPE questions as a practical tool for spiritual assessment. www.aafp.org</small>	

When conducting a spiritual assessment, a few guidelines:

- A clinician should always show respect for the patient’s expression of their faith or beliefs even if the clinician’s beliefs differ radically. Imposing one’s faith on another is never the goal of the spiritual assessment.
- A spiritual assessment focuses less on *what* an individual believes and more on *how* their faith and/or beliefs help them cope positively with their illness.
- The clinician does not conduct a spiritual history in order to “fix” anything. If something presents that makes the clinician uncomfortable or that is outside the clinician’s training, then the clinician places the appropriate referral for follow-up.
- Many patients use their faith to help them cope, and when the clinician shows an interest in their individual spiritual paths, then the clinician provides a therapeutic intervention. Even when patients do not use a faith or spirituality to help them cope, if the clinician respects this and is not judgmental, then the clinician again provides comfort.

CULTURAL FACTORS

Culture can include: race, ethnicity, language, sexual orientation, gender, age, disability, class/socioeconomic status, education and religious/spiritual orientation.

Culture shapes which symptoms are expressed and how they are expressed. Culture influences how Clients see symptoms, what society deems appropriate or inappropriate. Culture helps to conceptualize and provides rationale for diagnosis. Culture helps to build trust and rapport when the treatment team cares about the whole person.

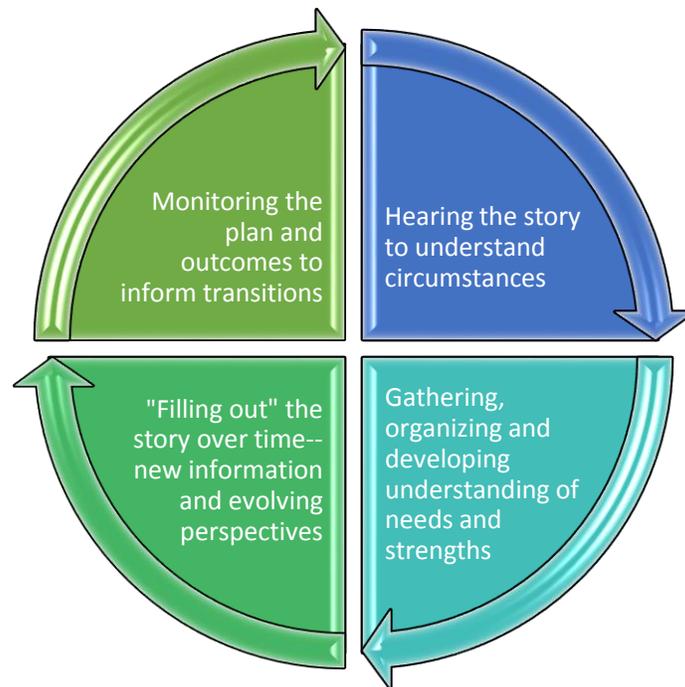
Culture is a set of shared norms, beliefs, meanings and value. It is dynamic and evolves over time. **The essential components of culture are as follows:**

- Learned
- Refers to system of meanings
- Acts as shaping template
- Taught and reproduced
- Exists in constant state of change
- Includes patterns of subjective/objective components of human behavior
- Often somatic—only Western cultures separate mind-body
- Possible intergenerational conflicts

QUESTIONS:

- *What does it mean to the client to be a part of a particular culture?*
- *How does the culture define illness and are there any traditional treatments?*
- *Are there beliefs or customs the client would like to keep related to treatment?*
- *Are there healers in the client's community that we should include on the treatment team?*
- *What are the characteristics of a good mental health provider?*
- *Are there treatments, herbs or practices that you find helpful?*

**Assessment is a process and requires connection,
empathy, and curiosity.**



The assessment is a structured process to gather information that helps the clinician understand WHAT has happened that brings the client into services now.

- Knowing what has happened provides context to identify and understand the needs and strengths of the client.
- Assessment includes determining willingness, capability, and availability of resources to achieve safety and well-being for the client and community.
- Requires identification and understanding of the unique responses and survival behaviors that client's demonstrate as a result of possible early, ongoing, and/or unresolved trauma.
- Clinician understanding and acknowledgment of life stories and perspective is critical for the client/family's coping and healing.
- Accepting that the experiences of grief, loss, and searching for identity happens over and over.
- Disconnected assessments often miss the why (function) of behavior that leads to the understanding of underlying needs.
- Ongoing assessment supports effective treatment plans. Disconnected assessments leads to ineffective treatment because the treatment focuses on the wrong outcome.

TREATMENT PLAN HELP

FOCUS

The Problem is the focus of treatment based on the mental health diagnosis, which includes symptoms, behaviors, and life functioning.

**The key is to identify how a symptom of a diagnosis manifests and creates impairment (i.e. delusions impact ability to achieve job success)

Example: A client diagnosed with Schizophrenia – may have symptoms such as auditory hallucinations, delusions, disorganized thinking, poor hygiene, social withdrawal, or other issue that may interfere with securing stable housing and/or maintaining positive family relations or otherwise impact his/her life functioning.

Example: A client diagnosed with a Depressive Disorder – may have symptoms such as arguing, yelling and screaming, temper tantrums, blaming others, or not taking responsibility which impacts his/her life functioning at work, school, and/or maintaining housing.

In some cases, there may be two diagnoses that are the focus of treatment (e.g. Bipolar Disorder & PTSD), so there could be more problems identified.

FUNCTIONAL IMPAIRMENT

“As a result of the mental health diagnosis...”

...there is a *significant* impairment in an important area of life functioning:

Living Arrangements/Housing

- Housing, food and clothing must be provided by or arranged for by others
- Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress
- Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization

Activities of Daily Living

- Needs assistance caring for themselves (hygiene, nutrition, health care)
- Unable to care for themselves in a safe and sanitary manner

Appendix H.2 – Treatment Plan Help

- Severe disruption of daily life due to frequent thoughts of death, suicide or self-harm often with behavioral intent and/or plan
- Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress

Primary Support Group

- Inability to maintain (role, e.g. parental) responsibilities with reliability and follow-through
- Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization
- Inability to establish or maintain satisfactory relationships with peers and/or adults
- Children and teens exhibit problem in their capacity for shared attention, engagement, initiation of effective two way conversations, and shared social problem solving
- Pattern of disruptive behaviors such as repeated and/or unprovoked violence towards family members or caretakers
- Disregard for the safety and welfare of self and family members

Education

- Performance is significant below expectations for cognitive/behavioral level
- Risk of deterioration due to (A qualifying diagnosis/symptom) with probable chronic relapsing and diminishing progress
- Inability to pursue educational goals in a normal time frame due to failing grades, repeated absence or truancy, expulsion, suspension
- Financial Economical Issues
- Frequent terminations from work
- Requires structured or supervised work
- Performance is significant below expectations for cognitive/behavioral level
- Inability to pursue vocational goals in a normal time frame due to repeated absences or terminations
- Inability to secure or maintain employment at a self-sustaining level (for example inability to conform to work/school schedule, poor relationships at work/schools, hostile behaviors on the job)

Social Relationships / Environmental / Community

- Seriously disruptive to family and/or community
- Regularly involved in assaultive behavior
- Risk of deterioration due to persistent chronic factors such as isolation, poverty, extreme chronic stressors such as life threatening or debilitating medical illness or victimization
- Dangerous to self or others physical safety
- Impairment in community functioning due to a lack of ability/reliability to maintain structured time for sustainable social/relational activities
- Impairment in community functioning due to a consistent lack of age appropriate behavioral controls, decision making, judgments which result in potential need for out of home care or placement
- Impairment in community functioning due to a no reliability in problem solving skills
- Impairment in community functioning due to an inability to maintain safety without assistance

LIST OF STRENGTHS

Strengths of **Wisdom and Knowledge**: Cognitive strengths that entail the acquisition and use of knowledge

Creativity [originality, ingenuity]	Thinking of novel and productive ways to conceptualize and do things.
Curiosity [interest, novelty-seeking, and openness to experience]	Taking an interest in ongoing experience for its own sake; exploring and discovering.
Love of learning	Mastering new skills, topics, and bodies of knowledge, whether on one's own or formally.
Open-mindedness [judgment, critical thinking]	Thinking things through and examining them from all sides; weighing all evidence fairly.
Perspective [wisdom]	Being able to provide wise counsel to others; having ways of looking at the world that make sense to oneself and to other people.

Strengths of **Courage**: Emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external and internal

Bravery [valor]	Not shrinking from threat, challenge, difficulty, or pain; acting on convictions even if unpopular.
Integrity [authenticity, honesty]	Presenting oneself in a genuine way; taking responsibility for one's feeling and actions.
Persistence [perseverance, industriousness]	Finishing what one starts; persisting in a course of action in spite of obstacles.
Vitality [zest, enthusiasm, vigor, energy]	Approaching life with excitement and energy; feeling alive and activated.

Strengths of **Humanity**: interpersonal strengths that involve tending and befriending others

Kindness [generosity, nurturance, care, compassion, altruistic love, "niceness"]	Doing favors and good deeds for others.
Love	Valuing close relations with others, in particular those in which sharing and caring are reciprocated.
Social intelligence [emotional intelligence, personal intelligence]	Being aware of the motives and feelings of other people and oneself.

Appendix H.2 – Treatment Plan Help

Strengths of **Justice**: civic strengths that underlie healthy community life

Citizenship [social responsibility, loyalty, teamwork]

Working well as a member of a group or team; being loyal to the group.

Fairness

Treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others.

Leadership

Encouraging a group of which one is a member to get things done and at the same maintain time good relations within the group.

Strengths of **Temperance**: strengths that protect against excess

Forgiveness and mercy

Forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance; not being vengeful.

Humility / Modesty

Letting one's accomplishments speak for themselves; not regarding oneself as more special than one is.

Prudence

Being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted.

Self-regulation [self-control]

Regulating what one feels and does; being disciplined; controlling one's appetites and emotions.

Strengths of **Transcendence**: strengths that forge connections to the larger universe and provide meaning

Appreciation of beauty and excellence [awe, wonder, elevation]

Appreciating beauty, excellence, and/or skilled performance in various domains of life.

Gratitude

Being aware of and thankful of the good things that happen; taking time to express thanks.

Hope [optimism, future-mindedness, future orientation]

Expecting the best in the future and working to achieve it.

Humor [playfulness]

Liking to laugh and tease; bringing smiles to other people; seeing the light side.

Spirituality [religiousness, faith, purpose]

Having coherent beliefs about the higher purpose, the meaning of life, and the meaning of the universe.

A Primer in Positive Psychology (2007), Peterson - Adapted for Use by Butte County Behavioral Health.

Clinical Techniques

Be careful not to put a therapeutic modality that another clinician following you may not be trained in!

- Age-appropriate Social Activities
- Alternative Coping Strategies
- Anger Management
- Appropriate Behavior
- Appropriate Ways to Express Feelings of Anger
- Assertiveness Skills (i.e. boundaries)
- Behavior Modification
- Behavioral Interventions
- Cognitive Behavioral Therapy Skills
- Communication Skills (i.e. “I” messages)
- Connection between Behaviors and Emotions
- Coping Skills
- Reward System
- Daily Living Skills
- Decision Making Skills (Options)
- Developmental Stages of Children
- Dialectical Behavioral Therapy
- Family Therapy
- Functional Skills Building
- Group Therapy
- Individual Therapy
- Linkage and Brokerage (educational, medical, social, vocational, rehabilitative)
- Logical/Natural Consequences
- Medication Management (support, education, monitoring, reviewing, renewing scripts/collateral support)
- Meditation/Mindfulness Skills
- Organizational Skills
- Parenting Skills
- Problem Solving Skills (options, flexibility)
- Psychoeducation
- Recovery (i.e. Hope, Support Systems, Autonomy, etc.)
- Rehabilitation Services (skills)
- Relaxation Skills
- Resiliency
- Sand Tray Play
- Self-Management Skills
- Self-Regulations Skills
- Self-Soothing Skills
- Social Skills
- Solution Focus Techniques (normalizing, scaling questions, past success, etc.)
- Stress Tolerance (Emotional Resiliency)
- Substance Use Disorder Information/Education
- Supportive/Active Listening
- Therapeutic Games

Evidence Based Services Intervention Strategies and Definitions

Term	Definition
Activity Scheduling	The assignment or request that a client participate in specific activities outside of therapy time, with the goal of promoting or maintaining involvement in satisfying and enriching experiences.
Assertiveness Training	Exercises or techniques designed to promote the client’s ability to be assertive with others, usually involving rehearsal of assertive interactions.
Cognitive/Coping	Any techniques designed to alter interpretation of events through examination of reported thoughts, typically through the generation and rehearsal of alternative counter-statements. This can sometimes be accompanied by exercises designed to comparatively test the validity of the original thoughts and the alternative thoughts through the gathering or review of relevant information.
Commands/Limit Setting	Training for parents/caretakers in how to give directions and commands in such a manner as to increase the likelihood of child’s compliance.
Communication Skills	Training in how to communicate more effectively with others to increase consistency and minimize stress. Can include a variety of specific communication strategies (e.g., active listening, “I” statements).
Crisis Management	Immediate problem solving approaches to handle urgent or dangerous events. This might involve defusing an escalating pattern of behavior and emotions either in person or by telephone, and is typically accompanied by debriefing and follow-up planning.
Directed Play	Exercises involving the child/youth and caretaker playing together in a specific manner to facilitate their improved verbal communication and nonverbal interaction. Can involve the parent/caretaker’s imitation and participation in the youth’s activity, as well as parent-directed play.
Emotional Processing	A program based on an information processing model of emotion that requires activation of emotional memories in conjunction with new and incompatible information about those memories.

Section H.2—Treatment Plan Helps

Term	Definition
Exposure	Techniques or exercises that involve direct or imagined experience with a target stimulus, whether performed gradually or suddenly, and with or without the therapist’s elaboration or intensification of the meaning of the stimulus.
Eye Movement/ Tapping	A method in which the client is guided through a procedure to access and resolve troubling experiences and emotions, while being exposed to a therapeutic visual or tactile stimulus designed to facilitate bilateral brain activity.
Family Engagement	The use of skills and strategies to facilitate family/ child’s positive interest in participation in an intervention.
Family Therapy	A set of approaches designed to shift patterns of relationships and interactions within a family, typically involving interaction and exercises with the youth, the caretakers, and sometimes siblings.
Functional Analysis	Arrangement of antecedents and consequences based on a functional understanding of a client’s behavior. This goes beyond straightforward application of other behavioral techniques.
Guided Imagery	Visualization or guided imagined techniques for the purpose of mental rehearsal of successful performance.
Ignoring or Differential Reinforcement of Other Behavior	The training of parents or others involved in the social ecology of the youth/client to selectively ignore mild target behaviors and selectively attend to alternative behaviors.
Insight Building	Activity designed to help a client achieve greater self-understanding.
Interpretation	Reflective discussion or listening exercises with the client designed to yield therapeutic interpretations. This does not involve targeting specific thoughts and their alternatives, which would be cognitive/coping.
Line of Sight Supervision	Direct observation of a youth for the purpose of assuring safe and appropriate behavior.
Medication/ Pharmacotherapy	Any use of psychotropic medication to manage

Term	Definition
Mentoring	Pairing with a more senior and experienced individual to serve as a positive role model for the identified client.
Milieu Therapy	A therapeutic approach in residential settings that involves making the environment itself part of the therapeutic program. Often involves a system of privileges and restrictions such as a token or point system.
Mindfulness	Exercises designed to facilitate present-focused, non-evaluative observation of experiences as they occur, with a strong emphasis of being “in the moment.” This involves the client’s conscious observation of feelings, thoughts, situations, or environment.
Modeling	Demonstration of a desired behavior by a therapist, confederates, peers, or others to promote the imitation and subsequent performance of that behavior by the identified client.
Motivational Interviewing	Exercises designed to increase readiness to participate in additional therapeutic activity or programs. These can involve cost benefit analysis, persuasion, or a variety of other approaches.
Natural and Logical Consequences	Training for parents/caregivers or clients in (a) allowing clients to experience the negative consequences of poor decisions or unwanted behaviors, or (b) Parent/caregivers delivering consequences in a manner that is appropriate for the behavior performed by the youth.
Parent Coping	Exercises or strategies designed to enhance parent or caretakers’ ability to deal with stressful situations, inclusive of formal interventions targeting one or more caretaker.
Parent-Monitoring	The repeated measurement of some target index by the caretaker.
Parent Praise	The training of parents or others involved in the social ecology of the child in the administration of social rewards to promote desired behaviors. This can involve praise, encouragement, affection, or physical proximity.

Section H.2—Treatment Plan Helps

Term	Definition
Peer Modeling/Pairing	Pairing with another client of same gender, background, or similar age to allow for reciprocal learning or skills practice.
Play Therapy	The use of play as a primary strategy in therapeutic activities. This may include the use of play as a strategy for clinical interpretation. Different from Directed Play, This is also different from play designed specifically to build relationship quality.
Problem Solving	Techniques, discussions, or activities designed to bring about solutions to targeted problems, usually with the intention of imparting a skill for how to approach and solve future problems in a similar manner.
Psychoeducational-Client	The formal review of information with the client about the development of a problem and its relation to a proposed intervention or skill.
Psychoeducational-Collateral	The formal review of information with the caretaker(s) or family about the development of the client’s problem and its relation to a proposed intervention. This often involves an emphasis on the caretaker/ family’s role in either or both.
Relapse Prevention	Exercises and training designed to consolidate skills already developed and to anticipate future challenges; with the overall goal to minimize the chance that gains will be lost in the future
Relationship/ Rapport Building	Strategies in which the immediate aim is to increase the quality of the relationship between the client and the therapist. For children, it can include play, talking, games, or other activities.
Relaxation	Techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, meditation, and similar activities. Guided imagery exclusively for the purpose of physical relaxation.
Response Prevention	Explicit prevention of a maladaptive behavior that typically occurs habitually or in response to emotional or physical discomfort.
Self-Monitoring	The repeated measurement of some target index by the client.

Section H.2—Treatment Plan Helps

Term	Definition
Self-Reward/Self-Praise	Techniques designed to encourage the client to self-administer positive consequences contingent on performance of target behaviors.
Skill Building	The practice or assignment to practice or participate in activities with the intention of building and promoting talents and competencies.
Social Skills Training	Providing information and feedback to improve interpersonal verbal and non-verbal functioning, which may include direct rehearsal of the skills.
Stimulus/Antecedent Control	Strategies to identify specific triggers for problem behaviors and to alter or eliminate those triggers in order to reduce or eliminate the behavior.
Supportive Listening	Reflective discussion with the client designed to demonstrate warmth, empathy, and positive regard, without suggesting solutions or alternative interpretations.
Tangible Rewards / Response Cost	The training of parents or others involved in the social ecology of the client in the administration of tangible rewards to promote desired behaviors. negative behaviors result in the loss of points or tokens
Therapist Praise/ Rewards	The administration of tangible or social (e.g., praise) reinforcers by the therapist.
Time Out	The training of or the direct use of a technique involving removing the child/youth from all reinforcement for a specified period of time following the performance of an identified, unwanted behavior.
Twelve-Step Programs	Any program that involve the twelve-step model for gaining control over problem behavior, most typically in the context of alcohol and substance use, but can be used to target other behaviors as well.

OTHER INTERVENTION MODALITIES

- Teach family **Alternative Coping Strategies** for solving family conflicts
- Teach **Anger Management Techniques** to reduce likelihood of violence
- Model **Appropriate Expressions** of feelings
- Provide **Assertiveness Training** for client in a group setting
- Teach/Model **Boundaries**
- **Cognitive Behavior Therapy** to address...
- **Brief Solution Focused Therapy**
- Teach **Collaborative Problem Solving** skills
- **Communication skill-building**
- **Conflict resolution**
- **Crisis Intervention/De-escalation**
- **DBT**
- **EMDR**
- Assist client to **Identify** consequences of behaviors
- **Insight-oriented therapy**
- **Life Review**
- **Limit setting**
- Encourage **Medication Compliance**
- **Medication support services** (Medical Staff only)
- **MET**
- **Parent Child Interactive Therapy**
- Provide **Positive Reinforcement/Praise** for effective management of emotions/anger
- **Problem Solving skill building**
- **Psycho-Education**
- Teach **Relaxation Techniques** to help cope with anxiety
- Teach **Relapse Prevention Skills** to maintain sobriety
- Use **Role-Play** to teach communication skills
- **Sand Tray Therapy**
- Teach **Social Skills**
- **Therapeutic Behavioral Service (TBS)**
- **Therapeutic Play**
- **Unstructured Play Therapy**

THE SEVEN “RESILIENCIES”

- Insight
- Independence
- Relationships
- Initiative
- Creativity
- Humor
- Morality



Characteristics of children who succeed in spite of troubled environments

Thirty-year longitudinal research by Emmy Werner (now replicated in various settings by many others) has resulted in the identification of certain factors that facilitate the development of youth who do not get involved in life and health destructive behaviors even though they may come from troubled families, neighborhoods or communities. The characteristics of the **Resilient Child** are:

- **Autonomy** (including healthy resistance)
- **Social Competence** (including relationship skills and humor)
- **Problem Solving Skills** (including the ability to think critically and take initiative)
- **Sense Of Purpose and Future** (including special interests, goal directedness, and motivation)

Children who succeed have adults in their lives who provide caring and support, transmit high expectations and facilitate responsible facilitation in and contribution to the functioning of the family, classroom, school and community. These adults—parents, teachers, neighbors, youth workers, aunts, uncles, grandparents, clergy, counselors, health care providers— are able to light a child’s dream of a better life. In some cases there was only ONE significant caring adult who made the difference.

PROGRESS NOTE HELP

The functional impairment/behavior/symptom is underlined. These can be changed to suit the functional impairment/behavior/symptom that has been identified in the treatment plan and is the focus of the treatment intervention. There are interventions that may go in more than one category. Please use these within your scope of practice.



Examples of Intervention/Therapeutic Sentences: (include focus of the technique from treatment plan)

ANXIETY

- Assessed thought process and reasons for symptoms of anxiety
- Explored triggers/situations that cause increased anxiety
- Referred for medication evaluation to address symptoms of anxiety
- Processed benefits of taking medication to decreased anxiety symptoms
- Encouraged client reading on roots of social anxiety
- Processed medication adherence and how it is helping to reduce anxiety symptoms
- Explored benefits medication adherence and changes in symptoms of anxiety to cause lack of socialization
- Taught relaxation skills to assist with reduction in anxiety symptoms
- Utilized relaxation homework to reinforced skills learned
- Assisted to analyze fears, in logical manner; Develop insight into worry/avoidance
- Encouraged identifying source of distorted thoughts
- Encouraged use of self-talk exercises
- Taught thought stopping techniques
- Identified situations that are anxiety provoking
- Taught/practiced problem-solving strategies
- Encouraged routine use of strategies
- Assisted to identify coping skills that have helped in the past
- Validated/reinforced use of coping skills
- Assisted to identify unresolved conflicts and how they play out

BORDERLINE PERSONALITY

- Assessed behaviors and thoughts that cause distress
- Explored interpersonal skills
- Explored trauma/abuse from past that cause reoccurring distress
- Validated distress and difficulties
- Explored how DBT may be helpful
- Encouraged outside reading on BPD
- Explored risky behaviors/self-injurious behaviors when distressed
- Assisted client to improve insight into self-injurious behaviors
- Encouraged the practice use of coping skills when distressed
- Assisted to identify and work through therapy interfering behaviors
- Processed benefits/effectiveness of medication
- Educated client on skills training/ Encouraged use of skills
- Explored all self-talk
- Reinforced use of positive self-talk
- Assisted to identify and explore triggers
- Review homework/Review Diary Card
- Reinforce completion of homework/diary card
- Reinforce use of DBT skills
- Encourage/reinforce trust in own responses

SUBSTANCE USE/ABUSE

- Explored drug/alcohol history
- Referred for physical exam to primary care physician; Encouraged follow up with physician
- List/identify negative consequences of substance use/abuse
- Educated on consequences of substance use on mental health
- Encouraged to remain open to processed ion around denial/acceptance
- Encouraged participation in AA/NA
- Supported/reinforced client's participation in substance abuse treatment
- Facilitated/explored understanding of risk factors
- Assisted to identify and list positive aspects of sobriety
- Reinforced development of substance free relationships
- Reviewed effects of negative peer influences
- Encouraged exercise and social activities that do not include substances
- Encouraged positive change in living situation
- Assisted to identify positive aspects of sobriety on family unit/social support system
- Reinforced working on sobriety
- Reframed/ Explore effects of negative self-talk
- Assessed stress management skills
- Taught stress management skills / Reinforced use of stress management skills
- Explored effective after-Client Plan

TRAUMA

- Worked together on building trust
- Explored issues around trust
- Taught/explored learning trust of others
- Assisted to identify and research family dynamics and how they played out (i.e. genogram)
- Explored effects of childhood experiences that cause distress (or anxiety/depression, etc.)
- Encouraged healthy expression of feelings
- Encouraged use of journaling
- Encouraged outside reading on trauma
- Explored how trauma impacts parenting patterns
- Educated on dissociation as a coping response
- Explored history of dissociative experiences
- Supported confronting of perpetrator
- Utilized empty-chair exercise to work through trauma
- Assisted to identify and explore benefits of forgiveness
- Explored roles of victim and survivor and how they are playing out

DEPENDENCY

- Explored history of dependency on others
- Identified how fear of disappointing others affects functioning
- Assisted to identify and list positive aspects of self
- Assigned positive affirmations
- Assisted to identify how distorted thoughts affect understanding
- Assisted to identify and explore fears of independence
- Identified ways to increase independence
- Taught and reinforced positive self-talk
- Explored effects of sensitivity to criticism
- Educated on co-dependency
- Explored issues around co-dependency
- Educated on benefits of assertiveness skills
- Taught/practice assertiveness skills
- Reinforced/encouraged assertiveness
- Encouraged use of “No”
- Assisted to identify and list steps toward independence
- Assisted to identify ways of giving without receiving
- Taught about healthy boundaries
- Practiced/reinforced/modeled use of healthy boundaries
- Encouraged positive decision making

DEPRESSION

- Assessed history of depressed mood
- Assisted to identify symptoms of depression
- Assisted to identify what behaviors associated with depression
- Explored/assessed level of risk
- Assessed/monitor suicide potential and risk
- Taught and assisted to identify coping skills to decrease suicide risks
- Assisted to identify patterns of depression
- Encourage journaling feelings as coping skill
- Assisted to identify support system
- Assisted client in developing WRAP plan; Encouraged use of WRAP plan
- Encouraged/reinforced positive self-talk
- Explored issues of unresolved grief/loss
- Taught/assisted to identify coping skills to manage interpersonal problems
- Reinforced/recommend physical activity
- Monitor and encouraged self-care (hygiene/grooming)
- Normalized feelings of sadness and responses
- Explored potential reasons for sadness/pain
- Assisted client to connect anger/guilt with depression

Descriptive Words

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Most Commonly Used

- Age-appropriate
- Appears
- Declines
- Demonstrates
- Inconsistent
- Initiates
- Noted
- Observed
- Offers
- Produces
- Refuses
- Reports
- Resists
- Seems
- Shows
- Situation-Appropriate
- States
- Withdraws

AFFECT

- Agitated
- Angry
- Animated
- Anxious
- Apprehensive
- Belligerent
- Bland/Blunted
- Bright
- Calm
- Cheerful
- Comfortable
- Composed
- Constricted
- Controlled
- Dazed
- Dejected
- Depressed
- Despondent
- Disappointed
- Eager
- Elated
- Energetic
- Enthusiastic
- Euphoric
- Exhilarated
- Fearful
- Fixed Expression
- Flat
- Frightened
- Frustrated
- Guilty
- Happy
- Hopeless
- Hostile
- Indignant
- Interested
- Irritable
- Labile
- Lacking Energy
- Matter-Of-Fact
- Motivated
- Nonchalant
- Overwhelmed
- Panicky
- Placid
- Powerless
- Pressured
- Puzzled
- Relaxed
- Remorseful
- Resentful
- Sad
- Scowling
- Self-Critical
- Self-Deprecatory
- Self-Effacing
- Serious
- Smiling
- Sober
- Spontaneous
- Staring
- Subdued
- Sullen
- Tearful
- Tense
- Unhappy

COGNITIVE

Mental State:

- Alert
- Attention Span
- Aware
- Clear
- Comprehension
- Concentration
- Confuse
- Delusions
- Disoriented
- Distractible
- Drowsy
- Dull
- Focused
- Hallucinations
- Insightful
- Memory (Recent, Remote)
- Perceptive
- Preoccupied
- Reality Testing

Thought Process:

- Abstracting
- Blocked
- Concrete Thinking
- Disorganized
- Expansive
- Flight Of Ideas
- Generalizing
- Grandiose
- Obsessive
- Poverty Of Thought
- Pressured
- Processing
- Racing Thoughts
- Rambling
- Scattered
- Tangential
- Tracking

MOTOR

Movements:

- Abrupt
- Active
- Agitated
- Aimless
- Balance
- Coordination
- Delayed
- Dexterity
- Dyskinesia
- Eye-Hand Coordination
- Fine Motor
- Fluid
- Forceful
- Gait
- Gestures
- Gross Motor
- Handwriting (Quality)
- Hypermobility
- Hyper-Responsive
- Jerking
- Latent
- Lethargic
- Listless
- Mannerism
- Motor Planning
- Nervous Habit
- Overstimulated
- Pacing
- Passive
- Perseverating
- Purposeless
- Quick
- Repetitive
- Restless
- Retardation
- Rocking
- Self-Stimulating
- Slow
- Spasm
- Spontaneous
- Startles
- Strong
- Tentative
- Tremor

Posture:

- Head down
- Open/closed
- Relaxed
- Rigid
- Slouching
- Slumped
- Tense

SOCIAL

- Aggressive
- Agreeable
- Apathetic
- Argumentative
- Articulate
- Assertive
- Boastful
- Care-Taking
- Competitive
- Compliant
- Concerned
- Condescending
- Congenial
- Considerate
- Cooperative
- Critical
- Cynical
- Deferring
- Dependent
- Detached
- Distrustful
- Docile
- Dominating
- Doting
- Engages In Power Struggle
- Engaging
- Expressive
- Flippant
- Forceful
- Gracious
- Guarded
- Indifferent
- Ingratiating
- Intrusive
- Isolating
- Joking
- Open
- Outspoken
- Passive
- Provocative
- Reclusive
- Reserved
- Sarcastic
- Self-Disclosing
- Self-Focused
- Sense Of Humor
- Sensitive
- Shy
- Solitary
- Spontaneous
- Submissive
- Superficial
- Supportive
- Suspicious
- Sympathetic
- Tactful
- Talkative
- Tentative
- Threatening
- Timid
- Tolerant
- Warm
- Watchful
- Withdrawn

Social Behaviors:

- Awareness of social/physical boundaries
- Body posture: open, closed, accessible
- Eye contact (direct, occasional, elusive)
- Group skills: parallel, competitive, cooperative
- Patient response to authority
- Placement of seating in group (isolates, dominates, on fringe)
- Quality of grooming
- Response of peers to patient
- Response of peers to patient
- Role of patient in group
- Selective interactions (peers, staff, men, women, young, old)
- Speech patterns (rapid, forced, spontaneous, latent)
- Tone of voice (monotone, inaudible, loud, soft)
- Verbal/nonverbal

TASK PERFORMANCE

Following Directions:

- Follows (1-2-or3) step directions
- Follows demonstrations
- Follows verbal directions
- Follows written directions
- Learns quickly
- Needs clarification
- Needs cuing
- Needs hands-on assist
- Needs repeated directions
- Retains instructions

Use of Time:

- Efficient
- Hurried
- Irregular attendance
- Organized
- Plans ahead
- Productive
- Realistic planning
- Scattered
- Sets goals
- Skips steps
- Slow to get started
- Utilizes time well
- Works intermittently
- Works slowly
- Works steadily

Choice of Activity:

- Ambivalent
- Apathetic
- Chooses familiar activity
- Creative, repetitive
- Decisive
- Detailed, short term
- Hesitant
- Indecisive
- Indifferent
- Quickly engages
- Resistant
- Seeks challenging activity
- Selects (type of activity)
- Slow to engage
- Takes initiative
- Unrealistic choice

Approach to Activity:

- Accurate
- Careful
- Careless
- Cautious
- Compulsive
- Disregards mistakes
- Eager
- Follows through
- Impulsive
- Interested
- Neat
- Orderly
- Patient
- Persevering
- Persistent
- Problem solving
- Quality of work
- Quick gratification
- Reckless
- Recognizes mistakes
- Seeks quick results
- Thorough
- Tolerates delays
- Tolerates frustration
- Unaware of mistakes
- Use of judgment

Independence/Dependence:

- Accepts direction
- Disregards direction
- Refuses direction
- Seeks reassurance
- Teaches others
- Competent
- Independent
- Responsible
- Self-reliant
- Debates suggestions
- Needs reminding
- Seeks direction
- Self-sufficient

Person-Centered Language

Deficit-Based Language	Strengths-Based, Recovery-Oriented Alternative
A schizophrenic, a borderline	A person diagnosed with schizophrenia who experiences the following...
An addict/junkie	A person diagnosed with an addiction that experiences the following...
Suffering from...	Working to recover from; Experiencing; Living with...
High-functioning vs. Low Functioning	Person's symptoms interfere with their relationship (e.g., work habits, etc.) in the following way...
Acting-out	Person disagrees with Recovery Team and prefers to use alternative coping strategies
Self-help	Recovery support groups/mutual aid groups
Unrealistic	Person has high expectations for self and recovery
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis; does not agree that they have a mental illness pre-contemplative stage of
Weaknesses	Barriers to change; needs
Unmotivated	Person is not interested in what the system has to offer; interests and motivating incentives unclear; Preferred options not available
Resistant; Not open to...	Chooses not to...Has own ideas...
Maintaining Stability/Abstinence	Promoting and sustaining recovery
Non-compliant with medications/treatment	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; Has a crisis plan for when meds should be used; beginning to think for oneself
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities