SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Departmental
Policy and Procedure

Section	Clinical	**Effective:**	4/1/2009
Sub-section	Documentation	**Version:**	2.0
Policy	Mental Health Client Treatment Plans	**Last Revised:**	12/11/2019
Policy #	8.101		
Director's Approval	Alice Gleghorn, PhD	**Date**	2/10/2020
Clinical Division Chief's Approval	John Winckler, LMFT	**Date**	2/10/2020
Supersedes:	Client Treatment Plans rev. 2/10/2016	**Audit Date:**	12/11/2022

1. PURPOSE/SCOPE

1.1. To ensure the involvement of clients (and/or their legal guardians) in the development and implementation of a comprehensive client treatment plan (hereafter "treatment plan") for outpatient specialty mental health services (SMHS).

1.2. This policy applies to all mental health programs of the Santa Barbara County Department of Behavioral Wellness (hereafter "Department"), including county-operated programs and contracted organizational providers.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Licensed Mental Health Professional (LMHP)** – an individual employed by the Department or any Department contracted agency who may provide or direct others in providing SMHS and are authorized to create treatment plans within their respective scope of practice by meeting one or more of the following criteria:

1. Holds a valid California license as an MD, DO, Psychologist, LCSW, LMFT, or LPCC.
2. Holds a valid California license as an RN.
3. Holds a valid California registration as an ASW, IMF, or PCCI.
4. Holds a valid waiver from the Department of Health Care Services (DHCS) to perform the duties of a Psychologist.

2.2. **Initial Admission** – a client is admitted to an outpatient mental health program, and the client meets either of the following criteria:

1. The client has never had an open admission to an outpatient mental health program; or
2. The client has had no open admission to any outpatient mental health program for at least 60 days.

2.3. **Interim Client Treatment Plan** – a treatment plan completed within a short period of time of the beneficiary coming into the system or program in order to quickly begin providing services that cannot be provided without a treatment plan.

2.4. **Planned Mental Health Service** – a specialty mental health service provided by a Department program other than "Crisis Intervention", "Crisis Stabilization", "Plan Development", "Assessment", "Interim Medication Support Services", "Interim Targeted Case Management", or "Intensive Care Coordination (ICC)".

2.5. **Support staff** – an individual employed by the Department or any Department contracted agency who may develop a treatment plan within their scope of practice. A treatment plan created by a support staff must be co-signed by an LMHP. A support staff holds one of the following job classifications:

1. Case Worker;
2. Psychiatric Technician;
3. Mental Health Rehabilitation Specialist; or
4. Alcohol and Other Drug (AOD) Support Specialist.

In Clinician's Gateway (CG), the following definitions apply:

2.6. **Renew** – an update to the annual treatment plan; involves a comprehensive look at the entire set of interventions and progress made by the client.

2.7. **Revise** – does not change the treatment plan end date; used when the existing treatment plan continues to meet the client's needs, and only a minor revision to reflect new objectives, goals, or interventions is necessary, or when a client is transferred to another service provider.

2.8. **Finalize** – the treatment plan has been authorized by all staff indicated in the "Authorization" section and the client/guardian has signed the treatment plan.

3. POLICY

3.1. Any client with an open admission to a Department's outpatient mental health program must have an active treatment plan no later than 60 days after admission.

4. TREATMENT PLAN REQUIREMENTS

4.1. A treatment plan must be finalized prior to the delivery of Planned Mental Health Services.

1. Time spent reviewing previous documentation in preparation for treatment plan development can be included as long as the time coded is clearly documented and reasonable.

a. In the event the client is a "no-show" to the appointment, chart preparation time can still be coded for by checking the "*No show chart review*" box in the outpatient progress note template.

4.2. The client must actively participate with the LMHP in developing and authorizing their individualized treatment plan. If the client is unwilling or unable to participate, the legal guardian may participate with the LMHP in developing and authorizing their individualized treatment plan, which must include:

1. A statement of the client's strengths, using the client's words to the fullest extent possible.
2. The client's special needs, as well as a brief statement of the methods to be used to address such special needs.
3. Specific, measurable, observable goals which address symptoms and/or functional impairments identified through the assessment.
   a. Each goal must include at least one intervention that must:
      i. Include the Medi-Cal service codes which describe those services.
      ii. Include descriptions of specific services addressing the client's symptoms and/or functional impairments.
      iii. Specify the duration of authorization, up to a maximum of 12 months following the start date of the treatment plan.
   b. The proposed frequency for delivery of an intervention must be stated specifically (e.g. daily, weekly, etc.), or as a frequency range (e.g. 1-4 times monthly).

4.3. Mental health interventions not listed in the treatment plan may be provided for a maximum of five (5) days without modification of the treatment plan if:

1. A client encounters an unplanned event or circumstance that significantly affects the client's mental and emotional state; and
2. The client's mental and emotional state is related to a mental health diagnosis eligible for Medi-Cal reimbursement.
3. If, as a result of such events or circumstances, a client requires interventions lasting more than five (5) days, and the interventions are not included on the current treatment plan, the treatment plan must be modified before further services are claimed to Medi-Cal.

4.4. Only one treatment plan is needed to authorize and coordinate all Planned Mental Health Services if clients are receiving services from various providers.

1. When a client has providers from multiple programs or agencies, staff from those programs/agencies will work collaboratively to:
   a. Develop and revise the treatment plan; and
   b. Coordinate goals and interventions with any other program that also provides services to the client.

4.5. A new, revised, or renewed treatment plan is authorized when:

1. The client and/or guardian (minors under age 17 may co-sign) and the LMHP sign the treatment plan;
    a. Minors may independently sign a treatment plan, assuming the treatment plan is not used to obtain the minor's consent to treatment.
2. The LMHP and the legally responsible person sign the treatment plan on behalf of the client if the client is a Lanterman Petris Short (LPS) conservatee; or
3. A valid and specific justification is documented in a progress note stating why the client's/guardian's signature was not obtained if a client/guardian refuses to sign the treatment plan.

4.6. The client and/or guardian will be offered a copy of their signed treatment plan for their records and documented in the electric health record.

4.7. A treatment plan must be renewed every 12 months, from the date the initial treatment plan was finalized.

4.8. A treatment plan can be revised if new objectives, goals, or interventions have been identified, a client is transferred to another service provider, and/or a new program has been added to the client's treatment.

5. INTERIM TREATMENT PLAN

5.1. Short-term and Long-term Outreach Programs may create an interim treatment plan with one (1) goal and one (1) intervention needed to finalize an interim treatment plan.

1. Interim treatment plans at a minimum must include a(n):
    a. Specific observable and/or quantifiable goals/treatment objectives related to the client's mental health needs and functional impairments as a result of the mental health diagnosis;
    b. Proposed type of intervention/modality;
    c. Detailed description of the intervention to be provided;
    d. Proposed frequency and direction of the intervention;
    e. Intervention that focuses and addresses the identified functional impairments as a result of the mental disorder and are consistent with the treatment plan goal;
    f. Intervention that is consistent with the qualifying diagnoses; and
    g. Required staff signatures (or electronic equivalent).

5.2. Staff may finalize an interim treatment plan without a client signature for clients in Short-term Outreach Programs.

1. If a client signature is not obtained, documentation via a Plan Development progress note must indicate the client's participation in the development of an agreement with the initial treatment plan.

6. TRANSFER OR ADDITIONS OF PROGRAMS

6.1. When a client transfers to a new program, the new program becomes responsible for the treatment plan.

1. The best practice is for the transferring (previous) program staff to revise the treatment plan before the transfer, with participation of the client or legal guardian.
2. If the treatment plan is not revised prior to the transfer, the new program will revise the treatment plan with the client and/or legal guardian prior to the delivery of services as needed.
3. A transferred treatment plan with revisions does not change the established renewal date.

7. PROVISION OF SERVICES PRIOR TO TREATMENT PLAN APPROVAL

7.1. The following service activities may be provided at any point, regardless of treatment plan status:

1. Assessment;
2. Plan Development;
3. Crisis Intervention; and
4. Crisis Stabilization.

7.2. Prior to a finalized treatment plan, the following SMHS and service activities may be provided:

1. Assessment;
2. Plan Development;
3. Crisis Intervention;
4. Crisis Stabilization;
5. Interim Medication Support Services, for an urgent need;
6. Interim Targeted Case Management, for an urgent referral/linkage to services; and
7. Interim Intensive Care Coordination (ICC), for urgent referral/linkage to services.

7.3. The following service activities may additionally be provided when a treatment plan has expired for no more than 60 days following the expiration date:

1. Interim Medication Support Services, for an urgent need;
2. Interim Targeted Case Management, for urgent referral/linkage to services; and
3. ICC, for an urgent referral/linkage to services.

7.4. When an "interim" service is provided, documentation must indicate how the intervention addressed urgent or interim assessment, plan development, or medication support needs.

ASSISTANCE

John Winckler, LMFT, Clinical Division Chief

Careena Robb, LMFT, QCM Coordinator

REFERENCE

California Code of Regulations – Rehabilitative and Developmental Services
Title 9, Chapter 11, Sections 1810.205.2, 1810.254, 1810.440(c) (1) (2), 1840.112(b) (2-5), 1840.314(d) (e),

California Code of Regulations – Professional and Vocational Regulations
Title 9, Chapter 16, Division 18, Article 3, Section 1820.5

California Welfare and Institutions Code
Section 5751.2

Department of Health Care Services – Mental Health Plan
Exhibit A, Attachment I

MHSUDS Information Notice No. 17-040 – Chart Documentation Requirement Clarifications

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
12/11/19	2.0	Added interim treatment plan, language regarding LMHP's, involvement of client in the development of a treatment plan, and updated formatting and organization of policy.

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).