



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Disability Services Administration
Division of Behavioral Health and Recovery
PO Box 45330, Olympia, WA 98504-5330

**CHARTER FOR DBHR INTEGRATED WAC
CHEMICAL DEPENDENCY TREATMENT AGENCIES
AND COMMUNITY MENTAL HEALTH AGENCIES**

Date: September 14, 2010

Customer/End User Group: Chemical Dependency, Problem Gambling, and Community Mental Health Agencies licensed and/or certified by the Department of Social and Health Services (the Department), Division of Behavioral Health and Recovery (DBHR).

Project Managers: Dennis Malmer and Pete Marburger

Executive Sponsors: David Dickinson, Director, DBHR
Victoria Roberts, Chief, DBHR

Problem Addressed: Chemical dependency and mental health agencies, licensed and/or certified by DBHR, that treat patients with substance abuse, problem gambling, and/or mental health conditions are required to meet multiple sets of laws (Revised Code of Washington (RCW)) and rules (Washington Administrative Code (WAC)), along with a number of federal rules, in order to provide treatment services. Agencies must comply with regulations authorized by:

Chapter 10.05 RCW*	Chapter 70.96A RCW*	42 CFR – Public Health (Medicaid)
Chapter 10.77 RCW	Chapter 71.05 RCW*	42 CFR Part 2
Chapter 43.20A.890 RCW*	Chapter 71.24 RCW*	42 CFR Part 8
Chapter 46.61 RCW	Chapter 71.34 RCW*	45 CFR Parts 160 & 164
Chapter 49.60 RCW	Chapter 74.50 RCW	
Chapter 70.02 RCW*		

Chapter 388-805 WAC
Chapter 388-816 WAC
Chapter 388-865 WAC (includes Credentialed Community Mental Health Agencies)

*Primary Rules

Scope and Background: To allow DBHR-licensed and/or -certified agencies that treat patients with substance abuse, gambling, and/or mental health conditions to meet one set of rules (WAC) rather than multiple sets of rules.

DBHR became an integrated division – substance abuse, gambling, and mental health – in July 2009. During the first year of integration, the DBHR Licensing and Certification Section explored and discussed a number of opportunities to collaborate and integrate licensing and certification procedures. The review process identified a number of similar procedures, which if consolidated, could lead to enhanced and more effective licensing and certification activities,

increased focus on patient health, patient safety, and risk management requirements, while reducing the regulatory burden on agencies that provide behavioral health treatment services.

High Level Deliverable: DBHR will write, review, and implement an integrated WAC that will allow licensed and/or certified chemical dependency, problem gambling, and mental health agencies that treat patients with substance abuse, gambling, and mental health conditions, or a combination of the three to meet one set of rules (WAC) to provide behavioral health treatment services.

Steps:

- Draft Integrated WAC charter
- Complete literature search
- Confirm project team members
- Determine project time line
- Determine resources available for the project
- Determine key assumptions
- Conduct cross-walk of current WACs
- Focus integrated WAC to address public and private behavioral health treatment entities
- Draft integrated WAC
- Provide for stakeholder review and comments
- Develop rule-making schedule and rule-making documents to codify new WAC
- Usability testing

Key Staff:

Pete Marburger
Tony O'Leary

Dennis Malmer
Deb Cummins

Kathy Sayre
Julián Gonzales

Linda Graves

Proposed Initial Community Partner Advisory Group:

Stacey Alles, Compass Health

Ann Christian, Washington Community Mental Health Council

Phillip Gonzales, Citizen's Advisory Council on Alcoholism and Drug Abuse

Linda Grant, Association of Alcoholism and Addiction Programs

William Hardy, Timberlands Regional Support Network

Mary Jadwisiak, Mental Health Advocacy Training and Consulting

Gayle A. Jones, Tulalip Tribal Behavioral Health Services

Pat Knox, Recovery Centers of King County

Jennifer LaPointe, Puyallup Tribal Treatment Center

Cheryl Mogensen, Kitsap Mental Health

Helen Nilon, Mental Health Planning & Advisory Council

Mikel Olsson, Behavioral Health Resources

Nancy Parker, Columbia River Mental Health

Jim Vollendroff, King County Mental Health Chemical Abuse and Dependency Services

Rick Weaver, Central Washington Comprehensive Mental Health

Key Assumptions: The DBHR Licensing and Certification Section will draft a new set of rules for licensing and certifying chemical dependency, problem gambling, and community mental health agencies under one WAC. The DBHR Licensing Certification Section will maintain four WACs for agencies to choose from which are:

- WAC 388-805 – Certification Requirements for Chemical Dependency Service Providers
- WAC 388-816 – Certification Requirements for Problem and Pathological Gambling


- WAC 388-XXX – Certification Requirements for Behavioral Health Services
- WAC 388-865 – Community Mental Health and Involuntary Treatment Programs

The new set of rules for agencies providing integrated behavioral health services must:

- Support the goal of recovery and resiliency for all clients who seek our care.
- Contain rules allowing for a single set of agency administrative, personnel, and clinical policy and procedures manuals that address specific treatment populations and levels of care.
- Contain rules allowing for clinical staff competency, patient rights, a single assessment, treatment plan, treatment plan review, clinical documentation, discharge plan, continuing care plan, patient records, complaints/grievance procedures, and quality management.
- Support a simple set of data requirements for publicly-funded patients (combined TARGET/CIS data base).
- Allow flexibility to publicly-funded agencies and private for-profit agencies to seek licensure or certification through the new integrated WAC.
- Align with Medicaid Rules, the State Plan, and Federal Block Grant requirements.

Key Constraints: Tackling this effort during a period of diminishing resources is both a challenge and an opportunity for DBHR, providers, contractors, and stakeholders. In order to be successful, there will need to be a dedicated effort by everyone involved in the project. It will also be critical to do substantial work with stakeholders so that the final product can meet the needs of providers, contractors, the State, and most importantly the clients we serve.

Project Managers (signature):


Pete Matburger


Dennis W. Malmer

Executive Sponsors (signature):


Victoria Roberts


David A. Dickinson

SAMPLE INTAKE ASSESSMENT AND EVALUATION FORM

SECTION I: CLIENT IDENTIFICATION

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. OTHER LAST NAME
5. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	6. DATE OF BIRTH	7. SOCIAL SECURITY NUMBER *	
8. STREET ADDRESS		9. CITY	10. STATE
12. COUNTY		11. ZIP CODE	
12. COUNTY		13. TELEPHONE NUMBER	

14. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK ALL THAT APPLY)

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Black, African American	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> White
<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Japanese	<input type="checkbox"/> Some other race
<input type="checkbox"/> Korean	<input type="checkbox"/> Not reported/unknown

15. SPANISH/HISPANIC/LATINO (CHECK ONE)

<input type="checkbox"/> Hispanic	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Not Spanish/Hispanic
<input type="checkbox"/> Cuban	<input type="checkbox"/> Other Spanish/Hispanic	<input type="checkbox"/> Unknown
<input type="checkbox"/> Mexican/Mexican-American/Chicano		

16. PRIMARY LANGUAGE USED IN YOUR HOME (CHECK ONE BOX ONLY)

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Finnish	<input type="checkbox"/> Japanese	<input type="checkbox"/> Romanian	<input type="checkbox"/> Tigrigna
<input type="checkbox"/> Amharic	<input type="checkbox"/> French	<input type="checkbox"/> Korean	<input type="checkbox"/> Russian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Cambodian	<input type="checkbox"/> German	<input type="checkbox"/> Laotian	<input type="checkbox"/> Salish	<input type="checkbox"/> Yakama
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Greek	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Language
<input type="checkbox"/> Czech	<input type="checkbox"/> Hmong	<input type="checkbox"/> Mien	<input type="checkbox"/> Spanish	<input type="checkbox"/> Language
<input type="checkbox"/> English	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Polish	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Unknown
<input type="checkbox"/> Farsi	<input type="checkbox"/> Ilocano	<input type="checkbox"/> Puyallup	<input type="checkbox"/> Thai	

CURRENT PHYSICAL HEALTH STATUS

17. DO YOU HAVE ANY MEDICAL CONCERNS OR PROBLEMS? NO YES

18. LIST ANY MEDICAL PROBLEMS YOU MIGHT YOU HAVE?

19. ARE YOU RECEIVING TREATMENT FOR YOUR MEDICAL PROBLEM? IF YES, PLEASE EXPLAIN:

20. WHEN WAS THE LAST TIME YOU SAW A MEDICAL PROVIDER AND FOR WHAT REASON?

21. PLEASE LIST ANY MEDICATION(S) YOU ARE CURRENTLY TAKING

MEDICATION	DOSE	WHO PRESCRIBES?	WHAT FOR?

NOT APPLICABLE -- I DON'T TAKE ANY MEDICATIONS

RELATED LEGAL DOCUMENTATION

22. DO ANY OF THE FOLLOWING APPLY TO YOU (YOUR CHILD)? IF YES, YOU ARE ASKED TO PLEASE PROVIDE A COPY OF THE DOCUMENT.

- YES NO LETTERS OF GUARDIANSHIP
- YES NO POWERS OF ATTORNEY
- YES NO ADVANCED DIRECTIVES FOR PSYCHIATRIC CARE
- YES NO ADVANCED DIRECTIVE FOR MEDICAL CARE

23. ARE YOU (YOUR CHILD) HERE BECAUSE YOU HAVE BEEN ASKED OR ORDERED BY THE COURT TO RECEIVE MENTAL HEALTH TREATMENT? YES NO

IF YES, PLEASE SPECIFY:

- LESS RESTRICTIVE ALTERNATIVE (LRA) OR CONDITIONAL RELEASE (CR)
- FAMILY COURT (INCLUDING PARENTING PLANS)
- DEFERRED PROSECUTION
- UNDER THE SUPERVISION OF THE DEPARTMENT OF CORRECTIONS (388-865-0420(2)(D)(VI))
- CURRENT PROBATION
- CURRENT LEGAL ISSUES
- OTHER _____

24. ARE YOU CURRENTLY UNDER THE SUPERVISION OF THE DEPT. OF CORRECTIONS? YES NO

IF SO, PLEASE PROVIDE THE NAME AND PHONE NUMBER OF YOUR COMMUNITY CORRECTIONS OFFICER: _____

25. DID YOU PROVIDE A COPY OF THE COURT ORDER? YES NO NA

26. DID YOU RECEIVE RELIEF FROM DISCLOSURE? YES NO NA

27. IF SO, DID YOU PROVIDE A COPY OF THE ORDER GRANTING RELIEF? YES NO NA

28. I HAVE RECEIVED THE FOLLOWING INFORMATION:

- CLIENT RIGHTS STATEMENT 388-865-0430(2) YES NO
- COUNSELING AND HYPNOTHERAPY DISCLOSURE STATEMENT YES NO
- INFORMATION ABOUT MENTAL HEALTH ADVANCE DIRECTIVES YES NO
- NOTICE OF PRIVACY PRACTICES YES NO

29. BY SIGNING THIS DOCUMENT, I AM GIVING MY VOLUNTARY CONSENT FOR THIS ASSESSMENT. IF MY ASSESSMENT DETERMINES THAT I (OR YOUR CHILD, IF YOU ARE REQUESTING SERVICES FOR YOUR CHILD) AM ELIGIBLE FOR SERVICES, I GIVE MY CONSENT FOR ONGOING TREATMENT.

CLIENT SIGNATURE _____ DATE _____

PARENT / GUARDIAN SIGNATURE (IF APPLICABLE) _____ DATE _____

CLINICIAN SIGNATURE _____ DATE _____

I AM AN AMERICAN INDIAN/ALASKAN NATIVE AND HAVE BEEN GIVEN INFORMATION ABOUT TRADITIONAL TRIBAL/CULTURAL TREATMENT OPTIONS. AT THIS TIME, I AM CHOOSING TO PURSUE TREATMENT AT _____ AGENCY.

INITIALS _____ DATE _____

SECTION II

Reminder:

- Intake evaluation must be culturally and age relevant. WAC 388-865-0420(2)(c)
- Intake evaluation must include a review of any documentation of a mental health condition provided by the individual. WAC 388-865-0420(d)(i).

1. GRADE LEVEL (PLEASE INDICATE HIGHEST GRADE COMPLETED) <input type="checkbox"/> Preschool / Kindergarten <input type="checkbox"/> 1st – 12th grade: Please write in grade level _____ <input type="checkbox"/> Some College <input type="checkbox"/> 2-Year Degree (AA, AS) <input type="checkbox"/> 4 Year Degree (BA, BS) <input type="checkbox"/> Post-Graduate Education <input type="checkbox"/> Unknown, Never attended, or below pre-school	
2. EDUCATION (INCLUDING HOME SCHOOLING) (CHECK ONE) <input type="checkbox"/> Full-Time (for grades 1-12, at least 20 hrs/wk, and for kindergarten & education after grade 12, at least 12 Hr/Wk) <input type="checkbox"/> Part-Time (less than Full-Time) <input type="checkbox"/> Not in Educational or Training Activities <input type="checkbox"/> Unknown	
3. EMPLOYMENT STATUS (CHECK ONE) <input type="checkbox"/> Paid Full time 35+ Hrs/Wk - Not Supported Employment <input type="checkbox"/> Paid Part time <35 Hrs/Wk - Not Supported Employment <input type="checkbox"/> Supported Employment Community Based, Normalized <input type="checkbox"/> Sheltered Workshop Onsite <input type="checkbox"/> Volunteer Work 1+Hr/Wk <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed - Other <input type="checkbox"/> Unknown / Missing	
4. PRIORITY CODE <input type="checkbox"/> C Chronically Mentally Ill - Adult Only <input type="checkbox"/> D Seriously Disturbed - Adult or Child <input type="checkbox"/> E Severely Emotionally Disturbed - Child Only <input type="checkbox"/> O Other (none of the above)	5. IMPAIRMENT KIND (INDICATE UP TO 3 CODES) <input type="checkbox"/> A Development or Intelligence <input type="checkbox"/> C Physical <input type="checkbox"/> D Chemical Dependency <input type="checkbox"/> E Vision (does not include just wearing glasses) <input type="checkbox"/> F Hearing Impairments <input type="checkbox"/> G Other Communication Difficulties <input type="checkbox"/> X Other Medical or Physical <input type="checkbox"/> Y Unknown <input type="checkbox"/> Z None
6. LIVING SITUATION (SEE DATA DICTIONARY FOR FURTHER DETAILS) <input type="checkbox"/> 10 Private Residence No Routine Support: Private residence without routine or planned support, including child clients living with parents. <input type="checkbox"/> 20 Private Residence With Routine Support: Private residence with routine support, including help with ADLs or symptom management. <input type="checkbox"/> 30 Foster Home / Adult Family Home: County licensed foster home, Therapeutic Foster Care Facilities and Adult Family Homes <input type="checkbox"/> 40 24-Hr Residential Care including Crisis Residential: 24-hr, 7-day residential care facility, including aggregate care, CCF, Group Home, Therapeutic Group Home, Board and Care, Crisis Residential, Residential Treatment, Rehab Center, Residential Care / Treatment Facility and Chemical dependency residential programs. <input type="checkbox"/> 50 Institutional Setting including Nursing & Developmental Disabilities: 24-hr, 7-day institutional care facility, including Skilled Nursing/Intermediate Care Facility, Institute of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Vet Affairs Hosp, Developmental Disabilities Facility and State Hospital. <input type="checkbox"/> 60 Jail / Juvenile or Adult Correctional Facility: Individual resides in a Jail and/or Correctional facility with care provided on a 24 hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch. <input type="checkbox"/> 70 Homeless or Shelter: No permanent place of residence, including no fixed, regular and adequate nighttime residence, a supervised publicly or privately operated shelter designed to provide temporary living accommodations, an institution that provides a temporary residence for individuals intended to be institutionalized and a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on street). <input type="checkbox"/> 80 Other: Living situation not elsewhere classified in this table. <input type="checkbox"/> 99 Unknown: Information on an individual's residence is not available.	

7. SPECIAL POPULATION STATUS:

- Child
 OA
 DD
 Deaf
 African American
 Asian/Pacific Islander
 American Indian/Alaskan Native
 Hispanic

8. HOW DOES THE INDIVIDUAL IDENTIFY THEIR SEXUAL ORIENTATION?

- Heterosexual
 Gay/Lesbian/Bisexual
 Unknown/Not voluntarily given by person

A. PRESENTING ISSUES Presenting problems/symptoms (including onset, frequency, and intensity) as described by the individual, inclusive of people who provide active support to the individual if the individual so requests, or is under the age of 13. WAC 388-865-0420(2)(d)(i).

B. RISK ASSESSMENT/SAFETY AND STABILITY (mark any boxes that apply and comment):

<input type="checkbox"/> No known risk factors requiring referral for provision of emergency/crisis services consistent with WAC 388-865-0452 388-864-0420(2)(d)(v)						
<input type="checkbox"/> Client has risk factors that necessitate a referral for emergency/crisis services. Referred to: _____						
<input type="checkbox"/> Self-Harm/Suicidal ideation/attempts (comments)	<i>Current</i>			<i>History</i>		
		Yes	Denied		Yes	Denied
	Ideation	<input type="checkbox"/>	<input type="checkbox"/>	Ideation	<input type="checkbox"/>	<input type="checkbox"/>
	Plan	<input type="checkbox"/>	<input type="checkbox"/>	Plan	<input type="checkbox"/>	<input type="checkbox"/>
	Attempts	<input type="checkbox"/>	<input type="checkbox"/>	Attempts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> At risk for harming others (comments)	<i>Current</i>			<i>History</i>		
		Yes	Denied		Yes	Denied
	Ideation	<input type="checkbox"/>	<input type="checkbox"/>	Ideation	<input type="checkbox"/>	<input type="checkbox"/>
	Plan	<input type="checkbox"/>	<input type="checkbox"/>	Plan	<input type="checkbox"/>	<input type="checkbox"/>
	Attempts	<input type="checkbox"/>	<input type="checkbox"/>	Attempts	<input type="checkbox"/>	<input type="checkbox"/>

Current substance use, abuse, and treatment History.

Attached is a completed GAIN-SS

YES NO

Was there a positive screen on the GAIN-SS (scores 2 or more in the IDS or EDS sections and 2 or more in the SDS section)?

YES NO

C. DIAGNOSTIC SUMMARY

Sufficient clinical information to justify the provisional diagnosis using the diagnostic and statistical manual (DSM IV TR) criteria, or its successor. Diagnostic Summary should include:

- Symptoms and duration experienced by the individual and how they meet the specific DSM criteria for the diagnoses given on Axis I and Axis II.
- Complete Axis III and IV based on available information and self report.
- A brief statement of the client's functioning that justifies the GAF/CGAS score.

DRAFT

DIAGNOSIS (code and name)

Axis I

Axis II

Axis III

Axis IV

Axis V

___ GAF (Adult 18+) ___ CGAS (Child 0-17)

SECTION III
Eligibility
State Plan Medically Necessary Definition (WAC 388-865-0420)

An individual must meet all of the following in order to be eligible for mental health services:

- Determination that a mental illness exists which is a covered diagnosis under Washington State's section 1915(b) captivated waiver program.
- There are medically necessary state plan services available to address the individual's needs.
- There is sufficient information to document medical necessity as defined in the state plan.
- The individual's impairment(s) and corresponding need(s) are the result of a mental illness;
- The intervention is deemed to be reasonable necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness
- The individual is expected to benefit from the intervention; and
- Any other or informal system or support can not address the individual's unmet need.

Access to Care Standards

- GAF/CGAS Below 60
- Covered Diagnosis ("A" diagnosis or "B" with qualifiers), as noted in the Access to Care Standards

Is Primary Diagnosis a "B" Diagnosis? yes no

If yes, complete this section to indicate what risk factors apply. Choose at least one box from the list.

<p>Adults or Children age 6 and above</p>	<ul style="list-style-type: none"> <input type="checkbox"/> High risk behavior demonstrated during the previous 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness; <input type="checkbox"/> Two or more hospital admissions due to a mental health diagnosis during the previous two years; <input type="checkbox"/> Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year OR is currently being discharged from a psychiatric hospitalization; <input type="checkbox"/> Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90 days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment);
<p>Clients age 6-17</p>	<ul style="list-style-type: none"> <input type="checkbox"/> At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs.
<p>Clients under age 6 and there is a severe emotional abnormality in the child's overall functioning as indicated by one of the following:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers). <input type="checkbox"/> Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers).

- Client meets eligibility criteria
- Client does *not* meet eligibility criteria

SECTION IV

Recommendations for a course of treatment (if eligible). The course of treatment must identify the use of one or more state plan modalities:

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MHP Assessor Signature, Degree/Specialty/ID

Date

Printed Name

IMPLEMENTATION GUIDELINES WAC 388-865-0420, 388-865-0425, and 388-865-0430
INTAKE EVALUATION

Standard	Implementation Guideline	Compliance
<p>388-865-0420 Intake Evaluation (1) All individuals receiving community mental health outpatient services, with the exception of crisis, stabilization, and rehabilitation case management services, must have an intake evaluation. The purpose of the intake evaluation is to gather information to determine if a mental illness exists which is a covered diagnosis under Washington state's section 1915(b) capitated waiver program, and if there are medically necessary state plan services to address the individual's needs.</p>	<ul style="list-style-type: none"> The individual receiving community mental health outpatient services has an intake evaluation that gathers information that supports a determination of whether a mental illness exists that is a covered diagnosis under Washington State's section 1915(b) capitated waiver program. The intake identifies a medically necessary state plan service(s) to address the client's needs. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(2) The intake evaluation must: (a) Be provided by a mental health professional. (b) Be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the intake.</p>	<ul style="list-style-type: none"> The intake is completed and signed by a mental health professional The intake is "initiated" within 10 working days from the date that services were requested. Initiate means the consumer has met face-to-face with a mental health professional. (If the individual was not seen within 10 working days, then there must be documentation specifying the reason why.) The intake was completed within 30 working days from the initiation of the intake. (If the intake was not completed within 30 working days, then there must be documentation specifying the reason why.) 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

Standard	Implementation Guideline	Compliance
<p>(c) Be culturally and age relevant.</p>	<ul style="list-style-type: none"> The intake evaluation documents the individual's age and culture and if it is relevant to their mental health treatment needs. Examples of culture relevance include ethnic identification, individual's history of poverty, education, religion, trauma, addictive behavior, family of origin and general life style. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(d) Document sufficient information to demonstrate medical necessity as defined in the state plan, and must include:</p>	<p><u>Current state plan definition of medical necessity:</u> The intake documents whether or not:</p> <ul style="list-style-type: none"> The individual has a mental illness covered by Washington State for public mental health services; Impairments(s) and corresponding needs(s) are the result of a mental illness; The intervention is deemed to be reasonable necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness; The individual is expected to benefit from the intervention; and Any other formal or informal system or support can not address the individual's unmet need. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(i) Presenting problem(s) as described by the individual, including a review of any documentation of a mental health condition provided by the individual. It must be inclusive of people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age;</p>	<p>The intake includes:</p> <ul style="list-style-type: none"> Presenting problem(s) described in the consumer's own words. A review of any documentation of a mental health condition, provided by the individual. Documentation of information from people who provide active support to the individual if so requested. (Mark NA if the client did not request involvement of other supports) Documentation of information from people who provide active support to the individual if individual is under age thirteen. (Mark NA if the client is 13 or older) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Standard	Implementation Guideline	Compliance
(ii) Current physical health status, including any medications the individual is taking;	<ul style="list-style-type: none"> Current physical health status, as reported by the individual; Any medications the individual is taking, as reported by the individual. (mark NA if the client is not currently taking any medications) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(iii) Current substance use and abuse and treatment status (GAIN-SS);	<ul style="list-style-type: none"> Current substance use and abuse and treatment status, as reported by the individual; The GAIN-SS (Mark NA for those under the age of 13). 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(iv) Sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM IV TR) criteria, or its successor;	<ul style="list-style-type: none"> The intake includes a concise clinical summary of the symptom criteria that justify the diagnosis using the DSM IV TR (or its successor). 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(v) An identification of risk of harm to self and others, including suicide/homicide.	<ul style="list-style-type: none"> The intake includes an assessment that identifies risk of harm to self and others, including suicide/homicide. If indicated in the risk assessment, there is documentation that a referral for emergency/crisis services has been made in accordance with WAC 388-865-0452 <p>Note: A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment.</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
(vi) Whether they are under the supervision of the department of corrections; and	<ul style="list-style-type: none"> There is documentation that the provider has asked the individual if they are under the supervision of DOC. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(vii) A recommendation of a course of treatment.	<ul style="list-style-type: none"> The intake includes a treatment recommendation that addresses the presenting problem. 	<input type="checkbox"/> YES <input type="checkbox"/> NO

INDIVIDUAL SERVICE PLANNING

Standard	Implementation Guideline	Compliance
<p>388-865-0425 Individual Service Plan The service plan must:</p> <p>(1) Be initiated with a least one goal identified by the individual, or their parent or other legal representative if applicable, at the intake evaluation or the first session following the intake evaluation.</p>	<ul style="list-style-type: none"> The clinical record includes documentation that the service plan was initiated at the intake evaluation or the first session following the intake evaluation. The service plan includes at least one goal identified by the individual, or their parent or other legal representative if applicable at the intake evaluation or the first session following the intake evaluation. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(2) Be developed within thirty days from the first session following the intake evaluation.</p>	<ul style="list-style-type: none"> The individual plan was developed within 30 days of the first session after the intake evaluation. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(3) Address age, cultural, or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.</p>	<ul style="list-style-type: none"> The individual plan addresses age, cultural or disability issues identified by the individual (Mark NA if the individual has not identified any age, culture, or disability issues relevant to treatment) 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>
<p>(4) Include treatment goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's identified recovery goals.</p>	<ul style="list-style-type: none"> The individual service plan includes treatment goal(s) that are measurable The individual service plan includes treatment goal(s) or objectives that allow the provider and individual to evaluate progress toward the individuals identified recovery goals. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(5) Be in language and terminology that is understandable to individuals and their family.</p>	<ul style="list-style-type: none"> The language and terminology in the plan is understandable to the consumer and the family members, from the consumer's level of functioning identified in the intake and throughout the record. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

Standard	Implementation Guideline	Compliance
<p>(6) Identify medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode.</p>	<ul style="list-style-type: none"> The service plan identifies medically necessary service modalities as defined in the state plan. The service plan includes documentation that the identified service modalities have been mutually agreed upon by the individual and provider. The service plan outlines specific interventions deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention and any other formal or informal system or support can not address the individual's unmet needs. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(7) Demonstrate the individual's participation in the development of the individual service plan. Participation may be demonstrated by the individual's signature and/or quotes, documented in the plan. Participation must include family or significant others as requested by the individual. If the provider developing the plan is not a mental health professional, the plan must also document approval by a mental health professional.</p>	<p>The service plan demonstrates:</p> <ul style="list-style-type: none"> Individual's participation by the individual's signature and/or quotes. Family or significant others are included in the development of the individual service plan as requested by the individual. Mark NA if the individual is 13 years of age or older and has not requested participation of other supports. The provider developing the plan is a mental health professional or the plan documents approval by a mental health professional. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(8) Include documentation that the individual service plan was reviewed at least every one hundred eighty days. It should also be updated to reflect any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable.</p>	<ul style="list-style-type: none"> There is documentation that the individual service plan is reviewed at least every 180 days; The individual service plan is updated when there are changes in the individual's treatment needs or as requested by the individual, or their parent, or the legal representative if applicable; 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

Standard	Implementation Guideline	Compliance
<p>(9) With the individual's consent, or their parent or other legal representative if applicable, coordinate with any systems or organizations the individual identifies as being relevant to the individual's treatment. This includes coordination with any individualized family service plans (IFSP) when serving children under three years of age.</p>	<ul style="list-style-type: none"> • The individual service plan documents: • Coordination with any system or organization the individual identifies as being relevant to the individual's treatment. (Mark NA if the individual, or their parent or legal representative did not give consent for this coordination, or there are no other systems involved that the individual identified as relevant to care). • If the individual is under three years of age and has an individualized family service plans (IFSP), the individual service plan demonstrates coordination with the IFSP (Mark NA if the individual is over the age of 3, or there is no IFSP) 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>
<p>(10) If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may pursue their rights under WAC 388-865-0255.</p>	<ul style="list-style-type: none"> • The consumer was provided with information that they may pursue their rights under WAC 388-865-0255 if they disagree with specific treatment recommendations or are denied a requested treatment service. (Mark NA if there is no evidence the individual disagreed with treatment recommendations or was denied any requested services) 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>

CLINICAL RECORDS

Standard	Implementation Guideline	Compliance
<p>388-865-0430 Clinical Record The licensed community mental health agency must maintain a clinical record for each individual served in a manner consistent with WAC 388-865-0435, 388-865-0436, or any successors. The clinical record must contain:</p>		
<p>(1) An Intake Evaluation;</p>	<ul style="list-style-type: none"> The record contains an intake evaluation. (An intake evaluation is not required for crisis, stabilization, and rehabilitation case management services) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<p>(2) Evidence that the consumer rights statement was provided to the individual, or their parent or other legal representative if applicable;</p>	<ul style="list-style-type: none"> Documentation the consumer has signed or been provided a complete set of consumer rights (or their parent or other legal representative if applicable.) This can include the Benefits Booklet and/or the rights contained in WAC 388-865-0410. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(3) Documentation that the provider requested a copy of and inserted into the clinical record if provided, any of the following:</p>		
<p>(a) Mental health advanced directives;</p>	<ul style="list-style-type: none"> The clinical record contains copies of any mental health advance directives, or documentation that a copy of the advance directive was requested and not provided. (Does not apply to individuals under 18) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<p>(b) Medical advance directives;</p>	<ul style="list-style-type: none"> The clinical record contains copies of any medical advance directives, or documentation that a copy of any medical advance directives were requested and not provided. (Does not apply to individuals under 18) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<p>(c) Powers of attorney;</p>	<ul style="list-style-type: none"> The clinical record contains copies of any powers of attorney, or documentation that a copy of any powers of attorney were requested and not provided. (Does not apply to individuals under 18) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Standard	Implementation Guideline	Compliance
(d) Letters of guardianship, parenting plans and/or court order for custody;	<ul style="list-style-type: none"> The clinical record contains copies of any letters of guardianship, parenting plans and/or court order for custody, or documents that these were requested and not provided or that this does not apply. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(e) Least restrictive alternative order(s):	<ul style="list-style-type: none"> The clinical record contains copies of any least restrictive order(s) or that documentation these were requested and not provided or that this does not apply. (Does not apply to individuals under 13)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(f) Discharge summaries and/or evaluations stemming from outpatient or inpatient mental health services received within the last five years, when available.	<ul style="list-style-type: none"> The clinical record contains discharge summaries and/or evaluations from inpatient/outpatient treatment within the last 5 years, or documentation these were requested and not provided or that this does not apply. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(4) Any crisis plan that has been developed.	<ul style="list-style-type: none"> The clinical record includes any crisis plan that is developed by the provider or that the consumer provides to the provider. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(5) The individual service plan and all revisions to the plan.	<ul style="list-style-type: none"> The clinical record contains a treatment plan and all subsequent revisions and reviews of the treatment plan. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;	<ul style="list-style-type: none"> The clinical record includes clear evidence that the services provided to the consumer are by or under the clinical supervision of a mental health professional. Evidence may include signatures on the treatment plan and/or documentation of clinical supervision. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(7) Documentation of any clinical consultation or oversight provided by a mental health specialist.	<ul style="list-style-type: none"> The clinical record includes documentation of mental health specialist consultation and or oversight if applicable. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(8) Documentation of:		
(a) All service encounters;	<ul style="list-style-type: none"> The clinical record includes documentation of all services provided to the consumer. 	<input type="checkbox"/> YES <input type="checkbox"/> NO

Standard	Implementation Guideline	Compliance
(b) Objective progress toward established goals as outlined in the treatment plan; and	<ul style="list-style-type: none"> The clinical record includes documentation of progress that directly relates to the goals in the treatment plan. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(c) How any major changes in the individual's circumstances were addressed.	<ul style="list-style-type: none"> The clinical record includes documentation of major events/changes that are reported by the consumer and how they were addressed by the provider or other systems. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 has occurred;	<ul style="list-style-type: none"> The clinical record includes documentation of all mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 has occurred; (Mark NA if there has been no information that would require a report) 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(10) Documentation that the department of corrections was notified by the provider when an individual on a less restrictive alternative or department of corrections order for mental health treatment informs the provider that the individual is under supervision by the department of corrections. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax. The disclosure to department of corrections does not require the person's consent.	<ul style="list-style-type: none"> The clinical record includes documentation that the Designated Mental Health Professionals (DMHPs), as defined in RCW 71.05.020: <ul style="list-style-type: none"> Evaluated individuals subject to a discharge review within 72 hours of their release from jail; Notified treatment providers and DOC when an offender under court-ordered treatment and DOC supervision violated the treatment order or conditions of supervision; or the professional detains the individual for involuntary treatment; and Notified DOC if petitioning an offender, who is in a state correctional facility or under DOC supervision, for involuntary treatment. The clinical record includes documentation that the Mental Health Treatment Provider, as defined in RCW 71.05.020: <ul style="list-style-type: none"> Asked individuals court-ordered to treatment about DOC Supervision Released information to DOC relating to treatment offenders Requested an evaluation of offenders under supervision who have violated a mental health treatment order. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA

Standard	Implementation Guideline	Compliance
<p>(a) If the individual has been given relief from disclosure by the committing court, the individual must provide a copy of the court order to the treating community mental health agency (CMHA).</p>	<ul style="list-style-type: none"> Documentation that the CMHA inquired whether or not the individual has been given relief from disclosure by the committing court. Documentation that the requests a copy of the court order giving relief from disclosure by the committing court. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>
<p>(b) There must be documentation that an evaluation by a designated mental health professional (DMHP) was requested in the following circumstance:</p>		
<p>(i) The mental health provider becomes aware of a violation of the court-ordered treatment of an individual when the violation concerns public safety; and</p> <p>(ii) The individual's treatment is a less restrictive alternative and the individual is being supervised by the department of corrections.</p>	<ul style="list-style-type: none"> If the individual is on an LRA, and supervised by DOC, the clinical record includes documentation that a DMHP evaluation was requested if the mental health provider became aware of a violation of the court-ordered treatment of an individual when the violation concerns public safety. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>
<p>(11) Either documentation of informed consent to treatment by the individual or parent or other legal representative or if treatment is court ordered, a copy of the detention or involuntary treatment order;</p>	<ul style="list-style-type: none"> The clinical record contains an informed consent to treatment signed by the consumer and/or legal guardian. A copy of LRA may be substituted if consumer refuses to sign consent and is court ordered to treatment. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>(12) Documentation that the individual, or their parent or other legal representative if applicable, are informed about the benefits</p>	<ul style="list-style-type: none"> If applicable, the clinical/medical record contains documentation that consumers and, as appropriate, family members were informed about the medication benefits and possible side effects in language that is understandable to the consumer. 	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA</p>

Standard	Implementation Guideline	Compliance
<p>and possible side effects of any medications prescribed for the individual in language that is understandable;</p>		
<p>(13) Documentation of confidential information that has been released without the consent of the individual under the provisions in RCW 70.02.050, 71.05.390, 71.05.630 and the Health Insurance Portability and Accountability Act (HIPAA);</p>	<ul style="list-style-type: none"> The clinical record contains documentation of the disclosure if information was disclosed without the consumer's consent under the provisions in RCW 70.02.050, 71.05.390, 71.05.630 and the Health Insurance Portability and Accountability Act (HIPAA). 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
<p>(14) For individuals receiving community support services, the following information must be requested from the individual and the responses documented:</p>		
<p>(a) The name of any current primary medical care provider;</p>	<ul style="list-style-type: none"> The clinical record includes the name of any current primary medical care provider, or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(b) Any current physical health concerns;</p>	<ul style="list-style-type: none"> The clinical record includes any current physical health concerns as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(c) Current medications and any related concerns;</p>	<ul style="list-style-type: none"> The clinical record includes current medications and any related concerns as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(d) History of substance use/abuse and treatment;</p>	<ul style="list-style-type: none"> The clinical record includes history of substance use/abuse and treatment as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO
<p>(e) Any disabilities or special needs;</p>	<ul style="list-style-type: none"> The clinical record includes any disabilities or special needs as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO

Standard	Implementation Guideline	Compliance
(f) Any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition; and	<ul style="list-style-type: none"> The clinical record includes any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(g) Information about past or current trauma and abuse.	<ul style="list-style-type: none"> The clinical record includes information about past or current trauma and abuse as reported by the individual; or documentation that this was requested and not provided. 	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA
(15) A description of the individual's strengths and resources;	<ul style="list-style-type: none"> The clinical record includes a description of the individual's strengths and resources; 	<input type="checkbox"/> YES <input type="checkbox"/> NO
(16) A description of the individual's self-identified culture.	<ul style="list-style-type: none"> The clinical record includes a description of the individual's self-identified culture. 	<input type="checkbox"/> YES <input type="checkbox"/> NO

388-865-0420

Intake evaluation.

(1) All individuals receiving community mental health outpatient services, with the exception of crisis, stabilization, and rehabilitation case management services, must have an intake evaluation. The purpose of an intake evaluation is to gather information to determine if a mental illness exists which is a covered diagnosis under Washington state's section 1915(b) capitated waiver program, and if there are medically necessary state plan services to address the individual's needs. (For a listing of the covered diagnoses and state plan services go to: http://www.dshs.wa.gov/pdf/hrsa/mh/Waiver_2008_2010_PIHP_NEW_%200408_with_final_revisions.pdf)

(2) The intake evaluation must:

(a) Be provided by a mental health professional.

(b) Be initiated within ten working days from the date on which the individual or their parent or other legal representative requests services and completed within thirty working days of the initiation of the intake.

(c) Be culturally and age relevant.

(d) Document sufficient information to demonstrate medical necessity as defined in the state plan, and must include:

(i) Presenting problem(s) as described by the individual, including a review of any documentation of a mental health condition provided by the individual. It must be inclusive of people who provide active support to the individual, if the individual so requests, or if the individual is under thirteen years of age;

(ii) Current physical health status, including any medications the individual is taking;

(iii) Current substance use and abuse and treatment status (GAIN-SS);

(iv) Sufficient clinical information to justify the provisional diagnosis using diagnostic and statistical manual (DSM IV TR) criteria, or its successor;

(v) An identification of risk of harm to self and others, including suicide/homicide. Note: A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(vi) Whether they are under the supervision of the department of corrections; and

(vii) A recommendation of a course of treatment.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380 . 10-09-061, § 388-865-0420, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.24.035, 07-06-050, § 388-865-0420, filed 3/2/07, effective 4/2/07. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166, 05-14-082, § 388-865-0420, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335 . 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

388-865-0425

Individual service plan.

The community mental health agency must develop a consumer-driven, strength-based individual service plan that meets the individual's unique mental health needs. The individual service plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable. The service plan must:

(1) Be initiated with at least one goal identified by the individual, or their parent or other legal representative if applicable, at the intake evaluation or the first session following the intake evaluation.

(2) Be developed within thirty days from the first session following the intake evaluation.

(3) Address age, cultural, or disability issues identified by the individual, or their parent or other legal representative if applicable, as relevant to treatment.

(4) Include treatment goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's identified recovery goals.

(5) Be in language and terminology that is understandable to individuals and their family.

(6) Identify medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode.

(7) Demonstrate the individual's participation in the development of the individual service plan. Participation may be demonstrated by the individual's signature and/or quotes documented in the plan. Participation must include family or significant others as requested by the individual. If the provider developing the plan is not a mental health professional, the plan must also document approval by a mental health professional.

(8) Include documentation that the individual service plan was reviewed at least every one hundred eighty days. It should also be updated to reflect any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable.

(9) With the individual's consent, or their parent or other legal representative if applicable, coordinate with any systems or organizations the individual identifies as being relevant to the individual's treatment. This includes coordination with any individualized family service plan (IFSP) when serving children under three years of age.

(10) If an individual disagrees with specific treatment recommendations or is denied a requested treatment service, they may pursue their rights under WAC 388-865-0255.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380 . 10-09-061, § 388-865-0425, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335 . 01-12-047, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

388-865-0430

Clinical record.

The licensed community mental health agency must maintain a clinical record for each individual served in a manner consistent with WAC 388-865-0435, 388-865-0436, or any successors. The clinical record must contain:

- (1) An intake evaluation;
- (2) Evidence that the consumer rights statement was provided to the individual, or their parent or other legal representative if applicable;
- (3) Documentation that the provider requested a copy of and inserted into the clinical record if provided, any of the following:
 - (a) Mental health advance directives;
 - (b) Medical advance directives;
 - (c) Powers of attorney;
 - (d) Letters of guardianship, parenting plans and/or court order for custody;
 - (e) Least restrictive alternative order(s);
- (f) Discharge summaries and/or evaluations stemming from outpatient or inpatient mental health services received within the last five years, when available.
- (4) Any crisis plan that has been developed;
- (5) The individual service plan and all revisions to the plan;
- (6) Documentation that services are provided by or under the clinical supervision of a mental health professional;
- (7) Documentation of any clinical consultation or oversight provided by a mental health specialist;
- (8) Documentation of:
 - (a) All service encounters;
 - (b) Objective progress toward established goals as outlined in the treatment plan; and
 - (c) How any major changes in the individual's circumstances were addressed.

(9) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred;

(10) Documentation that the department of corrections was notified by the provider when an individual on a less restrictive alternative or department of corrections order for mental health treatment informs the provider that the individual is under supervision by the department of corrections. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax. The disclosure to department of corrections does not require the person's consent.

(a) If the individual has been given relief from disclosure by the committing court, the individual must provide a copy of the court order to the treating community mental health agency (CMHA).

(b) There must be documentation that an evaluation by a designated mental health professional (DMHP) was requested in the following circumstance:

(i) The mental health provider becomes aware of a violation of the court-ordered treatment of an individual when the violation concerns public safety; and

(ii) The individual's treatment is a less restrictive alternative and the individual is being supervised by the department of corrections.

(11) Either documentation of informed consent to treatment by the individual or parent or other legal representative or if treatment is court ordered, a copy of the detention or involuntary treatment order;

(12) Documentation that the individual, or their parent or other legal representative if applicable, are informed about the benefits and possible side effects of any medications prescribed for the individual in language that is understandable;

(13) Documentation of confidential information that has been released without the consent of the individual under the provisions in RCW 70.02.050, 71.05.390, 71.05.630, and the Health Insurance Portability and Accountability Act (HIPAA);

(14) For individuals receiving community support services, the following information must be requested from the individual and the responses documented:

(a) The name of any current primary medical care provider;

(b) Any current physical health concerns;

(c) Current medications and any related concerns;

(d) History of any substance use/abuse and treatment;

(e) Any disabilities or special needs;

(f) Any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition; and

(g) Information about past or current trauma and abuse.

(15) A description of the individual's strengths and resources; and

(16) A description of the individual's self-identified culture.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), and 71.34.380. 10-09-061, § 388-865-0430, filed 4/19/10, effective 5/20/10. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0430, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0430, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0430, filed 5/31/01, effective 7/1/01.]