Comments on Round 2

Mental Health

Standards

#	Location	Comment	DSHS Response	Determination
1	Definition	Please add LPCs as many of our MH staff are LPCs	**This is HRSA's definition. Will leave as is. We recognize that LPC are mental health providers and so state in the Standards** **LPC are listed under Staff Qualifications**	

2	Funding of Mental Health Services that include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed DSM 5 mental illness, conducted in a group or individual setting, based on an ~~detailed~~ individualized treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, licensed professional counselors, marriage and family therapist and licensed clinical social workers	Suggested corrections in red	**This is HRSA's definition.** **DSM 5 has not been fully implemented in all areas.** **All professions are listed under Staff Qualifications**	
3	Services	Mental health counseling services includes ~~intensive~~ outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health or psychosocial Assessment	**Agree – will change**	

4		All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information ~~disclosure.~~	**Agree- will change**	
5	Agency and Staff Qualifications Mental and medical care coordination (to support mental health and medical treatment retention)	This could be a set up for failure. We cannot control whether medical care personnel coordinate treatment. Perhaps not an EXPECTED practice, but a PREFERRED practice.	**The intent is to begin coordinating with medical care personnel so that the client receives coordinated care. It is now an expected practice.**	
6	The following mental health services will be provided on-site:	Is there a provision for agencies that don't have MH professionals on staff? If these services have to be provided by a MH professional, what do agencies without the staff do? Could these be moved to the next category "…provided either on-site or through referral"?	**If an agency doesn't have MH professionals on staff, they would not be allowed to offer Mental Health Services. The agency receiving RW funding would refer to another provider. If the agency subcontracts with another provider for these services, these standards apply.**	
7	Agency and Staff Qualifications	How would these practices be different for our agency since we refer out for MH services?	**These standards do not apply if clients are referred unless the provider receives RW/State Services funding**	
8		-Psychotherapeutic services (individual, family, conjoint and group)	**Agree- will change**	

9		-Psychiatric nurse ~~-Psychotherapist~~ (this does not exist)	**Will remove**	
10	There is follow-up and documentation of referrals in the client record.	Not always possible due to time constraints	**There shouldn't be any time constraints in following up with a referral. We are obligated to know if the referral was successful or if other additional measures are needed.**	
11	Staff Education Appropriate continuing education units (CEUs) based on license requirement for each licensed mental health practitioner.	Can we be given the requirements for each type of provider?	**Each type of provider has different requirements. The agency employing the MH provider will know what the CEUs are.**	
12	Staff Supervision	A mental health or clinical supervisor must be a licensed clinical mental health practitioner. Supervisors' files reflect notes of weekly supervisory conferences. For those supervisors providing clinical supervision to those fully licensed individuals, must satisfy their respective boards to be an eligible supervisors	**Will add**	
13	Supervisors' files reflect notes of weekly supervisory conferences.	Are weekly conferences the norm? Seems pretty frequent-Could this be left up to the providers to determine?	Will delete "weekly." Agency will need to develop a policy/procedure for frequency of supervision.	

14	Interdisciplinary Case Conferencing Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months	Some clients will not need to have an Interdisciplinary CC every six months. How about "as needed". This will create an added burden when not necessarily needed.	**All clients need to be discussed.**	
15	Verification that guidance has been implemented	Counselor does not have the authority to make sure their guidance is implemented by other discipline staff.	**This is internal to your agency so we are unsure why guidance cannot be verified.**	
16	Intake and Eligibility Determination Before assistance is provided there should be written documentation in the client's file that Ryan White/State Services funding is being used as the payor of last resort.	What would this look like? Counselor note? Client affidavit? Not sure client counseling file is the best place for this.	**Copies of eligibility documents**	
17	Orientation will be provided to all clients. -Orientation includes written or verbal information on the following:	Does this just apply to the RW-funded agency or to the MH agency, if the MH agency is a subcontractor of the agency who is RW- funded?	**If the MH agency is a subcontractor, these Standards apply.**	
18	Psychosocial Assessment A psychosocial assessment will be completed no later than the third counseling session and will include the following:	There is too many REQUIRED here. The first session is usually filling out required paperwork. Second session clients can tell us their immediate issues, which we begin trying to help with.	**I would not think that completing intake documents was a counseling session….**	

19		I reviewed the Standards of Care for Mental Health, and they look very comprehensive. I like the fact that psychosocial assessment is establish by the third session instead of a time period (30 days).	**Thank you**	
20	Psychosocial Assessment -Family history -Education and employment history -STD/HIV risk assessment -Medical history, including HIV treatment and medications -Domestic violence assessment -Trauma assessment -Legal history -Leisure and recreational activities	Highlighted topics are not needed by the third session. Can be addressed, depending on presenting problem, at later sessions.	**Each of these topics should be touched upon – some in greater detail than others. An assessment form can be used to obtain this information. Also if the referring source has this information, this also can be incorporated into the psychosocial assessment when the client is asked if anything has changed.**	

21	Psychosocial Assessment	-Mental status exam (including appearance and behavior, attitude, speech, ~~talk~~,psychomotor activity, mood/affect, ~~self~~ attitude, insight, judgment, suicidal or homicidal tendencies, perceptual disturbances, -Domestic violence/IPV assessment -Trauma assessment -Social support and functioning, including client strengths/weaknesses, coping mechanisms and self-help strategies -Legal history -Leisure and recreational activities -Academic/Employment history	**Will change**	
22	-STD/HIV risk assessment	Does the MH provider need to assess this if it has been completed by the client's medical provider?	**Do not assume that another provider has obtained this information.**	
23	Psychosocial Assessment Clients are assessed for care coordination needs, and referrals are made to other case management programs as appropriate.	We aren't a case management program.	**Will remove the word "other"**	

24	Treatment Plan A treatment plan specific to individual client needs shall be completed no later than the third counseling session.	To have a workable treatment plan, with all this required information, by the third session is not realistic in many instances. Is it possible to take this on a case by case basis? We see clients who are psychotic, homeless, actively addicted. A treatment plan is a great "living, working" tool. To have it as a requirement by the third session makes it a piece of paperwork to complete, not a working document.	**We agree that the treatment plan is a living document, but there should be a plan in place by the third session. We are not saying that it has to be complete and no changes will be needed in the future.**	
25	The treatment plan will be signed by the mental health professional rendering service. Treatment plans are reviewed and modified at least every 90 days or more frequently as clinically indicated.	If the MH agency is not a RW- funded agency, but rather funded by a case management agency, does the RW-funded agency need to have a copy of this document for the client file?	**If using RW funds to provide services, these standards apply.**	
26	Psychiatric Referral There is a procedure in place to determine which clients require a psychiatric evaluation.	We rely on professional judgment. Please give an example of a procedure for determining which clients require a psychiatric evaluation.	**For consistency in your agency, write a procedure for what determines referral so that all providers are consistent.**	

27	Psychotropic Medication Management Mental health professional will discuss with the client inquiries and concerns about prescribed medications (side effects, dosage, interactions with HIV medications, etc.).	Again, this is tricky. Don't want to encourage treating outside your license. We encourage them to discuss medication concerns with their physicians or psychiatrist.	**Discussing with the client their concerns about their prescribed medications and encouraging them to discuss this with their provider is not outside the scope of a MH professional. MH providers should not make any recommendations to change psychotropic medications.**	
28	Provision of Services In emergency circumstances, an appointment will be scheduled within twenty four (24) hours.	What qualifies as an emergency?	**Your agency will need to define**	
29	Progress notes are completed according to the agency's standardized format for each session and will include: -Client name -Session date -Focus of session -Interventions -Progress on treatment goals -Newly identified issues/goals -Counselor signature and authentication	Does the RW-funded provider need to have documentation of these notes if they are not the MH provider?	**IF RW funds are used, these Standards apply**	
30	Coordination of Care Care will be coordinated across all medical care coordination team members.	We don't always get cooperation from medical care providers. This might give us all the responsibility and none of the control.	**Work with your AA if issues exist**	

31	Referrals -Pharmacist for psychotropic medication management	Refer to pharmacists???	**Yes, pharmacists are great at explaining medications, to include side effects to patients.**	
32	- Became eligible for benefits or other third-party payor (e.g., Medicaid, medical insurance, etc.)	Discharged if they get insurance? This does not seem ethical or therapeutic.	**Delete from this Standard. Will include in the Eligibility Policy.**	
33	General	These standards are written from the perspective of an agency that is receiving direct RW funding for services. That is not the situation at our agency. I'm not at all clear how our agency could meet some of these requirements. It seems to me, that the steps to make sure we would have the documentation available in our onsite client files would put an undue burden on the provider to provide this level of documentation as well as compromising the client/provider relationship to the point where a client would not be comfortable in confiding to a provider knowing copies of case note from confidential sessions are being provided to the agency. Would it be legal for the provider to give the agency access to this level of detail? I could easily see these standards causing current providers to consider terminating services to our patients and we already have a limited number of options to choose from when it comes to MH care.	**If you are contracting services with a provider and pay them with RW/State Services you are required to monitor that provider to make sure they are adhering to these standards.** **If you are referring to a provider for MH services, these Standards do not apply.**	