COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
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CalAIM Assessment Practice Guidelines | Mental Health Adult

Instructions: Enter information into each domain's text box to address both the bolded topics in black font and helpful tips in blue font. If the client prefers not to provide information for a specific topic, note that you asked and client declined to answer.

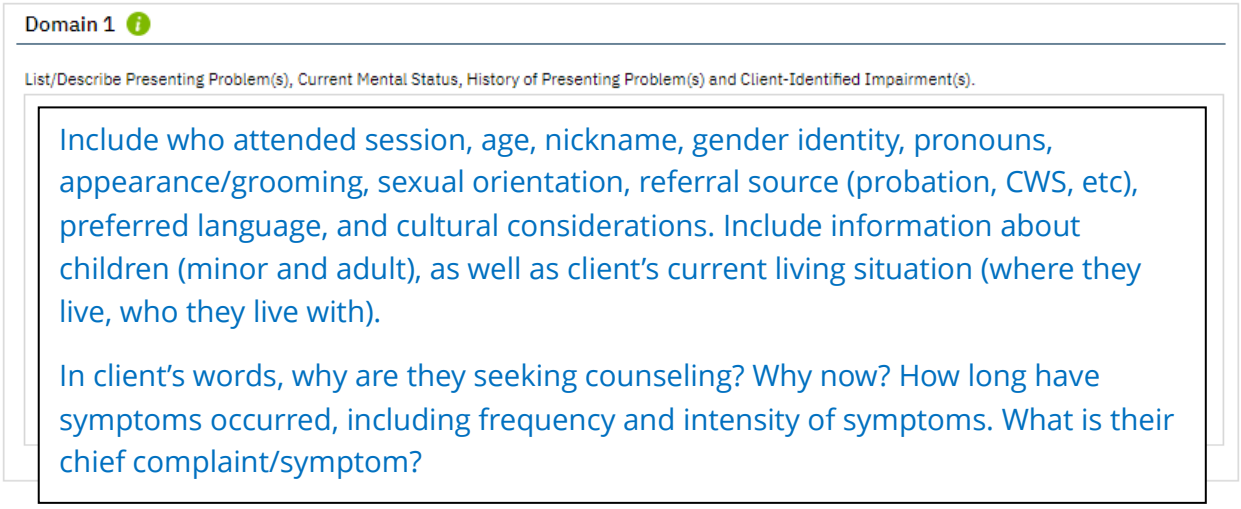
Required Information: When documenting that a client meets access criteria, a detailed description of how the client meets access criteria needs to be clearly documented in the assessment. This includes descriptions of functional impairments and how they relate to meeting access criteria, as well as how they relate to diagnostic criteria. See pages 9-11 for documentation examples. See page 12 for Access Criteria information and guidelines.

Domain 1 | Presenting Problem

Presenting Problem - Why is the client requesting services?

Presenting Problem – Current and history of presenting problem(s) and the impact problem(s) have on the client. Include, when possible, duration, severity, context, and cultural understanding of the chief complaint and its impact

Impairments in Functioning – Level of distress, disability, or dysfunction in one or more important areas of life functioning, as well as protective factors related to functioning

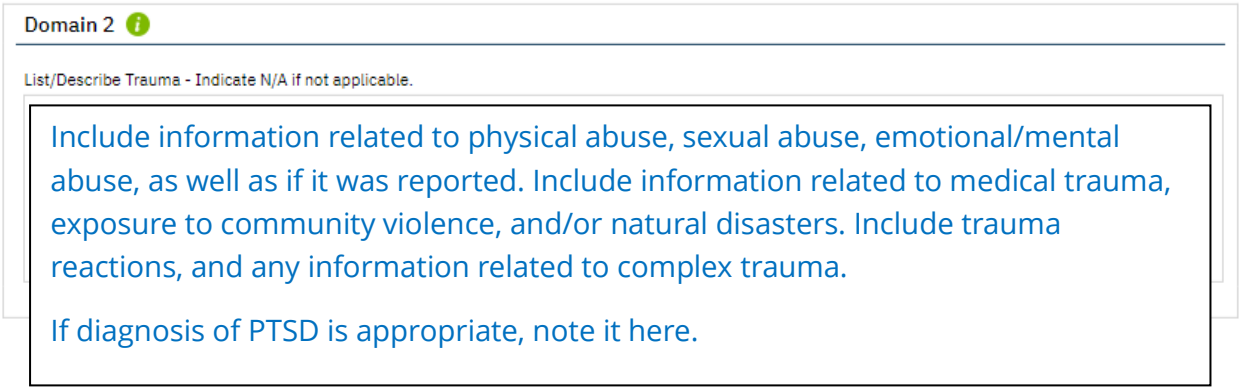


Domain 2 | Trauma

Trauma Exposures - Take cues from the client, it is not necessary to document the details of trauma in depth, but rather aim for a description of the client's psychological and emotional responses to one or more life events that are deeply distressing or disturbing

Trauma Reactions - Seek to understand the client's reaction to the stressful situation (avoidance of feelings, irritability, interpersonal problems, etc.) and/or impact of trauma exposure on client's well-being, developmental progression, and/or risk behaviors

Systems Involvement - The client's involvement with homelessness, criminal/juvenile justice, or child protective services

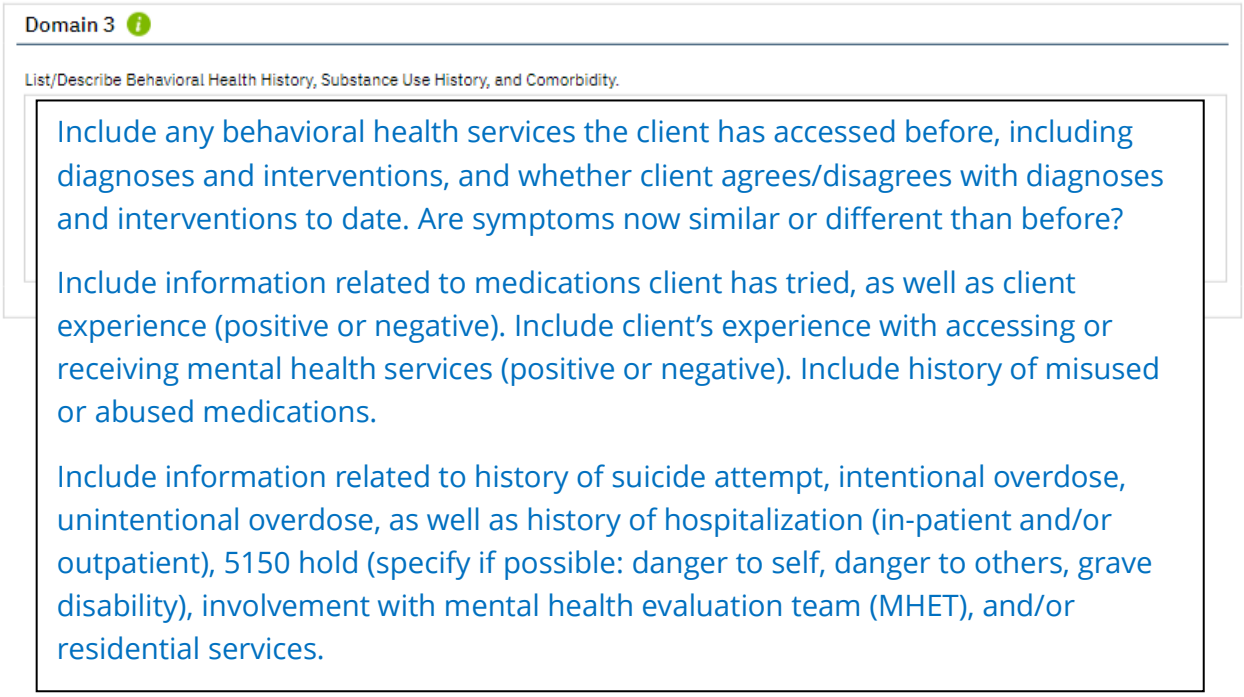


Domain 3 | Behavioral Health History

Mental Health History – Review of acute or chronic conditions not described in earlier domains. Mental health conditions previously diagnosed or suspected should be included

Substance Use/Abuse – Past/present use including type, method, frequency of use and impact of substance use on presenting problem

Previous Services – Review of previous treatment received for behavioral health needs including providers, types of services, length of treatment, efficacy/response to interventions

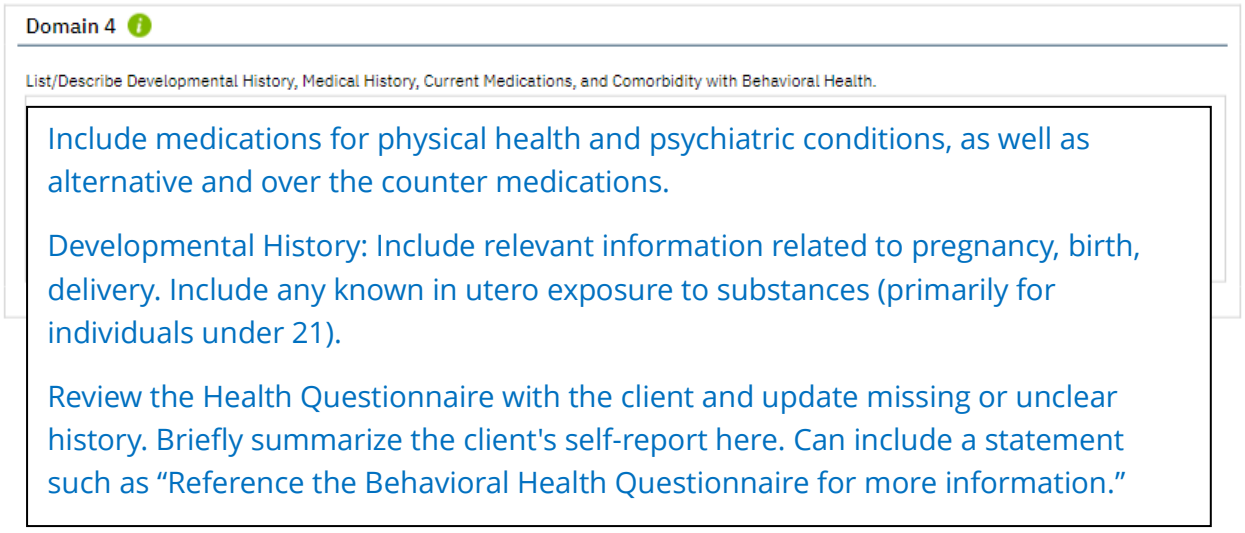


Domain 4 | Medical History

Physical Health Conditions – Current or past conditions, treatment history, and allergies (including to medications)

Medications – Current and past medications, previous prescribers, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. Start/end dates or approximate time frames for medication use and reason for ending use.

Developmental History – Prenatal and perinatal events and relevant or significant developmental history (primarily for individuals under 21)



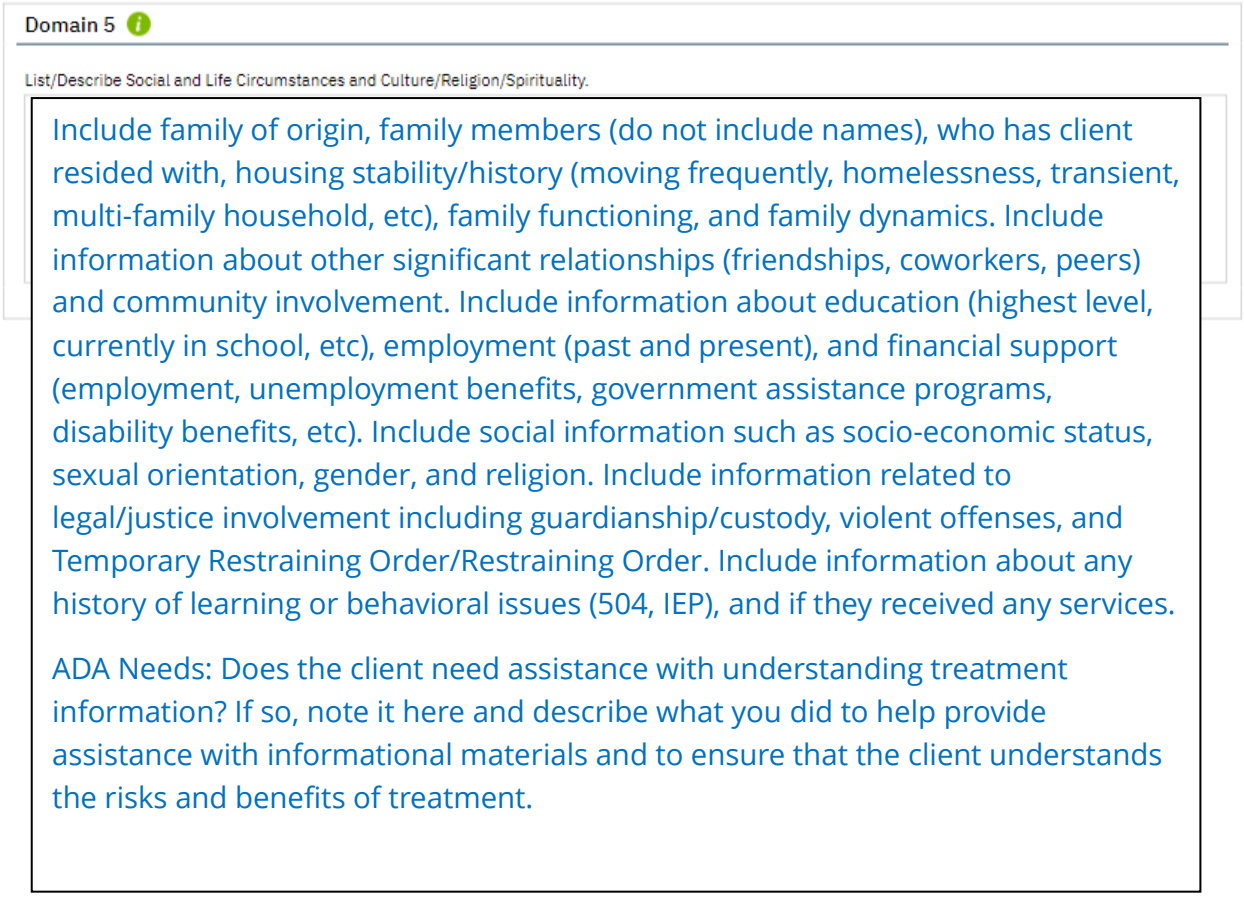
Domain 5 | Psychosocial Factors

Psychosocial Factors - Seek to understand the environment in which the client is functioning. This environment can be micro (family) and macro (systemic racism and broader cultural factors)

Family – Family history, current family involvement, significant life events within family

Social and Life Circumstances – Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, a description of how the individual interacts with others and in relationship with the larger social community

Cultural Considerations – Identify linguistic factors, beliefs, values, and traditions

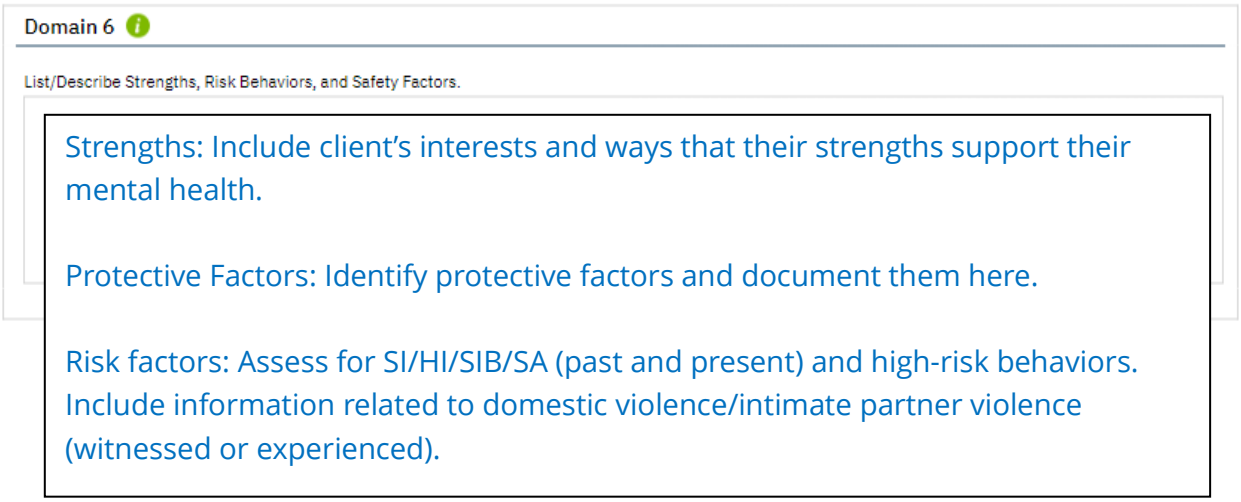


Domain 6 | Strengths/Risks

Strengths and Protective Factors – Personal motivations, desires and drives, hobbies and interests, coping skills, resources, supports, interpersonal relationships

Risk Factors and Behaviors – Behaviors that put the client at risk for danger to themselves or others such as suicidal ideation/plan/intent, homicidal ideation/plan/intent, inability to care for self, recklessness. Also describe willingness to seek/obtain help and triggers or situations that may result in risky behaviors (loneliness, gang affiliations, drug use).

Safety Planning – Utilize clinical discretion to determine if a safety plan is needed. Summarize safety plan, include the resources you provided, and the client's response to the plan. Upload copy of Safety Plan to SmartCare.



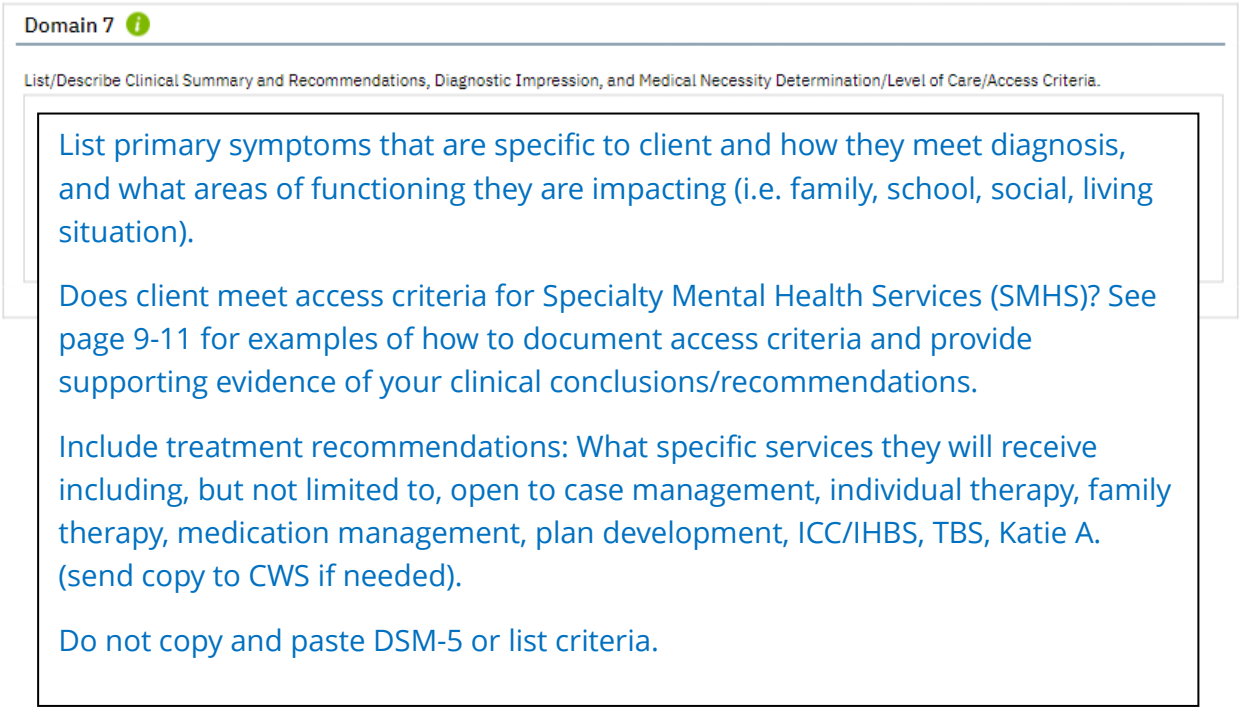
Domain 7 | Clinical Summary

Clinical Summary - Summarize a working theory about how the client's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed.

Clinical Impression – Summary of symptoms supporting diagnosis, functional impairments, and overall assessment

Diagnostic Impression – Document diagnoses and Rule Out diagnoses

Treatment Recommendations – Overall goals for care and recommended services/interventions



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Examples for Initial Intake:

Employment: Severe. Client's MH symptoms including depressed mood, insomnia, and other affective instability have contributed to her impairments in occupational functioning. Client is unable to work and is receiving SSA benefits.

Family: Moderate. Client's MH symptoms including efforts to avoid abandonment, affective instability, and fearfulness contribute to impairments in family functioning. She continues to experience guilt feelings over her parenting and past DV relationships she was in while raising her children.

Family: Severe. Client's MH symptoms related to trauma has resulted in mistrust of her family which results in client having no positive relationships with family members and if they do see each other, a verbal altercation typically occurs.

Residential: Mild. Client continues to live in subsidized housing apartment in Paso Robles, CA and without subsidized housing would not be able to afford housing.

Residential: Severe. Client's MH sx of depression and anxiety have resulted in inability to pay bills, rent, and has been unable to maintain stable housing. Client is currently unhoused and staying either at Prado or in their car.

Social: Moderate. Client's MH symptoms of depressed mood, insomnia, affective instability, and isolation contribute to her impairments in social functioning. Client will go through periods of being more social, then have episodes of isolation.

Social: Severe. Client's MH symptoms of depressed mood, insomnia, affective instability, and isolation contribute to her impairments in social functioning. Client will isolate from others for days/weeks at a time. She will avoid any attempts from others to engage in social activities or connection. She spends her days alone.

ADL/Self Care: Moderate. Client's MH symptoms such as difficulty concentrating, rumination, fatigue, and other negative symptoms are contributing to impairments in ADL/Self Care functioning. Client reports difficulty keeping up with laundry, shopping, and making healthy dinners for herself.

ADL/Self Care: Severe. Client's MH symptoms such as difficulty concentrating, rumination, fatigue, and other negative symptoms are contributing to impairments in ADL/Self Care functioning. Client reports they are unable to shower, brush teeth, cook meals, grocery

shop, do laundry or clean the house. Client cannot remember the last time they appropriately completed their ADLs.

Example for Annual:
"Client has been receiving services for [length of time OR since last intake date of ___] and continues to meet access criteria and this clinician recommends the following treatment plan for the next twelve months: [weekly therapy, case management services as needed, medication support services as directed, etc.] in order to [statement about needs and functioning: reduce symptoms of depression and anxiety, to increase distress tolerance to support, to improve functioning in relationships/school performance, etc]."

Sample Access Criteria Statements

Mental Health Documentation Guidelines

Severe Impairments

• Client's severe social withdrawal/isolation, inability to maintain employment, and multiple arrests due to psychiatric symptoms can only be treated with specialty mental health services

• Client's poor social relationships, lack of familial connections, inability to maintain employment and secure stable housing are likely to result in decompensation and a higher level of care without outpatient specialty mental health services

• Client's severe level of impairments resulted in LPS conservatorship due to his inability to access food, clothing or shelter. Specialty mental health services are required to prevent further marked deterioration.

• Client is not currently capable of independently accessing needed services without the intensive support of a case manager and higher level of care. His needs exceed what can be effectively provided at an outpatient clinic setting. Without additional support, client is likely to decompensate due to his mental illness.

Moderate Impairments

• Client's pattern of isolating self from close family and friends, history of passive SI w/ no plan) require outpatient specialty mental health services to maintain current gains.

• Client's recent explosive break up of her relationship and eviction from housing require outpatient specialty mental health services to ensure that she does not decompensate and require a higher level of care.

• After numerous unsuccessful trials of oral medication, client is stabilizing on injectable medication that is only available as a specialty mental health service. Without this medication client is highly likely to decompensate and require a higher level of care.

• Frequent family conflicts require coordinated care and home-based interventions to prevent the need for out of home care.

Developmental

• Client’s angry outbursts with peers and school refusal require specialty mental health services to allow him to develop appropriate social skills. Without SMHS, he is likely to fall further behind peers socially.

EPSDT

• Even though client's impairments are mild, he needs home-based specialty mental health services to reduce the angry outbursts because caregivers are not likely to access services through other available resources

Access Criteria for individuals 21 years of age and older

SMHS shall be offered for adult beneficiaries who meet both of the following criteria:

1. The beneficiary has **one or both** of the following:
    a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
    AND/OR
    b. A reasonable probability of significant deterioration in an important area of life functioning

    AND

2. The beneficiary's condition as described in item (1) above is due to **either of the following**:
    a. A diagnosed included mental health disorder
    OR
    b. A suspected mental disorder that has not yet been diagnosed