



COUNTY OF SAN LUIS OBISPO HEALTH AGENCY BEHAVIORAL HEALTH DEPARTMENT

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MH Assessment 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 1

List/Describe Presenting Problem(s), Current Mental Status, History of Presenting Problem(s) and Client-Identified Impairment(s).

Include who attended session, age, nickname, gender identity, pronouns, appearance/grooming, sexual orientation, referral source (probation, CWS, etc), preferred language, and cultural considerations. Include who client currently lives with, where they attend school, and grade. Include information related to legal guardianship/custody, and any Temporary Restraining Order or Restraining Orders.

In client's words, why are they seeking counseling? How long have symptoms occurred, including frequency and intensity of symptoms.

Domain 2 | Trauma

Has the client experienced trauma, abuse, neglect, or exploitation?

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 2

List/Describe Trauma - Indicate N/A if not applicable.

Include information related to physical abuse, sexual abuse, emotional/mental abuse, as well as if it was reported. Include information related to medical trauma, exposure to school violence, community violence, natural disasters, and/or caregiver disruption. Include trauma reactions, and any information related to complex trauma.

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 3

List/Describe Behavioral Health History, Substance Use History, and Comorbidity.

Include any known in utero exposure to substances.

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 4

List/Describe Developmental History, Medical History, Current Medications, and Comorbidity with Behavioral Health.

Include medications for physical health and psychiatric conditions, as well as alternative and over the counter medications.

Developmental History: Include information related to pregnancy, birth, and delivery, as well as milestones for first 3 years of life including walking, talking, and potty training.

Review the Health Questionnaire with the client and update missing or unclear history. Briefly summarize the client's self-report here. Can include a statement such as "Reference the Behavioral Health Questionnaire for more information."

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 5

List/Describe Social and Life Circumstances and Culture/Religion/Spirituality.

Include family of origin, family members (do not include names), who has client resided with, housing stability/history (moving frequently, homelessness, transient, multi-family household, etc), family functioning, and family dynamics. Include information related to client's ability to make and maintain friendships, and involvement in extracurricular activities. Include social information such as socio-economic status, legal/justice involvement, sexual orientation, gender, and religion. Include information about any learning or behavioral issues (504, IEP, concerns for Autism Spectrum Disorder), and if are they receiving any services.

ADA Needs: Does the client need assistance with understanding treatment information? If so, note it here and describe what you did to help provide assistance with informational materials and to ensure that the client understands the risks and benefits of treatment.

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 6

List/Describe Strengths, Risk Behaviors, and Safety Factors.

Strengths: Include client's interests and ways that their strengths support their mental health.

Protective Factors: Identify protective factors and document them here.

Risk factors: Assess for SI/HI/SIB/SA (past and present), running away/eloping, and high-risk behaviors. Include information related to domestic violence/intimate partner violence (witnessed or experienced).

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

Domain 7

List/Describe Clinical Summary and Recommendations, Diagnostic Impression, and Medical Necessity Determination/Level of Care/Access Criteria.

List primary symptoms that are specific to client and how they meet diagnosis, and what areas of functioning they are impacting (i.e. family, school, social, living situation).

Does client meet access criteria for Specialty Mental Health Services (SMHS)? See page 8 for examples of how to document access criteria and provide supporting evidence of your clinical conclusions/recommendations.

Include treatment recommendations: What specific services they will receive including, but not limited to, open to case management, individual therapy, family therapy, medication management, plan development, ICC/IHBS, TBS, Katie A. (send copy to CWS if needed).

Do not copy and paste DSM-5 or list criteria.

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
