County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**		Policy Issuer (Unit/Program)	BHS-CMH-YDF
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Title: Documentation Guidelines		Functional Area: Health Information Management	
Approved By: Matthew Quinley, LCSW Health Program Manager		Christopher Eldridge, LMFT Mental Health Program Coordinator	

Background/Context:

Title 15, Section 1406 requires that for each juvenile facility that provides on-site health services, the health administrator, in cooperation with the facility administrator, shall maintain individual and dated health records. Written policies and procedures shall provide for maintenance of the health record in a locked area or secured electronically, separate from the confinement record. Access to the medical and/or behavioral/mental health record shall be controlled by the health administrator and shall assure that all confidentiality laws related to the provider-patient privilege apply to the health record.

Definitions:

Mental Health Record: any item, grouping or collection of client specific information that is maintained, collected, used or disseminated by or for Sacramento County Division of Behavioral Health Services. A single mental health record for an individual consists of all materials that are part of the designated record set, even when these elements are physically separated from other chart components.

Avatar: a web-based information management system used by Sacramento County Division of Behavioral Health Services (DBHS) as the electronic mental health record.

Assessments: a collection of information and clinical analysis of the history and the current status of a youth's mental, emotional and/or behavioral health. Assessment information must be in either a specific document or section of the clinical record.

Progress Notes: are descriptions of a provider's direct or indirect service activities including billable and non-billable contacts and also convey information from collateral resources, consultation contacts and coordination with other system providers and agencies.

Purpose:

The objective of this policy and procedure is to detail the guidelines Juvenile Justice Institutions Mental Health Team (JJIMHT) members shall utilize to accurately and

comprehensively document the provision of mental health services within the Youth Detention Facility (YDF).

Details:

1. Substantiation of Need for Services
    A. The youth has a primary diagnosis from the California Department of Health Care Services Medi-Cal Included Diagnosis List that is substantiated by chart documentation.
        I. A youth's excluded diagnosis should be noted, however, there must be an included diagnosis that is the primary focus of treatment.
        II. Identify the DSM criteria for each diagnosis that is a focus of treatment.
    B. As a result of the included diagnosis, it must be documented that the youth meets at least one of the following criteria:
        I. A significant impairment in an important area(s) of life functioning.
        II. A probability of significant deterioration in an important area of life functioning.
        III. A probability that the youth will not progress developmentally as individually appropriate.
        IV. A condition, as a result of the included diagnosis, that can be corrected or ameliorated with mental health services.
    C. Identify how the proposed service intervention(s) meets both of the following criteria:
        I. The focus of the proposed intervention(s) is to address the identified condition affecting the performance in an important life area of functioning.
        II. The expectation that the proposed intervention(s) will do at least one of the following:
            - Significantly diminish the impairment
            - Prevent significant deterioration in an important area of life functioning
            - Allow the youth to progress developmentally as appropriate
            - To correct or ameliorate the condition
    D. Documentation must support the following:
        I. That the mental health condition could not be treated by lower level of care.
        II. That the mental health condition would not be responsive to physical health care treatment.
        III. If a youth does not meet the functional impairment criteria, the services provided must correct a documented mental illness or condition, or the documented risk of developing a mental illness or condition, or of not progressing developmentally as expected.
2. Signature Requirements
    A. Every clinical document must be followed by a complete signature or electronic signature which includes the writer's appropriate credential(s).
    B. Signatures must be legible or must have the name and appropriate credential(s) typed under the signature line.

C. All signatures require a date (XX/XX/XX)
D. Late entries must contain the date the late entry was written, not the date of service.
E. An addendum is new documentation used to add information to an original entry. Addendums should be timely and contain the current date, reason for the additional information being added to the record and appropriate signature.

3. Initial and Annual Assessments
   A. A completed initial assessment is required within 30 days of the opening episode date. JJIMHT clinicians shall complete assessments during the first contact with the youth; documentation must support any reason for a delay in the completion of an assessment.
   B. If the youth is released prior to the completion of the assessment document, an assessment will be completed using the data that has been collected.
   C. The corresponding Progress Note shall indicate the completion of a JJIMHT assessment.
   D. Complete assessments shall be done on an annual basis. History from previous assessments can be carried forward, however, all other items must be updated and a new assessment form is required.
      I. In some circumstances, the JJIMHT Program Coordinator may direct clinical staff not to complete an annual assessment, for example, youth who are to be in custody for less than 72 hours and have a previous assessment.
4. Minimum Requirements for Assessment Content
   A. Identifying information: unless included in another document (e.g. Admission/CSI Admission), the assessment must include:
      I. The date of initial contact and admission date.
      II. The youth's name and contact information.
      III. The youth's age, self-identified gender and ethnicity, and marital status
      IV. Information about significant others in the youth's life including parent/guardian or other legal representatives
      V. The youth's school and/or employment information
      VI. Other identifying information, as applicable
   B. Communication needs: documentation for whether materials and/or service provision are required in a different format (e.g. other languages, interpreter services, etc.)
   C. Relevant physical health conditions as reported by the youth or by other report must be prominently identified and updated, as appropriate.
   D. Presenting problem/referral reason and relevant conditions affecting the youth's physical health, mental health status and psychosocial conditions. Includes problem definitions by the youth and/or other relevant sources.
   E. Special status situations that present a risk to the youth or to others must be documented and updated, as appropriate.
   F. Youth's strengths in achieving goals, skills and interests, family involvement and resources, community and social supports, etc.
   G. Medications: name of prescribed medication(s), previously prescribed medication, any allergies or adverse reactions.

H. Allergies and adverse reactions: per youth report to any substances or items, or the lack thereof, must be documented in initial and annual assessments.
I. Substance exposure/use: document youth's past and present exposure and/or use of tobacco, alcohol, caffeine, over-the-counter and illicit drugs.
J. Mental health history: including previous treatment dates, reason(s) for referral and providers (when able), psychiatric hospitalization(s), crisis contact(s), diagnostic history, history of suicidality, history of engaging in self-injurious behavior, history of, or lack thereof, symptoms related to various mental health disorders, trauma exposure and relevant family history.
K. Pre-natal/perinatal events and developmental history.
L. Other history as relevant: living situation, contact(s) with law enforcement, involvement in illegal activity, gang affiliation, family history of involvement with law enforcement/incarceration, etc.
M. Mental status examination: includes signs and symptoms relevant to determine diagnosis and plan of action.
N. Complete diagnosis with primary diagnosis consistent with presenting problem, history, MSE and/or other assessment data.
O. Signature and credential(s).

5. Progress Notes
   A. JJIMHT clinicians will complete a progress note for all contacts with the youth detained in the YDF.
   B. JJIMHT clinicians are expected to complete the progress note along with any other related documentation and distribute relevant immediately following contact with a youth.
      I. It is not recommended for JJIMHT clinicians to make several contacts with youth and then, in one sitting, complete all corresponding documentation.
      II. Deviation from this practice must be granted from the JJIMHT Program Coordinator or designee.
   C. A youth's protected information must not be entered into another youth's mental health record. When referring to other youth, use non-specific terms such as "male peer," "female peer."
   D. JJIMHT will refer to other clinicians and other disciplines by position or title and not directly name the individual(s), e.g. "Unit staff," "nurse," "Supervising Probation Officer," "colleague," etc.
   E. JJIMHT clinicians will avoid the use of pejorative and judgmental language, and shall not describe criminal offenses in detail unless the offense is clearly relevant. Clinicians shall accurately identify relevant information taken from other sources, such as, Intake Report, Probable Cause Form, etc.
6. Minimum requirements for Progress Notes with Client Contact
   A. Date of Service (XX/XX/XXXX), "entry date" is recorded in Avatar.
   B. Service modality, "face-to-face" and Service Charge Code.
   C. Location ("Correctional Facility") and Note Type ("Standard").
   D. Time: direct/indirect service time and time spent on documentation.
   E. Documentation of specific services/interventions and language used:

I. Reason for contact/referral.
II. Assessment of the youth's current clinical or behavioral presentation.
III. Relevant history.
IV. Specific mental health/clinical interventions used and the youth's response to intervention.
V. Unresolved issues from previous contacts.
VI. Plans, next steps and/or clinical decisions, referrals made and any issues of risk.
VII. JJIMHT clinicians will utilize Subjective, Objective, Assessment, and Plan (SOAP) clinical documentation format for recording clinical notes in the progress note section.

F. The JJIMHT electronic mental health record provides an electronic signature, date and time.

7. Minimum requirements for Progress Notes without Client Contact
   A. Date of service (XX/XX/XXXX), "entry date" is recorded in Avatar.
   B. Service modality, Service Charge Code.
   C. Time: direct/indirect service time and time spent on documentation.
   D. Reason for the collateral/case management, specific interventions and reasons to support the intervention.
   E. Response from collateral contacts.
   F. Unresolved issues from previous contacts.
   G. Address any issues of risk.
   H. Plans, next steps and/or clinical decisions, clinician actions and referrals made.
   I. The JJIMHT electronic mental health record provides an electronic signature, date and time.
8. Corrections
   A. JJIMHT clinicians will utilize the Append Progress Note format to correct errors made during the completion of progress notes.
   B. JJIMHT clinicians will contact the authorized party to request the removal of progress notes erroneously entered when it is necessary to remove the note entirely from the record.
   C. JJIMHT clinicians will complete an Assessment Addendum to correct errors made during the completion of an assessment.
   D. JJIMHT clinicians shall ensure corrections are made to all copies of documents provided to Juvenile Medical Services (JMS) and Probation.

Reference(s)/Attachments:

JJIMHT Youth Assessment and Addendum

Contact Information:

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