COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2007-02

Program Support Bureau
550 S. Vermont, 10th Floor
Los Angeles, CA 90020

December 3, 2007

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Announcements

- The **SFPR Policy** and **Client Care Coordination Plan** are being revised. It is anticipated that both will be released at the start of the new year, 2008. Instructions, Frequently Asked Questions, revised Organizational Provider's Manual and training will be provided upon their release.
- MH 646 - Caregiver's Authorization Affidavit has been revised and posted on the internet.

Revised Child/Adolescent Initial Assessment and Infancy, Childhood & Enrichment (0-5) Initial Assessment Forms

Revised Forms Available on Internet

(www.dmh.lacounty.gov—see Provider Tools, Forms, Assessment)

DMH Official Form Usage

Directly Operated: *must* use the Assessment forms, when applicable, in their original format.
Contractors: *must* use the Assessment forms, when applicable, in their original format.

The Child/Adolescent Initial Assessment and the Infancy, Childhood & Relationship Enrichment Initial Assessment (0-5) forms have been revised. Changes in these forms were necessitated by revisions being made to the Client Care/Coordination Plan as well as the need to comply with certain court orders in the Katie A. settlement agreement.

Effective as of the date of this Clinical Records Bulletin, the Child/Adolescent Initial Assessment Revised 10/07 and the Childhood & Relationship Enrichment Initial Assessment (0-5) Revised 10/07 should be used. **Please note** that the Childhood & Relationship Enrichment Initial Assessment (0-5) should only be used by staff who have completed Department training in conducting assessments for the 0-5 population which includes documentation for the Childhood & Relationship Enrichment Initial Assessment form. If training has not been completed, the Child/Adolescent Initial Assessment should be used even when assessing clients in the 0-5 age population.

Key revisions to the Child/Adolescent Initial Assessment:

- **Added prompts to ensure impairments/symptomatology are adequately documented on the Assessment.** Changes on Page 1 (Reason for Referral/Chief Complaint) and Page 9 Diagnostic Summary).

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. How do you correct a mistake made in the clinical record?

Answers on the next page

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Key Revisions to the Child/Adolescent Initial Assessment (Continued from previous page)

- **Altered "Identifying Information" section on Page 1.** Added section regarding Agency of Primary Responsibility with reference to "MH 525: Contact Information" (Available on the internet under Provider Tools, Forms, Miscellaneous). Identifying information for Biological Parents and Primary Caregiver were separated out for situations when the Biological Parents are not the Primary Caregiver. In situations where the Biological Parent is the Caregiver, the Primary Caregiver section does not need to be completed.
- **Added check boxes and space on Page 3 under Prior Mental Health History and Medical History** to document for records requested from previous/current Providers of service.
- **Inclusion of "Vocational History" section and Current Status and Aspirations on Page 5.**
- **Added Page 7–"Relevant Past Living Situation" and "Family/Child's Current Visitation & Involvement Plan and Schedule"** to allow Providers working with children who have had multiple placements to gather information regarding both placements. This page will **only** be completed if the child has had more than one Living Situation.
- **Prompts to clear up vague areas or give examples of information to be gathered** include:
  * Strengths of child and family: Athletics, clubs, affiliations, etc (Page 1- Reason for Referral)
  * Emotional Abuse (Page 2 – History of Presenting Problem, Relevant Factors)
  * Number of Attempts, Facility (Name or Type), Type of Intervention (Page 3 - Prior Mental Health History)
  * Sexual orientation, sexual behavior, gender identity (Page 4 - Developmental Milestones, Adolescence)
  * Quality of attachment (attunement, balance & congruence), Problem Solving (Page 6 - Current Living Situation, Family Relationships)
  * Client/Family Perspective, Writer's Perspective (Page 6 - Current Living Situation, Family Strengths and Family Needs).

Key revisions to the 0-5 Assessment:

- **Added prompts to ensure impairments/symptomatology are adequately noted on the Assessment.** Changes can be found on Page 1 (Reason for Referral/Chief Complaint) and Page 11 (Summary & Formulation).
- **Altered "Identifying Information" section on Page 1.**
- **Added Page 7–"Relevant Past Family Systems Review" and "Family Visitation & Involvement Plan"**
- **Clarifying "To be entered in the IS" on Page 12.** While the 0-5 population is given a diagnosis using DC 0-3R, this diagnosis must be crosswalked to a valid DSM-IV diagnosis. The IS system only recognizes DSM-IV diagnostic codes.

Any questions regarding these revised forms should be directed to Jennifer Eberle at 213-738-3770.

c: Executive Leadership Team, District Chiefs, Program Heads, Program Record Keepers, ACHSA, QIC Chairs

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. If a mistake is made in the clinical record, draw a single line through the entry and write "mistaken entry." Write the correct entry as close to the mistaken entry as possible and date and sign with your first initial, last name and title. Do not use white out or an eraser.