County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	BHS-CMH-YDF
	Policy Number	07-02
	Effective Date	10/2009
	Revision Date	07/2017
Title: Psychiatric Documentation Guidelines	Functional Area: Psychotropic Medication	
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.

Title 15, Section 1437 requires the Youth Detention Facility (YDF) administrator or responsible physician, in cooperation with the behavioral/mental health director and the facility administrator, to establish policies and procedures to provide behavioral/mental health services. The services shall include medication support services.

Title 15, Section 1439 requires the YDF health administrator or responsible physician, in cooperation with the behavioral/mental health director and the facility administrator, to develop and implement written policies and procedures governing the use of voluntary and involuntary psychotropic medications. The policies and procedures shall include provision that youth and their legally authorized representative shall be informed of the expected benefits, potential side-effects and alternative to psychotropic medications. In accordance with Juvenile Justice Institutions Mental Health Team (JJIMHT) values, a youth's rights shall be protected and the youth should be actively involved with the planning and implementation of his/her treatment plan, including the prescribing of medications.

Purpose:

The intention of this policy and procedure is to delineate the guidelines by which JJIMHT physicians shall utilize to accurately and comprehensively document the provision of psychiatric services, use of psychotropic medication(s) and medication monitoring within the YDF.

Details:

1. Severity of Need
   A. The youth has, or is being evaluated for, a DSM-5/ICD-10 diagnosis.
   B. The presenting behavioral, psychological, and/or biological dysfunctions and functional impairment (occupational, academic, social) are consistent and associated with the DSM-5/ICD-10 psychiatric/substance-related disorder(s).
   C. One of the following:
      I. The youth has symptomatic distress and demonstrates impaired functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, academic, or social), that are the direct result of a DSM-5/ICD-10 diagnosis. This is evidenced by specific clinical description of the symptom(s) and specific measurable behavioral impairment(s) in occupational, academic or social areas, or
      II. The youth has a persistent illness described in DSM-5/ICD-10 with a history of repeated admissions to 24-hour treatment programs for which maintenance treatment is required to maintain community tenure, or
      III. There is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy, although the youth no longer has at least mild symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued medical necessity of treatment in this termination phase are the frequency and severity of previous relapse, level of current stressors, and other relevant clinical indicators. Additionally, the treatment plan should include clear goals needing to be achieved and methods to achieve them in order to support successful termination (such as increasing time between appointments, use of community resources, and supporting personal success).
   D. The youth does not require a higher level of care.
   E. The youth demonstrates motivation to manage symptoms or make behavioral change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
   F. The youth is capable of developing skills to manage symptoms or make behavioral change.
2. Intensity and Quality of Service
   A. There is documentation of a DSM-5/ICD-10 diagnosis. The assessment also includes the precipitating event/presenting issues, specific symptoms and functional impairments, community and natural resources, personal strengths, and the focus of treatment.
   B. There is a medically necessary and appropriate treatment plan, or its update, specific to the youth's behavioral, psychological, and/or biological dysfunctions associated with the DSM-5/ICD-10 psychiatric/substance-related disorder(s). The treatment plan is expected to be effective in reducing the patient's occupational, academic or social functional impairments and:
      I. Alleviating the youth's distress and/or dysfunction in a timely manner, or

II. Achieving appropriate maintenance goals for a persistent illness, or
III. Supporting termination.

C. The treatment plan must identify all of the following:
   I. Treatment modality, treatment frequency and estimated duration;
   II. Specific interventions that address the youth's presenting symptoms and issues;
   III. Coordination of care with other health care services, e.g., PCP or other behavioral health practitioners;
   IV. The status of active involvement and/or ongoing contact with youth's family and/or support system, unless there is an identified, valid reason why such contact is not clinically appropriate or feasible;
   V. The status of inclusion and coordination, whenever possible, with relevant community resources, current community-based providers;
   VI. Consideration/referral/utilization of psychopharmological interventions for diagnoses that are known to be responsive to medication;
   VII. Documentation of objective progress toward goals for occupational, academic or social functional impairments, target-specific behavioral, psychological, and/or biological dysfunctions associated with the DSM-5/ICD-10 psychiatric/substance-related disorder(s) being treated. Additionally, specific measurable interim treatment goals or specific measurable maintenance treatment goals (if this is maintenance treatment), are identified. Appropriate changes in the treatment plan are made to address any difficulties in making measurable progress;
   VIII. The description of an alternative plan to be implemented if the youth does not make substantial progress toward the given goals in a specified period of time; and
   IX. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting Severity of Need Criteria. This evolving clinical status is documented by written contact progress notes.

D. The youth has the capability of developing skills to manage symptoms or make behavioral change and demonstrates motivation for change, as evidenced by attending treatment sessions, completing therapeutic tasks, and adhering to a medication regimen or other requirements of treatment.
E. The youth is adhering to treatment recommendations, or non-adherence is addressed with the youth, and barriers are identified, interventions are modified, and/or treatment plan is revised as appropriate.
F. Progress as relevant to presenting symptoms and functional impairment is clearly evident and is documented in objective terms.
G. Treatment is effective as evidenced by improvement in functioning.
H. Requested services do not duplicate other provided services.
I. Visits for this treatment modality are recommended to be no greater than one to two sessions per week, except for: (i) acute crisis stabilization; or (ii) situations

where the treating provider demonstrates more than one visit per week is medically necessary.

J. As the youth exhibits sustained improvement or stabilization of a persistent illness, frequency of visits should be decreased over time (e.g., once every two weeks or once per month) to reinforce and encourage self-efficacy, autonomy, and reliance on self and natural supports.
K. All applicable elements in Intensity and Quality of Service Criteria are applied as related to assessment and treatment, if clinically relevant and appropriate.
L. For substance use disorders, treatment considers the use of medication-assisted treatment, when appropriate, to address cravings and relapse prevention unless medically contraindicated.

Reference(s)/Attachments:

JJIMHT Initial Psychiatric Evaluation Form

JJIMHT Psychiatric/Medication Progress Note Form

Related Policies:

BHS-CMH-YDF-07-01-Psychotropic Medication Guidelines

BHS-CMH-YDF-07-04-Physician's Orders

Contact Information:

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