Mental Health

Health Resources & Services Administration (HRSA) Definition: Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services offered to clients living with HIV. Services are based on a treatment plan conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance: Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services.

In Florida, mental health professionals, licensed or authorized include Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Psychiatrists, Psychologists, and Licensed Clinical Social Workers.

This service offers psychological treatment and counseling services, including individual and group, case consultations, assessments, crisis intervention counseling and Psychiatric evaluation and treatment provided by state licensed Psychiatrists, Mental Health professionals and or Master's prepared or Master's level clinical interns directly supervised by a licensed professional .

Eligibility: Clients must meet eligibility as specified in the System-Wide Standard of Care.

1.0 Employment Standards

The Agency providing Mental Health services shall ensure the following employment requirements are met:

1.0 Employment Standards

	Standards		Measures
1.1	Agencies shall comply with Florida State Statutes 490 and 491.	1.1	Current licensure displayed. Staff resume, license and certifications on file.

2.0 Scope of Service

The Agency providing Mental Health services shall comply with all the requirements outlined in this Standard of Care unless otherwise specified in their contract:

2.0 Scope of service

	Standards		Measures

2.1	Mental Health services include the following:
	
	• Biopsychosocial Assessments;
	• Treatment Plan development;
	• Treatment Plan review;
	• Urine Drug Screening;
	• Psychotherapeutic treatment to include:
	  ○ individual sessions
	  ○ group sessions
	  ○ case consultations
	• Crisis Intervention
	• Psychiatric Evaluation and Treatment
	• Other services as deemed clinically appropriate.
		2.1	Documentation in client clinical record

2.2	Biopsychosocial Assessment should be completed within two visits, but no longer than 30 days. Biopsychosocial Assessment will include at a minimum: • Presenting problem • History of the presenting illness or problem • Psychiatric history • Trauma history • Medication history • Alcohol/other drug use history; • Relevant personal and family medical history; • Mental health status exam • Cultural influences	2.2	Completed assessment, signed and dated by licensed professional in the client clinical record. If assessment is not completed in 30 days, reason for delay to be documented in progress note.

	• Educational and employment history; • Legal history • General and HIV related medical history • Medication adherence • HIV risk behavior and harm reduction • Summary of findings • Diagnostic formulation • Current risk of danger to self and others • Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies; • Domestic violence/abuse history • Treatment recommendations or plan.		
2.3	Biopsychosocial update is ongoing and driven by client's need, when a client's status has changed significantly or when client has left and re-entered treatment, but at least every six months.	2.3	Progress notes or new assessment demonstrating update in client clinical record.
2.4	Assessments and updated assessments completed by unlicensed providers shall be co-signed by licensed clinical supervisor.	2.4	Co-signature on file in client clinical record.
2.5	An individualized Treatment Plan shall be developed with client's participation within thirty (30) days of Biopsychosocial Assessment being completed. The Treatment Plan should be client-centered and consistent with the client's identified	2.5	Documentation in client's clinical record. The Treatment Plan shall have client's signature or his/her legal representative's signature as well as the therapist's signature. If the client's age or clinical condition precludes participation in

	strengths, abilities, needs and preferences. If the client is under the age of 18, the client's parent or legal guardian/custodian shall be included in the development of the individualized Treatment Plan.		the development of the treatment, an explanation must be provided in the Treatment Plan. If a Treatment Plan for a client under the age of 18 does not include the client's parent or legal guardian/custodian signature an explanation must be provided in the progress note.
2.6	The Treatment Plan shall contain all of the following components: • The client's diagnosis code (s) consistent with assessment(s) • Individualized, strength-based goals, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs expressed by the client • The Treatment modality (group or Individual) • Measureable objectives with target completion dates identified for each goal • The start date of services, recommended number of sessions, frequency, and duration of each service for the six month duration of the Treatment Plan (e.g., four units of therapeutic behavioral on-site services, two days per week for six months). It is not permissible to use "As Needed", "PRN" or the client will receive a service "X to Y times per week".".	2.6	The Treatment Plan in the client's clinical record reflects all required components.

	• The date of re-assessment. • Projected treatment end date.		
2.7	Treatment Plan is signed by a licensed professional.	2.7	Treatment Plan in client's clinical record is signed and dated by a licensed professional.
2.8	A formal review of the Treatment Plan with the client shall be conducted at least every six months. The Treatment Plan should be reviewed more often when significant changes occur.	2.8	Documentation of formal Treatment Plan review with the client shall be in the client's clinical record within the specified time frame.
2.9	Activities, notations of discussions, findings, conclusions, and recommendations shall be documented during the Treatment Plan review. Any modifications or additions to the Treatment Plan must be documented based on the results of the review. The Treatment Plan review shall contain the following components: • Current diagnosis code(s) and justification for any changes in diagnosis • Client's progress toward meeting individualized goals and objectives • Client's progress towards meeting individualized discharge criteria • Updates to after care plan • Findings • Recommendations • Dated signature of the client • If client is under 18, the dated signature of the client's parent or legal guardian/custodian	2.9	Written documentation must be included in the client's clinical record upon completion of the Treatment Plan review activities.

	• Signatures of the treatment team members who participated in review of the plan • Treatment Plan review completed by unlicensed providers shall be co-signed by licensed clinical supervisor If the Treatment Plan review process indicates the goals and objectives have not been met, documentation shall reflect the treatment team's re-assessment of services and justification if no changes are made.	
2.10	A periodic re-evaluation of the Treatment Plan shall be completed at least monthly and is amended based on life changes or client's circumstances.	2.10 Documentation in client's clinical record reflects re-evaluation in a monthly basis.
2.11	Psychiatric Services shall include the following: • Medication management • Brief individual medical psychotherapy • Brief group medical therapy • Behavioral health-related services: alcohol and other drug testing specimen collection • Behavioral health related services: verbal interactions • Medication assisted treatment • Medication management	2.11 Documentation in client's clinical record reflects all required services

	Note: Medication management cannot be provided in a group and must be combined with psychotherapy.	

3.0 Discharge

Clients who are no longer engaged in Mental Health services should or have achieved self-sufficiency should have their case closed based on the criteria and protocol outlined in the clients Treatment Plan and the Agency's Policies and Procedures Manual.

3.0 Discharge

	Standards		Measures
3.1	Upon termination of services, client's case shall be closed and a discharge summary completed within 30 days of last contact with Clinical Supervisor approval For face-to-face discharge, client's shall receive a discharge plan which has been approved by a Clinical Supervisor.	3.1	Documentation of discharge summary & Clinical Supervisor's approval in client's clinical record. For face-to-face discharge, document is signed by the client and the Clinical Supervisor.
3.2	Discharge summary should include the following: reason for closure, outline available resources and follow up instructions; signed by the mental health provider and the Clinical Supervisor.	3.2	A copy of the signed discharge summary including all required components is included in client's clinical record.
3.3	Cases may be closed when the client:	3.3	Documentation of reasons for case closure in client's clinical record.

	• Has achieved all goals listed on the Treatment Plan; • Has become ineligible for services; • Is deceased; • No longer needs the service • Decide to discontinue the service; • The Service provider is unable to contact the client thirty (30) days after expired eligibility; or • Is found to be improperly utilizing the service or is asked to leave the program.		
3.4	All discharged clients shall be offered an exit interview via one of the following: • face-to-face visit; • telephone call; or • written communication **Note: When the treating provider is not able to conduct an exit interview, reason must be documented in the record**	3.4	Documentation of an exit interview being offered shall be recorded in client's clinical record. If an exit interview was not completed the reason must be stated.
3.5	All attempts to contact the client and notification about case closure shall be communicated to the referral source and Clinical Supervisor.	3.5	Documentation of attempts to contact clients and communication about case closure with the referral source and Clinical Supervisor shall be in the client's clinical record.