COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
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Practice Guidelines | Mental Health Youth

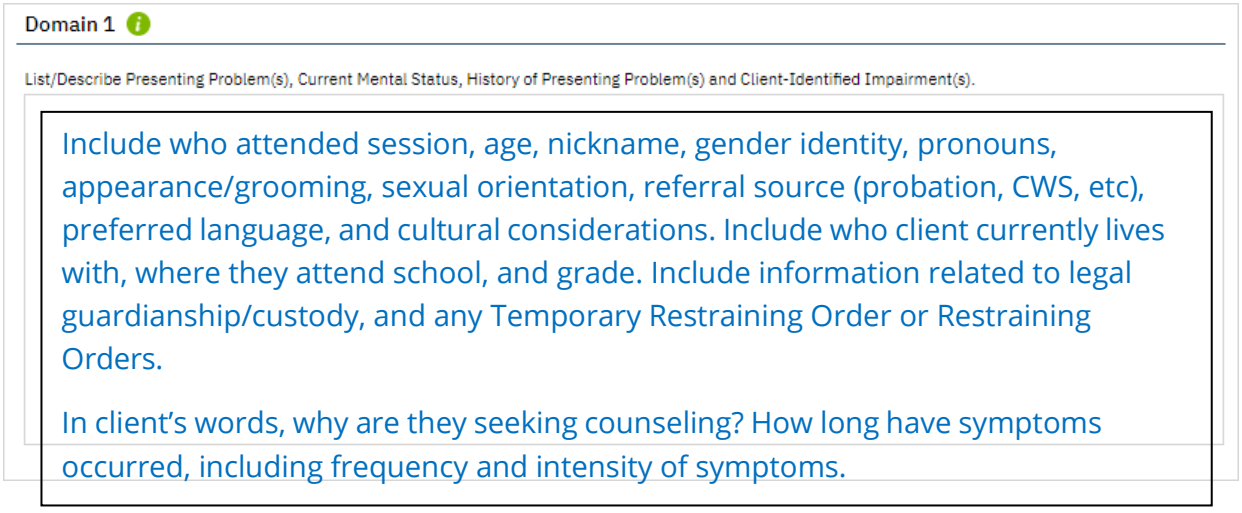
Instructions: Enter information into each domain's text box to address both the bolded topics in black font and helpful tips in blue font. If the client prefers not to provide information for a specific topic, note that you asked and client declined to answer.

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

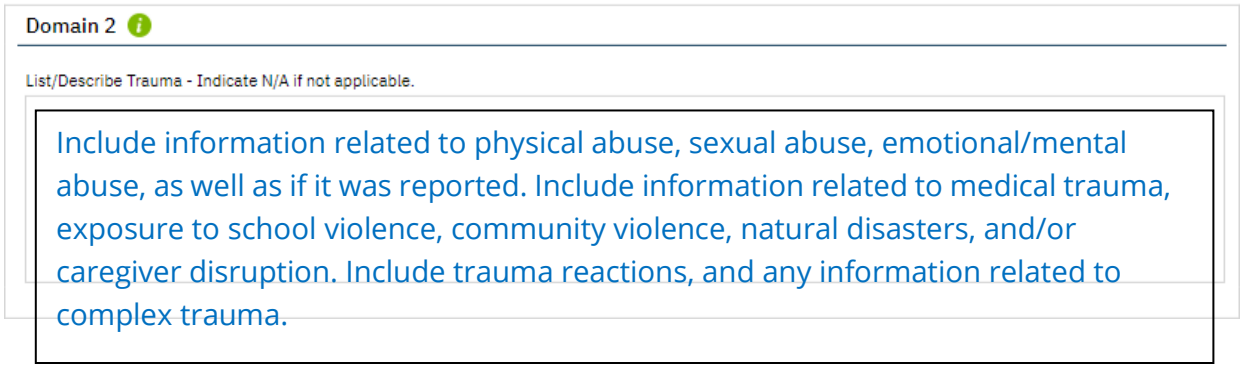


Domain 2 | Trauma

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

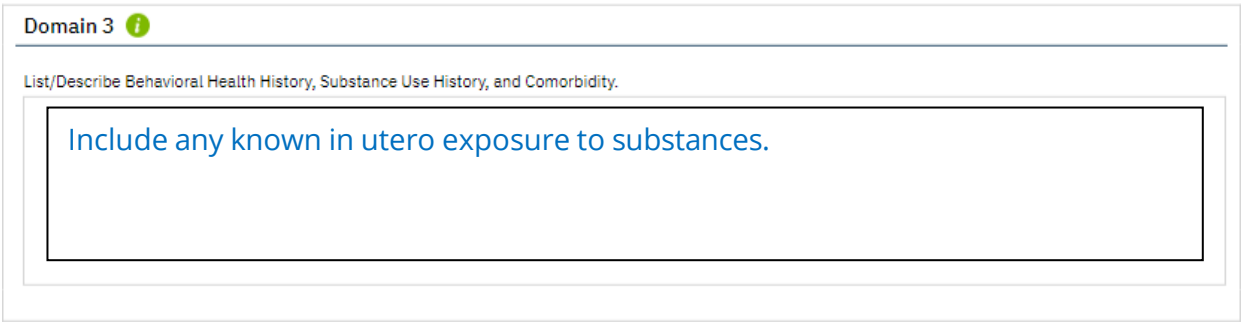


Domain 3 | Behavioral Health History

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

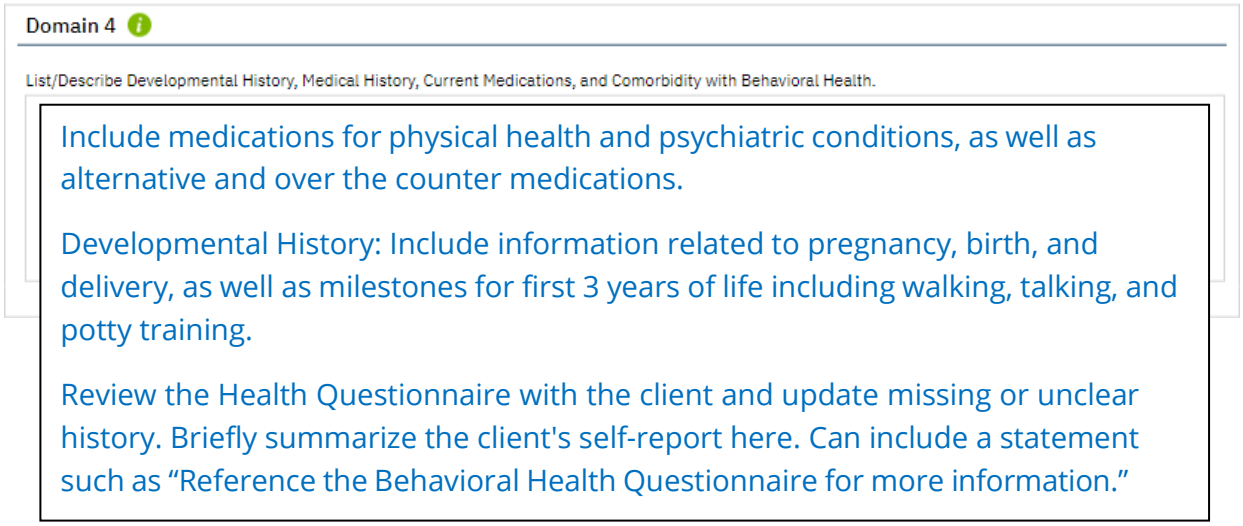


Domain 4 | Medical History

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)



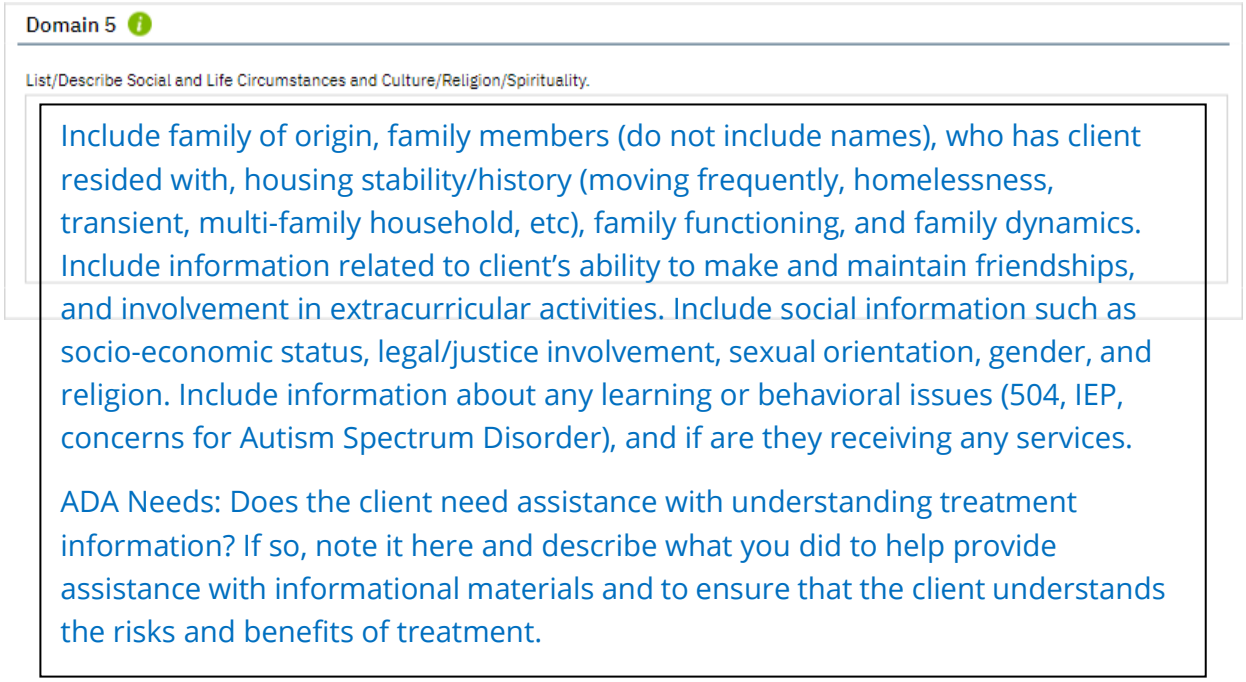
Domain 5 | Psychosocial Factors

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

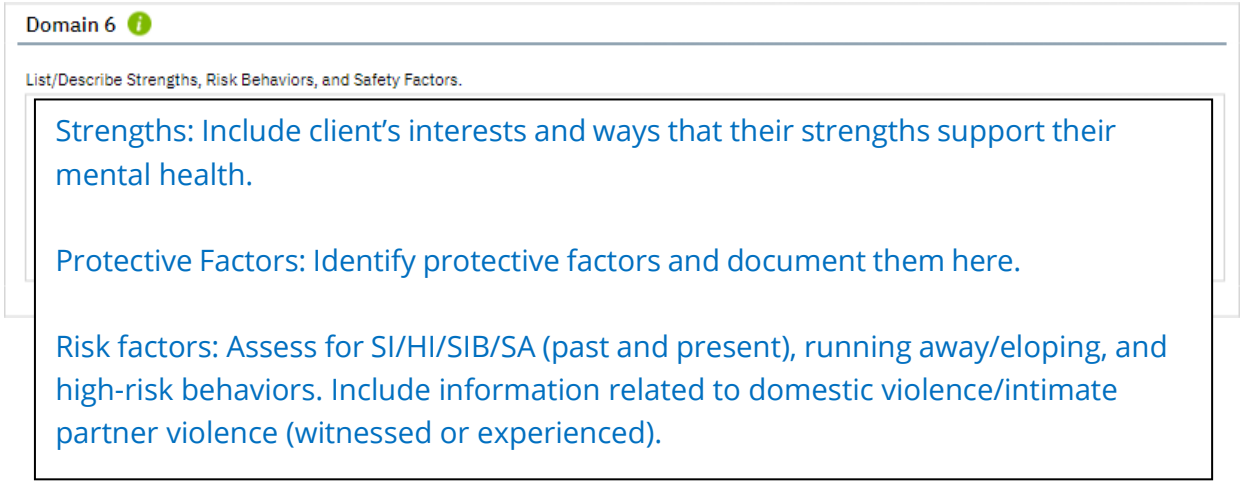


Domain 6 | Strengths/Risks

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.



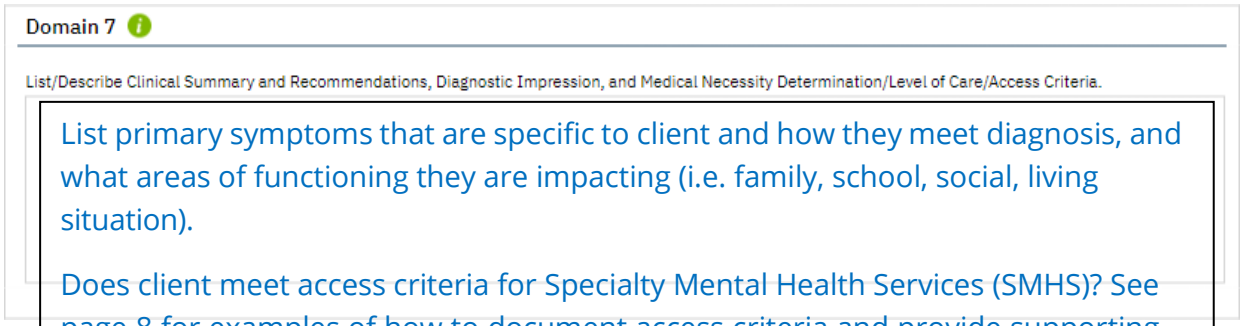
Domain 7 | Clinical Summary

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



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

Mental Health Assessment Progress Note Template for Timeliness Information

INTERVENTIONS:
Enter interventions completed throughout the assessment session.

****If more than 3 days are needed to write the Progress Note, it's okay to submit the note late and enter the following narrative:**

Progress Note entered X-days after the assessment service because Clinician needed additional time to complete the write-up of the CalAIM Assessment document.

PLAN:
Enter plan for services going forward.

Next Scheduled Appointment:
Did the client accept the first follow up appointment offered date? YES/NO

****If applicable****
If client did NOT accept the first follow up appointment offered, entered the date of the appointment that was offered: -

****If client does NOT meet access criteria ****
PLAN:
Based on the information provided by the client, **[CLIENT'S NAME]** does not meet access criteria for Specialty Mental Health Services at this time. A follow-up appointment is not needed. Client may return to Mental Health if services in the future are needed. Client provided with the following referrals and list of community services:
Close Reason: Client did not meet medical necessity criteria.

****If client meets access criteria and declines services****

PLAN:
Based on the information provided by client and clinical judgment, client appears to meet access criteria, however, at this time client is declining MH services. Client may return to MH in the future as needed.
Client Referred to:
Close Reason: Client completed assessment process but declined offered treatment dates