CLINICAL SERVICES

POLICY

MANUAL

TESSIE CLEVELAND COMMUNITY SERVICES CORPORATION

ADMINISTRATION POLICY MANUAL

Tessie Cleveland Community Services

CLINICAL POLICY MANUAL

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SECTION 1

GENERAL CLINICAL

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9. If the client has Medi-Cal the Intake worker forwards the intake package to the therapist on duty and completes the SRL in Clinitrak.
10. Therapist on duty opens the episode, completes the assessment and care plan, inputs diagnosis and funding source in Clinitrak.
11. Clinical Director determines and communicates to on-duty therapist and Coordinator of the day the programs that have funding available for which clients may be eligible. Eligibility criteria for Open Access programs is as follows:

    a. Outpatient Mental Health Services
        i. Medical Necessity - For a service to be considered medically necessary and reasonable it must meet the following criteria:
            i. Client must have a DSM IV diagnosis;
            ii. Must have an impairment or impairments that result from a mental disorder or disorders;
            iii. Must receive interventions designed to address the condition and significantly diminish the impairment or prevent significant deterioration in an important area of life functioning; and
            iv. The condition would not be responsive to physical health care based treatment.
        ii. In addition to the criteria listed above, persons under 21 years of age must also meet the following:
            i. Have a condition unresponsive to physical care based treatment; and,
            ii. Meet requirements of Title 22, Section 51340(e)(3)
        iii. In the case of targeted case management, in addition to the above, medical necessity is met under Section 1830.205 and Section 51340(f).

    b. Evidence-Based Practices (EBP)
        i. Must meet same criteria as identified above (a. Outpatient) and as specified in Documentation Guide for each specific EBP.

    c. Field Capable Clinical Services
        i. ages 0 and above
        ii. experiencing a serious and persistent mental illness or
        iii. have significant mental health problems that are not as severe or as persistent but whose level of functioning is adversely affected by their

mental health problems and are unable to participate in services provided in traditional mental health clinic programs

The following services are exempt from Open Access and the intake is handled by the specified Program Coordinator.

12. Wraparound (WA) referrals are received from DCFS Interagency Screening Committee.
    a. Clients may be referred to DCFS for Wraparound services and request TCCSC as the provided. The referrals will still come through the DCFS Interagency Screening Committee.
    b. The Wraparound Coordinator assigns the case based on available resources and needs of the family.

13. Full Service Partnership (FSP) TAY/CHILD
    a. Child Focal Population (ages 0-15)
        i. Zero to five-year-old (0-5) with serious emotional disturbance (SED) who is at high risk of expulsion from preschool, is involved with or at high risk of being detained by Department of Children and Family Services, and/or has a parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders.
        ii. Child/youth with SED who has been removed or is at risk of removal from their home by DCFS and/or is in transition to a less restrictive placement.
        iii. Child/youth with SED who is experiencing the following at school: suspension or expulsion, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation.
        iv. Child/youth with SED who is involved with Probation, is on psychotropic medication, and is transitioning back into a less structured home/community setting.

            1A child/youth is considered seriously emotionally disturbed (SED) if he/she exhibits one or more of the following characteristics, over a long period of time and to a marked degree, which adversely affects his/her functioning:

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations;
(4) A general pervasive mood of unhappiness or depression; (5) A tendency to develop physical symptoms or fears associated with personal or school problems. [34 C.F.R. Sec. 300.7(b)(9); 5 Cal. Code Regs. Sec. 3030(i).]

2. Transition-age Youth (TAY) Focal Population (ages 16-25)
   A transition-age youth must have a serious emotional disturbance (SED) or a severe and persistent mental illness (SPMI)2 and meet one or more of the following criteria:
   a. Homeless or currently at risk of homelessness.
   b. Youth aging out of:
      - Child mental health system
      - Child welfare system
      - Juvenile justice system
   c. Youth leaving long-term institutional care:
      - Level 12-14 group homes
      - Community Treatment Facilities (CTF)
      - Institutes for Mental Disease (IMD)
      - State Hospitals
      - Probation camps
   d. Youth experiencing first psychotic break.
   e. Co-occurring substance abuse issues are assumed to cross-cut along the entire TAY focal population described above. For transition-age youth, severe and persistent mental illness (SPMI) may include significant functional impairment in one or more major areas of functioning, (e.g., interpersonal relations, emotional, vocational, educational or self-care) for at least six (6) months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning

that would have been expected for the individual rather that deterioration in functioning.

14. Multi-disciplinary Assessment Team (MAT)
    a. Referral from MAT-DCFS Documentation Guide

15. Therapeutic Behavioral Services (TBS)
    a. Children under the age of 21 with full scope Medi-Cal
    b. Are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs;
    c. Are being considered for placement in these facilities; or
    d. Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

16. Day Treatment Intensive (DTI)
    a. Must be between the ages of 5-12
    b. At risk of hospitalization, a more restrictive facility, or an out of home placement.

17. Program Coordinator maintains a referral tracking log.

18. Program Coordinator notifies referral source and/or client when referral is received.

19. Program Coordinators assigns referral to program and staff that best meets needs.
    a. Cultural and linguistic
    b. Age
    c. Diagnosis
    d. Gender

20. Program coordinator assigns cases in the following priority order:
    a. Discharged from hospital within 72 hours
    b. Imminent danger to self or others
    c. Psychotic
    d. DCFS clients
    e. All others

21. Therapist receives referral
    a. Confirms Medi-Cal eligibility with billing department
    b. Determines if an open episode exist.
        i. If client has an open episode with another agency therapist contacts agency to determine if client is actively receiving services and/or coordinates transition of services.

22. Therapist attempts initial contact
    a. First contact attempt to be within 48 hours of assignment of case
    b. Second attempt to be within no more than one week of assignment.
    c. If therapist is unsuccessful after two attempts, a third attempt must be made which can be either face-to-face or a written notice.
    d. If two intake appointments are missed by the client, the referral is returned to the Program Coordinator as No Outcome.
    e. If client is non-responsive to all attempts therapist returns referral to Program Coordinator.

23. Assigned therapist contacts client/caregiver to:
    a. Explain services, locations and hours of operation
    b. Inquire if client is receiving mental health services elsewhere and what type.
    c. Intended treatment plans with current agency.
    d. Explore financial arrangements.
    e. Determine linkage needs including services not provided by TCCSC
    f. Address Advances Directives and documents outcome.
    g. Schedule intake appointment.

24. Therapist opens an episode and enters diagnosis in Clinitrak within 24 hours of first face-to-face intake appointment.

25. The therapist completes intake documentation in accordance with policy.

Procedures for Completing the Service Request Log

The Service Request Log must be completed for all walk-ins, phone calls and referrals that are sent to us directly (DMH, schools, other providers, etc.)

****all referrals received through DMH's SRTS system are <u>not required</u> to be entered into the Service Request Log****

Open Access Walk-ins

- Intake coordinator conducts intake interview and completes intake paperwork (which will now include the Service Request Log (SRL) form in Clinitrak)

Referrals sent directly to Outreach

- Outreach will complete the paper/PDF Service Request Log form
- SRL forms are sent to the Clinical Director Assistant (CDA)
- CDA enters into Clinitrak (create client demographics and completed SRL form)
- CDA follows up with Outreach for final disposition and enters it into SRL form in Clinitrak: Once outreach completes and submits the referral form and the SRL, Referral Coordinator would have the dispositions.

Referrals Received from outside sources (emailed/faxed to us directly from DMH/Schools/Other entities)

- All referrals will be sent to Clinical Director Assistant (CDA)
- CDA contacts person on referral and completes the SRL form (directly in Clinitrak or paper first, then data entry into Clinitrak)
- CDA will let them know the next available Open Access date
- After Open Access Date, CDA reviews Open Access information and enters deposition into SRL

Walk-ins (non-Open Access days)

- Provide the person with a Service Request Log form and have them complete it
- Let them know the next available Open Access date
- Completed SRL form is given to Clinical Director Assistant (CDA)
- CDA enters into Clinitrak (create client demographics and completed SRL form)
- After Open Access Date, CDA reviews Open Access information and enters deposition into SRL

Phone Calls **(will monitor how many calls we get to see if more than one person needs to be assigned this task)**

- All request for services phone calls will be sent to Clinical Director Assistant (CDA)
- CDA will complete the SRL form (directly in Clinitrak or paper first, then data entry into Clinitrak)
- CDA will let the caller know the next available Open Access date
- After Open Access Date, CDA reviews Open Access information and enters deposition into SRL

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.02**
SUBJECT: Documentation	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE: June 18, 2011**
Electronic File Location:	Page **1** of **1**

Purpose:

To ensure services are individualized, integrated, family-focused and culturally responsive.

Policy:

TCCSC has adopted the Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services as its official standard for service delivery and provides services as defined as Specialty Mental Health Services under Code of California Regulation (CCR) Title 9, Chapter 11.

Procedures:

1. TCCSC utilizes the Clinical Documentation Guide as a guide for completing documentation of client intake, assessment, and client care.
2. Direct service staff is trained in utilizing and accessing Clinical Documentation Guide.
3. The Clinical Documentation Guide is located in the Public Folders under the Policies and Procedures folder.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.03**
SUBJECT: Prohibited Interventions	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **1**

Purpose:

To establish agency standards of prohibited Interventions.

Definitions:

Policy: TCCSC prohibits the use of corporal punishment, aversive stimuli, withholding nutrition or hydration, demeaning, shaming or degrading language or activities, forced physical exercise, invasive procedures, punitive work assignments, punishment by peers, group punishment, and/or withholding inclusion in activities. Any intervention that produces adverse side effects or is deemed unacceptable according to prevailing professional standards will be discontinued immediately.

Procedures:

1. TCCSC administrative staff and clinical supervisors monitor interventions used and prohibit the use of inhuman and/or punitive behavioral interventions and practices.
2. If a clinician and/or case manager is suspected of using such interventions and practices their work will be reviewed by our risk management coordinator and disciplinary action will be enforce when needed.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.04**
SUBJECT: Psychiatric Consultation Referral and Monitoring	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **4**

PURPOSE: To provide guidelines for referring clients to psychiatric services, managing psychoactive medications and to provide a foundation for quality management relating to the use of the major classes of psychoactive medications.

POLICY: To ensure clients are referred to psychiatric services when there is a need and to ensure proper monitoring of medication.

DEFINITIONS:

PROCEDURE:

A. Medication Referral

1. Clinicians are to assess the need for a psychiatric referral at intake and throughout client's treatment. Clinicians are to refer clients for a psychiatric medication evaluation when a client is:

i. discharged from a psychiatric hospital
ii. experiences audio and/or visual hallucinations
iii. displays extreme aggression
iv. experiences delusions and/or paranoia
v. has a history of psychotropic medication use
vi. displays extreme hyperactivity and/or impulsiveness
vii. has a sudden change in personality
viii. experiences extreme mood changes and/or depressive symptoms
ix. de-compensating
x. experiences a significant change in functioning and/or behavior
xi. exhibits disorganized speech and/or behavior
xii. any other relevant clinical issue as deemed by clinician

B. Management and Monitoring

1. Monitoring of individuals taking any medication should be determined by the unique clinical situation and condition of the individual, including type of medication(s), health risk factors, duration of treatment, concurrent general medical conditions and associated medications and laboratory monitoring of serum levels. All such activity and results shall be documented in the clinical record.

2. Refusal to undergo a medical examination and/or appropriate medical monitoring is a special situation that must be addressed by the treatment team and/or prescribing physician. Risks and benefits of prescribing medication shall be discussed with the individual being treated and guardian if the client is a minor. The physiological dangers inherent in this situation must be considered and the nature and outcomes of such deliberations must be clearly documented in the clinical record.

C. Outpatient Medication Review

1. The prescribing physician must document review of medications with the client or guardian when:

i. a new medication is prescribed
ii. at least annually even in the absence of medication changes
iii. the client refuses taking medication

2. The "Psychotropic Medication Authorization Form" issued by Juvenile Court must be used when applicable.

3. Information to be provided to the client/guardian shall include:

I. An explanation of the nature of the illness and of the proposed treatment (name, dose, route, frequency and purpose).

II. A description of any reasonable and foreseeable material risks or discomforts.

III. A description of anticipated benefits.

IV. A disclosure of appropriate alternative procedures or courses of treatment, if any.

V. Special instructions regarding food, drink or lifestyles.

VI. Whenever medications are reviewed, it is recommended that the client be given information about the class of medication, including common usage, important side effects and interactions with other medications.

VII. Patients shall be advised of the possible additional side effects which may occur after three months of use of certain medications; such side effects may

include persistent involuntary movements, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

VIII. If a short term medication is prescribed to a client, the client and/or caregiver will only be provided information on that specific medication.

D. Associated Assessment

1. Relevant information contained in progress notes from other clinical disciplines and staff should be reviewed and considered by the treating physician in formulating medication treatment planning. Factors influencing the physician's treatment decisions obtained from other treating clinicians should be documented.

2. Physicians should be capable of utilizing the full spectrum of psychotropic agents available for the specific population being treated and consistent with the physician's background, training and scope of practice.

3. In circumstances where multiple clinicians are involved in the treatment, physicians should periodically review and discuss medication treatment plans with other disciplines and document this activity in the clinical record.

E. Availability
In emergency cases, Dr. Nucum can be reached by pager at (714) 655-5380 and Dr. Speight at (323) 491-8872.

F. Medical Referrals

1. When necessary the physician will refer clients to medical clinic or hospital in the area for any physicals or other medical examinations are required. A list of medical/clinics and hospitals will be provided to clients.

   CLINIC/HOSPITAL LIST:
   Kedrin Community Health Center
   4211 Avalon Boulevard
   Los Angeles, CA 90011
   (323)233-0425

LA Cienega Medical & Industrial Clinic
3344 South La Cienega Boulevard
Los Angeles, CA 90016
(310)837-0149

Los Angeles Free Clinic
8405 Beverly Boulevard
Los Angeles, CA 90048
(323)653-8622

Martin Luther King Medical Center
12021 Wilmington Ave
Los Angeles, CA
(310) 668-4701

Harbor UCLA Professional Building
Universal Care Clinic
(310) 222-1282
21840 Normandie Ave,
Torrance, CA

Antelope Valley Hospital
(661) 949-5000
1600 W Avenue J
Lancaster, CA 93534

Antelope Valley Heath Center
(661) 471-4000
335-B East. Avenue K-6
Lancaster, CA 93535

Olive View–UCLA Medical Center
(747) 210-3000
14445 Olive View Dr.
Sylmar, CA 91342

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.05**
SUBJECT: Crisis Intervention Protocol	
APPROVED BY: Sandy Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE: November 1, 2018**
Electronic File Location:	Page **1** of **3**

Purpose:
To implement a protocol in which crisis are responded to with a safe resolution and ensures the protection of the staff, client and community

Definitions:

- After hours refers to any event occurring outside of posted regular office hours.
- Operational Hours refers to any event that occurs during regular posted office hours.

Policy:
All staff shall comply with crisis protocol for crisis occurring during or after office hours

After Hour Procedures:

1. Call placed to agency's 24-hour crisis services line by client, caregiver, parent or other.
2. 24 hour answering service staff receives call and obtains nature of call
3. Caller is placed on hold, and on call staff is contacted and provided with details of call.
4. Call is connected to on call staff
5. On call staff conducts phone interview to obtain additional information and makes an assessment to assist with determining course of action
6. On call staff contacts clinical supervisor for consultation
7. On call staff coordinates response from agency staff and/or other community resources.
    a. Primary Clinician
    b. Case Manager
    c. LA COUNTY:
        i. PMRT
        ii. LAPD System Wide Mental Health Assessment Response Team
        iii. (SMART)
        iv. SHERIFF Mental Evaluation Team (MET)
    d. RIVERSIDE COUNTY:
        i. Riverside County 24/7 Mental Health Urgent Care - Provides 24 hour/7 days/365 urgent care mental health screening and assessment services and medications to address the needs of

those in crisis in a safe, efficient, trauma-informed, and least-restrictive setting.

ii. Riverside County HELPLine - 24 Hour Crisis/Suicide Intervention - The HELPline is a free, confidential Crisis/Suicide Intervention service. Operated by highly trained volunteers, the line is open 24-hours a day, seven days a week.
Phone: (951) 686-HELP (4357)

iii. Locations: Riverside: 9990 County Farm Rd. Riverside, CA 92503 (951) 509-2499 Palm Springs: 2500 N Palm Canyon Dr, Suite # A4 Palm Springs, CA 92262 (442) 268-7000

8. On call staff arrives on location within (1) hour
9. On call staff works to deescalate the situation and intervenes to ensure the safety of all individuals in the environment.
10. On call staff conducts assessment to determine need for hospitalization based on criteria. LPS designated staff will conduct an assessment if on location to determine need for hospitalization.
    i. Voluntary
    ii. Involuntary (51/50)
11. On call staff facilitates action plan based on results of assessment
12. If client agrees to voluntary hospitalization, on call person locates a bed within local hospitals and assist with transporting and/or arranges transportation to hospital if needed.
13. If hospitalization is involuntary on call person will support the process and assist with transition.
14. If hospitalization is not need/agreed to, on call person develops a safety plan with the client, caregiver, parent, other.
15. On call staff consults with supervisor and treating clinician to provide update on outcome
16. Staff completes crisis intervention progress note for activities

Operational Hour Procedures:

1. Call comes in to office and is received by receptionist.
2. Caller is identified and asked if they know who their therapist is
3. Caller is placed on hold and the therapist is contacted to respond to the crisis.
    a. If therapist is not available (sick, vacation) the therapist's Program Coordinator and/or living will are contacted to respond to the crisis.
    b. If therapist does not respond within 15 minutes the therapist's Program Coordinator is contacted

4. TCCSC staff contacts the client and arrives on location to visit client within one hour and provide client with interventions to help deescalate and keep the client safe.
5. Staff conduct an assessment to determine the need for hospitalization and will work with outside assessing units (law enforcement, etc.) if they have been called to respond and arrive on the scene to determine the need for either voluntary or involuntary (5150) hospitalization.
6. Staff facilitates an action plan based on the results of the assessment.
    a. If client agrees to voluntary hospitalization, staff will locate a bed within local hospitals and assist with transporting and/or arranges transportation to hospital if needed.
    b. If hospitalization is involuntary staff will support the process and assist with transition.
        i. If hospitalization is not needed or agreed to, staff will develop a safety plan with the client, caregiver, parent, other.
    c. Staff will consult with Supervisor to provide update on outcome and completes crisis intervention progress note for activities
7. A staffing is held for the client within 24 hours of the incident to discuss a plan for the client

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.06**
SUBJECT: Outreach Services	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose: Outreach is the first step to engaging individuals and families to accept care for immediate health and safety needs. The outreach staff actively collaborates with other homeless service providers and community resources to ensure clients have access to services and resources and to ensure continuum of care.

Definitions:

Outreach worker – A paraprofessional or therapist with primary responsibility for providing outreach services in accordance with contractual terms.

Policy: Outreach services will link individuals and families to needed services and resources and will be done in a way to respect the dignity of services recipients and focus on their strengths.

Procedures:

1. Outreach services are performed by a team lead by a professional or paraprofessional staff member, depending on contractual requirements.
    a. Staff will be non-judgmental, patient, persevering and will possess the:
        i. Ability to establish and maintain a trusting relationship.
        ii. Ability to handle rejection.
        iii. Sensitivity to the needs of the individuals and families in crisis.
        iv. Capacity to view all persons positively and recognize their strengths.
        v. Positive regard and respect for service recipients.
        vi. Cultural sensitivity and linguistic competence.
2. Outreach workers will receive training and supervision on special services needs of service recipients including:
    a. The nature of the service population.
    b. Methods of engaging individuals and families.
    c. Crisis intervention methods.
    d. Making linkages and referrals to community partners, collaborators and community services.
    e. Identifying medical needs or problems and special health needs of the targeted populations, including:
        i. Substance Abuse
        ii. Mental Illness
        iii. HIV/AIDS
        iv. Victims of violence, abuse or neglect

v. Pregnant and homeless mothers with young children
vi. Criminal Justice System involvement
vii. Development disabilities
viii. Older Adults

f. The agency's plans for managing medical and psychiatric emergencies.
g. Safety guidelines for street outreach.

3. Outreach worker builds trust with homeless individuals and assesses immediate health and safety needs.
    a. Outreach workers assigned to a shelter will arrive and begin providing services at the agreed upon specified time.
        i. Will adjust outreach schedule if requested to the convenience of the service recipient.
        ii. Works collaboratively with shelter case manager to identify needs and assist subject with task completion/follow through.
    b. Outreach worker displays a willingness to work with the individual and family in a non-threatening manner showing respect for the client's autonomy and confidentiality.
        i. Assessment is done in a location that provides the maximum amount of privacy.
        ii. Worker obtains client and/or families permission to complete the needs assessment
4. Outreach worker utilizes needs assessment to identify the following:
    a. Safety, including potentially life-threatening situations.
    b. Basic and immediate needs including food, clothing, shelter, hygiene, and laundry;
    c. Level of functioning.
    d. Overall mental health.
    e. DMV, Birth records etc
    f. Substance abuse issues.
    g. Need for legal assistance
    h. Need for public assistance, (SSI,GR,GAIN etc)
    i. Health information including harm reduction, STDs, HIV/AIDS, pregnancy prevention;
    j. Strength and capabilities, including capabilities for making decisions.
5. Outreach worker consults with supervisor and others as necessary to ensure client's needs are appropriately identified and a plan to meet them is developed.
6. Outreach worker completes outreach note in Clinitrak within 24 hours of each client episode.

   a. Supervisor reviews and approved note discussing any concerns or suggestions with outreach worker as appropriate.

7. Outreach worker follows-up with client, whenever possible, to obtain information regarding follow through with appointments, linkages, determine progress, and stability.
   a. Outreach worker may contact direct resources/linkages provided, in an effort to obtain information regarding outcome and follow-up.
   b. Outreach worker will follow up with shelter case managers to provide current status of service recipients.
8. Once Outpatient mental health services episode is opened and services are obtained, the Mental Health therapist and case manager completes goals/needs, and outreach services are discontinued.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.07**
SUBJECT: Discharge and After Care Planning	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE: December 1, 2020**
Electronic File Location:	Page **1** of **2**

Purpose: Discharge planning is important in order to maintain gains achieved during the course of treatment and to link clients to community resources to help strengthen their ability to develop support systems and improve self-reliance

Policy: Discharge planning begins upon intake.

Procedure:

1) Assess client's strengths, needs, formal/informal support systems, high risk factors, and functional impairments.
2) Client works towards attaining mutually agreed upon goals and outcomes considered for success.
3) During the course of treatment, community and family supports are identified that assist the client with aftercare management.
4) Formal and informal supports are developed, accessed and their use is reinforced to create client familiarity.
5) Therapist consults with Coordinator/ Clinical Supervisor for approval to discharge.
6) Coordinators enter the discharge date in the dashboard to notify the entire team.
7) Therapist discusses progress, plans for discharge and aftercare with client and support system.
8) Treatment is titrated and established timeframe for discharge is mutually agreed upon. Linkage to informal and formal support systems is reinforced.
    a. If client leaves program prior to achieving goals and desired outcomes, therapist will provide client with referral to multiple service providers that could meet the needs.
    b. Client, family and therapist work together to create a culturally appropriate aftercare plan.
    c. Therapist coordinates discharge with collaborating partners.
9) Therapist completes discharge forms according to individual program guidelines. (see Documentation Guide)
10) Agency conducts a follow-up contact at 3 and 6 months following discharge, to determine client's ability to function successfully. (Client Follow-up Survey)
    a. If client regressed and family requests services, immediate readmission will occur and an assessment will determine course of intervention.
11) Any client who is unable to be treated by the agency contract will be linked to a community agency that is able to provide needed services.

12) In the case a client loses third-party benefits the agency will continue serving them until they are fully linked to a provider that can services them within their resources.
13) In the case a Therapist/ Case manager needs to be removed from the case, the client's case will be transferred to a new Therapist/ Case manager and the Coordinator will do the following:
    1) Call the client and/or caregiver to inform them that the therapist will be removed from the case and their case will be transferred to a Therapist/ Case Manager.
    2) Inform Clinical Director if the client and/or caregiver is upset with changes. Clinical Director will call the client and family to explain changes.
    3) Inform Research Department of cases transferred to a new Therapist.
    4) Have team member go out with new staff to introduce to the family.
    5) Review client's records to ensure that all paperwork is present.
    6) Consult with the new Therapist, if needed.
    7) No later than two weeks, make sure cases are being seen by the new Therapist/Case Manager.
    8) Notify the Training Coordinator about changes in therapist/case manager.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.08**
SUBJECT: ASSESSMENT AND TREATMENT OF CO-OCCURRING SUBSTANCE ABUSE	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	

Purpose:

1.1 To provide guidelines for the identification and treatment of individuals with co-occurring mental health and substance-related disorders at TCCSC.

DEFINITION:

2.1 Co-occurring Disorder: Individuals with mental illness are considered to have co-occurring substance abuse disorder when they have a history of alcohol and/or drug use, abuse or dependency that interferes with their ability to function in an age-appropriate manner in the key life domains (e.g., Axis IV, current DSM).

2.2 Substance Use: The use of any psychoactive substance that interferes with the individual's mental status and functioning in the key life domains, but does not meet current DSM criteria for substance abuse or dependence.

2.3 Substance Abuse and Dependence: The use of any psychoactive substance meeting current DSM criteria for psychoactive substance dependence or abuse. Potential drugs of abuse include alcohol, as well as other psychoactive drugs.

Policy:

3.1 Recognizing that co-occurring substance-related disorders (COD) are a significant problem for a large number of people with mental disorder, the policy and goals of TCCSC are to:

- 3.1.1 Improve the quality of care for individuals with a COD;
- 3.1.2 Ensure that treatment planning for individuals with a COD is comprehensive, addressing the person's substance-related and mental illness needs; and
- 3.1.3 Ensure that individuals who are qualified for services and substance-related services are not denied access to these services because of concomitant substance abuse problems.

PROCEDURE:

4.1 Individuals with a COD require specialized services to support their stability and functioning in the community. Integrated treatment of the mental health and substance-related disorders within a single treatment and setting is the standard of care.

4.2 Treatment of co-occurring disorders shall focus on staged interventions with a longitudinal perspective.

- 4.2.1 Abstinence is a hallmark of recovery from substance-related disorders.

4.2.2 Interventions that result in reduced symptomatology and engage and retain individuals with a COD in treatment reduce morbidity even without achieving abstinence.

4.2.3 Adherence to prescribed medication regimens is fundamental to recovery for those individuals with a COD where medication is a principal part of their treatment and recovery.

4.3 Clinical treatment of individuals with a COD shall be based on scientific evidence and conform to all applicable therapeutic guidelines/parameters, standards of care, and quality improvement.

4.3.1 Individuals with a COD can benefit from treatment whether initiated by the individual, court order, family intervention, threat of loss of employment, etc.

4.3.2 Alternatives for individuals with a COD who use substances, or are non-compliant with medication, shall be provided within the continuum of care.

4.3.3 Interventions designed to improve the general health status of individuals with a COD, including smoking cessation, diet and exercise, and sexually transmitted disease (STD) prevention are essential components of the overall treatment.

4.4 TCCSC Mission

4.4.1 Policies and practices that restrict access to treatment for people with a COD are in conflict with effective treatment principles and the agency's primary responsibility.

4.4.2 Policies and practices requiring no substance use for specific periods of time prior to receiving indicated mental health services, including medication services, are not consistent with the policy. Policies and practices that involve withholding treatment to entire categories of individuals with COD because of substance use and abuse history are unacceptable.

4.4.3 The recognized standard of care for individuals with a COD is that the individual's support systems (family members, significant others, etc.) should be involved with treatment. Program design, procedures, and structures should specify how this principle is incorporated.

4.5 Screening and Assessment

4.5.1 Screening and assessment of individuals referred to TCCSC must include psychiatric, substance use, physical health, and psychosocial components. When screening identifies substance-related problems, a

comprehensive assessment and placement in services specifically matched to the assessed level of need must be completed.

4.6 Individuals with a Co-Occurring Disorder Either Under the Influence of Alcohol and Other Drugs and/or Presenting with Mental Health Symptoms

4.6.1 Individuals with a COD either under the influence of alcohol and other drugs and/or presenting with mental health symptoms, shall be provided, among other interventions, services, referral services, and outreach services based upon their level of impairment. Case management services shall be used to assist in such instances.

4.6.2 Individuals with a COD either under the influence of alcohol and other drugs and/or presenting with mental health symptoms, shall be assessed and given the appropriate level of intervention to ensure the safety of the individual(s) and the community.

4.6.3 Individuals with a COD currently receiving treatment and who present as under the influence of alcohol and other drugs shall have their treatment, including medication services, modified based on their level of impairment.

4.7 Integrated Treatment/Continuum of Care Integrated, simultaneous utilization of mental health and substance-related treatment interventions is TCCSC's standard of care.

4.7.1 Individuals shall be assessed to determine substance-related problems. If it is determined that an individual needs additional substance related services the clinician will provide resources to meet their needed level of care. All added services will be added to client's coordination plan.

4.7.2 All efforts shall be made to retain the individual in treatment, regardless of the individual's current alcohol and/or drug use and compliance with psychiatric treatment. Specific retention and treatment strategies are based on the individual's needs.

4.7.3 Every attempt shall be made to include family members and significant others in the individual's treatment, consistent with the rights and the best interests of the individual.

4.8 Professional Training Clinicians and treatment providers shall be trained in COD treatment. Expert consultation and specific COD training shall be available on an ongoing basis.

4.9 Psychopharmacologic Treatment of Substance Abusing Clients by Mental Health Psychiatrists Psychopharmacologic management of individuals with a COD shall be informed by a comprehensive knowledge of potential pharmacologic inter-relationships among drugs of abuse and associated general medical conditions, psychopharmacologic medications, and anti-craving medications.

- 4.9.1 Drug testing results are part of the individual's clinical record and the information is subject to confidentiality laws and regulations.
- 4.9.2 Laboratory examinations relevant to substance use disorders must be available, including toxicology, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), tuberculosis, liver enzymes, hepatitis B virus (HBV), hepatitis C virus (HVC), complete blood count (CBC) and indices, serology for STDs and thyroid function.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.09**
SUBJECT: PHYSICIAN AVAILABILITY	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

PURPOSE: To ensure TCCSC clients have access to a licensed child psychiatrist 24 hours per day/7 days per week.

POLICY: A psychiatrist shall be available at regularly scheduled times for routine office visits and shall be on-call 24 hours per day/7 days a week for crisis and emergencies situations.

Procedure: A physician will be able to meet his/her clients and provide psychiatric consultation to all clients receiving Outpatient, DTI, TBS, FSP and/or Wraparound services as follows:

1) Therapists who have a client needing a medication evaluation will contact the TCCSC scheduling clerk. The following information is required to schedule a medication visit:

a. Client's name and MIS number
b. Caregiver's name and relationship to client
c. Home telephone number
d. Therapist's name and contact information

2) The scheduling clerk will provide the therapist with the date and time for the next available routine visit.

3) The physician will advise the scheduling clerk when a follow-up visit is needed to monitor psychotropic medications.

4) The scheduling clerk will maintain time on the physician's schedule for consultations, case conferences and/or priority medication visits.

5) The scheduling clerk will refer calls from clients wanting to schedule a medication visit to the therapist or case manager for follow-up.

6) The scheduling clerk will contact the client's caregiver within 48 hours to confirm the appointment. When a client cancels, the scheduling clerk will attempt to reschedule with another client.

7) The psychiatrist will educate staff, clients and families regarding diagnostic impressions, treatment options, possible side effects of prescribed drugs and appropriate use of medication.

8) The psychiatrist will participate in case conference, provide staff training and consult with staff and families on an as-needed basis.

9) Any child discharged from a psychiatric hospital, referred by a psychiatric emergency room or crisis intervention team will be provided a priority medication appointment as soon as possible, within no more than 48 hours following referral.

10) Any client with an urgent need for medication, as approved by the Clinical Director, will be given an appointment the next regularly scheduled medication day.

11) In a crisis or emergency, as approved by the Clinical Director, the on-call psychiatrist will be contacted to determine appropriate crisis intervention.

12) If necessary clients may be referred to local hospitals for any medical problems.

HEALTH CENTERS IN SPA 1	
	Antelope Valley Health Center 335-B East Avenue K6 Lancaster, CA 93535 (661) 723-4526

HEALTH CENTERS IN SPA 6	
	Martin Luther King, Jr. Center for Public Health 11833 S. Wilmington Avenue Los Angeles, CA 90059 (323) 568-8100
	Ruth Temple Health Center 3834 S. Western Avenue Los Angeles, CA 90062 (323) 730-3507

DIVISION: Clinical	**NUMBER: 1.09**
SUBJECT: PHYSICIAN AVAILABILITY	
APPROVED BY: Moses Cleveland	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
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HEALTH CENTERS IN SPA 7	
	Whittier Public Health Center 7643 S. Painter Avenue Whittier, CA 90602 (562) 464-5350

HEALTH CENTERS IN SPA 8	
	Curtis R. Tucker Health Center 123 W. Manchester Boulevard Inglewood, CA 90301 (310) 419-5325
	Torrance Health Center (Immunization and STD services only) 711 Del Amo Boulevard Torrance, CA 90502 (310) 354-2300

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.10**
SUBJECT: Client Medical Record	
APPROVED BY: Carolyn Chadwick	**EFFECTIVE DATE: December 2005**
TO BE PERFORMED BY: Medical Records	**REVISION DATE: June 05, 2019**
Electronic File Location:	

Purpose: Health information must be captured and maintained to safeguard confidentiality and in accordance with guiding laws and regulations. Quality client care depends on ease of access and sharing medical information, by providing a secure means of collecting and warehousing both physical and electronic health data.

Policy: TCCSC shall create and maintain a medical record containing all data and/or information required by law and contract, gathered about the client from intake to discharge, in the most secure and confidential manner feasible.

Procedures:
The TCCSC client medical record is an amalgamation of physical and electronic records incorporating all medical information into a complete record of care. Each client has a unique and distinct medical record.

1. Composition
    a. The medical record contains all components required by Title XXII and others specific to the client. The record at a minimum will contain the following:
        i. Administration
            1) Demographic Information
            2) Payor Financial Information
            3) Transfer of Coordinator/SFPR
        ii. Consents and Notices
            1) Consent for Services
            2) HIPAA/Acknowledgement of Receipt (Privacy Notice)
            3) Consent for Release of Information
        iii. Correspondence - All information received from or sent to other than TCCSC
        iv. Assessments and Plans - Documents are filed sequentially with most current on top
            1) Change/Update of Diagnosis
            2) Coordination Plan
            3) Care/Safety Plan
            4) Assessment Addendum
            5) Assessment (Child/Adolescent, Adult, 0-5, or Short)
            6) Discharge Information
        v. Ancillary Med - Documents are filed sequentially with most current on top
            1) Laboratory Results
            2) Medical Consultations Evaluation by Physician

vi. Physician Notes and Orders - Documents are filed sequentially with most current on top
    1) Physician's Orders
    2) Outpatient Medication Review
vii. Progress Notes including but not limited to:
    1) Documentation of care received by client
    2) Records of any communication with client/caregiver/family
    3) Unusual circumstances, such as;
        a) Complications
        b) Injuries to client
        c) Adverse reactions to treatment
        d) Death of client
        e) Use of non-violent physical crisis intervention
viii. Medication Notes including but not limited to:
    1) History
    2) Prescription information
    3) Adverse reactions, if any
ix. The following forms are filed in correlation with documents amended by the client:
    1) Letter of Amendment to Health Information
    2) Statement of Disagreement/Request to Include Amendment and Denial with Future Disclosures

2. Validity, Accuracy, and Integrity
    a. Medical information is collected as close to the source as possible
        i. Client
        ii. Family
        iii. Caregiver
    b. Identification of client is conclusive and supported with positive documentation
    c. Entries into the client medical record must be:
        i. Accurate
        ii. Timely and dated
        iii. Entered by authorized personnel
        iv. Signed by author
        v. Countersigned by supervision when required by law and/or contractual agreement
    d. When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be readable/accessible. The correction entry must include the following:

i. Documents created in a paper format:
   1) State reason for correction in black ink
   2) Draw a single straight line through the incorrect entry
   3) Date when the error was found
   4) Initial error

ii. Documents originally created in a paper format, and then scanned electronically:
   1) Electronic version must be corrected by printing the documentation
   2) State reason for correction in black ink
   3) Draw a single straight line through the incorrect entry
   4) Date when the error was found
   5) Initial error
   6) Resubmit corrected document to coordinator
   7) Coordinator submits document to IT department informing them that the document is a resubmission
   8) IT department archives incorrect document and scans the corrected document

iii. Documents created electronically:
   1) Print out form and make necessary corrections in black ink
   2) State reason for correction
   3) Draw a single straight line through the incorrect entry
   4) Date when the error was found
   5) Initial error
   6) Resubmit corrected document to coordinator
   7) Coordinator submits document to IT department informing them that the document is a resubmission
   8) IT department archives incorrect document and scans the corrected document

e. Once an entry has been signed physically and electronically, alterations cannot be made in the form. If errors are later found in the entry or if information must be added, this will be done by means of addendum to the original entry. The addendum should also be signed physically or electronically and should include the date signed. Staff will provide caregivers, if needed, a copy of the form with changes.

f. If a document is scanned incorrectly, has wrong patient information, or is mislabeled, the following must be done:
   i. Staff who found the error must report the mistake to their Coordinator or Supervisor.
   ii. Coordinator confirms the error and informs IT department to make corrections:
      Scanned Incorrectly
      1) IT department will hide the incorrect scanned document and rescan document correctly.
      Wrong patient information
      1) IT department will be notified and they will correct the error
      Mislabeled
      1) IT department will correct the label of document in the client medical record

e. Standardized forms, well-documented procedures, and policies on mis-use of electronic passwords and signature stamps are utilized to ensure high-quality and meaningful entries into the medical record

f. Chart auditing and case record reviews further protect the client medical record against entry errors and form the basis for systemic process improvements

g. Employees and/or their dependents who receive care from TCCSC will have their record audited by management

3. Retention
   a. As mandated by State of California Title 22 and required by contractual agreements client medical records must be retained for 10 years in accordance with State and Federal guidelines and regulations.
4. Storage/Security
   a. The ***physical*** medical record is secured:
      i. By an offsite records management company that provides HIPPA compliant, secure storage and control in accordance with Principles of Global Facility Protection, which include:
         1) Intrusion detection and alarm systems
         2) Physical access controls
         3) Fire detection and suppression systems
         4) 24/7 central monitoring of protection systems
      ii. By policy establishing limitations to medical record access
   b. The ***electronic*** medical record is secured:

i. By policy and practice governing security of all TCCSC data
ii. Routine data-backup and redundancy
iii. Double password controlled access
iv. System access to employee records will be restricted

5. Retrieval
    a. External access to medical records information can be granted under the following circumstances:
        i. Court order or subpoena
        ii. Client/Caregiver signed release of information for the specific release request
        iii. By TCCSC policy governing data access
    b. If physical chart is required, Coordinator of staff requesting the physical chart will notify the Program Liaison the reason for retrieval.
    c. Program Liaison will obtain permission from Executive Director to retrieve chart from off site record management company.
        i. If permission is granted, Program Liaison and/or authorized personnel will contact off site to retrieve chart within 24 hours of request being approved.

6. Monitoring
    a. Medical Record quality is ensured through regular chart audits

Reference Policies:
Storage and Data Security
Referral and Intake
Clinical Documentation Manual
Behavioral Support Management
Chart Auditing

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.11**
SUBJECT: Medication Prescribing, Monitoring and Managing	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: 6/18/2011**
TO BE PERFORMED BY: TCCSC Physicians	**REVISION DATE:**
Electronic File Location:	Page **1** of **6**

Purpose: To provide the foundation and guidelines to manage TCCSC's Medication Support Services PRESCRIPTION ONLY Program to ensure the reduction of risks associated with prescribing and managing psychotropic medications, such as adverse medication reactions and/or errors.

Policy: TCCSC will ensure medications are prescribed and managed in accordance with industry standards, FDA requirements, and all applicable licensure, contractual and legal requirements.

Definitions:

Adverse Medication Event - An injury resulting from a medical intervention related to a medication, including harm from an adverse drug reaction or a medication error.

Significant Adverse Medication Reaction - A response to a medicinal product that is noxious and unintended and that occurs at doses normally used in humans for the prophylaxis, diagnosis, or treatment of disease or for the restoration, correction, or modification of physiological or psychological function.

Significant Medication Error – Gross mistakes made in prescribing medication incorrectly, such as prescribing wrong medication, wrong dosage, wrong time given or issuing to the wrong person.

Procedures:

Referral and Assessment

A. Medication Referral
   1. Therapists are to assess the need for a psychiatric referral at intake and throughout client's treatment. Therapists are to refer clients for a psychiatric medication evaluation when a client is:
      a. discharged from a psychiatric hospital
      b. experiences audio and/or visual hallucinations
      c. displays extreme aggression

d. experiences delusions and/or paranoia
e. has a history of psychotropic medication use
f. displays extreme hyperactivity and/or impulsiveness
g. has a sudden change in personality
h. experiences extreme mood changes and/or depressive symptoms
i. de-compensating
j. experiences a significant change in functioning and/or behavior
k. exhibits disorganized speech and/or behavior
l. any other relevant clinical issue as deemed by clinician

B. Assessment
1. Psychiatrist conducts a consultation with client and/or responsible authority figure. Psychiatrist also access to the following information within the clinical case record
    a. Age
    b. Sex
    c. Diagnosis and associated conditions
    d. Any food and medication allergies
    e. Any sensitivities or areas of clinical concern
    f. Height and Weight when necessary
    g. Drug and alcohol use and abuse
    h. Any current or past medications
    i. Pregnancy and lactation information (when necessary)

C. Prescribing Medication
1. Medications are prescribed only by psychiatrist.
2. Acceptable medication orders utilized by the organization are as follows:
    a. As needed (PRN) orders
    b. Standing Orders
    c. Automatic Stop Orders
    d. Taper Orders

e. Range Orders
f. Orders for Medication at Discharge or Transfer

3. Elements of a complete order consist of the following:
    a. Name of Prescriber
    b. Address of office
    c. Office telephone number
    d. Office fax number
    e. Prescriber's California License number
    f. Prescriber's DEA number
    g. Prescriber's NPI number
    h. Patient Name
    i. Date Written
    j. Address and date of birth of patient, (if Class 2 medication)
    k. Name of Medication
    l. Dosage and Strength of medication
    m. Directions including route, frequency and possibly a PRN as needed
    n. Number of refills
    o. Quantity (amount given)
    p. Signature of prescriber
4. Psychiatrist maintains a list of look-alike/sound-alike medications. This list is referred to:
    a. When prescribing a medication not typically prescribed and/or prescribing a medication that has not been prescribed before.
    b. Medical Director annually reviews and modifies Look Alike/Sound Alike Medication list as necessary
5. When an order is identified as incomplete, illegible or unclear, the Medical Director and/or prescribing physician corrects the error by one or all of the following ways:
    a. Talk to and clarify the order with the pharmacy directly
    b. Rewrite prescription as necessary in a legible manner

6. Medical Director reviews and makes necessary updates prior to ordering preprinted order sheets.

D. Use of High Alert Medications
   1. The Medical Director maintains a list of identified high alert medications.
   2. Psychiatrist manages high alert medications by meeting with the client and/or legal consenting adult about the risk of utilizing high alert medications
      i. Psychiatrist reviews with client and/or caregiver all high risk issues affecting the patient and documents positive or negative response. If high risk issues are reported, psychiatrist makes adjustments to medication, as necessary

E. Use of Multiple Psychotropic Medications
   1. Psychiatrist limits use of multiple psychotropic agents in the same class, and prescribes them only when clinically necessary.
   2. If it is determined that use is needed, psychiatrist provides informed consent, including risks and benefits, discusses alternatives, possible side effects, and monitors use

F. Use of High Dose Pharmacotherapy
   1. Psychiatrist prescribes the minimal amount of medicine necessary to induce response. In isolated and clinically necessary circumstances, psychiatrist may use a higher than recommended dosage.
   2. In the event this is clinically necessary, psychiatrists provides informed consent (see Informed Consent Policy) to the client and/or legally responsible adult, including risks and benefits, discuss alternatives, side effects and monitors use.

G. Prevention, Identification and Management of Side Effects
   1. Prevention of Side Effects
      a. Psychiatrist and therapists are to use effective strategies to ensure prevention of side effects by ensuring client and/or caregiver understand possible or likely side effects, encouraging consistency in attending appointments, and consistency in use of medications.

   2. Identification of Side Effects
      a. Psychiatrist asks open ended and specific follow up questions to obtain information on worrisome side effects.
      b. In the event of indication of tardive dyskenesia, psychiatrist conducts the AIMS scale test.
   3. Management of Side Effects
      a. Psychiatrist monitors for side effects and if a significant side effect is identified, the psychiatrist will change medications as needed

H. Response to adverse medication events, reactions or errors
   1. In the event that staff is notified of an adverse medication event, reaction or error occurs, the prescriber is immediately notified.
   2. Psychiatrist responds to the issue and develops a corrective action plan for ameliorating the situation, including, but not limited to:
      a. Notifying the client and/or caregiver
      b. Complete agency incident report
      c. Reviewed by Medical Director and submit to Executive Director
      d. Complete and submit the MedWatch Online Voluntary Reporting form 3500 for medication errors and serious adverse medication reaction as necessary.
   3. Implements its process for responding
      a. Data is collected on any adverse reactions or medication errors through the completion of an incident report.

DIVISION: Clinical	**NUMBER: 1.11**
SUBJECT: Medication Prescribing, Monitoring and Managing	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: 6/18/2011**
TO BE PERFORMED BY: TCCSC Physicians	**REVISION DATE:**
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I. Monitoring of Medication Management System
   1. The Risk Manager collects data on the performance of the medication management system including:
      a. Significant medication errors
      b. Significant Adverse Reactions
   2. Risk Manager analyzes and compiles a quarterly report by conducting a root cause analysis
      a. The report is provided to the Board, Medical Director and CQI.
      b. Data is compared over time to identify risk points, levels of performance, patterns, trends, and variations of the medication management system
      c. Based on analysis, agency identifies opportunities for improvement for medication management system and takes action on improvement opportunities

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.12**
SUBJECT: SUICIDE RISK ASSESSMENT AND MITIGATION	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: 11/01/2016**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **5**

Purpose: To establish policy and procedures related to the use of a standardized suicide risk assessment for all clinical staff and establish procedures for reviewing and mitigating suicide risk.

Policy: A suicide assessment, including the appropriate components of the C-SSRS, must be completed for all clients and potential clients six years of age or older at all service contacts (whether by phone or face to face with the client/potential client) including screening, triage, and assessment in accordance with the procedures below.

Definitions:

Suicide Screening and Assessment Descriptors:

Suicide Assessment: An assessment that includes the completion of the Columbia-Suicide Severity Rating Scale (C-SSRS), current mental status report, synopsis of any active psychiatric symptoms, identified protective factors, acute and chronic risk factors, and clinician judgment.

Columbia-Suicide Severity Rating Scale (C-SSRS): An evidence-based suicide risk screening tool that assesses the full range of ideation and behavior items with recommendations for next steps (e.g., referral to mental health professionals).

C-SSRS (Lifetime/Recent Full Version): Assesses lifetime history of suicidality as well as any recent suicidal ideation and/or behavior in the last three (3) months (Attachment 1).

C-SSRS (Recent/Screen Version): Provides a truncated form of the Full Version. Screens for suicidality in a potential client.

Low Suicide Risk: A client who indicates upon response to the C-SSRS:

No suicidal ideation or behaviors occurring within lifetime (“No” to item 1 and 2)

Moderate Suicide Risk: A client who indicates upon response to the C-SSRS:

Suicidal ideation with method occurring in the past month (“Yes” to Item 3 in the C-SSRS Ideation Section); and/or

Suicidal intention with or without a specific plan, but not occurring within the past one month ("Yes" to Item 4 and/or 5 in the C-SSRS Ideation Section); and/or

Actual, interrupted, or aborted suicide attempt(s) or preparatory behavior, but not occurring within the past three months ("Yes" to the Behavior Question(s) on the C-SSRS or to Item 6 on the C-SSRS screen versions).

High Suicide Risk: A client who indicates upon response to the C-SSRS:

Suicidal intention with or without a specific plan occurring in the past month ("Yes" to Item 4 and/or 5 in the C-SSRS Ideation Section); and/or

Actual, interrupted, or aborted suicide attempt(s) or preparatory behavior occurring within the past three months ("Yes" to the Behavior Question(s) on the C-SSRS or Item 6 on the C-SSRS screen versions).

Common Terminology of Suicide Behaviors:

Aborted Attempt: An act committed by an individual in an effort to cause his or her own death that was deliberately not completed.

Interrupted Attempt: Steps taken by an individual to injure self that is stopped by something or someone before the potential for harm has begun.

Preparatory Behavior: Any act of preparation for an imminent suicide attempt occurring before potential for harm has begun. This can include anything that goes beyond the verbalization or thought of self-harm, such as obtaining the elements of the intended method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving away belongings).

Suicide: A death of an individual by a deliberate self-inflicted injury.

Suicide Attempt: An act committed by an individual in an effort to cause his her own death.

DIVISION: Clinical	**NUMBER: 1.12**
SUBJECT: SUICIDE RISK ASSESSMENT AND MITIGATION	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: 11/01/2016**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
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Procedures:

1. For all newly active clients, an initial Suicide Assessment, which includes the use of the C-SSRS (Lifetime/Recent Full Version), shall be completed as a baseline assessment (Attachment 1).

2. If an existing client does not have an initial suicide assessment, which includes the use of the C-SSRS (Lifetime/Recent Full Version), the C-SSRS (Lifetime/Recent Full Version) shall be completed at the next service contact (Attachment 1).

3. The C-SSRS (Recent/Screen Version) must be completed for all clients and potential clients six years of age or older at all service contacts when it has been determined based upon the Lifetime/Recent Full Version C-SSRS that client is either moderate or high risk until it is determined that the client's risk level has reached the low risk criteria.

4. For those clients who are assessed and determined based upon the Lifetime/Recent Full Version C-SSRS to be low risk will be reassessed every Treatment plan cycle period (whether by phone or face to face with the client/potential client). If it is determined during the course of treatment that client's suicide risk increase, the clinician will complete a new Lifetime/Recent Full Version C-SSRS and based upon the severity rating will follow the policy as documented.

5. For children under the age of six, a suicide assessment should be completed as clinically appropriate.

6. If there are multiple contacts with the client/potential client on the same day by the same staff, the suicide assessment only needs to be completed once. If the contacts are by different staff, each staff must complete a suicide assessment.

7. If the contact is with a significant support person, the applicable elements of a suicide assessment are recommended. Information gathered from a significant support person should be included when determining the risk.

8. For any client who is determined to be at moderate to high suicide risk after (answering yes to either question 1 or 2), staff making the determination shall immediately:

A. Contact the appropriate authorities if it is determined that there is an immediate life threat.

B. If it is determined after assessment that there is no immediate threat of life, the clinician will consult with Supervisor/Coordinator to determine steps to be taken including but not limited to:

a) Conduct an evaluation of the client to determinate if he/she meets the criteria of danger to self and, if applicable, initiating an application for involuntary detention in accordance with California Welfare and Institutions Code (WIC) Sections 5150/5585.

b) Develop a Safety Plan with the client and significant other(s) to identify and monitor current stressors that may serve as risk factors and/or identify protective factors including, but not limited to:

- Considering past suicide attempts and triggers to the attempts.
- Considering risk of modeling, e.g., from exposure to a recent death by suicide event for an adolescent client or a client who has a history of a family member who has died by suicide.
- Considering current risk factors/stressors such as age (adolescent), pending custody proceedings, school, relationships, job, legal or financial issues.
- Considering past or current substance use and obtaining consultations as needed regarding concurrent co-occurring disorders interventions.
- Considering current medical conditions such as pain or psychiatric symptoms that may decrease coping or increase ideation/plans, such as psychosis.
- Considering recommendation of psychotherapy or psychoeducation for maximizing social, coping, or stress management and/or other indicated skills.
- Encouraging inclusion of family, friends, or significant others in order to contribute to and support the safety plan.

• Assisting individual and family/friends involved in treatment in planning the removal of immediately available or preferred methods of self-harm.
• Identifying resources to contact in the event of crises.
• Determining level of client and/or significant other engagement in increasing protective factors and reducing identified risk and seeking consultation if there is insufficient engagement for the level of risk determined.

c) Document the notification (progress note) of the Coordinator/Supervisor and, if applicable, the treating Psychiatrist on the same business day or sooner depending on the risk level in order to inform him/her of the risk and to determine if a medication consultation prior to the next scheduled consultation is advised.

d) The Coordinator/Supervisor will notify the Program Liaison to schedule a treatment team review of the client's case including, as applicable, stressors, diagnosis, substance use implications, inclusion of family involvement or other indicators of risk, interventions and plan of communication until the risk has dissipated.

9. Program Liaison will immediately notify the Clinical Director of any suicide attempts or suicides.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 1.13**
SUBJECT: LPS Holds	
APPROVED BY:	**EFFECTIVE DATE: July 1, 2017**
TO BE PERFORMED BY: Licensed Clinicians	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose: The County of Los Angeles requires that Full Service Partnership contracted agencies have on staff licensed, trained, and DMH certified clinicians to perform Lanterman-Petris-Short (LPS) evaluations and, when necessary, are authorized to write the application for a 5150 psychiatric hold. This was done to, as DMH notes, "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." Additionally, the LPS Act also established a right to prompt psychiatric evaluation and treatment, in some situations, and set out strict due process protections for mental health clients

Policy: TCCSC shall at all times have LPS certified licensed clinicians on staff who will complete LPS evaluations and applications for holds on TCCSC clients who present a danger to self and/or others or who are gravely disabled.

Process

1. TCCSC's Clinical Director (CD) develops and maintains a list of certified LPS evaluators (Evaluator) and assigns requests on a rotating basis.
2. The therapist or physician determines the client needs an evaluation because he/she may be a danger to self, danger to others, and/or gravely disabled.
3. Therapist calls the CD and requests a LPS evaluation.
4. CD immediately contacts the on-call LPS Evaluator and provides the therapist information.
5. Evaluator contacts the therapist to consult on the case and to determine how best to contact client/caregiver.
6. Evaluator contacts client/caregiver and completes a 5150 assessment and prepares DMH required documentation.
    a. If it is determined that the client needs hospitalization, Evaluator contacts hospital to arrange for admission.
        i. If unable to locate a hospital with an available bed, Evaluator contacts TCCSC's after-hours crisis contact to request assistance locating a facility that will take the client.
        ii. Evaluator arranges transportation to the hospital, via LACDMH ACCESS hotline or through other DMH approved means.
        iii. Evaluator waits with the client until transportation is on-site, the client is loaded in the vehicle, and the client is handed-off in accordance with DMH policy.
    b. If a hold is not warranted, the LPS Evaluator will complete necessary paperwork and give the family and/or contact person instructions on what to do should the client's behaviors escalate and needs further intervention or evaluation.
7. Evaluator follows-up with CD and therapist to notify of assessment outcome.

8. Evaluator writes a note in Clinitrak documenting the outcome of the client visit.
9. Evaluator completes check request form for compensation, if the hold is done outside of normal business hours and submits it according to the CD for processing.
    a. Evaluators will receive compensation for 5150 assessments if it is performed outside of TCCSC's regular business hours; the rate of which will consider the professional level of the employee, the experience and expertise required to perform the task and the amount of time typically required to complete the task and ensure safety of the client.
10. CD arranges a staffing with client's care team to discuss the case and make recommendations for continued treatment.

SECTION 2

DAY TREATMENT INTENSIVE (DTI)

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: TCCSC Clinical Staff	**NUMBER: 2.01**
SUBJECT: Authorizations	
APPROVED BY: Moses Cleveland	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose:
To ensure compliance with the September 1, 2003 DMH implementation of required change in criteria for reimbursement of all Day Treatment Intensive Clients by imposing specific payment authorization and claims certification and program integrity requirements to ensure that claimed services are actually provided and that they are provided in accordance with sound fiscal, business and medical practices and professional standards, are not unnecessary or substandard, do not result in unnecessary costs to or reimbursement by the Medicaid or Medi - Cal Program and/or do not otherwise constitute fraud or abuse (CCR Title 9).

Definitions:
"Day Treatment Intensive" means a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development therapy, rehabilitation and collateral (Title 9, CCR, Section 1810.212).

Policy:
To ensure compliance with DMH requirement of initial and on-going payment authorization by the Central Authorization Unit (CAU) via the secured Internet based system, designed for the payment authorization of Day Treatment Intensive (DTI) services.

Procedure:

1) TCCSC provider must request an authorization for every Day Treatment service whether initial or continued from Central Authorization Unit (CAU) for Day Treatment Intensive (DTI) services prior to the start of such services.
2) DTI must be reauthorized in 3 months intervals if the client continues to meet service and medical necessity criteria.
3) Providers will submit the following required documents to the CAU:
   A Client Care Plan for all authorization requests.
   A Service Necessity Assessment (SNA)
4) The CCP and SNA will be completed and submitted to the CAU via the Authorization System for the Day Treatment Secure Internet website: https://dmhdowney1.co.la.ca.us

a) TCCSC provider will access the online system and click on the "Day Treatment & TBS Authorization System" in the left column of the screen.
b) TCCSC provider can then click on the Training and testing Only link to learn the system without entering data to learn and familiarize themselves with the system.
c) DTI data entry system is the first link in the left column, Production data entry.
d) TCCSC provider will be prompted to enter their user name and password. Provider user name will be their employee number behind tcs (i.e. tcs1234). Everyone's initial password will be 123456. Provider will be prompted to change password screen to choose a new password.
e) To create a Day Treatment Service Plan, provider will click on Add Day Treatment Intensive. To access an existing service plan, click on Authorization Search.
f) In order save an authorization, the provider will be prompted to enter the following with the aid of a drop down menu: Client's MIS number, Provider Number, Clinician responsible for treatment, Diagnosis, Service Type, and Client Current Status
g) Provider must request 5 days per week and provided requested start and stop date with a span no more than three months.
h) Provider must complete the following fields to complete the authorization:
    1. Client Care Plan including: Long term Goals and Barriers, Current Focus/Short Term Goals, Progress and Review for Goals (To be filled out if Re-Authorizing a client for service)
    2. Service Needs Assessment including: Living Arrangement, Symptoms, Functional Impairments, Expected Behavior Changes, Previous Treatment, Reason for higher level of care, Specific Interventions, Psychotropic Medication, Axis I-V.

5) Authorization request must have a turnaround time of 7 days for processing with CAU and must be submitted 7 days prior to end of authorization period for approval. Authorizations should be submitted 15 days prior to the current plan expiring.
6) TCCSC provider must request prior authorization from the CAU when DTI will be provided more than five days per week.

7) TCCSC provider must request payment authorization for continuation of DTI every three months.
8) DTI staff must develop a treatment plan and complete the appropriate online Client Care Plan to complete an authorization requests as outlined in Day Treatment Concurrent Mental Health Services Therapeutic Behavioral Services handbook in Section III pages 7-30.
9) If DTI staff cannot access the SNA on the Authorization System for Day Treatment secure Internet Website, The provider will contact the CAU at (213)738-2466 for a copy of the SNA questions. When completed the SNA may be faxed to the CAU at (213)351-2495.
10) DTI staff may also choose to submit additional supportive documentation, which may include client progress notes, psychological testing results, etc. Staff may also be asked by the CAU to submit additional supporting documents.
11) Staff will be notified of the determination via the same secure website link.
12) If authorized, providers will be able to provide the services requested, enter the units of service in the Information System (IS) and the IS will prepare a claim to Medi-Cal on it regular monthly cycle.
13) If the authorization is denies, both the client or their representative and DTI staff have the right to appeal the decision.
14) When appealing the decision, DTI clinician may contact the clinician with CAU by phone or email to present clinical argument for appeal. DTI clinician will provide CAU clinician with any requested documentation for appeal or make requested changes to authorization request.

SECTION 3

WRAPAROUND

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: TCCSC Clinical Staff	**NUMBER: 3.01**
SUBJECT: Crisis Response Plan	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: Wraparound Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **1**

PURPOSE: To ensure Wraparound clients have access to staff 24 hours/7 days per week, to respond in a crisis.

POLICY: Wraparound clients shall be provided their Wraparound staff's pager numbers, TCCSC's number and instructions on how to access staff during and after normal working hours. Wraparound staff shall respond to a page in accordance with TCCSC's Pager policy (see Policy 1003 – Pager Communication). The Wraparound staff shall be involved in developing the client's Crisis Response Plan and shall know his/her responsibilities in an emergency or crisis.

PROCEDURE:

1) During the initial CFT meeting, each client will be given contact information for each team member, including TCCSC Wraparound staff and informal/formal supports, to contact.
2) Each crisis response plan will identify specific needs of the client and the role of every Wraparound staff involved in creating the plan.
3) Wraparound staff will assist in developing his/her client's specific Crisis Response Plan and will be instructed on how to respond accordingly.
4) In case of a crisis, the CFT will enact the Crisis Response Plan and will take steps identified and/or necessary to abate the crisis.

SECTION 4

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

SECTION 5

FULL SERVICE PARTNERSHIP (FSP)

SECTION 6

OUPATIENT

SECTION 7

SCHOOL-BASED

SECTION 8

MULTIDISCIPLINARY ASSESSMENT TEAM

(MAT)

SECTION 9

P. A. T. H.

SECTION 10

CLIENT RIGHTS

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.01**
SUBJECT: PROTECTION OF CLIENT RIGHTS, RESPONSIBILITIES AND ETHICAL OBLIGATIONS	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose:

To ensure that all Tessie Cleveland Community Services Corp. (TCCSC) staff respect the dignity, privacy, self-worth, self-determination and personal beliefs of all clients within the therapeutic relationship and are conversant with and abide by the provisions of law pertaining to clients' rights.

Definitions:

Client Rights-

TCCSC clients have certain rights, including the right to:

- Have confidentiality
- Have a client-driven treatment plan
- Refuse treatment services Information regarding discharge policies
- Review their medical records
- Privacy
- Know the cost of services
- Be free from unnecessary physical restraint and physical abuse

Client Responsibilities-

TCCSC requires cooperation from clients to ensure they receive the best possible service and care. Client responsibilities include**:**

- Provide all the facts when they begin treatment
- Participate in the development of their treatment plan and work toward their goals
- Report concerns regarding treatment
- Maintain scheduled appointments or call 24 hours ahead to cancel
- Provide staff with necessary personal information and documentation (i.e. proof of income, copy of medical insurance card, copy of social security card)
- Inform TCCSC of changes in name, insurance, address, phone number and financial status
- Pay share of cost, if applicable, and/or inform TCCSC in advance of inability to pay

- Treat staff and fellow clients with respect
- Report grievances
- Respect the confidentiality of fellow clients

Policy:

TCCSC staff will respect and promote client rights and responsibilities in a non-discriminatory manner. TCCSC staff will provide a safe and secure therapeutic environment for clients to participate in treatment and work towards goal attainment.

Procedures:

TCCSC protects the legal and ethical rights of all clients by providing:

I. Proactive efforts to educate clients about their rights.
   a. Client Rights are posted in visible areas within the agency.

II. Fair and equitable treatment including:
   a. The right to receive services in a non-discriminatory manner
   b. The freedom to express and practice religious and spiritual beliefs.

III. Clients with sufficient information to make an informed choice about using TCCSC's services during initial contact which includes and is available in the major languages of Service Areas 6, 7, and 8 (English and Spanish):
   a. A written summary of their rights and their responsibilities at initial contact, which includes:
      i. A copy of *LA County's Guide to Medi-cal Mental Health Services* (http://file.lacounty.gov/dmh/cms1_159129.pdf)
      ii. A copy of TCCSC's Clients Rights and Responsibilities pamphlet with includes:
         a. Basic expectations for use of TCCSC's services
         b. Hours that services are available
         c. Rules, expectations, and other factors that can result in discharge or termination of services

d. An explanation of how to lodge complaints/grievances, grievances, or appeals.

IV. Client grievance forms are available to all clients, including information on how to complete and submit form. (TCCSC GRIEVANCE FORM)
   a. All client rights and grievance information is culturally sensitive and linguistically appropriate.

V. TCCSC shall provide a second opinion at the request of a beneficiary, when TCCSC determines that the medical necessity criteria as described in Diagnostic Statistical Manual Version 5 (DSM 5) has not been met. TCCSC shall determine to whom the second opinion request is assigned, and the second opinion must be rendered in a face-to-face encounter. The second opinion process shall be at no cost to the beneficiary.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.02**
SUBJECT: LINGUISTICALLY SENSITIVE WRITTEN AND ORAL COMMUNICATION	
APPROVED BY: Moses Cheeseman	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose:

To provide Tessie Cleveland Community Services Corp. (TCCSC) guidelines to ensure all non-English speaking TCCSC clients receive equal access to services in the language of their choice (i.e., clients' primary or preferred language). Under no circumstances shall a client be denied services because of language barriers.

Definitions:

N/A

Policy:

I. TCCSC will continue to recruit and hire mental health professionals who are proficient in non-English languages

II. In accordance with applicable Federal, State and County Policy and Agreements, TCCSC will provide equal access to all non-English speaking mentally ill consumers in the greater Los Angeles area.

III. TCCSC will provide all clients with documents and consent forms in the language spoken by client, legal guardian and/or caregiver.

Procedures:

TCCSC accommodates the communication and cultural needs of clients by:

I. Communicating, in writing and orally, in the languages of the major population groups served;
    a. TCCSC provides services in Service Planning Areas 6, 7, and 8.
        i. Major languages of areas served are English and Spanish

II. Providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed;
III. Providing telephone amplification, sign language services, or other communication methods for deaf or hearing impaired persons;
IV. Providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and

considers the person's literacy level.

V. Providing brochures and other forms of literature (such as the beneficiary guides) will be made available in the threshold languages of: Armenian, Cambodian/Khmer, Cantonese, Farsi, Korean, Mandarin, other-Chinese, Russian, Spanish, Tagalog and Vietnamese. (DMH Patient Rights - Website)

a. TCCSC maintains a roster of staff proficient in non-English languages.

i. TCCSC staff proficient in a non-English language may qualify for bilingual compensation.

ii. Identified bilingual staff available for translation services will be provided training, as needed.

b. Exception: Client needs may better be served by referral to an agency provider of similar but more culturally or language-specific services. The referral process will allow latitude for clinical judgment in some cases.

II. TCCSC provides interpreter services for clients and their family members. The agency maintains a list of staff members, all of whom have been carefully screened and trained, who make themselves available, free of charge, to provide interpreter services.

a. If an in-house interpreter is not available, the agency uses the AT&T; Language Line, which offers interpreter services in numerous languages.

III. If a client, legal guardian and/or caregiver choose to use a family member or friend as a translator, they may do so.

IV. It is strongly recommended that minor children not be used as translators.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLIENT RIGHTS	**NUMBER: 10.03**
SUBJECT: POSTING OF CLIENT RIGHTS	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **1**

Purpose:

To ensure that all clients, legal guardians, and/or caregivers have access to client rights through posting of client rights in visible areas within the agency.

Definitions:

N/A

Policy:

I. Proactive efforts are made to educate clients, legal guardians, and/or caregivers about their rights. The list of Client's Rights is posted in visible areas within the agency. It includes information on how to process the forms. Client's Rights information is also given to clients, legal guardians, and/or caregivers during the intake process and is available upon request. (TCCSC Clients Rights & Responsibilities Pamphlet)

II. All Client's Rights and Grievance information is culturally sensitive and linguistically appropriate.

Procedures:

I. Clients, legal guardians, and/or caregivers will be informed of their rights through posting of the information in visible areas within the agency and educated about the grievance procedure when applicable.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER:10.04**
SUBJECT: CONFIDENTIALITY	
APPROVED BY: Moses Cheeseman	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **6**

Purpose:

1. To establish TCCSC responsibilities for maintaining confidentiality of client information.
2. To assure all applicable County, State and Federal laws, rules and regulations pertaining to confidentiality are appropriately incorporated into TCCSC operations.
3. To assure all pertinent sources of information within the purview and responsibility of TCCSC are maintained and shared in accordance with all applicable confidentiality policies, regulations and laws.

Policy:

1. TCCSC shall ensure and protect the privacy and confidentiality of all sources of client information in accordance with all applicable County, State and Federal laws, policies and procedures, including but not limited to:

    a. All information and records obtained in the course of providing services to voluntary and involuntary recipients of specified services, including mental health, community mental health, admissions and judicial commitments to mental institutions. (State of California Welfare and Institutions Code [WIC] Section 5328)

    b. All Protected Health Information (PHI) as specified in the Health Information Portability and Accountability Act of 1996 (HIPAA). (HIPAA 45 CFR 160.103 and 164.500)

2. Employees shall take personal responsibility to ensure they understand and use current and relevant confidentiality laws, regulations and guidelines as applicable to their job responsibilities and duties. For purposes of this policy, the term "employee" is used broadly and is defined to mean any permanent or temporary employee, temporary agency or locum tenens employee, persons employed under contract or purchase of service agreement, unpaid students, interns, volunteers and any other persons who represent TCCSC in the course of their work duties.

3. Confidentiality of client information shall be maintained in all formats, such as paper, electronic mail, computerized information systems, photographs, audio

and video recordings communication with media and other verbal and non-verbal (gesturing, etc.) communication, in keeping with all applicable laws, regulations and procedures.

4. Confidentiality shall be assured without compromising applicable legal rights of access for information by any appropriate party, including employees, clients, family, professionals and agencies or other pertinent groups.

5. Each coordinator shall be responsible for enforcing all confidentiality policies and regulations within his/her scope of responsibility.

Procedure:

1. All TCCSC employees, including students, volunteers and interns, shall review, sign and abide by all applicable confidentiality oaths.

2. Confidentiality shall be applied to the use, dissemination or release of all information and records in the course of providing services to either voluntary or involuntary recipients as specified in the State of California W&I Code, Section 5328. All information and records developed in the course of providing services shall be deemed confidential unless otherwise indicated.

3. Employees shall never access or use confidential and/or sensitive and/or Protected Healthcare Information (PHI) with anyone who does not have the "need to know". This shall include, but not be limited to, use and storage of passwords in a manner that assures they are not shared with unauthorized persons.

4. Release of client information to any party shall be carried out only upon completion of a valid and current written authorization for use and disclosure. Exceptions shall be made only when release without client/legal representative consent is mandated by legal statute, or when communication without such written consent is legally authorized as specified in W&I Code 5328 and HIPAA Standards as described in DMH Policy Practices Notice.

5. Situations mandating release of information with or without consent include, but are not limited to, the following:

a. By a mandated reporter who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects has been the victim of child abuse (Penal Code Section 11166).

b. By a mandated reporter who encounters suspected elder or dependent adult abuse or neglect

6. When the patient, in the opinion of his/her therapist, presents a serious danger to a reasonably identified victim or victims. (Tarasoff Decision).

7. Upon receipt of a properly served subpoena. Subpoenas for consumer (client) records shall be referred to:

Clinical Director
TCCSC
8019 South Compton Avenue
Los Angeles, CA 90001

8. Information and records obtained in the course of providing services may be shared in communications between qualified professionals in the provision of services or appropriate referrals (WIC, Section 5328). Among employees, client records or information contained in such records may be released to TCCSC employees when they are performing their job duties and such information is needed in the fulfillment of their responsibilities.

9 Employees who receive requests for treatment information from consumers and/or family members shall refer and comply with LA County DMH's policies of Client/Personal Representative Access to Mental Health Records or Providing Notification and Patient Information to Family Members for specific guidelines.

10. Employees shall not make use of confidential information and records relative to TCCSC clients in connection with outside work or business interests. Confidential information possessed by TCCSC and required by professional clinicians in carrying out private services to clients shall be obtained only through appropriate channels.

11. Confidentiality shall be maintained in all programs that are collaborative in nature between TCCSC and various departments and service delivery systems (e.g.,

drug and alcohol treatment, developmental disabilities, health services) in keeping with all applicable statutes and regulations. Programs requiring such collaboration across service delivery systems shall develop and implement an appropriate interagency confidentiality policy, such as a Memorandum of Understanding, Trading Partner Agreement or other appropriate document or mechanism to assure all applicable regulations, statutes and procedures regarding confidentiality across all systems are adequately addressed.

12. Employee shall also apply all pertinent confidentiality guidelines to documents not typically included in a clinical record, such as telephone calls or Patients' Rights, and interpreter services as well as all information maintained in computer or hand tally databases/logs, such as telephone number, name, address and social security number.

13. Employees shall follow the appropriate procedures for maintaining confidentiality in the reporting of incidents involving injuries, deaths and alleged patient abuse.

14. Employees shall assure that client records are distributed, maintained and stored in a manner that will assure access only to those employees authorized to review records.

15. Confidentiality of HIV and AIDS information as it pertains to TCCSC clients shall be maintained.

16. Information stored in electronic data systems shall be maintained in keeping with all applicable confidentiality regulations. This shall include data from both microcomputer systems and Network computers/MIS and Clinitrak.

<u>Client Records</u>

1. Only staff who have signed an Annual Oath of Confidentiality, may have access to client records.

2. All client records shall be maintained in accordance with applicable Federal and State client record confidentiality laws. No information regarding a client in written or verbal form can be provided to any individual without the explicit, time limited, written consent of the client, or by without duly served subpoena for such records. Employees may share client information with one another only on a need to know basis, e.g., when it is necessary to assist in accessing services or in furthering that

client's treatment progress and follow all applicable HIPPA laws governing discussing client information.

3. Physical medical records are secured:
   a. By an offsite records management company that provides HIPPA compliant, secure storage and control in accordance with Principles of Global Facility Protection, which include:
      1) Intrusion detection and alarm systems
      2) Physical access controls
      3) Fire detection and suppression systems
      4) 24/7 central monitoring of protection systems

4. Electronic medical records are secured:
   a. By policy and practice governing security of all TCCSC data
      i. Routine data-backup and redundancy
      ii. Double password controlled access
      iii. System access to employee records will be restricted

5. Retrieval
   a. External access to medical records information can be granted under the following circumstances:
      i. Court order or subpoena
      ii. Client/Caregiver signed release of information for the specific release request
      iii. By TCCSC policy governing data access
   b. If physical chart is required, Coordinator of staff requesting the physical chart will notify the Clinical Director(s) the reason for retrieval.

   c. Clinical Director(s) will obtain permission from Executive Director to retrieve chart from off-site record management company.

   d. If permission is granted, Clinical Director(s) and/or authorized personnel will contact off site to retrieve chart within 24 hours of request being approved.

6. Staff seeing clients in the field are to take appropriate steps to ensure that any confidential client information (i.e., assessments, involuntary holds, progress notes) and computers are maintained in a manner that ensure compliance with all Federal and State client record confidentiality laws.

a. Staff are assigned HIPPA compliant travel equipment, which can include boxes or backpacks, to help keep computers and person information secure while they are in the field.
b. Equipment is assigned to staff at the start of employment by the I.T. Department.
    i. The I.T. Department provides each employee with a unique code to secure the contents within equipment, which includes combination locks.

7. At no time shall medical records be kept unsecured.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.05**
SUBJECT: RELEASE OF CONFIDENTIAL INFORMATION	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **4**

Purpose:

To establish Tessie Cleveland Community Services Corp. (TCCSC) responsibilities for maintaining confidentiality when releasing client information and to assure all pertinent sources of information are shared in accordance with applicable confidentiality policies, regulations and laws.

Definitions:

N/A

Policy:

I. TCCSC shall ensure and protect the privacy and confidentiality of all sources of client information in accordance with all applicable County, State and Federal laws, policies and procedures, including but not limited to:

   a. All information and records obtained in the course of providing services to voluntary recipients of specified services, including mental health, community mental health, admissions and judicial commitments to mental institutions. (State of California Welfare and Institutions Code [WIC] Section 5328)

   b. All Protected Health Information (PHI) as specified in the Health Information Portability and Accountability Act of 1996 (HIPAA). (HIPAA 45 CFR 160.103 and 164.500)

II. Confidentiality shall be assured without compromising applicable legal rights of access for information by any appropriate party, including employees, clients, family, professionals and agencies or other pertinent groups.

III. Each Supervisor/Program Coordinator shall be responsible for enforcing all confidentiality policies and regulations within his/her scope of responsibility.

Procedures:

I. All TCCSC employees, including students, volunteers and interns, shall review, sign and abide by all applicable confidentiality oaths.

II. Confidentiality shall be applied to the use, dissemination or release of all information and records in the course of providing services to either voluntary recipients as specified in the State of California W&I Code, Section 5328. All information and records developed in the course of providing services shall be deemed confidential unless otherwise indicated.

III. Employees shall never access or use confidential and/or sensitive and/or Protected Healthcare Information (PHI) with anyone who does not have the "need to know". This shall include, but not be limited to, use and storage of passwords in a manner that assures they are not shared with unauthorized persons.

IV. Release of client information to any party shall be carried out only upon completion of a valid and current written authorization for use and disclosure. Exceptions shall be made only when release without client/legal representative consent is mandated by legal statute, or when communication without such written consent is legally authorized as specified in W&I Code 5328 and HIPAA Standards as described in DMH Policy Practices Notice.

V. Situations mandating release of confidential information with or without consent include, but are not limited to, the following:

a. By a mandated reporter who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects has been the victim of child abuse (Penal Code Section 11166). (Mandated Reporting of Suspected Child Abuse and Neglect)

b. By a mandated reporter who encounters suspected elder or dependent adult abuse or neglect. (Mandated Reporting for Suspected Elder/Dependent Adult Abuse and Neglect)

c. When the client in the opinion of his/her psychotherapist, presents a serious danger to a reasonably identified victim or victims (Tarasoff Law).

VI. Information and records obtained in the course of providing services may be shared in communications between qualified professionals in the provision of services or appropriate referrals (WIC, Section 5328). Among employees, client records or information contained in such records may be released to TCCSC

employees when they are performing their duties and such information is needed in the fulfillment of their responsibilities.

VII. Employees who receive requests for confidential client information from consumers and/or family members shall refer to TCCSC'S Clients' Right to Copies policy for specific guidelines.

VIII. Documents/information that are not generated by TCCSC may *not* be released.

VIII. Employees must complete or receive a request to release confidential client information to disclose any client information. (RELEASE OF INFORMATION FORM)

a. Form ensures TCCSC's responsibility for maintaining confidentiality of client
b. Informed, written consent includes the following elements:
   i. An updated release of information form must be completed and signed by client, legal guardian and/or caregiver on an annual basis.
   ii. the signature of the person whose information will be released, or the parent or legal guardian of a person who is unable to provide informed consent;
   iii. the specific information to be released;
   iv. the purpose for which the information is to be used, except where disclosure is mandated by law or the person is receiving service under court supervision or directive;
   v. the date the consent takes effect;
   vi. the date the consent expires, upon case closure, or as the law requires, when a contracted or cooperating service provider requires the release of information for ongoing service provision; (not to exceed one year from date of effect for clients admitted to program and not to exceed 90 days for single contact clients)
   vii. the name of the person to whom the information is to be given;
   viii. the name of the person within the organization who is providing the confidential information; and a statement that the person or family may withdraw consent at any time and when permitted by law, confidential information may be released without the informed, written consent of the person or legal guardian.

c. After the release of information form is completed and signed by the client, legal guardian and/or caregiver, the form will be maintained within the client's chart in the Medical Records office.

d. Situations mandating release of information with or without a release of information form include, but are not limited to the following:
   i. By a mandated reporter who has knowledge of or observes a client in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects has been the victim of child abuse
   ii. By a mandated reporter who encounters suspected elder or dependent adult abuse or neglect.
   iii. When the client, in the opinion of his/her therapist, presents a serious danger to a reasonably identified victim or victims. Refer to "Duty to Warn and Protect Third Parties in Response to a Threat (Tarasoff Decision)".

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.06**
SUBJECT: PERMISSION FOR RECORDING, FILMING, OR PHOTOGRAPHY	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose:

To establish guidelines for audio/videotaping, photographing, or filming clients to insure protection of clients' rights to privacy.

Definitions:

a. Audiotape - A recording of the voice alone.

b. Consent - A written agreement signed by the client or guardian which assumes legal competency, knowledge, comprehension and voluntariness.

c. Film - See photographing.

d. Photographing - A visual image reproduced as a photographic still, film, videotape or digital image on any device.

e. Recordings - Any reproduction, audio or visual.

f. Videotape - A recording of the voice and image.

Policy:

Clients may be audio/videotaped, photographed, or filmed only when prior written consent has been obtained from the client, client's legal guardian or parent of a minor, and for the following purposes:

a. Supervision of staff, interns, students, volunteers
b. Evaluation of the treatment process
c. Staff development or training
d. Community education
e. Research
f. Personal or social purposes
g. To determine the identification of a client

DIVISION: CLINICAL	**NUMBER: 10.06**
SUBJECT: PERMISSION FOR RECORDING, FILMING, OR PHOTOGRAPHY	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **2** of **2**

Procedures:

1) TCCSC staff must obtain approval from Clinical Director prior to any photographing and/or audio/videotaping of client on behalf of TCCSC.

2) TCCSC staff will discuss the purpose and type of recording to be done with client, and have form completed and signed by client, parent and/or legal guardian.

   a) If consent is denied, staff is informed of request and appropriate arrangements will be made to ensure confidentiality. Client, parent and/or legal guardian may revoke consent at anytime. (Media Consent Form)

3) TCCSC staff submits the consent form to medical records to be filed in client's chart.

4) If it is determined that there is no longer an essential need to maintain photograph and/or audio/videotape materials, copies of materials will be returned to client or destroyed in the instance that:

   a) Client, parent and/or legal guardian withdraws consent.

   b) Client is discharged.

   c) Purpose for which materials were intended has been completed

5) Tapes, photographs or films may not be used by any person, group or organization outside of TCCSC without explicit permission of TCCSC and client.

6) These procedures must be followed for each instance where recording, filming or photography will take place.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.07**
SUBJECT: CLIENT'S RIGHTS TO COPIES	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose:

To ensure that a uniform process exists for Tessie Cleveland Community Service Corp. (TCCSC) clients to access copies of personal mental health records.

Definitions:

N/A

Policy:

Clients can inspect or receive copies of personal records, by appointment, during regular TCCSC business hours. Every client has a right to inspect all documentation, including treatment and billing records, enclosed in their personal chart.

Procedures:

I. To inspect or copy personal mental health records, a client must submit a request in writing to their direct service provider. A form will be provided to you for this request. (CLIENTS RIGHTS TO COPIES FORM)

a. All client requests to inspect or copy personal records will be channeled through the Clinical Directors office.

b. Within ten (10) working days after the receipt of a formal written request for client records, the clinical team will determine whether to comply with the request and notify the client accordingly.

c. An extension of ten (10) working days may be granted in specified instances if:

i. A voluminous amount of records must be found and assembled.

d. TCCSC may deny a client's request to inspect and/or copy personal records. When considered harmful only that section of the requested health information will be forwarded to a qualified mental health professional for interpretation.

i. A client may request that the denial be reviewed.

ii. Client will be notified of the outcome of the review

II. Fees and Charges

a. Copies of personal records will be made available to the client upon payment of certain fees and charges. These will be determined by the TCCSC Administration.

i. These fees represent the reasonable cost for duplication, including labor, materials, overhead, postage, etc.

ii. Monies collected as fees and charges for this service are subject to accounting procedures and controls prescribed by TCCSC Administration.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.08**
SUBJECT: CLIENT GRIEVANCE PROCEDURES	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose:

To encourage the resolution of all client grievances and to facilitate the mediation and settlement of issues as soon as possible.

Definitions:

I. Formal grievance proceedings are available for any TCCSC client complaint which states that a staff member or the agency has:

a. Violated a right of the client(s) as defined by TCCSC client rights policies.

b. Treated a client in an arbitrary or unreasonable manner.

c. Denied, involuntarily reduced or terminated services or failed to provide services authorized by a treatment plan due to negligence, discrimination or other improper reason.

d. Engaged in coercion to improperly limit client self-efficacy.

e. Unreasonably failed to intervene to protect a client whose rights are jeopardized by the actions of another client in a setting controlled by TCCSC.

f. Failed to treat a client in a humane and dignified manner.

Policy:

Grievance procedures shall be fully available to anyone applying for or receiving mental health services provided by Tessie Cleveland Community Services Corp. (TCCSC). No TCCSC employee shall retaliate against a consumer for filing a grievance.

Procedures:

I. Filing of Grievances:

a. A grievance may be filed by a client, or if he or she is unable to do so, by a person designated by the client and/or legal guardian or conservator appointed by a legal entity. (TCCSC GRIEVANCE FORM)

b. A grievance must be filed within forty-five (45) days of the action complained of, unless good cause is shown for a late filing. A grievance may be withdrawn at any time by the affected client, unless it was filed by a guardian or conservator. Withdrawal of a grievance will not affect any agency disciplinary action.

c. A grievance should be filed in writing with the Clinical Director.

d. Any person filing a grievance may appoint, in writing, a representative of his or her choice to assist in pursuing the grievance.

e. Any chosen advocate may appear and advocate for the grievant at any proceedings pertaining to the grievance.

f. All records relating to the grievance shall be confidential unless disclosure is authorized, in writing by all parties involved.

g. A copy of all records concerning a grievance shall be kept on TCCSC premises.

I. Procedure after Grievance Filing:

a. As soon as possible after the filing of a grievance, Clinical Director will interview the grievant, interview appropriate other parties, examine relevant records and take any other action which will enable a full understanding of the issue.

b. The inquiry, disposition and if necessary, Clinical Director's decision will be completed within twenty-one (21) days of receipt of the grievance, unless the Clinical Director authorizes an additional fifteen (15) days for reasonable cause with written notice to the grievant.

c. The Clinical Director will mediate, provide information and counseling or take other actions likely to assist the parties in resolving the issue. The Clinical

Director will encourage all parties to accept an informal resolution. The Clinical Director will inform the grievant that he or she has ten (10) business days to consider signing an acceptance of the proposal that will terminate the grievance, or, in the alternative, that he or she has right to a formal decision on the grievance. Failure of a grievant to respond to an offered resolution within ten (10) business days shall be treated as a withdrawal of the grievance.

d. If the grievant requests a formal decision or rejects a proposed resolution, the Clinical Director will prepare a written report of the information found, and present it to the TCCSC Chief Executive Officer (CEO) and/or Risk Manager (RM) and the grievant. The grievant and his or her representative, shall be given the opportunity to present additional material and, upon request, to appear in person before the CEO and/or RM. The CEO and or RM will provide a written decision to the grievant, including a statement of any actions to be taken and the grievant's appeal rights.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.09**
SUBJECT: Mandated Reporting for Suspected Elder/Dependent Adult Abuse and Neglect	
APPROVED BY: Moses Cheeves	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **8**

Purpose:

To provide Tessie Cleveland Community Services Corp. (TCCSC) with guidelines regarding cases of suspected elder or dependent adult abuse.

Definitions:

a. **Elder** is defined as any person residing in this state, 65 years of age or older. (Welfare and Institutions Code [WIC] 15610.27).

b. **Dependent adult** means any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. (WIC 15610.23(a))

c. **Dependent adult** includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (WIC 15610.23(b))

d. **Developmental disability** means a disability that originated before an individual attains the age of 18, continues, or can be expected to continue, indefinitely and constitutes a substantial disability for that individual. This term shall include mental retardation, cerebral palsy, epilepsy and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature. (WIC 4514(a))

e. **Abuse of an elder or a dependent adult** is defined as physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment resulting in physical harm or pain or mental suffering. (WIC 15610.07(a))

   i. **Physical abuse** means any of the following:

   - Assault
   - Battery
   - Unreasonable physical constraint or prolonged or

continual deprivation of food and/or water.

- Sexual assault, which means any of the following:
  - Sexual battery
  - Rape
  - Spousal rape
  - Incest
  - Sodomy
  - Oral copulation
  - Sexual penetration

- Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
  - For punishment;
  - For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions were given; or
  - For any purpose not authorized by the physician and surgeon. (WIC 15610.63)

ii. **Neglect** means either of the following:

- The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or

- The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

- Neglect includes, but is not limited to, all of the following:

  - Failure to assist in personal hygiene or in the provision of food, clothing, or shelter;

- Failure to provide medical care for physical or mental health needs. (No person shall be deemed neglected or abused for the sole reason that he/she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.)
- Failure to protect from health and safety hazards;
- Failure to prevent malnutrition or dehydration; or
- Failure of an elder or dependent adult to satisfy the needs specified above for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health. (WIC Code 15610.57)

iii. **Financial abuse** of an elder or dependent adult occurs when a person or entity:

- Takes, secretes, appropriates or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud or both; or
- Assists in taking, secreting, appropriating or retaining real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud or both.

iv. **Abandonment** means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. (WIC 15610.05)

v. **Isolation** means any of the following:

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his/her mail or telephone calls.
- Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he/she is competent or not, and is made for the purpose of preventing the elder

or dependent adult from having contact with family, friends or concerned persons.
- False imprisonment, as defined in Section 236 of the Penal Code.
- Physical restraint of an elder or dependent adult for the purpose of preventing the elder or dependent adult from meeting with visitors.

vi. **Abduction** means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state of any conservatee without the consent of the conservator or the court. (WIC 15610.06)

vii. **Mental suffering** means fear, agitation, confusion, severe depression or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult.

viii. **Goods and services necessary to avoid physical harm or mental suffering** include, but are not limited to, all of the following:

- The provision of medical care for physical and mental health needs;
- Assistance in personal hygiene;
- Adequate clothing;
- Adequately heated and ventilated shelter;
- Protection from health and safety hazards;
- Protection from malnutrition, under those circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment; or
- Transportation and assistance necessary to secure any of the needs described above. (WIC 15610.35)

Policy:

I. **Regarding Confidential Information and Privileged Communication**

a. All information obtained in the course of providing mental health services is made confidential under Welfare and Institutions Code, Section 5328 et seq. Confidential information may be disclosed for reporting purposes. Such disclosure should be not more than the minimum amount of information necessary to achieve the goal of the report. (45 CFR 164-512(c))

i. The fact that information described in 3.5.1 has been disclosed must be documented in the client's medical record. Documentation will include:

- Date of disclosure;
- Purpose/circumstance of disclosure;
- The names of persons/agencies to whom the disclosure was made; and
- The specific information disclosed. (45 CFR 164.528(b)(2))

b. In any court proceeding or administrative hearing, neither the physician-patient nor the psychotherapist-patient privilege applies to the specific information reported pursuant to "Elder Abuse and Dependent Adult Civil Protection Act". (WIC 15632(a))

II. **Immunity**

a. The employer of a mandated reporter shall incur no civil or other liability for failure of these persons to comply with the requirements of the "Elder Abuse and Dependent Adult Civil Protection Act". (WIC 15659(f))

b. No mandated reporter who reports a known or suspected instance of elder or dependent adult abuse shall be civilly or criminally liable for any report required by section 3.2. (WIC 15634(a))

i. A mandated reporter may present to the State Board of Control a claim for reasonable attorney fees incurred in any action against that person on the basis of making a report required or authorized by this article if the court has dismissed the action upon a demurrer or motion for

summary judgment made by that person, or if he/she prevails in the action. (WIC 15634(c))

c. No mandated reporter who, pursuant to a request from an adult protective services agency or a local law enforcement agency investigating a report of known or suspected elder or dependent adult abuse, provides the requesting agency with access to the victim of a known or suspected instance of elder or dependent adult abuse, shall incur civil or criminal liability as a result of providing that access. (WIC 15634(b))

   i. A mandated reporter may present to the State Board of Control a claim for reasonable attorney fees incurred in any action against that person on the basis of making a report required or authorized by this article if the court has dismissed the action upon a demurrer or motion of summary judgment made by that person, or if he/she prevails in the action. (WIC 15634(c))

d. No person required to make a report pursuant to this article, or any person taking photographs at his/her discretion, shall incur any civil or criminal liability for taking photographs of a suspected victim of elder or dependent adult abuse or causing photographs to be taken of such a suspected victim or for disseminating the photographs with the reports described in section 3.2. (WIC 15634(a))

e. A mandated reporter may present to the State Board of Control a claim for reasonable attorney fees incurred in any action against that person on the basis of making a report required or authorized by this article if the court has dismissed the action upon a demurrer or motion for summary judgment made by that person, or if he/she prevails in the action. (WIC 15634(c))

III. **Liability**

   a. Failure to report physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment. (WIC 15460(h))

b. Any mandated reporter who willfully fails to report physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, in violation of this section, where that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment. (WIC 15360(h))

Procedures:

IV. **Reporting Requirements**

a. Any mandated reporter who, in his/her professional capacity, or within the scope of his/her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect, or is told by an elder or dependent adult that he/she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect, or reasonably suspects that abuse, shall immediately consult with their supervisor. After a consultation, the reporter will report the suspected instance of abuse by telephone immediately or as soon as practicably possible and by written report sent within two working days. (WIC 15630(b)(1))

i. Reasonable **suspicion** means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, upon his/her training and experience, to suspect abuse. (WIC 15610.65)

ii. **Written reports** shall be submitted on forms adopted by the State Department of Social Services. These reporting forms are distributed by the county adult protective services agencies and long-term care ombudsman programs. (WIC 15658(a)(1))

iii. **Written reports** collect the following information:

- The name, address, telephone number and occupation of the person reporting;
- The name and address of the victim;

- The date, time and place of the incident;
- Other details, including the reporter's observations and beliefs concerning the incident;
- Any statement relating to the incident made by the victim;
- The name of any individuals believed to have knowledge of the incident; and
- The name of the individuals believed to be responsible for the incident and their connection to the victim.

b. When **two or more** mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report. (WIC 15630(d))

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.10**
SUBJECT: Mandated Reporting of Suspected Child Abuse and Neglect	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: Apil 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose:

To provide Tessie Cleveland Community Services with guidelines regarding cases of suspected child abuse and neglect.

Definitions:

N/A

Policy:

I. Mandated Reporters

a. Section 11166 of the Penal Code requires any child care custodian, medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

II. Reporting Responsibilities

a. Child abuse must be reported "when one acquires knowledge of or observes facts which give rise to a reasonable suspicion" – Penal Code, Section 11166(a). Reasonable suspicion occurs "when it is objectively reasonable for a person to entertain such a suspicion, based on facts that could cause a reasonable person in a like position, drawing when appropriate on his/her training and experience, to suspect child abuse" – Penal Code, Section 11166(a).

b. When two or more persons who are required to report are present and jointly have knowledge of a suspected instance of child abuse, and when there is agreement among them, the reporting requirements may be carried out by a member of the team selected by mutual consent. Any member who has knowledge that the designated member has failed to report shall make the required report. No supervisor or administrator may impede or inhibit such

reporting duties. No person making such report shall be subject to any sanction for fulfilling this responsibility.

III. Reportable Child Abuse and Neglect

a. Physical injury that is inflicted by other than accidental means on a child by another person.

b. Sexual abuse – Penal Code, Section 11165(b).

c. Willful cruelty or unjustifiable punishment of a child that includes infliction of unjustifiable physical pain or mental suffering – Penal Code, Section 11165(d).

d. Cruel or inhuman corporal punishment or injury – Penal Code, Section 273(d).

e. Severe and general neglect of a child – Penal Code Section 11165(c).

f. Abuse in out-of-home care, including "negligent" abuse – Penal Code, Section 11165)f).

g. Venereal disease diagnosed in any child less that 14 years of age – Penal Code, Section 288(a) and (b) or Attorney General Opinion 83-911.

IV. Legal Liability/Immunity

a. Penal Code, Section 11172, provides that persons required to make reports of known or suspected instances of child abuse are immune from civil or criminal liability for making a required or authorized report. Failure to report child abuse is a misdemeanor, punishable by confinement in the County jail for a term not to exceed six (6) months or by a maximum fine of $1,000 or by both.

b. Mandated reporters who provide child protective agencies with access to the victim of a known or suspected instance of child abuse shall not incur civil or criminal liability as a result of the access. Because immunity from

liability does not eliminate the possibility that actions may be brought against mandated reporters, claims for reasonable attorney' fees incurred in any action against that person on the basis of making the required report may be presented to the State Board of Control for review. If all requirements are met under Penal Code, Section 11172, up to a maximum of fifty thousand dollars ($50,000) will be paid for such attorney fees.

V. Confidentiality vs Reporting

a. The duty to report child abuse supersedes the confidentiality provision of the Lanterman-Petris-Short Act (Welfare and Institutions Code, Section 5328).

Procedures:

I. Reporting Protocol

a. When a mandated reporter suspects, by observation or acquired knowledge, that a child has been abused, reporter will immediately consult with their supervisor. After a consultation, an immediate telephone report must be made to the Department of Children's Services/Child Protective Services or to law enforcement. In an emergency, a telephone report must be made to the Police Department. All cases of suspected child sexual abuse must be reported to law enforcement.

b. The telephone report shall contain the name of the person making the report, the name and location of the child, the nature and extent of the injury, and any information related to the specific incident of suspected child abuse being reported – Penal Code, Section 11167.

c. The telephone report shall be followed by a written report within thirty-six (36) hours. This report shall be written on Department of Justice form #SS8572 (Suspected Child Abuse Report 11166) which has instructions for completion on the back of the form. This completed form is routed to the agency that received the telephone report of the incident. Forms may be obtained from the Department of Children's Services/Child Protective Services or from the DMH/Children and Youth Services Bureau, Coordinator of Child Abuse Services.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.11**
SUBJECT: CONSENT TO SERVICE MINORS WITHOUT CONSENT FROM A PARENT OR LEGAL GUARDIAN.	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **20**

Purpose:

To provide guidance regarding consent for mental health treatment services for minor (under 18 years of age) clients. The general rule is that the parent or legal guardian must consent to medical care for a minor; however, there are numerous exceptions to this rule, especially when dealing with adolescents aged 12-18 in the outpatient mental health and substance abuse treatment setting where they may be legally permitted to provide their own consent to treatment if certain conditions are met.

Also, in an emergency, care may be provided to a minor even without consent if there is difficulty locating the parent or guardian. This policy will also address minor clients who are wards or dependents of the Court.

Policy:

To clarify for TCCSC staff which minors are considered "adults" for medical consent purposes ("emancipated" and "self-sufficient" minors), and those instances when a minor aged 12 to 18 may qualify to consent to his/her own outpatient mental health care or substance abuse program treatment under the so-called "sensitive services" exceptions. It also clarifies financial responsibility for treatment provided to minors pursuant to their own consent.

Definitions:

1. Parent or Legal Guardian Consent

a. Right of Parent/Legal Guardian to Consent

i. It is the general rule that the parent or legal guardian must consent to medical or behavioral health care for minor patients, unless the minor has the right to consent to the care under minor consent laws. Only one parent is necessary to provide consent, and unless the provider is aware of evidence to the contrary, it can be assumed that the other parent has not objected. Adoptive parents have the same rights as natural parents. In a same-sex couple only the biological parent would have authority to consent unless the other partner adopts the child. If same-sex partners

both adopt the same rules would apply and either adoptive parent could consent. If only one partner is an adoptive parent, and the other is not the biological parent, only that partner could consent.

ii. A parent who is him/herself still a minor (under 18) may consent to their minor child's medical care so long as they are sufficiently mature to rationally weigh the risks and benefit of that care and understand the nature of the treatment proposed.

b. Implied Consent in an Emergency

i. In an emergency, care may be provided to a minor without parent/guardian consent if necessary to alleviate pain or prevent serious medical harm if the parent or guardian has not yet been located. Unless there is evidence to indicate that the parent/guardian would object to the care, consent may be implied.

c. What the Right to Consent Includes

i. When services are provided to a minor client who does not qualify for minor consent, the parent/guardian will have the right to consent to or refuse the recommended medical treatment. In the case of outpatient mental health services this would typically involve minors under 12 years of age, or minors who are living at home with their parents (or legal guardians) and receiving services at the request of their parents or the school. The parent or guardian shall also have a right to know how the minor's private medical information will be used or disclosed, and how the parent or guardian may access that information.

d. The Right to Refuse Treatment

i. The parent/guardian's right to consent includes the right to refuse treatment. Health care providers who believe that the refusal of care will harm a minor client should immediately discuss the situation with a supervisor; if the refusal of care triggers suspicion of medical neglect, child protective services should be immediately contacted pursuant to mandated

child abuse reporting requirements (i.e., if the refusal of care will likely harm the child, a report must be made).

e. Divorced Parents

i. When parents divorce the Court decides who will have physical custody and who will have legal custody of the child/ren. In most situations, the parent who has physical custody also has legal custody. Often, the parents will have "joint" or shared legal custody. The parent(s) who has legal custody has the right to consent to medical care. If only one parent has legal custody, then only that parent may consent to medical care. If the parents have "joint legal custody" usually either parent can consent to the treatment unless the court has required both parents to consent to the proposed care. Such an order is rare. In most situations, providers can presume that either parent can consent unless there is evidence to the contrary (some providers like to obtain consent from both divorced parents when treatment is provided to a minor child, but again, this is not usually required by the court). However, if either parent disputes the other parent's legal right to make medical decisions the provider should ask to see documentation of the court's order and place a copy in the chart. If there is any question about legal custody or a divorced parent's right to consent to medical care for the minor, the provider should contact TCCSC or the Child, Youth and Families Administration.

f. Delegation of Authority to a Third Party

i. A parent or guardian who has the legal authority to consent to care for the minor child has the right to delegate this authority to other third parties (aged 18 and older); for example, the parent may delegate authority to consent to medical care to the school, to

a coach, to the step-parent, or to a baby-sitter who is temporarily caring for the child while the parent is away or at work. A copy of the written delegation of authority shall be kept in the chart. (Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent) but a handwritten note that clearly delegates authority to consent to an adult person (18 or older) is also acceptable.

ii. Typically providers will limit care to routine procedures that the parent already has consented to, or to emergency situations when relying on delegated consent. If the person with delegated authority is requesting a new course of treatment, change in medications, or other non-routine procedure, it is recommended that the new treatment be deferred until the parent's return, unless it is clearly medically indicated. If you are unsure, check with a colleague for another opinion or discuss it with your supervisor. Document any discussions or concerns.

g. Caregiver Affidavits and Caregiver Authority to Consent

i. In some cases, a minor child lives with and is being raised by a "surrogate parent." If this adult is a "qualified relative" (often the grandparent, or an aunt or older sibling) who has stepped into the role of parent because the biological parents are no longer willing or able to care for the child he or she may fill out a Caregiver's Affidavit. (Caregiver's Authorization Affidavit) These so called "caregivers" who have "unofficially" undertaken the care of the child are authorized by law to consent to

most medical and mental health care and to enroll these children in school; the use of this form does not legally bind the caregiver to the child or imply any other legal obligations. Once they have completed the "Caregiver's Affidavit" form (which is then placed in the chart) they may consent to medical care for the minor child. The affidavit is valid for one year after the date on which it is executed and a new form should be completed and placed in the chart each year as needed. If the parent(s) returns, the "caregiver's" authority is ended, and once again the parent has authority to consent to or refuse care for the child.

h. Financial Liability of Parent/Guardian

If the parent or guardian consents to the treatment of a minor, the parent or guardian is financially liable for that treatment. The parent or legal guardian is also financially responsible when care is provided pursuant to delegated consent or a Caregiver's Affidavit. The parent or guardian is not financially responsible for services provided to emancipated or self-sufficient minors, or for "sensitive services" that the minor is receiving subject to minor consent. However, if the parent or guardian participates in outpatient mental health treatment or counseling, or alcohol or drug abuse treatment, the parent or guardian is financially liable for those services rendered with their participation (even though the services are being provided pursuant to minor consent).

2. <u>Dependents and Wards of the Court</u>
Minors who are dependents or wards of the court do not lose their own rights re: consent to sensitive services, and the provider should not deny such services if the minor otherwise qualifies to provide his/her own consent.

a. <u>Dependents (Welfare and Institutions Code section 300)</u>
A minor who has been neglected, abused, abandoned, or otherwise has no parent(s) or guardian willing or able to exercise appropriate care or control can be adjudged a "dependent child" of the juvenile court. (Welfare and Institutions Code 300.). When a child is adjudged a dependent child of the court on the ground that the child is a person described in Welfare and Institutions Code section 300, the court may make any and all reasonable orders for the care, supervision, custody, conduct, maintenance, and support of the child, including medical treatment, subject to the further order of the court.

b. <u>Children in Temporary Custody (Welfare and Institutions Code Section 305)</u>
A police officer may take a child into temporary custody if the child is believed to be a dependent described under section 300, and who is in need of medical care or who is in danger; also included are children who are about to be released from a hospital into the care of a parent where there is a danger of harm to the child, and children who are found in a street or public place suffering from a sickness or injury that requires care. A social worker may authorize care for such a minor upon the recommendation of the provider after notifying the parent or guardian that such care will be provided. If the parent or guardian objects, a court order authorizing the necessary care is necessary.

c. <u>Authority to Provide Medical Care to Dependents: Children in Temporary Custody</u>
Welfare and Institutions Code section 369 (a) states that "Whenever any person is taken into temporary custody under Article 7 (commencing with Section 305) and is in need of medical, surgical, dental, or other remedial care, the social worker may, upon the recommendation of the attending physician and surgeon or, if the person needs dental care and there is an attending dentist, the attending dentist, authorize the performance of the medical, surgical, dental, or other remedial care." The social worker must notify the parent or guardian, if any, of the care found to be needed before that care is provided and if the parent or guardian objects, the care shall only be given upon order of the court in the exercise of its discretion.

d. Authority to Provide Medical Care to Dependents: Children Concerning Whom a Petition has Been Filed (Unadjudicated Cases)
Welfare and Institutions Code section 369(b) states that whenever it appears to the court that any person concerning whom a petition has been filed with the court is in need of medical, surgical, dental, or other remedial care, and that there is no parent, guardian, or person standing in loco parentis capable of authorizing or willing to authorize the remedial care or treatment for that person, the court, upon the written recommendation of a licensed physician and surgeon, or it the person needs dental care, a licensed dentist, and after due notice to the parent, guardian, or the person standing in loco parentis, if any, may make an order authorizing the performance of the necessary care for that person.

e. Authority to Provide Medical Care to Dependents: Children Placed by Court Order with the Care and Custody of Social Worker
Welfare and Institutions Code section 369(c) states that when a dependent child is placed by the court within the care and custody or under the supervision of a social worker of the county in which the dependent child resides, and it appears to the court that there is no parent, guardian, or person standing in loco parentis capable of authorizing or willing to authorize medical, surgical, dental, or other remedial care or treatment, that the court may after due notice to the parent or guardian, if any, order that the social worker may authorize the care for the dependent child by licensed practitioners as may from time to time appear necessary.

f. Authority to Provide Medical Care to Dependents: Children who Require Immediate Medical , Surgical or other Remedial Care:
Welfare and Institutions Code section 369(d) provides that in an emergency situation, care may be provided without a court order upon the authorization of a social worker. The social worker must make reasonable efforts to obtain the consent of, or notify the parent, guardian or person standing in loco parentis prior to authorizing that care. "Emergency situation" means that the child requires immediate treatment to alleviate severe pain, or there is a need for an immediate diagnosis and treatment of an unforeseeable medical, surgical, dental or other remedial or contagious disease which, if not immediately diagnosed and treated, would lead to serious disability or death.

g. Release of Information:

In any case in which the court orders the performance of any medical, surgical, dental or other remedial care for dependent minors, the court may also make an order authorizing the release of information concerning that care to social workers, parole officers, or any other qualified individuals or agencies caring for or acting in the interest and welfare of the child under order, commitment or approval of the court.

h. Dependent minors who have been removed from the physical custody of a parent under Welfare and Institutions Code section 361:
If a child is found to be a dependent of the court under section 300 and has been removed from the physical custody of the parent under section 301, only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for that child. The juvenile court may issue a specific order delegating this authority to a parent upon making findings on the record that the parent poses no danger to the child and has the capacity to authorize psychotropic medications. Court authorization for administration of psychotropic medications shall be based upon a request from a physician, indicating the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of the side effects of the medications.

i. Los Angeles Superior Court Order re: Dependents of the Court
The Superior Court of the State of California, in and for the City and County of Los Angeles Unified Family Court, Juvenile Division has issued a Standing Order, No. 210A for mental health treatment for dependents of the court or those whose dependency status is pending, which grants authority to the Foster Care Mental Health Unit of the Department of Public Health to authorize mental health treatment for minors. The authority extends to consent for assessment, treatment, sharing of information, determination of eligibility, and provision and payment for outpatient services when the parent or guardian is unavailable, unable or unwilling to provide such consent (staff must document attempts to reach the parent or guardian). The order does not permit inpatient placement, or antipsychotic medications unless there is consent from the parent or guardian or further order of the court.

j. Wards of the Court (Section 601 and 602)
A minor who refuses to obey his parents or who violates curfew, or who is deemed to be a habitual truant, may be adjudged a ward of the court (section

601). A minor who violates the law may be also be adjudged a ward of the court (section 602).Welfare and Institutions Code section 727 provides that "When a minor is adjudged a ward of the court on the ground that he or she is a person described by section 601 or 602 the court shall make any and all reasonable orders for the care, supervision, custody, conduct, maintenance, and support of the minor, including medical treatment, subject to further order of the Court." Documentation supporting the authority of a probation worker, social worker, juvenile hall staff, etc. should be obtained and placed in the record prior to providing services pursuant to such an order.

k. Foster Parents
A foster parent's right to consent to treatment for a minor depends upon whether the minor has been placed with the foster parent by court order, or with the consent of the minor's legal custodians, or on a temporary basis before a detention hearing has been held. Written evidence of the foster parent's authority (e.g., a copy of a court order or the consent of the minor's parent or legal guardian) should be placed in the minor's medical record before proceeding with treatment. Finally, the court order must specifically allow the foster parent to consent to medical treatment. A placement order alone is insufficient.

l. Documentation When Treating Dependents and Wards of the Court
In situations where someone other than the parent or guardian is providing consent, (unless it is an emergency) care must be taken to establish a non-parent's legal authority to consent to care before treatment begins. Often this requires identification of the child's status as well as the ability or inclination of the natural parents to provide consent. A copy of the Court Order delegating this authority (to a Foster Care, for example) should be placed in the client's medical record before care is provided. If a ward or dependent qualifies for "sensitive services minor consent," and could therefore legally provide his/her own consent to the treatment, the provider should not seek authorization from the court appointed legal guardian or from the parent. The ward or dependent enjoys the same consent privileges and confidentiality as a minor in the care and custody of the parent.

m. Court Authorization to Consent
In rare situations a court may summarily grant consent to medical treatment upon verified application of a minor aged 16 or older who resides in California if consent for medical care would ordinarily be required of the parent or guardian,

but the minor has no parent or guardian available to give the consent. (If the minor is suspected of being a runaway, Child Protective Services should be notified.) For example, if a non-emancipated, non-self-sufficient 16 year old in a non-emergency situation would clearly benefit from antipsychotic medications, but the parent or guardian was out of the state and had not delegated authority to any other adult, the provider might choose to get such an order rather than delay the medical treatment while a surrogate decision maker could be found. A copy of the court order should be obtained and placed in the patient's medical chart before treatment is provided pursuant to the order.

n. Financial Liability: Dependents and Wards of the Court
Services for minors who are dependents or wards of the Court, or who are referred through the Foster Care Mental Health Program, will generally be paid through full-scope Medi-Cal or through the parent's insurance. If needed, supplemental coverage is also available through a special DHS fund for this purpose.

3. Minors Treated as "Adults"

a. Emancipated and Self-Sufficient Minors' Right to Consent
Certain minors are considered to be "adults" under the law for purposes of medical consent. They can consent to both "sensitive services" and to non-sensitive services. They still have to have mental capacity to consent, but they do not suffer automatic legal incapacity due to their young age. These minors are clearly defined under the law and include "emancipated minors" and "self-sufficient minors."

b. Definition of Emancipated Minor
Emancipated minors include 1) minors 14 and older who have been emancipated by court order, 2) minors who are serving in the active US military forces, and 3) minors who are married or who have been married (parenthood by itself does not emancipate a minor).

c. Definition of Self-Sufficient Minor
Self-sufficient minors are defined by law as minors aged 15 and older who are living separate and apart from their parents and who are also managing their own financial affairs regardless of their source of income. The law permits "notification" of the parent or guardian of the care (as opposed to "consent") if the

minor has told the provider where the parent is located, however such disclosures are discretionary, not mandatory. It is recommended that the self-sufficient minor be consulted regarding parental notification and that in general, such notification be in accordance with the wishes of the minor.

d. Use of the Checklist for Minor Consent and Minor Consent Forms
When minors seek medical services pursuant to their status as "adults" they may also independently qualify for minor consent for "sensitive services." For example, they may be receiving "sensitive services" such as outpatient mental health care that is described by Family Code section 6924(b) or outpatient substance abuse services described in Family Code section 6929, and they may be consenting to their own antipsychotic medications pursuant to their status as an emancipated minor. All relevant boxes on the Checklist for Minor Consent should be checked.

The minor may then sign the "Consent of Minor" form (MH 521E) and services may be provided directly to the minor. The minor's medical care is confidential, and information about the care should not be divulged to parents/guardians without the minor's specific authorization except in rare instances when required or permitted by law. In the case of self-sufficient minors receiving non-sensitive services (e.g. antipsychotic medications), a parent or guardian may be contacted regarding the care if the minor has provided information about the parent/guardian's whereabouts; however, prudent providers would not make such a disclosure without first notifying the minor and getting the minor's consent to make such a disclosure.

e. Financial Responsibility - Emancipated and Self-sufficient Minors
Generally, a minor seeking services as an "adult" (emancipated or self-sufficient minor) will be financially responsible for his/her own care. When the minor is still "covered" by the parent's insurance plan, the issue of whether insurance will be billed or not must be discussed with the minor, and specific permission to bill insurance should be obtained. Failure to obtain permission, or billing without the minor's knowledge and consent, could result in a breach of confidentiality.
Note: If the emancipated or self-sufficient minor receives services that also qualify under "sensitive services minor consent" it is important not to bill the parents directly or indirectly (through their insurance plan). Other sources are often available to pay for the care.

4. Minors Seeking "Sensitive Services"

a. Minor's Right to Consent to Treatment for "Sensitive Services"
Minors seeking certain sensitive services may be legally authorized to provide their own consent to those services. The minor also controls whether or not the parent will have access to records generated as a result of receiving those services. When minor consent applies, sensitive services should never be provided over the minor's objection; in other words, even if the parent provides consent, non-consent by the qualified minor bars treatment.

b. Overview of Sensitive Services
"Sensitive services" that may be provided to minors aged 12 and older without parental consent (or knowledge) include rape care and treatment (see discussion of additional, separate provision of law below), treatment of infectious reportable conditions (including HIV testing), outpatient mental health and residential care treatment (not ECT or psychotropic medications) if certain conditions are met (see discussion below), and outpatient substance abuse treatment (not methadone). Minors of any age may consent to their own care and treatment for sexual assault and rape under a separate provision of the law; however, if the minor is under the age of 12, or 12 and older seeking sexual assault care as opposed to rape care and treatment, the provider must attempt to notify the parent or guardian of the care and treatment unless the provider believes that the parent or guardian committed the rape or assault.

c. Outpatient Mental Health Care and Minor Consent
The law states that minors 12 and older may consent to mental health treatment or counseling on an outpatient basis if both of the following requirements are satisfied: 1) the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services, and 2) the minor would either present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling, or is the alleged victim of incest or child abuse.

The attending professional person should clearly chart that these criteria have been met if services are provided pursuant to this provision of the law. Parent/guardian consent is required if psychotropic medications are prescribed or if inpatient mental health facility services are provided. The law also does not authorize a minor to consent to convulsive therapy or psychosurgery.

d. Involvement/Notification of Parent or Guardian in Outpatient Behavioral Health Services
If outpatient mental health treatment or counseling services are provided pursuant to "sensitive services minor consent" (Family Code section 6924) the law states that it shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person must state in the record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

e. Substance Abuse Programs and Minor Consent
The law states that minors aged 12 and older may consent to outpatient services for the treatment of alcohol and drug abuse (Family Code 6929). This does not include methadone treatment (Noted: if minor is pregnant, methadone treatment may be provided under Family Code 6925 as part of her reproductive health care.) See the previous discussion in part 4.d. above, regarding involvement of the parent or legal guardian, unless the provider deems it inappropriate. The same rules for involving the parent or legal guardian, and charting the decision to involve them, or not, apply in the case of substance abuse treatment.

Behavioral health care providers providing services at government funded substance abuse programs should consult 42 USC section 290dd-2 and 42 CFR Part 2 sections that address the rights of participants in those programs. It should be noted that because minors 12 or older may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem, parents or guardians have no legal authority to demand drug testing of their minor children who are 12 or older. Furthermore, parents and guardians should not be advised of their minor child's participation unless written authorization is received from the minor permitting such a disclosure. California Family Code section 6929 (g) includes a provision for parental access to the record which only applies to private programs that receive no federal or state funding; that subsection should therefore not be followed in the County programs, as it is in direct conflict with federal statutes.
Minors who are under 12, or who require methadone treatment, require parent or guardian consent.

f. Financial Liability of Minor Seeking "Sensitive Services"
When the minor seeks services under the "sensitive services" minor consent rules, it is important that the "Payor Financial Information Form" (PFI) be completed as described in the procedures. If the minor is "covered" by the parent's insurance plan, the issue of whether insurance will be billed or not must be discussed with the minor, and specific permission to bill insurance should be obtained. Failure to obtain permission, or billing without the minor's knowledge and consent, could result in a breach of confidentiality.

III. Procedures

1. Parent/Guardian Consent (See Below for Procedures for "Minor Consent")

a. Consent will be obtained from the parent or guardian prior to treatment, unless an emergency exists. If a procedure is complex, or where there are risks that may not be commonly understood, informed consent will also be obtained (see related policy on "Informed Consent"). At intake, the parent or guardian will be provided with Consent Form CYF MRD 80 - Parent/Legal Guardian Consent - to review. The name of the provider, agency, or clinic will be filled in by staff where indicated on the form prior to handing the form to the parent or guardian.

b. In the case of an emergency situation, consent may be implied and the treatment may proceed without consent so long as there is no evidence to indicate that the parent or guardian would refuse the treatment. An emergency will be deemed to exist if immediate services are required to alleviate severe pain, or immediate treatment or diagnosis of a medical condition is required because the condition could lead to serious disability or death if not immediately diagnosed and treated. If treatment is provided without consent pursuant to the emergency "exception" the provider should document his/her belief that an emergency situation exists and describe in the chart the specific details pertaining to the emergency situation as well as all attempts to contact the parent or guardian.

c. The provider will ask if the parent/guardian has any questions about the form, and will then discuss general privacy practices and confidentiality concerns, review the conditions of treatment, including risks, benefits and alternatives (including doing nothing), and will then ask the parent/guardian to sign the form. Generally, it is presumed that people are being truthful in filling out the form and it is not necessary to ask to see picture ID or a birth certificate to verify the

information on the form. (Note: typically a photocopy of the insurance card is obtained by clerical staff at the initial visit.) However, if there is reason to doubt the information on the consent form (for example, if the provider does not believe that this adult is really the child's parent) then further inquiry is justified and appropriate. It is also presumed that the person consenting to the care for the minor is not doing it over the objections of the other parent, or in the case of divorced parents, over the objection of the other parent who may have legal custody as well. If there is evidence that a conflict does exist, the matter should be immediately referred to a supervisor and services should not be provided until the matter has been resolved.

d. If the adult (age 18 or older) presenting with the minor child has documentation that the parent/guardian has delegated authority to consent to this other adult, the provider may use his/her discretion to provide services. In some cases, it would be prudent to wait until the parent/guardian can accompany the child for services, while in other cases, telephone consultation with the parent to confirm the services provided and to obtain oral informed consent until such time that a written form can be signed will be appropriate.

e. If the adult (age 18 or older) presenting with the minor child claims to be a qualified relative who is raising the child in the parent's absence, the Caregiver's Affidavit form should be filled out. Proof of identity should be obtained and copied in this case, and the form and proof of identity should be placed in the chart. The Caregiver may then proceed with the above steps in providing consent and informed consent. The Caregiver's Affidavit form should be renewed annually.

f. If the adult (age 18 or older) presenting with the minor child is a foster parent, probation officer, law enforcement officer, social services worker or any other person working within his/her official capacity as an individual who works with wards or dependents of the court, and is seeking medical care for the minor child, documentation verifying that the individual has legal authority to seek such treatment should be obtained. Typically DHS will forward the 1122 A form to the provider or to Foster Care Mental Health. Another avenue may be through the panel attorneys appointed by the court for DHS kids. A court order granting such authority to the individual would be another example of this type of documentation. If the child is an “in-home” dependent, the parent or legal guardian should give consent to mental health services. If there are questions, the provider should immediately discuss this with a supervisor; if necessary,

contact Tessie Cleveland Community Servicesor Children, Youth and Family Administration. Note: if the child is a dependent of the Court pursuant to Welfare and Institutions Code 300 et seq., consent for antipsychotic medications may not be provided by the parent/guardian unless this authority has been specifically restored to the parent/guardian by the Court after a hearing on the matter.

g. If language barriers exist, an interpreter or AT&T translation services should be contacted. If other communication barriers exists (e.g., hearing disability), attempts must be made to find a "signer" or other person or means to communicate with the parent/guardian. Providers need to know that without communication they do not have consent.

h. If a procedure is complicated, or has risks that might not be commonly appreciated, more information must be disclosed to the parent/guardian, and an informed consent form should be signed and placed in the chart. A copy should be given to the parent/guardian to keep. Any time a new treatment is proposed, or a new medicine prescribed, informed consent discussions should be undertaken with the parent/guardian as part of good patient care and ongoing education.

   If an unusual situation presents itself (e.g., where a person presenting him/herself as the parent does not appear to be the legally authorized parent/guardian, or where the parent/guardian refuses recommended medical care) the provider must immediately discuss the situation with a supervisor. In some cases, legal counsel might need to be contacted (e.g., confusion over the divorce decree or the court order delegating parental rights to a foster parent).

   If the parent or legal guardian is not physically present, but can give verbal consent by telephone, ask another staff person to “listen in” on the other line (with permission) while verbal consent is given. Carefully document the verbal consent and then obtain written consent as soon as practicable. Faxed consent is also adequate when face-to-face consent is not possible and you have reasonably determined identity of the parent. Have the parent sign a written consent at the next appointment or as soon as practicable. Phone and faxed consent should be used only when the situation justifies this and it would not make sense to wait for the parent to arrive from work for example.

2. <u>Minor Consent</u>

a. If a minor (under 18) presents for services and qualifies for Minor Consent, the Checklist for Minor Consent should be filled out (MRD 80 M2). If services will be provided because the minor is emancipated or self-sufficient, the minor should complete the form and sign it. A copy of the appropriate documentation confirming that the minor is emancipated or self-sufficient should be obtained (for example, the identification card issued by the DMV stating that the minor is emancipated, or the military ID card). If services are provided pursuant to the "sensitive services" exception, the Provider should complete and sign the form.

b. The minor may then be provided with the Minor Consent form (MRD 80 M1) to review. The name of the provider, agency, or clinic will be filled in by staff where indicated on the form prior to handing the form to the minor.

c. The provider should ask if the minor has any questions about the form, and should then discuss general privacy practices and confidentiality concerns, especially as might be related to insurance billing issues. If the minor does not wish his/her parent/guardian to know he/she is receiving services, care must be taken that insurance not be billed. A copy of the insurance card should not be made, and the fact that insurance should not be billed should be clearly noted in bold letters on the Minor Consent form (e.g., "DO NOT BILL INSURANCE"). Other arrangements for payment may be discussed at this time. In the case of a minor receiving sensitive services, the PFI form should be completed (see Item 10 below). The provider should also review the conditions of treatment, including risks, benefits and alternatives (including doing nothing), and then ask the minor to sign the form which is then placed in the chart. A copy is given to the minor patient.

d. If minor consent is justified pursuant to the outpatient mental health "sensitive services" exception, the provider will specifically state in the medical record progress notes that both of the legal requirements for minor consent are satisfied: 1) that the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services (including the basis for that opinion), and 2) that the minor would either present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling (describing the harm that would occur), or is the alleged victim of incest or child abuse (describing the allegations). Note: if there are

allegations of incest or child abuse that would trigger a reasonable suspicion of child abuse, a mandated child abuse report must also be filed.

e. If outpatient mental health treatment or counseling services or outpatient substance abuse services are provided, the law states that the treatment shall include the involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person must therefore state in the record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. Specific details must be included in the charting to support the opinion.

f. If minor consent appears justified pursuant to the "sensitive services" exception for outpatient behavioral health services, but the professional person is uncertain whether the criteria actually exist, charting should reflect this concern beginning with the initial interview. Under most circumstances, the issue should be resolved within the first several visits. Each visit should be supported with charting that explores the issue and discusses why it appears to the provider that the criteria apply.

g. Sometimes a minor who initially meets criteria for "sensitive services" minor consent for outpatient behavioral health services no longer meets those criteria after a period of treatment or counseling. If and when that point is reached, the professional person offering the services must inform the minor patient that further therapy or counseling will require parent/guardian consent, and appropriate steps should then be taken to either obtain that consent with the minor patient's permission, or to discontinue services.

h. The Payor Financial Information Form (PFI) is required for each client who is receiving services pursuant to the minor consent for "sensitive services." Minors receiving sensitive services should not be enrolled in sensitive Medi-Cal; that program has been discontinued as of July 1, 1998. Part I of the PFI, fields 1-20 only, should be completed. Part II fields 5 (clinician's signature) and 6 (comments - indicate that client is "minor consent") should also be completed. This is the documentation that the billing office will need in order to demonstrate that no billing to third party payers was submitted and no UMDAP liability was charged to

the Responsible Parties. A PFI submitted without the clinicians' signature or without a note that the client is "minor consent" will not be accepted by the billing office. Billing staff must return incomplete PFI forms to the clinic for completion and resubmission.

If an unusual situation presents itself, for example, where the minor is referred for 5150 assessment, or is emancipated but does not appear to have the mental capacity required to thoughtfully weigh the risks and benefits of the proposed treatment, the supervisor should be immediately advised and appropriate steps taken to resolve the matter.

IV. Special Instructions

1. A consent form is necessary for each new episode at each program provider.
2. The client may withdraw consent at any time.
3. If the minor is under LPS Conservatorship, the conservator should be contacted to arrange for consent to services.
4. Consent forms should be witnessed by someone other than the minor's provider. Another member of the staff may act as witness. All witnesses should be 18 years of age or older.
5. Note that the clinician and the agency run the risk of liability when treatment is initiated without documented consent.
6. The Minor Consent Form (MRD 80 M1) or Parent/Legal Guardian Consent Form (CYF MRD 80) should be used by staff of Community Behavioral Health Services. A private practitioner network (PPN) provider is NOT required to use these forms if the PPN provider prefers to use his/her own form which addresses the necessary consent elements.
7. The consent form includes a statement that pertains to the completion of assessment forms and other inter-agency outcomes measures.
8. If the minor or parent/legal guardian is willing to provide consent, but does not wish to (or is unable to) sign the form, it should be so noted on the form and in the progress notes of the minor's record.
9. The consent form must be permanently filed in the minor's record according to Tessie Cleveland Community Services chart order policy.
10. A copy of the Consent Form should be given to the minor or parent/legal guardian who signs it.

11. Note that the Consent Forms refer to the Notice of Privacy of Practices which will be required under HIPAA privacy regulations beginning April 14, 2003. Until the Notice of Privacy Practices becomes available for distribution to our clients, simply check the box indicating that the client did not receive the Notice of Privacy Practices and write in "n/a" (not applicable) as the "explanation."
12. Note that there may be situations where an "Educational Surrogate" has authority pursuant to his/her role in assisting a student obtain educational services as part of the IEP process to consent to a mental health assessment or any behavioral health service that is considered part of IEP services available to the student.
13. In the case of dependents of the court, the Foster Care Mental Health Unit can sign the consent form for the minor once they have Form 1122-A. DHS either sends Form 1122-A to Foster Care Mental Health Unit along with the screening packet, or alternatively, the foster parent or DHS gets the form and forwards it to Foster Care Mental Health. For questions about Form 1122-A or the authority of Foster Care Mental Health Unit to authorize behavioral health care for a minor, call 970-3875. The fax is 970-3813.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 10.12**
SUBJECT: CONSENT FOR SERVICES	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE: 6/18/11**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose:

To safeguard the client and agency by ensuring individuals and/or legally responsible representative fully understand services and the risks and benefits of treatment.

Policy:

All persons obtaining mental health treatment from TCCSC will have a duly executed informed consent on file and will be fully informed of the rights and responsibilities therein.

Procedure:

1. Informed consent to treat is obtained during the first face-to-face appointment with a client and/or their legal representative.
    a. Client is informed of:
        i. proposed care, treatment and services for the individual served.
        ii. reasonable alternatives
        iii. pros and cons of the proposed and alternative care, treatment, and services
    b. Client's rights to refuse or withdraw consent at any time are explained and financial obligations for services.

2. Treatment services are explained in a clear and understandable language to a client and/or their legal representative possessing adequate mental capacity.
    a. Using words at the level of comprehension of client and/or their legal representative.
    b. In a language understandable to the client and/or their legal representative, preferably in their primary language.
    c. When client and/or their legal representative is oriented to time, place, person and situation.

3. Legal mandates to report are disclosed including:
    a. Child abuse
    b. Elder abuse
    c. credible threats to harm self or others

4. At the time informed consent is explained, the client and/or legal representative is also presented with the Client Right's and Grievance's brochures.

DIVISION: CLINICAL	**NUMBER: 10.12**
SUBJECT: CONSENT FOR SERVICES	
APPROVED BY: Moses Cheatwood	**EFFECTIVE DATE: 6/18/11**
TO BE PERFORMED BY: ALL STAFF	**REVISION DATE:**
Electronic File Location:	Page **2** of **2**

5. The Consent form is signed by the client and/or legal representative and becomes a part of the official medical record and treatment can commence.

6. If client and/or legal representative refuses to sign the consent form and agrees to services, a witness signs the form attesting to client's verbal consent.

SECTION 11

BEHAVIOR SUPPORT MANAGEMENT

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 11.01**
SUBJECT: BEHAVIOR SUPPORT MANAGEMENT	
APPROVED BY: Moses Chadwick	**EFFECTIVE DATE:**
TO BE PERFORMED BY: All Staff	**REVISION DATE:1/12/14** MoC
Electronic File Location:	Page **1** of **11**

Purpose:

To establish agency-wide practices for the safe and appropriate use of behavioral techniques to ensure safety of the staff, client and family in cases of crisis which may cause potential injury and/or threaten safety of self and others. The agency's philosophy for Behavioral Support Management (BSM) policies and practices promote positive behavior and protect the safety of clients and staff and that use of restraint is reserved for those occasions when unanticipated, severely aggressive or destructive behavior places the client or others in imminent danger.

Definitions:

Crisis Prevention Institute® Non-Violent Physical Crisis Intervention - program developed by the *Crisis Prevention Institute® is a* training program that is a holistic behavior management system based on the philosophy of providing the best *Care, Welfare, Safety, and Security*SM for staff and those in their care, even during the most violent moments. The program focuses on preventing disruptive behavior by communicating with individuals respectfully and with concern for their well-being. The program teaches physical interventions only as a last resort—when an individual presents an imminent danger to self or others—and all physical interventions taught are designed to be non-harmful, noninvasive, and to maintain the individual's dignity. Follow-up debriefing strategies are also key components of the training program.

Policy:

Physical restraint shall be used with extreme caution, in emergency situations only, in accordance with all legal and regulatory requirements, and only after other less intrusive alternatives have failed or been deemed inappropriate. All TCCSC employees are limited to the use Nonviolent Physical Crisis Intervention techniques when dealing with an individual whose behaviors poses a threat of imminent, serious, physical harm to self and/or others.

Procedures:

Guidelines and Practice of Behavioral Support Management

I. Introduction

When dealing with at-risk, troubled, oppositional, acting out, maladaptive and/or defiant youth, program staff might be required to employ behavior support management techniques to foster adaptive, appropriate and pro-social behavior and assure the safety of the individual youth, other clients and/or the staff. Such techniques start with the establishment of written guidelines, rules and expectations of appropriate and pro-social behavior. When a client's behavior is in opposition to the written rules and guidelines and places him/herself and/or others in harm's way, additional behavior management techniques may be utilized. Those behavior support management techniques range from verbal persuasion to the agency's standard use of the Crisis Prevention Institute's Non-Violent Physical Crisis Intervention physical interventions and in compliance with all legal requirements.

TCCSC's concern with the safety of its clients advocates a practice of behavioral support management that includes utilizing:

1. Information from the client's assessment and care plan (behavior support and management plan) which includes:
    a. a screening of the potential risk of harm to self or others to determine the need of BSM interventions
    b. Strategies to help client de-escalate their behavior and prevent harassing, violent, or out-of-control behavior
    c. Effectiveness of previous uses of behavioral interventions and what interventions should or should be used
    d. Medical conditions or other factors that could put the client at risk of injury
    e. Signature of client and/or caregiver agreeing to the plan
2. The Crisis Prevention Institute, Inc.'s (CPI) Nonviolent Crisis Intervention ® training program promotes a philosophy of Care, Welfare, Safety, and

Security SM for both staff and clients. The focus of the program is on verbal de-escalation techniques. Restrictive behavior management interventions such as physical restraint less restrictive interventions have been tried and failed. Which teaches the following to keep staff, clients and caregivers safe and minimizes the use of restrictive behavior management interventions:

a. Behavior support management techniques designed to foster pro-social behavior. Such techniques are utilized not exclusively for the purpose of behavioral control. Behavioral support techniques include respondent and operant conditioning, shaping, extinction, redirection and social modeling with both primary and secondary reinforcement integrated within the programming. Such techniques can be used appropriately to reduce excessive negative behavior and promote pro-social behavior and development;
b. Employ the least intrusive method possible to assure the safety of all parties concerned (i.e. the individual child, other clients and staff)
c. When possible, assure that less intrusive interventions have been offered to the child before more restrictive methods are applied;
d. When faced with the necessity of applying such interventions, protect as much as possible, the dignity and privacy of the client.

II. The Continuum of Behavior Management Techniques

Fundamentally, the continuum of behavioral support management techniques and interventions can be divided into three general categories:

1. Behavioral management interventions that foster adaptive and pro-social behavior;
2. De-escalation procedures when the child becomes agitated

3. Special treatment procedures when the client's intensity and duration is such that de-escalation techniques, including brief physical holdings, are no longer effective to bring the behavior under control.

III. Behavior Support Management Techniques Designed to Foster Pro-Social Behavior

Behavior support management techniques are therapeutic interventions utilized to foster pro-social behavior and discourage maladaptive behavior within the clients.

TCCSC employs behavior support management techniques that include:

1. Practices to maintain a safe environment and prevent the need for restrictive behavior management interventions.
2. Fully informed clients and families regarding the behavior support system at the time of admission. (i.e. level system, pre-determined consequences for certain adaptive and maladaptive behaviors)
3. Group consequences that are approached with great care and effort not to infringe on individual's appropriate care.
4. Specific procedures and interventions that are prohibited. At a minimum, the following are prohibited:
    a. Procedures that deny a nutritionally adequate diet
    b. Physically abusive punishment.
    c. Any behavior support intervention that is implemented by another client without the expressed consent of a staff member
    d. Any behavior support management intervention that is contrary to local, state and/or national licensing or accrediting bodies, should school or program be so licensed and/or accredited.
    e. Application of consequences that are not in accordance with the client's rights.
5. Regular reviews of how TCCSC practices compare with current information and research on effective practice.
    a. As members of the Crisis Prevention Institute® our certified instructors receive continuous updates on current information and

best practices in the field of crisis prevention and behavior management through the Instructor Forum, CPI's quarterly newsletter, and through the Journal of Safe Management of Disruptive and Assaultive Behavior, a professional journal published by CPI. CPI offers a variety of additional resources to Certified Instructors, including advanced training courses, on-site consultations, free access to CPI's Professional Staff Instructors through a toll-free line, and various print materials.

6. Regular reviews of policies, procedures and incident reports to determine whether:
    a. Additional resources are necessary
    b. Changes on current practice are needed

VI. De-Escalation Interventions

De-escalation techniques are specifically delineated as those interventions that are designed to de-escalate agitated behavior that, if unchecked by the staff and/or the client, may rise to the level of being a danger to self, others, destruction of property or serious disruption of the therapeutic environment. The purpose of de-escalation interventions is to reduce maladaptive and agitated behavior and replace it with pro-social behavior. The skilled practice and application of de-escalation techniques are the most effective way to prevent the use of special treatment procedure.

1. De-escalation Technique include Verbal Interventions (Extensive training on the following topics are in place):
    a. Staff members need to mentally prepare. Remain calm, become aware of what the person is saying and doing, feel respect for person not the behavior.
    b. Share your observations and listen to what is being processed.
    c. Identify what is causing the issue and/or feeling.
    d. Assist the person with developing more productive avenues to express feeling.
2. TCCSC, employs the following de-escalation interventions and elements into their behavioral support plan:

a. When appropriate, the least restrictive behavioral de-escalation interventions are used and the following protocols are delineated:
    i. Type of behavior interventions utilized,
    ii. What contextual circumstances call for what type of behavioral interventions and
    iii. The duration and methods employed in the de-escalation process.

2. Physical Holds
    a. Brief physical holds may only be utilized under the following conditions:
        i. Danger to self (i.e. attempting to or in the process of head banging, punching the wall, attempting to swallow a "sharp," scratching or carving in an attempt to cause damage, etc.).
        ii. Danger to others (i.e. attempting to or endangering others by slapping, kicking, biting, etc.).
        iii. Substantial destruction of facility/staff/others property (i.e. damaging furniture, computer equipment, etc.).
        iv. As last possible resort

3. Physical holds are never used as punishment and should not exceed:
    a. 10 minutes
        a. Prolonged physical restraint increases the risk of restraint-related death. Whenever possible, all reasonable and alternative non- restrictive interventions should be used if the duration of a physical restraint exceeds 10 minutes.

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4. Staffing
    a. Individual hold- one staffing
    b. Team hold- minimum of three staff
5. Clients who require a physical hold are monitored continuously, face-to-face and are assessed throughout the duration of the hold by staff for any harmful or psychological reactions.

VI. Risk Management and Performance Improvement (documentation)

1. All staff are trained on Non-Violent Physical Crisis Intervention and receive a detailed model of procedures to utilize following an incident that requires the use of a physical hold.
    a. All employees involved will complete a TCCSC critical incident report immediately following the event. Incident reports are filled out immediately following the de-escalation of the event. (TCCSC CRITICAL INCIDENT REPORT)
    b. Staff will report incident to program coordinator and complete the incident report form.
        i. Coordinator will report and forward incident report to the Risk Manager.
        ii. A copy of the incident report is provided to the caregiver and the original is placed in the client's file.
            a. Incident reports include the following documentation:
                1. Clinical justification for use of physical hold
                2. Name of client
                3. Staff involved
                4. Reasons for intervention
                5. Length of application and intervention
                6. Verification of continuous visual observation of client during hold
                7. Verification of de-briefing and de-escalation procedures used
        iii. All critical incident reports will be reviewed by Clinical Director and program coordinator to discuss
            a. Precipitated behavior of restraint
            b. Discussion of whether proper restraint procedures were followed
            c. Consideration of whether any follow-up is appropriate for individuals involved.

c. Program Coordinator will notify caregiver when CPI was administered.
    i. PC will contact caregiver immediately if it is determined that contact will aid in reducing adherent behavior.
    ii. In all cases, caregiver will be notified of use of CPI prior to close of business day.

d. Staff documents the use of Non-violent Crisis Intervention in the client's chart, including:
    1. Clinical justification for use of physical hold
    2. Name of client
    3. Staff involved
    4. Reasons for intervention
    5. Length of application and intervention
    6. Verification of continuous visual observation of client during hold
    7. Verification of de-briefing and de-escalation procedures used

VII. Informed Consent

1. Parents/guardians and clients are informed, at the time of admission regarding behavior management interventions including physical holding and special treatment procedures. (TCCSC'S BSM PAMPHLET)
    a. Upon admission, the family and client are informed about the general conditions under which behavior management techniques are utilized, including physical holdings, seclusion and/or restraint. A written consent is obtained for the parent/guardian, and if applicable, by the client for the use of these interventions.
    b. As part of the admission process, the staff presents the parent/guardian with a written, general explanation of behavior management policies and procedures, including the use of physical holdings, seclusion and/or restraint.

c. Parent/Guardian signature(s) are obtained for the use of those interventions. Clients are equally informed about these interventions and are encouraged to sign the consent form. They may refuse to sign the form but parental/guardian written consent will permit the application of those interventions.

VIII. Staff Training and Competence

1. All staff are trained and competent in the use of Non-violent physical crisis intervention.
    a. All staff must go through the 8 hour initial competency based training course and receive a 3 hour refresher course every 2 years and/or as needed. Both include pre/post test observed in practice to ensure competency. Training covers all permitted interventions, including:
        i. When it is appropriate to use restrictive intervention
        ii. Proper and safe use of interventions, including time limits
        iii. Understanding the experience of being placed in a physical hold
        iv. Signs of distress
        v. Response techniques to prevent and reduce injury
        vi. Negative effects that can results from misuse of physical holds
    b. All clinical staff receive training on recognizing and assessing
        i. Physical and mental status of clients, includes signs of distress
        ii. Nutritional and hydration needs
        iii. Readiness to discontinue use of intervention
        iv. When medical or emergency personnel are needed
2. All staff are given copies of the Behavior Support Management policy.
3. TCCSC educates, assesses and documents the competence of staff in minimizing the appropriate use of physical holdings and/or restraint and, before they participate in any use of said interventions, are also educated and trained in their safe use.

a. In order to minimize the use of these procedures, all direct care staff as well as any other staff involved in the use of said interventions receive ongoing training in and demonstrate an understanding of the:
    i. Underlying causes of threatening behaviors exhibited by the client;
    ii. Possibility that a client may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior that may result from delirium in fever and hypoglycemia;
    iii. Behaviors that can affect the client's behavior – including staff's own behaviors.
    iv. Use of de-escalation, mediation, self-protection and other techniques, such as time-out,
    v. Signs of physical distress in individuals who are being held, restrained, or secluded.

IX. DEBRIEFING

1. The CPI COPING Model of the Nonviolent Crisis Intervention training program incorporates the following factors into the debriefing process:
    a. Evaluation of client's physical and emotional well-being
    b. Identification for the needs of counseling or other services related to the incident
    c. Identification of antecedent behaviors and modification of care plan if necessary
    d. Facilitation of the client back into routine activities

2. The CPI COPING Model has two different formats, one for staff debriefing and one for re-establishing Therapeutic Rapport with a client after he/she has acted out.
    a. Debriefing occurs with the client immediately following the incident and includes personnel involved and the program coordinator.

b. Debriefing with caregiver occurs when clients are transported home after the program or activity and includes the client and staff person involved in incident. Staff discuss the client's current physical and emotional status; the precipitating events that led to the use of a physical hold; and how the incidents was managed and any necessary changes that need to occur to mitigate future incidents

SECTION 12

RIVERSIDE COUNTY

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 12.01**
SUBJECT: RIVERSIDE COUNTY REFERRAL AND INTAKE POLICY	
APPROVED BY: Carolyn Chadwick	**EFFECTIVE DATE: April 15, 2009**
TO BE PERFORMED BY: All Clinical Staff	**REVISION DATE: March 5, 2018**
Electronic File Location:	Page **1** of **3**

PURPOSE:
To ensure referrals are disposition timely and assigned or referred to staff with appropriate competencies to provide required services.

POLICY:
TCCSC shall accept for care, treatment or services only those individuals whose service needs it can meet. Referrals are assigned based on acuity and availability of staff.

DEFINITION:
TCCSC Client – Individuals 0-21 who meet program specific requirements as indicated in the procedure section.

PROCEDURE:

1. Complete the Riverside University Health Services Behavioral Health Provider Request Referral Form
    a. If a client is in need of immediate intervention for safety reasons, the client will be assigned or referred for appropriate services.
    b. When an American Indian client is identified, therapist coordinates services with local tribal council to ensure cultural mores and legal requirements are met.

2. The referral is forwarded to the appropriate Program Coordinator who will send to Riverside County for authorization.

3. Program Coordinators determines which staff will most appropriately meet the client's needs, such as Cultural and linguistic, Age, Diagnosis, and Gender

4. The referral is given to the appropriate staff. Eligibility criteria for each is as follows:
    a. Outpatient Mental Health Services
        i. Medical Necessity - For a service to be considered medically necessary and reasonable it must meet the following criteria:
            i. Client must have a DSM V diagnosis;
            ii. Must have an impairment or impairments that result from a mental disorder or disorders;
            iii. Must receive interventions designed to address the condition and significantly diminish the impairment or prevent significant deterioration in an important area of life functioning; and
            iv. The condition would not be responsive to physical health care based treatment.

ii. In addition to the criteria listed above, persons under 21 years of age must also meet the following:
    i. Have a condition unresponsive to physical care based treatment; and,
    ii. Meet requirements of Title 22, Section 51340(e)(3)
iii. In the case of targeted case management, in addition to the above, medical necessity is met under Section 1830.205 and Section 51340(f).

5. Program Coordinator maintains a referral tracking log.
    a. Program Coordinator ensures notice is sent to clients who cannot be served or cannot be assigned within 45 days to determine continued need for services
    b. If client responds and services are still needed, client is moved to Level 1 acuity.
    c. If services are no longer desired, referral will be cancelled.

6. Program Coordinator notifies referral source and/or client when requested services are not provided by TCCSC and makes referral to appropriate provider.

7. Clients referred for Outpatient services are assigned in the following priority order:
    a. Discharged from hospital within 72 hours
    b. Imminent danger to self or others
    c. Psychotic
    d. Department of Child Protective Services clients
    e. All others

8. Therapist receives referral
    a. Confirms Medi-Cal eligibility with TCCSC's IS department
    b. Determines if an open episode and Single Fixed Point of Responsibility exist.
        i. If client has an open episode with another agency therapist contacts agency to determine if client is actively receiving services and/or coordinates transition of services.
        ii. If the IS identifies an existing SFPR, therapists completes transfer of coordinator form.

9. Therapist attempts initial contact
    a. First contact attempt to be within 48 hours of assignment of case
    b. Second attempt to be within no more than one week of assignment.
    c. If therapist is unsuccessful after two attempts, a third attempt must be made which can be either face-to-face or a written notice.
    d. If two intake appointments are missed by the client, the referral is returned to the Program Coordinator as No Outcome.

e. If client is non-responsive to all attempts after 30 days therapist returns referral to Program Coordinator
    i. Program Coordinator or designee sends intake follow-up letter to last known address notifying client that referral is closed and instructions if services are still needed.

10. Assigned therapist contacts client/caregiver to:
    a. Explain services, locations and hours of operation
    b. Inquire if client is receiving mental health services elsewhere and what type.
    c. Intended treatment plans with current agency.
    d. Explore financial arrangements.
    e. Determine linkage needs including services not provided by TCCSC
    f. Address Advances Directives and documents outcome.
    g. Schedule intake appointment.

11. Therapist opens an episode and enters diagnosis in Clinitrak within 24 hours of first face-to-face intake appointment.

12. The therapist completes intake documentation in accordance with policy.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER: 12.02**
SUBJECT: CHANGE OF PROVIDER POLICY	
APPROVED BY: Carolyn Chadwick	**EFFECTIVE DATE: March 5, 2018**
TO BE PERFORMED BY: Riverside Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

PURPOSE:

Provide a formal process for beneficiaries to request a change in program of service or rendering staff.

POLICY:
TCCSC recognizes that beneficiaries have the right to request change in program of service and/or practitioner to achieve maximum benefit from mental health services. Every effort shall be made to accommodate such requests.

DEFINITION:
1. **Provider** - Person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program.

2. **Program of Service** - A specific location and/or provider.

3. **Practitioner** - Staff who provides services to beneficiaries (i.e. psychiatrist, psychologist, nurse, psychiatric social worker, case manager, therapist, etc.).

4. **Voluntary Change of Provider:**
   a. Only changes of program of service and/or practitioner, resulting from beneficiary requests constitute voluntary changes of provider.
   b. The following occurrences do not constitute a voluntary change of provider:
      a. A beneficiary changes program of service due to staff turnover, staff reorganization, or termination of a provider contract;
      b. A beneficiary moves to a different geographic area within the County and, therefore, changes program of service and practitioner;
      c. A beneficiary changes program of service from a child to an adult provider; and
      d. A beneficiary is discharged from the system.

PROCEDURE:

1. Beneficiaries may request a program of service and/or practitioner change by completing and submitting the Request for Change of Provider form.
2. Request for Change of Provider forms are available upon request at program of service locations.
3. Beneficiaries may request assistance with completing the Request for Change of Provider form from any mental health staff.
4. Completed Request for Change of Provider forms shall be submitted to staff.
5. Clinic staff shall submit the Request for Change of Provider forms upon receipt to Program Director.
6. Program Director shall attempt to accommodate all beneficiary requests to change program of service and/or practitioner.
    a. The beneficiary is under no obligation to provide any reasons for his/her request to change program of service location or practitioner. However, in order to improve the quality of programs and understand the nature of the request, program managers shall attempt to obtain information regarding the request from the beneficiary. The program of service may be able to clarify a misunderstanding or resolve a concern at a level that is satisfactory to the beneficiary. The beneficiary may, at this time or any other, rescind the request.
    b. Frequent or repeated requests or an insufficient number of practitioners are examples of reasons why program managers may not be able to accommodate a beneficiary with a change of provider. Program Director shall document the reasons.
7. Within 10 working days of receiving a Request for Change of Provider form, Program Director shall attempt to verbally notify the beneficiary of the outcome, followed by the appropriate written confirmation.
    a. The appropriate written confirmation of notification shall be maintained in a separate administrative file and retained for 10 years.
    b. If the beneficiary is not satisfied with the outcome of the request, he/she may pursue the RUHBS beneficiary problem resolution process and file a grievance.

DIVISION: CLINICAL	**NUMBER: 12.02**
SUBJECT: CHANGE OF PROVIDER POLICY	
APPROVED BY: Carolyn Chadwick	**EFFECTIVE DATE: March 5, 2018**
TO BE PERFORMED BY: Riverside Clinical Staff	**REVISION DATE:**
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8. All submitted Request for Change of Provider forms shall be collected by the Program Director at the end of each workday and maintained in a separate administrative file.
9. Request for Change of Provider forms shall be retained by the Program Director for 10 years.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 12.03**
SUBJECT: Interpreter Services	
APPROVED BY: Sandy Chadwick	**EFFECTIVE DATE: March 5, 2018**
TO BE PERFORMED BY: Riverside Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **2**

Purpose: To ensure TCCSC is sensitive to and provides services that meet the cultural and language needs of our clients and/or caregivers.

Policy: Whenever possible and feasible, clinical staff will be assigned to provide services that reflect the culture and who speak the primary language of the client and/or caregiver. When this is not possible, staff will have ready access to interpreter services and written aids.

Definition:

1. RUHS-BH – Riverside University Health System – Behavioral Health

Procedures:

1. Whenever possible, the need for an interpreter should be determined prior to an appointment.
    a. Assessing how well a person can understand English is the first step in identifying the need for an interpreter
    b. Even when a client appears to have adequate proficiency in English, a stressful or unfamiliar situation may affect the client's ability to communicate effectively.
2. When making an appointment, staff should ask if an interpreter is needed.
    a. Engaging an interpreter is recommended if:
        i. requested by the client
        ii. the client cannot comprehend or respond to basic questions in English
        iii. the client is difficult to understand, or can only respond in a limited way
        iv. the client relies on family or friends to communicate
        v. the client prefers to speak in his/her own language
        vi. the client speaks English as a second language, and is in a stressful, complex or unfamiliar situation.
3. Staff should determine if there is a TCCSC staff person available qualified to provide these services.
    a. If so, staff will use TCCSC resources to provide interpreter services.
4. If it is determined that interpreter services are needed, and no one is available to provide those services, staff call RUHS-BH's free 24 hours a day, 7 days per week services by calling 800-706-7500.
    a. If the client cannot hear or speak well, staff will call 877-735-2929.

5. Staff will also assess whether clients/caregivers need written information in a language other than is available with TCCSC.
    a. This includes the need for large print, accessible electronic format, and other formats.
    b. If so, staff request such materials by contacting RUHS-BH at 800-706-7500.

TESSIE CLEVELAND COMMUNITY SERVICE CORPORATION
POLICY AND PROCEDURE

DIVISION: Clinical	**NUMBER: 12.04**
SUBJECT: NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)	
APPROVED BY:	**EFFECTIVE DATE: November 1, 2019**
TO BE PERFORMED BY: Riverside Clinical Staff	**REVISION DATE:**
Electronic File Location:	Page **1** of **3**

Purpose: To ensure that a Notice of Adverse Benefit Determination (NOABD) is completed each and every time there is a reduction, change, termination, or denial of services.

a. **Policy**: Staff will complete a NOABD whenever there is a reduction, change, termination or denial of services of a Medi-Cal or Drug Medi-Cal recipient and The client DOES NOT agree with the termination, denial or reduction of services client. If the client does not have Medi-Cal or Drug Medi-Cal, then you DO NOT need to complete an NOABD. If the client has met their treatment goals and is discontinuing services, no NOABD is needed.
b. If the client withdraws from services (e.g., does not return to or make contact with the clinic),

   No NOABD is needed if there is no response to a 10-day pending termination letter.
   GENERAL COMMENT – A POLICY DOES NOT HAVE NOTES. THESE SHOULD BE PART OF THE OUTLINE – LIKE a. b. c., etc.

Definition: The NOABD used to be referred to as a Notice of Action (NOA). It is a Medi-Cal/Drug Medi-Cal requirement that notifies the beneficiary in writing of Tessie Cleveland Community Services' "determination" (of what?) in response to a request form, or on behalf of, the beneficiary.

Which NOABD forms should be used:

There are 4 different types of NOABDs that may be used:

a) NOABD Denial of Authorization for Requested Services

1. Must be mailed within 2 days of the date of action and is used when
   a. The client is requesting medication but we refer them to their primary care provider instead.
   b. The Client is requesting individual therapy but we refer them to group therapy instead.

   c. Client is receiving one level of service but is terminated due to behaviors indicating they are not benefiting from that level (e.g., client is receiving services in a residential program but is terminated

due to repeated violations of the programs polices and is referred to an Intensive Outpatient Treatment (IOT) program).

d. Client is not appropriate for a specific service/level of care that requires an authorization or referral from the county to provide services (e.g., Day Treatment, Residential, TBS)
e. When the ASAM level of care (LOC) indicates a lower LOC but the client continues to insist they only want a higher level (e.g. ASAM indicates outpatient, but client demands residential) *Note: If the client initially calls requesting a higher level but after discussion is understanding they don't meet criteria for that level of service, no NOABD is necessary.
f. If referring to IEHP or other Health Plans, see #2 below.

b) NOABD Delivery System

1. Must be mailed within 2 days of the date of action and is used when:
    a. Client does not meet criteria for Specialty Mental Health Services or Substance Abuse Services through the contracted agency and is referred to an outside agency, to IEHP, or a community agency.

c) NOABD Modification of Requested Services

1. Must be mailed within 2 days of the date of action and is used when:
    a. When stepping down to a lower level of care (when benchmarks have been met) but the client is not in agreement.
    b. When the ASAM LOC indicates a higher level of care but the service is not available (e,g,. a residential bed), and a lower level of care is authorized in the interim.

**Note: Reducing services as part of the continuum of successful treatment and the client understands/agrees, no NOABD is necessary.

d) NOABD Failure to Provide Timely Access to Services

1. Must be mailed within 2 days of the date of action and is used when:
   a. An initial service cannot be provided within 24 hours (emergent), 48 hours (urgent), 14 days (psychiatric), or 10 days (routine) whether due to no appointment availability for whatever reason, clinic or program issues. Do not use if an appointment was offered within the timeframes but the client declined and requested an appointment beyond the timelines.

Procedure:

1. The decision for issuing the notice will be made by a licensed/license waivered staff using criteria identified above for each of the NOABD form.
2. The licensed/licensed waiver staff will complete the NOABD form and distribute (to whom) according to timeline provide by RUBH.