COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

Clinical Practice Guidelines

July 2023

Better Health for All

Acknowledgements

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COUNTY OF SANTA CLARA
Behavioral Health Services

Intent of Clinical Practice Guidelines

This guide is intended to assist practitioners with guidelines for services and treatment provided to individuals enrolled in the County of Santa Clara's Specialty Mental Health Services (SMHS) and Substance Use Treatment Services (SUTS), through County Clinics and County Contracted Providers (CCPs). Information in this guide derives from standards delineated by the California Department of Health and Care Services (DHCS), California Advancing and Innovating Medi-Cal (CalAIM), County of Santa Clara (CSC), and the CSC Behavioral Health Services Department (BHSD) standards and guidelines. The development and utility of a practice standards guide is intended to meet mandated requirements to provide a practice guideline based on valid and reliable clinical evidence. The intent of this clinical practice guide is to provide behavioral health practitioners with guidance and recommendations for clinical practice that is evidenced-based. The purpose of having a clinical guide is to help create consistency, reliability, and quality in clinical practice.

This guide provides requirement guidelines for services rendered in outpatient settings for Medi-Cal services, through whole person-care approaches, to reduce health disparities. This guide will cover relevant topics to support and provide consistent and streamlined approaches while working with children, youth, adults, and families, struggling with moderate to severe mental illness, substance use, and co-occurring illnesses, of all gender and cultural identities. This guide will consider the needs of our beneficiaries and promote the use of best practices to care. Most importantly, this guide is intended to reduce variability in treatment, in individuals' care and to improve individuals' health outcomes. This means that individuals will be cared for in the same manner regardless of who and where they are treated. The information in this guide is intended for providers who are licensed, registered and waivered practitioners, experienced and new, to Medi-Cal services; to follow a standard of care that is inclusive and in alignment with CalAIM, DHCS, and the CSC BHSD.

This guide was created in consultation with healthcare professionals in the behavioral health field. There will be a clinical practice guideline committee that will meet bi-monthly in order to review and revise the existing clinical standards guideline to align with current evidence-based practices and regulatory requirements. Also, to monitor emerging trends, advancements, and research findings to incorporate relevant updates into the guideline. Additionally, to collaborate with behavioral health experts to ensure a comprehensive and interdisciplinary approach to guideline development. Lastly, the committee will conduct periodic reviews and evaluations to assess the effectiveness of the clinical standards guideline. This guideline will be up for review annually or when there are new state requirements.

Cal-AIM

California Advancing and Innovating Medi-Cal (CalAIM) initiative is a multi-year DHCS initiative to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure access to the right care in the right place at the right time.

The behavioral health components of CalAIM are designed to support whole-person, integrated care; move the administration of Medi-Cal behavioral health to a more consistent and seamless system by re-

ducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform. The majority of these policy changes launched in 2022, but implementation will continue through 2027.

The Key Principles guiding these changes are the following:

Person centered. It is important that people who live with mental health and substance use disorders are at the center of the behavioral health system. This means that their lived experiences and personal priorities should be paramount when it comes to defining the optimal continuum of care, as well as that they have a key role to play in shaping behavioral health policies and practices. DHCS and other agencies charged with designing and implementing policies in partnership with those whose lives are affected by them.

Focus on equity. All care provided under the continuum should be designed and delivered in a way that actively addresses disparities by race, ethnicity, ability, sexual orientation, and gender identity. This includes examining where providers are located, investing in a diverse behavioral health workforce, and addressing racism and discrimination with a specific focus on individuals who are experiencing homelessness, justice-involved and other populations who are disproportionately impacted by systemic racism and discrimination.

Least restrictive setting. Services always should be provided in the least restrictive setting that is appropriate for the care and supports needed. While it sometimes is necessary for people to receive inpatient or residential services, the unnecessary use of an inpatient or residential bed is a powerful signal that more community-based and crisis services are required (including housing supports and other community supports)

Full array of services. The core continuum of care should include a full range of services and provider types for both children and adults are identified, reflecting that many people may require only preventive or outpatient services while some people may at times need short-term residential or hospital-based care to keep them safe and/or to address physical health issues. It also requires looking beyond medical care alone to consider community supports and the importance of housing, food, employment, connection, and community.

Informed Consent

Informed consent is an essential piece to the relationship between practitioners and clients. Informed consent is not only a safeguard to potential risks, it provides the client an opportunity to consider the information they'll share throughout treatment. Snyder and Barnett (2006) identify the potential benefits of informed consent as providing clients with "autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision-making, and enhancing the therapeutic alliance."

Practitioners must obtain informed consent from their client, per requirements identified on the CSC Mental Health Companion Guide. When information regarding mental health services and SUTS is provided, the practitioner must provide information aligned within their licensure and ethical guidelines.

Telehealth Consent

When providing treatment through telehealth, whether its via video (or telephone, the provider must obtain consent for the service. Consent may be obtained in writing or verbally, prior to initiating telehealth services. CSC-BHSD requires a written consent for Telehealth services. The CSC Mental Health Companion Guide provides details on consent documentation. At any time during treatment beneficiary may choose they no longer want to utilize telehealth services and the provider must comply with their request.

Mental Health Minor Consent

Under Family Code §6924 and Health & Safety Code §124260, a minor has the right to consent to their own treatment when specific requirements are met. Consent to treatment must be obtained to provide mental health services. California laws for minor consent are as follows:

Family Code §6924	Health & Safety Code §124260
The minor is 12 years of age or older In the opinion of the provider, the minor is mature enough to participate in outpatient services, and Without the treatment, the minor either presents a danger of serious physical or mental harm to themselves or others OR the minor is a victim of incest or child abuse. The practitioner must involve the minor's parent/guardian unless, in the opinion of the provider, the involvement would be inappropriate.	The minor is 12 years of age or older In the opinion of the provider, the minor is mature enough to participate in outpatient services. Treatment authorized by this section must include involvement of the minor's parent/guardian, unless after consulting with the minor, the provider determines that involvement of the minor's parent(s)/guardian(s) would be inappropriate.

SUTS Minor Consent

Under 42 CFR Part 2, minors (individuals under the age of 18) may consent to their own substance use treatment (SUTS) in certain circumstances. Generally, a minor must have the mental capacity to consent to their own treatment, meaning they understand the nature and consequences of the treatment, as well as the risks and benefits. As a clinician, it is best clinical practice to thoroughly explain the services they are consenting to in order for the minor to make an informed decision.

Additionally, 42 CFR Part 2 requires that minors' substance use disorder treatment records be kept confidential, even from parents or legal guardians, unless the minor provides written consent, or a court order such as a subpoena requires disclosure. This confidentiality protection is intended to encourage minors to seek treatment without stigma or fear of negative repercussions, such as legal consequences.

However, limits of confidentiality still apply under 42 CFR. If a beneficiary's use of substances requires a medical emergency, then information may be disclosed to medical personnel.

Screening Tools

BHSD Call Center currently uses telephone screenings to determine the appropriate system of care for anyone requesting SMHS. DHCS developed standardized Adult and Youth Screening Tools to determine the most appropriate Medi-Cal mental health delivery system referral (i.e., MHP or MCP) for beneficiaries who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. DHCS conducted a robust stakeholder process to develop statewide Screening and Transition of Care Tools for both adults and beneficiaries under 21 years old (youth) for use by County Mental Health Plans (MHPs) and Medi-Cal Managed Care Plans (MCPs) with the intention to create consistencies in screening across the state. The two screening tools are The Adult Screening Tool for Medi-Cal Mental Health Services and Youth Screening Tool for Medi-Cal Mental Health Services. The statewide implementation of these two screening tools is effective January 1, 2023. The screening tools may be administered by clinical and non-clinical staff. The screening tools are based on a scoring system of questions that answered "yes" or "no". The questions are weighted based on the symptomology being addressed in each question. The screening tools are meant to be a quick evaluation of the best delivery system to provide a full clinical assessment of the beneficiary.

Adult Screening Tool

The adult screening tool consists of 14 "yes" or "no" questions. Questions 1-3 of the tool are not scored. Questions related to suicide and self-harm are weighted more heavily on the tool and require immediate evaluation by a clinician. If a beneficiary scores 0-5 on the tool they must be referred to the MCP for a clinical assessment. Beneficiaries who score a total of 6 and above must be referred to the MHP for a clinical assessment. If the beneficiary responds "Yes" to questions related to substance use or abuse, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The beneficiary may decline this referral without impact to the mental health delivery system referral.

Youth Screening Tool

There are two versions of the youth screening tool depending on who the screener is speaking with. One is to be completed by the youth themselves and the other one is to be completed when someone is calling on the youth's behalf. Both tools consist of 23 questions "yes" or "no" questions. If a beneficiary scores 0-5 on the tool they must be referred to the MCP for a clinical assessment. Beneficiaries who score a total of 6 and above must be referred the MHP for a clinical assessment. There are certain risk factors such as being involved in the criminal justice system, child welfare, and/ or currently unhoused that constitutes a referral to the MHP no matter how they score on other questions. Questions related to suicide and self-harm are weighted more heavily on the tool and require immediate evaluation by a clinician. If the beneficiary responds "Yes" to questions related to substance use or abuse, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

***DHCS has currently not developed a standardized screening tool for SUTS. The Call Center utilizes the Integrated Screening Tool for appropriate placement throughout SUTS.

Upon completion of the screening tool the Call Center staff will send the Integrated Screening Tool (IST) and screening tool to the assigned agency or county clinic. Once received by the assigned provider, the provider must honor the screening tool and must offer an assessment to the beneficiary in a timely manner.

Example: A beneficiary calls the County of Santa Clara's Behavioral Health 24/7 Call Line, and they express that they have a low mood and have been hearing voices. After further screening, beneficiary discloses that his daily living activities are being affected and that his experiencing significant impairments due to

his mental health condition. This beneficiary scores a 7 on the screening tool and must be referred to the MHP (CSC-BHSD) for further assessment.

MHP vs MCP vs DMC-ODS Responsibilities

CSC-BHSD is comprised of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) for our county. Once appropriate delivery system is established through the screening tools, the provider can more thoroughly assess the level of care needed to treat the beneficiary. In general, the MHP and DMC-ODS focuses solely on the behavioral health needs, while a Managed Care Plan (MCP) has a broader and lower severity scope. The MHP and DMC-ODS generally focus solely on behavioral health needs, while a Managed Care Plan (MCP) has a broader and lower severity scope.

MHP	DMC-ODS	MCP
Provides coverage for mental health services such as, therapy, counseling, and psychiatric services. Under CalAIM, MHPs are required to provide or arrange for the delivery of SMHS.	A program in California that provides substance use disorder treatment services to beneficiaries who are Medi-Cal eligible. Under DMC-ODS, beneficiaries can receive a range of substance use disorder treatment services such as, outpatient, residential treatment and medication assisted treatment (MAT). This program promotes the use of evidence-based practices, and it is modeled after the American Society of Addiction Medicine Criteria (ASAM Criteria).	Responsible for both mental health and other medical benefits but may contract-out for mental health benefits to another entity, usually one that specializes in providing mental health services. MCPs are required to provide or arrange for the provision of non-specialty mental health services (NSMHS) for beneficiaries who meet the criteria for NSMHS. Currently the two MCPs in the County of Santa Clara are Anthem Blue Cross and Santa Clara Family Health Plan.

The MCP's are required to provide transportation to all appointments related to the beneficiary's health care needs, including transportation to all behavioral health appointments. You may assist the beneficiary with accessing these services.

Clinical judgment refers to the ability of behavioral health professionals to critically analyze client information, interpret clinical data, and make informed decisions regarding diagnosis, treatment, and client management. It involves the integration of scientific knowledge, experience, and expertise to assess the individual client's unique circumstances and make the best possible clinical decisions.

Assessment

Assessment is a process of collecting data from the many realms of an individual's life in order to make informed decisions about supports and services that will benefit an individual and family. This process must be comprehensive enough to inform a wide range of treatment decisions, including those related to safety planning, intensity and frequency of services, types of interventions used, and even the timing of an individual's transition away from formal services.

Assessment occurs at the onset of services, resulting in the creation of a formal written document. It also occurs on an ongoing basis throughout the course of treatment, as the individual and provider work together to evaluate progress and make the adjustments needed to arrive at the individual's stated goals. In general, indicators of an effective person-centered assessment process include:

- Focuses on improving recovery, wellness & resiliency
- Sets the stage for building on strengths
- Demonstration of cultural sensitivity and inclusiveness
- Development of relationship and therapeutic alliance
- Enhanced Individuals' and family/supports' engagement
- Establishment of a clinical formulation
- Information gathered is comprehensive and accurate to understand the Individual's needs and desires/hopes to determine most appropriate services option(s)
- Individual and family feel comfortable and safe disclosing thorough information, and that they feel they are in an equal, trusted partnership with the provider

Specialty Mental Health Services

The CCR Title 9 definition of "Assessment" is:

"Assessment" means a service activity designed to evaluate the current status of an individual's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the individual's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures. (CCR Title 9 Division 1, 1810.204)

Previously, there were many assessment templates used which caused inconsistencies in information gathering and sharing. With CalAIM, the new policy is to have standardized assessment domains for specialty mental health services.

Timeline

Providers should use their clinical judgment in determining the timeframe for conducting initial and subsequent assessments for SMHS. Nonetheless, it is expected that providers will complete these assessments within a reasonable timeframe and in alignment with commonly accepted standards of practice. Clinical managers are authorized and possess the discretion to establish a timeline for the completion of assessments, based on the specific requirements of their program. Please refer to your clinic manager for specific assessment timeline. While providers have flexibility in completing assessments, it is crucial that they continue to uphold the established timelines for specific outcome measurement tools, such as the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist-35 (PSC-35), as mandated by DHCS.

Age Group/Population

For children ages 0-3, CalAIM recommends the following assessments:

- Ages and Stages Questionnaires (ASQ): ASQ is a developmental screening tool that assesses a child's physical, cognitive, social, and emotional development. It is designed to be completed by parents or caregivers and can be used to identify developmental delays or areas of concern.

For children ages 3-18, CalAIM recommends the following assessments:

- Pediatric Symptom Checklist (PSC): PSC is a screening tool that assesses a child's emotional and behavioral health. It is designed to be completed by parents or caregivers and can be used to identify potential mental health concerns.

For children ages 0-21, CalAIM recommends the following assessments:

- Child and Adolescent Needs and Strengths (CANS): CANS is an assessment tool used to identify a child's strengths, needs, and level of functioning in various domains, including emotional and behavioral health, physical health, and social and family functioning.

The PSC-35 and CANS are tools that should be used to inform the domains. These tools do not replace the assessment. CSC BHSD uses the IBHA, which providers are expected to continue to use.

Refer to appendix A for ASAM Criteria Rating

The assessment for mental health services for individuals include the following domains include:

1. Domain 1 – Presenting Problem – Centers around capturing the primary motive for seeking care, as expressed by the individual themselves, if applicable. Collateral information may be utilized as well. The objective is to record a comprehensive narrative of the factors that prompted the decision to seek assistance. It encompasses both the person's present condition and relevant historical information concerning the primary concern leading to care-seeking.
    - Current Mental Status Exam
    - Impairments in Functioning
2. Domain 2 – Trauma – Encompasses data related to traumatic events, the individual's responses to those experiences, and the influence of trauma on the presenting problem. It is important to acknowledge and incorporate traumatic incidents into the individual's story.
    - Trauma Exposures
    - Trauma Reactions
    - Trauma Screening
    - Systems Involvement

3. Domain 3 – Behavioral Health – Centers on the individual's behavioral health history, including their past needs and the interventions they have received to address those needs. It also involves examining the history of substance use or abuse to identify any co-occurring issues.
    - Mental Health History
    - Substance Use/Abuse
    - Previous Services
4. Domain 4 – Medical – Combines medical and medication aspects with the psychosocial assessment. By examining the interconnection between behavioral health needs, physical health conditions, developmental history, and medication usage, we gain valuable context that aids in understanding the needs of the beneficiaries under our care.
    - Physical Health Conditions
    - Medications
    - Developmental History
5. Domain 5 – Social – Assists clinicians in comprehending the context in which the individual receiving care operates. This context encompasses both the micro-level environment, such as the family, and the macro-level environment, including systemic racism and broader cultural factors.
    - Family
    - Social and Life Circumstances
    - Cultural Considerations
6. Domain 6 – Risk/Protective Factors – Examines the potential risks faced by the individuals receiving our services, alongside the protective factors and strengths that play an equally crucial role in their clinical assessment. Clinicians are advised to thoroughly investigate the unique strengths and protective factors of each individual and gain a comprehensive understanding of how these positive attributes effectively mitigate the risks they are currently encountering.
    - Strengths and Protective Factors
    - Risk Factors and Behaviors
    - Safety Planning
7. Domain 7 – Summary – Offers clinicians a valuable opportunity to effectively communicate their working hypothesis regarding how the presenting challenges of the person under care are influenced by the various areas investigated during the assessment. Furthermore, it guides the formulation of treatment plans based on this theory, outlining the recommended course of action.
    - Clinical Impression
    - Diagnostic Impression

Substance Use Treatment

Since June 2017, to align access to substance use treatment services across the state, DHCS established the American Society of Addiction Medicine (ASAM) as the standard assessment to be utilized for substance use disorders (SUD). Within the ASAM there are 6 standardized domains which include:

1. Dimension 1 – Acute Intoxication and/or Withdrawal Potential – Focuses on assessing and addressing acute intoxication and withdrawal potential in individuals seeking addiction treatment. Clinicians must conduct a thorough evaluation to determine the severity of intoxication or withdrawal symptoms, as they significantly impact the individual’s immediate safety and treatment needs. This dimension helps clinicians establish appropriate levels of care, interventions, and monitoring to ensure the individual's physical stability during the early stages of treatment. Additionally, it highlights the importance of utilizing evidence-based protocols and medications to manage withdrawal symptoms effectively.

2. Dimension 2 – Biomedical Conditions and Complications – Emphasizes the evaluation and management of biomedical conditions and complications that coexist with addiction. Clinicians should conduct a comprehensive assessment to identify any physical health issues, such as chronic diseases, infectious diseases, or injuries, that may impact the individual's overall well-being and treatment outcomes. This dimension underscores the importance of integrating addiction treatment with medical care, promoting a holistic approach to address both addiction and co-occurring medical conditions. It guides clinicians in developing personalized treatment plans that prioritize the individual’s physical health and well-being.

3. Dimension 3 – Emotional, Behavioral or Cognitive Conditions and Complication (Add Bubble about Trauma informed care) – Focuses on evaluating and addressing emotional, behavioral, or cognitive conditions and complications that accompany addiction. Clinicians should assess the individual’s mental health status, including psychiatric disorders, trauma history, and cognitive impairments, to provide appropriate interventions and support. This dimension emphasizes the need for integrated treatment approaches that address both addiction and co-occurring mental health conditions. It guides clinicians in developing individualized treatment plans that consider the complex relationship between addiction and emotional or cognitive issues, ensuring comprehensive care and improved treatment outcomes.

4. Dimension 4 – Readiness to Change – Highlights the individual's readiness to engage in the treatment and recovery process. Clinicians should assess the individual’s motivation, willingness, and commitment to change addictive behaviors and adopt a recovery-oriented lifestyle. This dimension recognizes the importance of utilizing evidence-based motivational interviewing techniques and interventions to enhance the individual's motivation and resolve ambivalence towards treatment. It guides clinicians in tailoring treatment plans that align with the individual's readiness to change, promoting engagement, and fostering a positive therapeutic alliance.

5. Dimension 5 – Relapse, Continued Use or Continued Problem Potential – Involves evaluating the individual’s risk for relapse, continued substance use, or ongoing problems related to addiction. Clinicians should assess factors that contribute to relapse potential, such as environmental triggers, social support systems, and coping skills. This dimension emphasizes the development of relapse prevention strategies, including individualized coping mechanisms, skills training, and ongoing monitoring and support. It guides clinicians in developing comprehensive treatment plans that address the individual's relapse and ongoing problem potential, fostering sustained recovery and minimizing setbacks.

6. Dimension 6 – Recovery/Living Environment – Focuses on evaluating the individual's recovery and living environment. Clinicians should assess the safety, stability, and support available in the individual's living arrangements, as these factors significantly influence treatment outcomes. This dimension highlights the importance of a recovery-oriented living environment that promotes abstinence, supportive relationships, and access to necessary resources. It guides clinicians in identifying potential barriers and facilitating appropriate interventions, including housing assistance, family therapy, and community support, to enhance the individual's recovery environment.

When conducting assessments using the ASAM criteria for young children, it is crucial to approach the process with careful consideration of their unique developmental needs. Here are guidelines on how to assess young children using the ASAM framework, ensuring comprehensive and appropriate evaluations:

- Family-Centered Assessment: Recognize that assessing young children requires a family-centered approach. Assessments should consider both the child and their parents or caregivers, acknowledging the impact of the family environment on the child's well-being and treatment needs. This approach allows for a whole understanding of the child's circumstances. Providers should obtain consent from the client before disclosing information to parent(s)/caregiver(s).
- Parent/Caregiver Collaboration: Conduct collateral interviews and gather information from parents or caregivers to gain insight into the child's history, family dynamics, and potential substance use or mental health concerns. Engage in open and non-judgmental communication to establish trust and gather accurate information.
- Child-Focused Assessments: Use direct assessments with the child using child-friendly and developmentally appropriate techniques. This may involve play-based assessments, observation, or structured interviews tailored to the child's age and cognitive abilities. These assessments should consider the child's emotional, cognitive, social, and physical development.
- Trauma-Informed Approach: Recognize the potential impact of trauma on young children and integrate trauma-informed assessment strategies.

In the Clinical Summary or additional notes for each dimension, the provider should indicate whether the risk rating pertains to the child, the caregiver, or both. The purpose of rating each dimension is to identify the priorities and problems that need to be addressed in the treatment plan, determine the required services for each dimension, and establish the appropriate level of care based on the dose and intensity of services needed.

Timeline

Initial assessment periods for non-residential DMC and DMC-ODS services are as follows, with the first date of service counting as "day 1":

- Up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established OR
- Up to 60 days if the person in care is under age 21 OR
- Up to 60 days if a provider documents that the person in care is experiencing homelessness and therefore requires additional time to complete the assessment.

The assessment should be updated as clinically appropriate when the person's condition changes. If a person in care withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.

Integrated Behavioral Health Assessment (IBHA)

The county clinics primarily employ the Integrated Behavioral Health Assessment (IBHA), while CCPs have the option to utilize the IBHA or their own assessment tools according to their preference.

The integrated assessment aims to provide a comprehensive understanding of an individual's needs and guides the development of an effective treatment plan that addresses both mental health and substance use disorders. By using an integrated assessment, behavioral health providers can ensure that individuals receive the appropriate level of care and support for their unique needs.

With the integration process, BHSD has developed an IBHA that covers the domains for both mental health and substance use treatment. The IBHA is a comprehensive evaluation that is intended to identify behavioral health and medical components that may be contributing to the individual's condition.

Providers could utilize the ASAM for any age since CSC BHSD has an integrated assessment. However, SUTS does not treat anyone under the age of 12 year of age. Beneficiaries under the age of 12 are treated under MH.

Below is the Crosswalk used for the County's IBHA

County IBHA Headers	DHCS CalAIM MH Domains	ASAM Criteria
Identifying Information		
Presenting Problem	Domain 1	
Acute Intoxication and/or Withdrawal Potential	Domain 1 & 3	Dimension 1
Biomedical Conditions/Compliance (Current Medications; current or relevant past medical conditions, PCP info)	Domain 4	Dimension 2
Emotional/Behavioral/Cognitive Conditions/ Complications (MSE, Abuse & Neglect Questions)	Domain 1 & 2	Dimension 3
MH History (Psychosocial and Trauma)	Domain 2 & 3	Dimension 3
Substance Use	Domain 3	Dimension 1 & 4
Readiness to Change - Substance Use and Mental Health	Domain 3	Dimension 4
Relapse or Continued Problem (Treatment History; triggers, maintains, lessons)	Domain 3	Dimension 5
Wellness & Recovery Environment (cultural factors/ considerations. Family History & Current Situation, Social Relationships, Education/Vocation, Inter-agency/Legal, Strengths/Protective Factors)	Domain 5 & 6	Dimension 6
Clinical Impression - MH: "Medical Necessity Impairments" (Health, Daily Living Activities, Social Functioning, Living Arrangement)	Domain 1 & 7	
Clinical Impression - SUTS (Impairment Levels/ Symptoms)		
Diagnosis	Domain 7	
Narrative Summary/Level of Care Recommendation	Domain 7	
Signatures of Writer and/or LPHA (if writer is not LPHA)	Signatures	Signatures

Assessment Updates

The frequency of updating a behavioral health assessment can vary depending on several factors, including the individual's specific needs and the severity of their behavioral health concerns. In general, it is recommended to review and update a behavioral health assessment periodically to ensure it remains accurate and comprehensive.

Even though there is no fixed timeframe, the following situations may warrant an assessment update:

- Significant changes in symptoms or functioning: If there are noticeable changes in the individual's mental health symptoms, behaviors, or overall functioning, it may be necessary to update the assessment to reflect the individual's current state.
- Treatment plan/problem list adjustments: If there are modifications to the treatment plan/problem list, such as changes in medication, therapy approaches, or other interventions, updating the assessment can help align the treatment with the individual's current needs.
- Progress monitoring: Regular assessment updates can provide a measure of progress over time. By comparing previous assessments and treatment goals, progress notes, and outcome tools (CANS, PSC-35), providers can evaluate the effectiveness of the treatment and make necessary adjustments.
- Life transitions or stressors: Significant life events, transitions, or new stressors can impact an individual's behavioral health. In such cases, updating the assessment can help capture any changes or challenges related to these factors.

Transformational Care Planning

Transformational Care Planning (TCP) has been a service planning model used in The County of Santa Clara since 2013. It is a Person-centered and strength-based approach to helping beneficiaries achieve their life goals. TCP is organized around the individual's/family's needs and builds on principles of inclusion, hope, wellness, resiliency, and recovery. The values and core principles of Transformational Care Planning remains in the service delivery model and direct approach to how we want to deliver services to all beneficiaries and their families. In addition to looking at goals in an individual's life and the barriers that prevent achieving their goals, it is about how we listen to an individual's experiences and work with them to achieve their desires and needs, supporting their recovery journey. The principles of TCP will continue to exist in daily practice for all programs (engaging beneficiaries into services, screening, assessment, outcome tools, transition & discharge planning throughout services, transition of care, etc.).

For federally funded programs that still require a treatment plan, the development of a care plan will still be practiced, utilizing the principles of TCP.

A person-centered care plan process includes:

- Collaboration and partnership between members of the family or natural support system and service providers in all aspects of the development of the plan
- Articulation of results that are desired by the individual and significant support people
- Focus on strengths, developmental assets, and protective factors of the individual and their natural support system
- Utilization of the expertise of that family/system about the individual, and the individual's expertise about themselves
- Incorporation of cultural elements that affect the plan
- Foundation on the values of the individual

Treatment Planning

Problem List

In accordance with clinical standards, the utilization of a Problem List has, for the most part, replaced the use of treatment plans, except for situations where federal requirements mandate the continued use of a treatment plan. The Problem List serves as a combination of symptoms, conditions, diagnoses, and/or risk factors that are identified through assessments, psychiatric diagnostic evaluations, crisis situations, or other treatment factors. Problems identified during treatment should promptly be addressed by the service provider and subsequently added to the Problem List.

Problem list replaces treatment plans for all programs EXCEPT:

- Narcotic Treatment Program (NTP)
- Perinatal Outpatient
- Therapeutic Behavior Services (TBS)
- Targeted Case Management (TCM)
- Intensive Care Coordination (ICC)

The responsibility for creating and managing the Problem List falls with the providers who are responsible for the individual's care. It includes clinician-identified diagnoses, concerns expressed by the individual themselves, and issues identified by other service providers, including Mental Health Rehabilitation Specialists, Peer Support Specialists, and other members of the treatment team. The Problem List plays an important role in facilitating continuity of care by providing a comprehensive and easily accessible overview of problems. This allows the quick identification of the individual's care needs, including current diagnoses, as well as key health and social issues.

Additionally, a person-centered Problem List should be collaboratively developed with the individual and carefully documented in their chart. Problem Lists are to be updated regularly at appropriate intervals, involving the individual. When used as intended, treatment teams can effectively utilize the Problem List to quickly obtain essential information about an individual's concerns, the duration of the issue, and the identity of the provider who recorded the concern. Furthermore, the Problem List allows for tracking the issue over time, including its resolution. Keeping the Problem List up to date is crucial for accurately communicating the individual's needs and supporting care coordination. The Problem List serves as a fundamental tool for treatment teams and should be diligently maintained for effective treatment.

The Problem List must be updated to accurately reflect the current presentation of the individual under care.

The Problem List shall contain, but not be limited to, the following elements:

- Diagnoses identified by providers within their authorized scope of practice, if applicable.
    - If applicable, include diagnostic specifiers from the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Problems identified by providers within their authorized scope of practice, if applicable.
- Problems or illnesses identified by the person receiving care and/or their significant support person, if applicable.
- The name and professional title of the provider responsible for identifying, adding, or removing the problem, along with the date of identification, addition, or removal.

Providers must add or remove problems from the Problem List when there are relevant changes in the individual's condition.

DHCS does not impose a specific timeframe for updating the Problem List, nor does it mandate a specific frequency for updates once a problem has been initially added. However, providers are required to update the Problem List within a reasonable timeframe and in accordance with generally accepted standards of practice.

Use supervision support in the development of Problem Lists, to ensure your client's current needs are addressed.

Evidence-Based Practices

Evidence-Based Practices (EBPs) were integrated to services to support continued individual outcome improvement, and ensure services are consistent with current evidence-based knowledge and implement mechanisms to address meaningful clinical issues affecting individuals.

Per BHIN-21-075,DMC-ODS providers are to use two DHCS required EBPs, one being Motivational Interviewing and one additional BHSD- supported EBP from the list below into the provision of services . Providers may implement other EBP's or promising practice in addition to those identified.

It is recommended to use clinical supervision to address the use of EBPs appropriate to the services provided and the individual's clinical needs.

BHSD Supported EBPs Utilized by all Progr

EBP	Description
Motivational Interviewing	A person-centered, directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution focused strategies that build on the past successes of people in care
Assertive Community Treatment (ACT/FACT)	Recovery-oriented, strengths-based, and person-centered. Treatment is assertive in that the team is proactive and persistent in efforts to engage beneficiaries who would likely benefit from this level of support. A self-contained trans-disciplinary team staffed with a team leader, psychiatrist, nurses, social workers, therapists, and specialists in co-occurring treatment, employment and educational services, supportive housing, and peer-support services.
Cognitive - Behavioral Therapy (CBT)	Based on the theory that most emotional reactions, thought processes and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
Dialectic Behavioral Therapy (DBT)	Talk therapy based on CBT, adapted for individuals who experience emotions intensely, to support understanding and acceptance of challenging emotions, to bring positive changes.
Psycho-Education	Is designed to educate people in care about mental health, substance abuse and related behaviors and consequences. Psychoeducational groups provide information designed to have a direct application to the lives of people in care; to instill self-awareness, suggest options for growth and change, identify community resources that can assist people in care with recovery, develop an understanding of the process
Seeking Safety	Present-focused treatment model to support individuals attain safety from trauma and substance misuse. This modality is largely conducted in groups, however, can also be conducted individually.
Solution Focused Brief Therapy (SFBT)	A short-term, practical, goal-driven model, where the emphasis is on clear, concise, realistic goal negotiations. The model assumes clients have some knowledge of what would make their life better, even though they may need some help describing the details of their better life and that everyone who seeks help already possesses at least the minimal skills necessary to create solutions.
Trauma-Informed Care	Services that consider an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
Trauma Recovery and Empowerment Model (TREM)	Manualized group-based model to facilitate trauma recovery for individuals, primarily women, who are survivors of trauma with histories of exposure to sexual and physical abuse, to support their learning to regulate intense emotions and strengthen social connections.
Wellness Recovery Action Plan (WRAP)	Can be used for both mental and physical health conditions. WRAP is often facilitated by Peer Support Specialists, who have been trained in the Foundations of WRAP and Advanced WRAP Training. However, WRAP can be facilitated by anyone and all levels of staff. Introductory WRAP training is essential to a recovery-oriented system of care workforce.

Additional BHSD Supported EBPs Utilized by Program Type

12-Step Facilitation Recovery	Core Elements	Illness Management and Recovery	Problem Solving Therapy (PST)
ABC's of Mental Health	Criminal Conduct and Substance Abuse Treatment Pathways to Self-Discovery and Change	Integrated Core Practice Model	Prolonged Exposure Therapy for PTSD
Acceptance Commitment Therapy (ACT)	Criminal Thinking	Integrated Dual Diagnosis Treatment	Psychodynamic Therapy
Adolescent Community Reinforcement Approach (A-CRA)	Delivered in Partnership with Health Care	Integrated Services for Mental Health and Aging	Question Persuade and Refer (QPR)
Ages and Stages Questionnaire (ASQ)	Delivered in Partnership with Law Enforcement	Integrated Services for Mental Health and Developmental Disability	Reach Out and Read
Age-Specific Service Strategy	Delivered in Partnership with Social Services	Interactive Journaling	Relapse Prevention
Aggression Replacement Therapy	Delivered in Partnership with Substance Use Services	Living in Balance	Risk and Responsivity
Anger Management	Early Detection and Intervention for the Prevention of Psychosis (EDIPP) REACH	Managing and Adaptive Practice (MAP)	Seven Challenges
Attachment Based Family Therapy (ABFT)	EMDR	Matrix Model	Skills Streaming
Breaking Barriers	Ethnic-Specific Service Strategy	Medication Assisted Treatment (MAT)	Strengthening Families
Brief Family Therapy	Families and Schools Together (FAST)	Mental Health First Aid	Strengths Based Interviewing
Brief Marijuana Dependence Counseling	Family Acceptance Project LGBTQ+	Moral Recognition Therapy	Supported Employment/Individual Placement Services
Brief Psychodynamic Therapy	Family Centered Therapy	Motivational Enhancement Therapy	Supported Housing
Brief Strategic Family Therapy (BSFT)	Family Psychoeducation	Multi-Family Generational Groups (REACH)	Supportive Education
Broad Spectrum Treatment and Naltrexone for Alcohol Dependence	Family Support	Multisystemic Therapy (MST)	Targeted Outreach and Case Management
Child Parent Psychotherapy (CPP)	Family Systems Therapy	Neurosequential Model of Therapeutics™ (NMT)	Thinking for a Change
Circle of Security	Framework for Recovery	New Generation Medications	Transition to Independence Model (TIP)
Community Reinforcement and Family Training (CRAFT)	Functional Family Therapy (FFT)	Assisted Outpatient Treatment (AOT)	Treatment/Therapeutic Foster Care Oregon (TFCO)
Compassionate Communication	Healing the Trauma	Nurtured Heart Approach	Triple P (note Levels used)
Conscious Leadership	Helping Women Recover	Parent Child Interactive Therapy (PCIT)	Virginia Model for Competency Development
Contingency Management	Homebuilders	PIER Model REACH	

EBPs by Program Type	
(purple)	All
(blue)	MHD
(yellow)	SUTS
(green)	MHD and SUTS
(orange)	CJS

Treatment Team

An important aspect of providing comprehensive and person-centered care within the healthcare system is the establishment of a multidisciplinary treatment team. This section outlines the guidelines and best practices for creating and implementing a multidisciplinary treatment team that consists of Licensed Practitioners of the Healing Arts (LPHAs), Mental Health Rehabilitation Specialists (MHRS), Rehabilitation Counselor, Peer Support Specialists (PSS), and Medical Providers. By combining the unique expertise and perspectives of each team member, this approach aims to deliver integrated and holistic care to beneficiaries receiving services.

The treatment team collaboratively develops personalized care plans, considering the unique needs and preferences of beneficiaries receiving services. Team members share their expertise and insights to create comprehensive and integrated treatment strategies that encompass mental health, physical health, psychosocial rehabilitation, and peer support interventions.

When developing a Treatment Team, consider the beneficiary's current needs and supports that will meet their overall wellbeing and success towards meeting their treatment goals. By adding team members whose expertise supports the beneficiary's unique needs, their success increases.

In order to ensure the highest standard of care and maintain consistency within The County of Santa Clara BHSD, it is important for each provider to have an understanding of their roles and, most importantly, their scope of practice. This section presents a chart designed to assist providers in understanding their specific scope of practice

Understanding and adhering to your designated scope of practice ensures the safety and well-being of beneficiaries while promoting efficient teamwork among behavioral health professionals.

Care Coordination

Care coordination refers to the organization of individual care activities between two or more healthcare professionals or systems involved in an individual's care to facilitate the appropriate delivery of services. With the CalAIM implementation an individual's needs can be addressed concurrently by providers in different agencies or systems, coordination of care is a necessary provision to make this work. The goal of care coordination is to meet the individual's needs through proactive and deliberate activities that include the person in care and to organize or coordinate with other service providers to facilitate the appropriate delivery of services across providers, treatment settings, and healthcare systems. In the county's behavioral health system, care coordination ensures that beneficiaries receive a wide-range of integrated and client-centered care which can result in better health outcomes and overall better quality of life.

When coordinating care among different healthcare providers for individuals with behavioral health issues, obtaining a release of information (ROI) is a critical step to facilitate effective communication and collaboration. An ROI allows the sharing of confidential patient information between providers, ensuring that all involved parties have access to the necessary information for comprehensive and coordinated care.

Effective care coordination ensures that individuals receive consistent and uninterrupted care, which is particularly important for individuals with complex behavioral health issues. As a provider, it is your responsibility to support your client's care, given the challenges they already face, especially when attempting to navigate such complex health systems. In supporting clients, consider bringing in natural supports, such as family members. Including those in their natural support system utilizes a person-centered approach, as it will guide their process to support their needs.

Scope of Practice Matrix	Physician	Licensed or Waivered Psychologist (post doctorate)	Licensed, Registered or Waivered staff: ACSW/ LCSW, AMFT/ LMFT, APCC/ LPCC (post MA/MS)	RN with Master's degree in MH Nursing or related field	Psychiatric Nurse Practitioner	Registered Nurse	Licensed Vocation Nurse/ Licensed Psychiatric Technician	Trainee/ Student/ Intern: Post BA/BS degree. Enrolled in MA/ MS/ doctorate program	Mental Health Rehabilitation Specialist: BA/ BS in MH related field and 4 yrs MH experience	Certified Peer Specialist	Other Qualified Staff approved by BH Director: typically 18+, High School Equivalency, Driver's License	Mental Health Rehabilitation Specialist: BA/ BS in MH related field and 4 yrs MH experience
Assessment: MH + medical history (hx), Substance use + exposure, strengths, risks, barriers to achieving goals	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Assessment: Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the person's physical and MH	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No
Behavioral Health Prevention Education Service (Outreach)	No	No	No	No	No	No	No	No	No	Yes*	No	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Care/Client/Treatment Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes*,++	Yes++	No	Yes*,++	Yes++
Intensive Care Coordination (ICC)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Intensive Home-Based Services (IHBS)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Medication Support	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No	No
Medication Prescribing	Yes	No	No	No	Yes	No	No	No	No	No	No	No
Medication Administering	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No	No
Medication Dispensing	Yes	No	No	Yes+	Yes	Yes+	No	No	No	No	No	No
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Problem List	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*	Yes*
Psychological Testing	No	Yes	No	No	No	No	No	No	No	No	No	No
Psychotherapy	Yes	Yes	Yes	No	Yes	No	No	No	No	No	No	No
Rehabilitation Counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Self Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes*	No	No
Targeted Case Management	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*
Therapeutic Behavioral Services (TBS)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*	Yes*

* Under the direct supervision of an LPHA/LMHP
+ Training and certification requirement may apply
++ May require close supervision if issues of danger to self or others are present
+++ Typically limited to post-master's doctorate students

For more on Care Coordination, refer to the CalMHSA Documentation Guide

Transition of Care

This section of the Clinical Practice Guidelines aims to provide guidance on the transition of care requirements under CalAIM.

It is essential to consider and plan for the transition early in an individual's/family's engagement in a treatment program. Generally, there are beginning, middle, and end phases or stages in behavioral health treatment. Some programs may have defined time limits while others may use assessment and outcome data to determine readiness for transition. Conditions exist in all programs under which services will be offered, continued, or terminated. An explanation of these conditions early in the process helps individuals/ families have a clearer understanding about what they may expect from treatment. It also helps to define roles of the providers and establish healthy boundaries. Transition planning should continue throughout treatment/services to help individuals/families see a life beyond mental illness/ substance use and prepare for success.

Transition of care refers to the process of transferring an individual's care from one provider, setting, level of care to another or discharge. It involves various transitions, including but not limited to hospital discharges, transfers between care facilities, and changes in care settings or providers within the county or community.

- Client Centered: Providers should make an effort to assure the individual's needs, preferences, and goals are the forefront of the transition process. The transition plan should be tailored to the individual's unique circumstances, including their health condition, social determinants of health, and support network.
- Continuity of Care: Providers should make their best efforts to assure continued care is maintained throughout the transition process. This involves ensuring the seamless transfer of relevant treatment information such as, treatment plans, and care responsibilities between providers, with the aim of avoiding disruptions in treatment.
- Collaboration: Providers should practice effective communication and collaboration among all involved providers, care teams, and the individual. Providers should share accurate information exchange in a timely manner to ensure a shared understanding of the individual's needs, goals, and care plan, promoting a smooth transition.

Providers should utilize The Transition of Care Tool to support timely and coordinated care when beneficiaries who are currently receiving behavioral health services from either the MCP or MHP need services transitioned to the other Medi-Cal mental health delivery system, or need to add services provided by the other delivery system.

SUTS providers should utilize the Assessment Level of Care (ALOC) when transitioning an individual to a higher or lower level of care or when transitioning out of services.

Various types of transitions to other programs sometimes occur. Transitions to different programs may include a lower level of care with reduced services or a program that is a better match for the Individual/ family's preferences or needs. Transitions to a different program should also be planned for and can include the following:

- Discussion with individual/family to assess possible challenges
- Review of strategies, skills, and supports

- Arrange visit to the new program location with current provider to meet the new provider(s) and tour the facility ("warm hand-off")
- Coordination with the new provider to assure understanding of strengths, needs, supports, and goals ("warm hand-off")
- Provide copies of Care Plan, Narrative Summary & Assessment info to the new provider
- Use of additional supports, such as family, peers, parent mentor, etc. wherever possible
- Provide individual/family with a written transition or WRAP plan
- Overlap of services with the new provider of at least 30 days (CM services may be provided and billed during the overlap of 30 days)
- Ensure the individual/family has been prescribed medications with refills to cover up through their initial psychiatric appointment with their new service provider
- Do not close the case until the other agency has confirmed the initial psychiatry appointment has been completed

Providers receiving an Individual/family from another program can help facilitate the transition plan. Helpful things to consider may include:

- The Individual's/family's loss of the relationship, environment, etc.
- Accommodating the adaptation and adjustment to a new program and provider
- Co-coordinating the receipt of the Care Plan, Narrative Summary, assessment, etc. from the previous provider ("warm hand-off")
- Overlap of services with the previous provider of at least 30 days
- Inform the previous provider as to when the Individual is opened and has seen the new psychiatrist for medication evaluation and support.
- Discussing with the Individual/family what helped in the previous program, the accomplishments and strengths gained, and what they would like most from their new program
- Review documentation from the previous provider with the Individual/family and update if needed

The Transition Plan

It best serves the Individual/family to have a written plan they can refer to. This can be a helpful tool for them when challenges arise. Helpful items to consider on a Transition Plan may include:

- Progress made: Increase in family and/or individual functioning, awareness of personal accomplishments, and ability to identify most-utilized personal strengths
- Prevention Planning ("What are the things I can do on a regular basis to stay well?")
- Community Supports ("Who can I turn to for support or assistance?")
- Social Groups
- Recreational centers/groups
- Organizations, e.g., churches/spiritual, cultural, YMCA, etc.
- Health care resources, e.g., medical dental, mental health, etc.

- "Trigger" Plan/Coping skills ("How do I know if I'm starting to slip and what I will do to avoid relapse?")
- Natural Supports (Who am I connected to? Who are my teachers? Who are my spiritual guides?, etc.)
- Individual/Family/Supports Strengths
- Steps to access formal services (if needed)
- Roles and responsibilities of Individual/family/supports
- Personal vision/dream for their life in the community

The commonly utilized Discharge Summary could include information such as those described above and provided to the Individual/family.

Diversity & Equity

Diversity and equity ensure that individuals from all backgrounds have equal access to behavioral health services. This includes addressing barriers such as language, cultural competency, stigma, and socioeconomic factors that may disproportionately affect certain communities. By promoting diversity and equity, more people can receive the care they need, leading to better overall mental health outcomes. Having a diverse behavioral health workforce that reflects the community it serves fosters trust and rapport with patients. When individuals see professionals who share their racial, ethnic, or cultural background, they may feel more comfortable seeking help and be more likely to engage in treatment. Representation also enables providers to better understand the experiences and challenges faced by diverse communities, leading to more tailored and effective interventions.

Diversity and equity efforts aim to eliminate mental health disparities that exist among different population groups. Certain communities, such as racial and ethnic minorities, LGBTQ+ individuals, and those with disabilities, may experience higher rates of mental health issues and face unique challenges in accessing appropriate care. By addressing disparities and ensuring equitable access to quality services, behavioral health systems can work towards reducing these gaps and improving health equity for all. Promoting diversity and equity in behavioral health is not only ethically important but also essential for ensuring that mental health services are accessible, effective, and relevant to all individuals. By embracing diversity and striving for equity, behavioral health systems can better address the needs of diverse communities, reduce disparities, and foster a more inclusive and just society.

Cultural Sensitivity

Cultural sensitivity is vital in delivering high quality behavioral health services. The awareness and consideration of cultural factors that may influence an individual's mental health, well-being, and the way they perceive and seek treatment. It involves understanding diverse cultural backgrounds and beliefs of clients/patients and adapting to meet specific needs of the beneficiaries and communities we serve. The purpose of this section in the clinical practice guide is to offer guidance on promoting cultural sensitivity and providing culturally responsive care within the Behavioral Health Services Department of County of Santa Clara.

Culturally competent care: Providers should aim to effectively deliver services that meet the social, cultural, and linguistic needs of beneficiaries from diverse backgrounds. It involves understanding and respecting the beliefs, values, behaviors and needs of individuals and communities and tailoring services accordingly.

Cultural awareness: Providers should maintain awareness of their own cultural biases, assumptions, values, and stereotypes. They should recognize that cultural backgrounds significantly shape individuals' beliefs about mental health, help-seeking behaviors, and treatment preferences.

Trauma-Informed: In order to promote Trauma-Informed care it is important for providers to acknowledge and address the effects of historical trauma, discrimination, and cultural influences on mental health outcomes.

Gender Affirming Care

Understanding Gender Diversity: Providers should try to develop a thorough understanding of gender diversity and the range of gender identities beyond the traditional binary. This includes knowledge about transgender, non-binary, and gender non-conforming individuals, as well as the unique challenges they may face. Continuous education and efforts to raise awareness are important for staying informed about current best practices and promoting a gender-affirming approach.

Providers should respect beneficiaries' self-identified gender and use appropriate names and pronouns that align with their gender identity. Demonstrating genuine respect, empathy, and non-judgmental attitudes creates a safe and supportive environment for individuals to discuss their mental health needs openly.

Mental Health Disparities

Transgender and gender non-conforming individuals often face unique mental health disparities, including higher rates of depression, anxiety, and suicidality. Providers should address these disparities through EBPs, counseling, and support. Additionally, providers should promote resilience, coping skills, and providing resources specifically for gender diverse beneficiaries in order to improve mental health outcomes.

Language

CSC BHSD provides language assistance services in various languages at no cost. As a healthcare provider, it is strongly encouraged to utilize these services to effectively address the cultural needs of beneficiaries.

Free auxiliary aids and services, such as large print documents and alternative formats, are available upon request. Please contact 800.704.0900 (TTY: 800.855.7100 or 711) to access these services.

Other Considerations

For more information on County of Santa Clara's efforts on cultural sensitivity, please refer to County of Santa Clara's Cultural Competency Plan. **Beneficiary Rights**

As a County of Santa Clara Behavioral Health practitioner, it is important to uphold and advocate for beneficiary rights. By doing so, you are ensuring that beneficiaries are treated fairly and that their legal entitlements are respected. This ensures fairness and, provides transparency and promotes accountability. For detailed information on beneficiary rights please refer to the Mental Health and SUTS Beneficiary Handbook .

Below are some clinical practice guidelines to ensure that beneficiary rights are respected and protected:

- Be well-informed about the rights of beneficiaries: As a provider, you should be familiar with the guidelines and protocols related to beneficiary rights specific to County of Santa Clara BHSD. Stay current with any changes or updates from DHCS and County of Santa Clara in these guidelines to ensure that you are providing the most accurate information to your beneficiaries.
- Obtain informed consent: When providing behavioral health services, obtain informed consent from the beneficiary or their legal guardian. Assure that the consent is explained clearly and thoroughly including the benefits, risks, and potential outcomes of treatment.
- Provide access to records: Beneficiaries have the right to access their health records. As a provider, make sure that you provide the necessary steps to help beneficiaries access their records if needed. Also, explain the potential consequences of sharing their records with other parties such as, court officials, probations officers etc.
- Respect confidentiality: As a provider, you should ensure that the confidentiality of your beneficiaries is always protected. Make sure that all sensitive information is kept secure whether it be in an EHR or lockbox and only share with authorized individuals.
- Include beneficiaries in decision-making: It is best clinical practice to involve beneficiaries in their treatment planning and decision-making as much as possible. Make sure that you are providing clear information about their diagnosis, treatment options, and potential outcomes to help beneficiaries make informed decisions. Additionally, make sure that you are working within your scope of practice based on your education, training and experience.
- Uphold the right to privacy: Make sure that beneficiaries are provided with privacy during treatment sessions. Create a safe and confidential environment for beneficiaries to share their thoughts and emotions without fear of judgment or stigma. Additionally, explain what and how information will be shared with third parties such as their attendance with school officials, probation officers, etc.
- Respond to complaints and grievances: As a provider, you should respond promptly and respectfully to any complaints or grievances from beneficiaries. Take appropriate action to address any issues and work with beneficiaries to find a resolution. Please refer to the County of Santa Clara's grievance procedure (link).
- Advocate for beneficiaries: As a provider, it is your responsibility to advocate for the rights of your beneficiaries. This may include ensuring that beneficiary voices are heard, and their needs are being effectively met. This can involve advocating for a service that might benefit your client and their well-being.

By following these clinical standard guidelines, providers can make sure that they are providing good quality behavioral health services while maintaining the rights of their beneficiaries.

Grievance and Appeals

Beneficiaries who are unhappy or have concerns with the behavioral health services they are receiving are entitled to a grievance and appeals process. It is essential for providers to handle these situations with sensitivity, professionalism, and a commitment to resolving conflicts in a fair and timely manner.

Providers must acknowledge the grievance promptly upon receipt. This may involve acknowledging the individual's concerns, expressing empathy, and assuring them that their grievance will be taken seriously and addressed in a timely manner. There are federally mandated procedures and timelines on how to handle individual grievances; for detailed information please refer to the Individual Problem Resolution Policy & Procedure.

Appendix A

ASAM Criteria – Determining Severity Ratings

Dimension 1: Detoxification/Withdrawal Potential Assessment

SEVERITY / INTENSITY RATING

(0=no problem or stable / 1=mild / 2=moderate / 3=substantial / 4= severe)

0 ______Individual fully functioning w/ good ability to tolerate, cope with withdrawal discomfort
______No signs or symptoms of withdrawal present or are resolving and if alcohol, a CIWA-Ar score of less than 3
______No signs or symptoms of intoxication

1 ______Adequate ability to tolerate or cope with withdrawal discomfort.
______Mild to moderate intoxication, or signs, symptoms interfere w/daily functioning, but not a danger to self or others
______Minimal risk of severe withdrawal resolving and if alcohol, a CIWA-Ar score of 3-7
______Sub intoxication level

2 ______Some difficulty tolerating and coping w/withdrawal discomfort
______Intoxication may be severe, but responds to treatment so individual does not pose imminent danger to self or others
______Moderate signs and symptoms with moderate risk of severe withdrawal
______Somewhat intoxicated
______If alcohol, a CIWA-Ar score if 8-11

3 ______Demonstrates poor ability to tolerate and cope with withdrawal discomfort
______Severe signs and symptoms of intoxication indicating possible imminent danger to self & others
______Severe signs and symptoms or risk of severe but manageable withdrawal; or withdrawal is worsening despite detoxification at less intensive level of care
______Very intoxicated
______If alcohol, a CIWA-Ar score if 12-15

4 ______Incapacitated, with severe signs and symptoms of withdrawal
______Severe withdrawal presents danger (e.g. seizures)
______Continued use poses an imminent threat to life
______Stuporous
______If alcohol, a CIWA-Ar score over 15

Dimension 2: Biomedical Conditions and Complications

0 ______Fully functioning with good ability to tolerate or cope w/ physical discomfort
______No biomedical signs or symptoms are present, or biomedical problems stable
______No biomedical conditions that will interfere with treatment or create risk

1 ______Demonstrates adequate ability to tolerate and cope with physical discomfort
______Mild to moderate signs or symptoms interfere with daily functioning, but would likely not interfere with recovery treatment nor create risk

2 ______Some difficulty tolerating and coping with physical problems and/or has other biomedical problems
______Has a biomedical problem, which may interfere with recovery treatment
______Has a need for medical services which might interfere with recovery treatment (e.g., kidney dialysis)
______Neglects to care for serious biomedical problems
______Acute, non-life threatening medical signs and symptoms are present

3 ______ Demonstrates poor ability to tolerate and cope with physical problems and/or general health is poor
______ Has serious medical problems he/she neglects during outpatient treatment that require frequent medical attention
______ Severe medical problems are present but stable
______ Medical problem(s) present that would be severely exacerbated by a relapse
______ Medical problem(s) present that would be severely exacerbated by withdrawal (e.g., diabetes, hypertension)
______ Medical problems that require medical or nursing services

4 ______ Incapacitated, with severe medical problems
______ Severe medical problems that are life threatening risk

Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

0 ______ No or stable mental health problems

1 ______ Sub-clinical mental disorder
______ Emotional concerns relate to negative consequences and effects of addiction
______ Suicidal ideation without plan
______ Social role functioning impaired, but not endangered by substance use; mild symptoms that do not impair role functioning (e.g. social, school, or work)
______ Mild to moderate signs and symptoms with good response to treatment in the past
______ Or past serious problems have long period of stability or are chronic, but do not pose high risk of harm

2 ______ Suicidal ideation or violent impulses require more than routine monitoring
______ Emotional, behavioral, or cognitive problems distract from recovery efforts
______ Symptoms are causing moderate difficulty in role functioning (e.g. school, work)
______ Frequent and/or intense symptoms with a history of significant problems that are not well stabilized, but not imminently dangerous
______ Emotional/behavioral/cognitive problems/symptoms distract from recovery efforts
______ Problems with attention or distractibility interfere with recovery efforts
______ History of non-adherence with required psychiatric medications

3 ______ Frequent impulses to harm self or others which are potentially destabilizing, but not imminently dangerous
______ Adequate impulse control to deal with thoughts of harm to self or others
______ Uncontrolled behavior and cognitive deficits limit capacity for self-care, ADL's
______ Acute symptoms dominate clinical presentation (e.g. impaired reality testing, communication, thought processes, judgment, personal hygiene, etc.) and significantly compromise community adjustment and follow through with treatment recommendations

4 ______ Individual has severe and unstable psychiatric symptoms and requires secure confinement
______ Severe and acute psychotic symptoms that pose immediate danger to self or others (e.g. imminent risk of suicide; gross neglect of self-care; psychosis with unpredictable, disorganized, or violent behavior)
______ Recent history of psychiatric instability and/or escalating symptoms requiring high intensity services to prevent dangerous consequences

Dimension 4: Readiness to Change

0 ______ Willingly engaged in treatment as a proactive participant, is aware of/admits to having an addiction problem and is committed to addiction treatment and changing substance use and adherence with psychiatric medications
______ Can articulate personal recovery goals
______ Willing to cut negative influences
______ Is in Preparation or Action Transtheoretical Stage of Change

1 ______ Willing to enter treatment and explore strategies for changing AODA use or dealing with mental health disorder but is ambivalent about need for change (is in Contemplation Stage of Change)
______ Willing to explore the need for treatment and strategies to reduce or stop substance use
______ Willing to change AODA use but believes it will not be difficult or will not accept a full recovery treatment plan or does not recognize that he/she has a substance use problem

2 ______ Reluctant to agree to treatment for substance use or mental health problems but willing to be compliant to avoid negative consequences or may be legally required to engage in treatment
______ Able to articulate negative consequences of AODA use but has low commitment to change use of substances
______ Low readiness to change and is only passively involved in treatment
______ Variably compliant with outpatient treatment, self help or other support groups

3 ______ Exhibits inconsistent follow through and shows minimal awareness of AODA or mental health disorder and need for treatment
______ Appears unaware of need to change and unwilling or only partially able to follow through with treatment recommendations

4 ______ Unable to follow through, has little or no awareness of substance use or mental health problems and associated negative consequences
______ Not willing to explore change and is in denial regarding illness and its implications
______ Is not in imminent danger or unable to care for self – no immediate action required
______ Unable to follow through with treatment recommendations resulting in imminent danger of harm to self/others or inability to care for self

Dimension 5: Relapse/Continued Use/ Continued Problem Potential

0 ______ No potential for further AODA or MH problems
______ Low relapse or continued use potential and good coping skills
______ Is engaged with ongoing recovery/support groups
______ Has positive expectancies about treatment
______ No use of illicit drugs
______ Has no demographic risk factor (under 25 years of age, never married or having lived as married, unemployed, no high school diploma or GED)
______ No current craving
______ No impulsivity noted
______ Appropriately self-confident
______ Not risk-taking or thrill-seeking
______ No psychiatric medication required or adherent with psychiatric medications

1 ______ Minimal relapse potential with some vulnerability
______ Some craving with ability to resist
______ One or two changeable demographic risk factors
______ Marginally affected by external influences
______ Mostly non-impulsive
______ Mostly confident
______ Low level of risk-taking or thrill-seeking
______ Fair self-management and relapse prevention skills
______ Needs support and counseling to maintain abstinence, deal with craving, peer pressure, and lifestyle and attitude changes
______ Mostly adherent with prescribed psychiatric medications
______ Episodic use of alcohol (less than weekly)
______ Sporadic use of drugs (<1/week), not injected)

2 ______ Impaired recognition and understanding of substance use relapse issues
______ Difficulty maintaining abstinence despite engagement in treatment
______ Able to self-manage with prompting
______ Some craving with minimal/sporadic ability to resist
______ One or two durable demographic risk factors
______ Moderately affected by external influences
______ Neither-impulsive nor deliberate
______ Uncertain about ability to recover or ambivalent

______Moderate level of risk-taking or thrill-seeking
______Mostly adherent with prescribed psychiatric medications with failure likely to result in moderate to severe problems
______Regular use of alcohol (once or twice a week)
______Moderate use of drugs (1-3X/week), not injected

3 Little recognition and understanding of substance use relapse
______Has poor skills to cope with and interrupt addiction problems, or to avoid or limit relapse or continued use
______Severe craving with minimal/sporadic ability to resist
______Three demographic risk factors
______Substantially affected by external influences
______Somewhat impulsive
______Dubious about ability to recover
______High level of risk-taking or thrill-seeking
______Mostly non-adherent with prescribed psychiatric medications with failure likely to result in moderate to severe problems
______Frequent use of alcohol (3 or more times a week)
______Frequent use of drugs (more than 3X/week) and/or smoking drugs

4 ______Repeated treatment episodes had little positive effect on functioning
______No skills to cope with and interrupt addiction problems or prevent/limit relapse or continued use
______Severe craving with no ability to resist
______Four or more significant demographic risks
______Totally outer-directed
______Very impulsive
______Very pessimistic or inappropriately confident about ability to recover but is not in imminent danger or unable to care for self – no immediate action required
______Dangerous level of risk-taking or thrill-seeking
______Not at all adherent with prescribed psychiatric medications with failure likely to result in severe problems
______Daily intoxication
______Daily use of illicit drugs and/or IV drug use
______Is in imminent danger or unable to care for self

Dimension 6: Recovery Environment

0 ______Has a supportive environment or is able to cope with poor supports
______Living in a dry, drug-free home
______Few liquor outlets/no overt drug dealing
______Subcultural norms strongly discourage abusive use
______Positive leisure/recreational activities not associated with use
______No risk for emotional, physical or sexual abuse
______No logistical barriers to treatment or recovery

1 Has passive support in environment; family/significant other support system need to learn techniques to support the individual's recovery effort (e.g. limit setting, communication skills, etc.)
______Significant others are not interested in supporting addiction recovery, but individual is not too distracted by this situation, and is able to cope with the environment
______Individual demonstrates motivation and willingness to obtain a positive social support system
______Safe supportive living situation in a non-dry or non drug-free home
______Alcohol & drugs readily obtainable
______Subcultural norms discourage abusive use
______Leisure/recreational activities conducive to recovery available
______Some risk for emotional, physical or sexual abuse
______Logistical barriers to treatment or recovery can be readily overcome

2 ______ Environment is not supportive of addiction recovery, but with clinical structure, individual is able to cope most of the time

______ Living alone

______ Ready access to alcohol & drugs near home

______ Subcultural norms inconsistent about abusive use

______ Leisure/recreational activities neutral for recovery

______ Above average risk for emotional, physical or sexual abuse

______ Logistical barriers to treatment or recovery serious but resolvable

3 ______ Environment is not supportive of addiction recovery, and coping is difficult, even with clinical structure

______ Someone in the household currently dependent or abusing

______ Bars/liquor stores/dealers prevalent

______ Subcultural norms encourage abusive use

______ Alcohol and drugs readily available at preferred leisure/recreational activities

______ Substantial risk for emotional, physical or sexual abuse in current environment

______ Substantial logistical impediments to treatment or recovery

4 ______ Environment is not supportive of addiction recovery and is hostile and toxic to recovery or treatment progress

______ Unstable residence, living in shelter or mission, homeless

______ Extensive drug dealing/solicitation

______ Subcultural norms strongly encourage abusive use

______ Leisure/recreational activities poise severe risks

______ Currently being emotionally, physically or sexually abused

______ Extreme logistical impediments to treatment or recovery

______ Unable to cope with negative effects of the living environment on recovery - no immediate action required

______ Environment is not supportive of addiction recovery, and is actively hostile to recovery, posing an immediate threat to safety and well-being - immediate action required

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