Medi-Cal Specialty Mental Health Services
Documentation Standards

ASSESSMENT

The following areas will be included as appropriate as part of a comprehensive client record:

A. Relevant physical health conditions reported by the client will be prominently identified and updated as appropriate.
B. Presenting problems and relevant conditions affecting the client's physical health and mental health status will be documented, for example: living situation, daily activities, and social support.
C. Documentation will describe client strengths in achieving client plan goals.
D. Special status situations that present a risk to client or others will be prominently documented and updated as appropriate.
E. Documentation will include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
F. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be clearly documented.
G. A mental health history will be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
H. For children and adolescents, pre-natal and peri-natal events and complete developmental history will be documented.
I. Documentation will include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over the counter drugs.
J. A relevant mental status examination will be documented.
K. A five axes diagnosis from the most current DSM, or a diagnosis from the most current ICD, will be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

DIAGNOSTIC FORUMULATION MULTI-AXIAL ASSESSMENT

A multi-axial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are five axes included in the DSM-IV multi-axial classification:

AXIS I	**Clinical Disorders**
	Other Conditions that may be a focus of Clinical Attention
AXIS II	**Personality Disorders**
	Mental Retardation
AXIS III	**General Medical Conditions**
AXIS IV	**Psychosocial and Environmental Problems**
AXIS V	**Global Assessment of Functioning**

CLIENT TREATMENT PLANS

Client Treatment Plans will:

1) Have specific observable and/or specific quantifiable goals.
2) Identify the proposed type(s) of intervention.
3) Have a proposed duration of intervention(s).
4) Be consistent with the diagnoses, and the focus of intervention will be consistent with the client plan goals, and there will be documentation of the client's participation and agreement with the plan.

MENTAL HEALTH PROGRESS NOTES

All entries in the client record will include:

- Date of service delivery (00/00/00);
- Identify the type of MH service delivered;
- Location of Service;
- Duration/Length of Service in minutes (with sufficient documentation to justify the time expended);
- Signature of the person providing the service (or electronic equivalent) and co-signature, if applicable;
- Service provider's professional degree, licensure, job title and;
- Relevant identification number, if applicable.

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- **Progress Notes Content**
  Client encounters, including relevant clinical decisions and interventions. Descriptions of:
  - Mental Health Symptoms
  - Treatment interventions. For example, progress or attempts at progress by both the client and service staff (forward the established personal milestones or other relevant treatment objectives).
  - Responses reflective of the Treatment Plan problem, goals and objectives.
  - Services related to the diagnosis, signs and symptoms established goals, and expressed in terms of changes in the individual's functioning. If there is little progress, a clear explanation of the limited progress must be included. Follow-up care.

- **Intervention**
  - Discuss staff's intervention(s). What has staff done to help the client process through the identified behavioral issue?
  - Discuss staff's counseling and/or training interventions in detail. Be specific and refer to the client's goals/desired results/personal milestones.
  - Make sure your interventions are justifiable. Discuss the sequence of interventions that has been applied/utilized.
  - Did you need additional assistance from colleagues, supervisors, etc.?
  - Discuss issues of concern or significance.

  Staff should be aware of the role in the reduction of a beneficiary's mental health disability and/or improvement and report this information in the Progress Note.

- **Behavior**
  - What specific behavior is the client displaying?
  - If the client expresses any type of feeling and/or emotions, please explain.
  - If the client is being unsafe, explain how the client is being unsafe.
  - What is the client's target behavior? Connect the situation to the client's behavioral goals.
  - Discuss behavioral issues of concern or significance.

- **Response**
  - What is the client's response to your counseling/intervention?
  - The result may be good or bad. How did the client respond?
  - Discuss any need for follow-up or client monitoring if follow-up is necessary. Write it in the Progress Notes and make sure follow-up happens.
  - Make sure ALL follow-up work is also charted and reference the Progress Note (date, type of Progress Note, and the referring staff person.
  - Discuss issues of concern or significance.

PROGRESS NOTES CONTENT

For GROUP therapy/rehabilitation, a Progress Note must be written for each beneficiary.

A. Summary of behavioral health goals/purpose of the group session.
B. Focus and report on the beneficiary's group interaction and involvement.
C. Do not use the names of other beneficiaries in the Progress Note.

BASIC CHARTING GUIDELINES

1. MUST BE LEGIBLE.
2. Use black ink ONLY.
3. All signatures require a date (00/00/00).
4. All documentation requires the authorized signature and discipline/title.
5. Errors: Never use correction tape, white-out, yellow-out, (correction fluid), etc. If you make an error, draw one (1) line through the error and initial.
6. Only universal and county designated acronyms are accepted.
7. Do not use the name of other client(s) in the charting.
8. Do not "rubber stamp" your verbiage.
9. Always attempt to obtain the client's signature where indicated. If the client is unable or unwilling to sign, note it on the signature line, date it, and document why the client refused to sign or note inability to sign.