

MENTAL HEALTH SERVICES

A. DEFINITION:

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

B. GOAL(S):

1. Assist HIV-positive clients with reduction of symptoms related to mental health disorders thereby reducing barriers to medical care
2. Provide psychiatric evaluation and medication monitoring if indicated
3. Comply with the State of Arizona requirements for the provision of behavioral health services, and the Planning Council's Universal Standards of Care

C. SERVICES:

Mental health counseling services includes intensive mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Arizona. Counseling services may include general mental health therapy, counseling, bereavement support for clients. General mental health therapy, counseling and short-term* bereavement support is available for non-HIV infected family members or significant others. Crisis counseling and referral will be available to clients and care givers. Medical services are provided by a licensed medical, board certified psychiatrist.

* Short term is defined based on the mental health professional's judgment.

D. QUALITY MANAGEMENT:

Program Outcome:

- **90%** of treatment goals are addressed and **50%** are met, upon completion of mental health treatment.
- **85%** of clients receive an assessment prior to implementing the treatment plan.
- **85%** of clients have a completed treatment plan within 90 days from the clients' first visit.
- **85%** of treatment plans address primary medical care needs and make appropriate referrals as needed.

Indicators:

- Number of clients attending Mental Health services who are engaged in treatment.*
 - Number of clients who have addressed at least 2 treatment goals.
- *Engaged=individual invested in treatment and attends a minimum of 50% of substance abuse services appointments

Service Unit(s):

- Face-to-face individual level Mental Health visit and/or face-to-face group level Mental Health visit

<i>Standard of Care</i>	<i>Outcome Measure</i>	<i>Numerator</i>	<i>Denominator</i>	<i>Data Source</i>	<i>Goal/Benchmark</i>
An appointment will be scheduled within three (3) working days of a client’s request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Documentation in patient’s file.	Number of days documented between client request and appt.	Number of clients	Client Files CAREWARE	75% of clients will have an appointment scheduled within three working days of request for mental health services.
Assessment will occur that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20. A comprehensive assessment including the following will be completed within 10 days of intake or no later than and prior to the third counseling session: <ul style="list-style-type: none"> • Presenting Problem • Developmental/Social history • Social support and family relationships 	Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I.	Number of new client charts with assessment completed within 10 days of intake	Number of new clients	Client Files CAREWARE	75% of new client charts have documented comprehensive assessments completed within 10 days of intake.

<ul style="list-style-type: none"> • Medical history • Substance abuse history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Psychosocial history (Education and training, employment, Military service, Legal history, Family history and constellation, Physical, emotional and/or sexual abuse history, Sexual and relationship history and status, Leisure and recreational activities, General psychological functioning). 					
<p>A treatment plan must be completed that is compliant with ADHS guidelines A.A.C. Title 9 Chapter 20. A treatment plan shall be completed within 30 days that is specific to individual client needs. The treatment plan shall be prepared and documented for</p>	<p>Documentation in client's file.</p>	<p>Number of client charts with treatment plans within 30 days of first visit</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>75% of client charts will have documentation of a treatment plan within 30 days of first visit.</p>

<p>each client. Individual, and family case records will include documentation of the following:</p> <ul style="list-style-type: none"> • Client’s presenting issue • Identification of entities to provide all services • Signature of client or guardian • Signature and title of behavioral health professional and date completed • One or more treatment goals • One or more treatment methods • Frequency of treatment sessions • Projected treatment end date • Date the treatment plan shall be reviewed • Discharge planning, which includes education on relapse prevention 					
<p>Progress notes are completed for every professional counseling session and must include:</p> <ul style="list-style-type: none"> • Client name • Session date • Observations • Focus of session • Interventions • Assessment • Duration of session • Counselor authentication, in accordance with current 	<p>Legible, signed and dated documentation in client record.</p>	<p>Number of client charts with progress notes</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>75% of client charts will have documented legible, signed and dated progress notes.</p>

<p>Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards (www.jcaho.org).</p>					
<p>Discharge planning is done with each client after 30 days without client contact or when treatment goals are met:</p> <ul style="list-style-type: none"> • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current JCAHO standards 	<p>Documentation in client's record.</p>	<p>Number of discharged clients</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>75% of client charts have documentation of discharge planning within 30 days of treatment goals being met or no client contact.</p>
<p>Clients accessing Psychiatric care are medically adherent and are engaged in their psychiatric treatment plans.</p>	<p>Clients are assessed for psychiatric care and when engaged in psychiatric care, are medically adherent.</p>	<p>Number of psychiatric clients</p>	<p>Number of clients</p>	<p>Client Files CAREWARE Agency Policy and Procedure Manual</p>	<p>75% of clients accessing psychiatric care are medically adherent and are engaged in their psychiatric treatment plans.</p>
<p>Access to and maintenance in Medical Care: RW clients' ongoing participation in primary HIV medical care</p>	<p>Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care. Assessed initially, then re-assessed and documented every 3 months.</p>	<p>Number of clients assessed/verified for medical care initially and every 3 months</p>	<p>Number of clients</p>	<p>Client Files CAREWARE</p>	<p>75% of clients are assessed and verified for engagement in medical care. This is assessed initially, then re-assessed and documented every 3 months.</p>