

PEER REVIEW ADEQUACY CHECKLIST

Client Case # _____

Corrections Needed: ___ Yes ___ No

Type of client (Adult/Child) _____

Corrections Made (date): _____

Ethnic identity _____

Signature: _____

Therapist: _____

Corrections reviewed by: _____

Reviewer: _____

Date corrections reviewed: _____

Date Reviewed: _____

Diagnosis: _____

Number of sessions: _____ (Premature voluntary termination by client considered in review)

A. General (5)

yes ___ no ___ n/a ___

-- Appropriate referral/linkages

yes ___ no ___

-- Clinician accessible to client

yes ___ no ___ n/a ___

-- Appropriate correspondence with release of Information

yes ___ no ___

-- Frequency of contact adequate

yes ___ no ___ n/a ___

-- Clinician demonstrated awareness of client's cultural and racial
identity

Appropriate referral/linkages.

Check yes when:

1. The client clearly displays a need for other services besides diagnostic assessment/counseling and is referred to the proper professionals and proper referral forms are completed.

Check no when:

1. The client clearly displays a need for other services besides counseling and is not referred to the proper professionals and/or proper referral forms are not completed.

Check n/a when:

1. The client displays no need for other services besides counseling.

Appropriate correspondence with Release of Information.

Check yes when:

1. An ROI form is completed when there is any contact with or need for collateral material from an outside source or agency.

Check no when:

1. An ROI form is not completed when there is any contact with an outside source or agency.

Check n/a when:

1. There is no contact with an outside source or agency.

Clinician demonstrated cultural sensitivity to client.

Check yes when:

1. The client **does not** file a racial or ethnic grievance that results in corrective action and potential cultural/racial information is noted on the psychosocial history.

Check no when:

1. There is evidence of a lack of sensitivity documented.
2. Inconsistencies in the information reported by the client and the therapist regarding racial, ethnicity, or cultural issues.
3. A racial or ethnic grievance is filed and substantiated resulting in corrective action.

Check n/a for:

1. Any situations not stated in the previous guidelines.

COMMENTS _____

B. Diagnostic Assessment (complete only if Diagnostic Assessment Services Provided) (22)

- | | |
|--------------------|--|
| yes__ no __ | -- All areas of psycho-social history assessed |
| yes__ no __ | -- Physical health assessment reviewed |
| yes__ no __ | -- Diagnosis appropriate and parsimonious |
| yes__ no __ | -- Appropriate tests were administered |
| yes__ no __ n/a __ | -- Testing administered per protocol for particular instrument or explanation for deviation noted. |
| yes__ no __ n/a __ | -- MMPI-II/MMPI-A |
| yes__ no __ n/a __ | -- Bender-Gestalt |
| yes__ no __ n/a __ | -- House - Tree - Person |
| yes__ no __ n/a __ | -- Draw - A - Family |
| yes__ no __ n/a __ | -- Hand Test |
| yes__ no __ n/a __ | -- WRAT |
| yes__ no __ n/a __ | -- Wechsler Memory Scale |
| yes__ no __ n/a __ | -- Adaptive Behavior Scale |
| yes__ no __ n/a __ | -- WAIS-R/WISC-III |
| yes__ no __ n/a __ | -- Other _____ |
| yes__ no __ n/a __ | -- Other _____ |
| yes__ no __ n/a __ | -- Client received appropriate testing for purpose of a formal evaluation |
| yes__ no __ n/a __ | -- Number of sessions appropriate for type of evaluation |
| yes__ no __ n/a __ | -- Written note/evaluation completed in a timely manner |
| yes__ no __ n/a __ | -- Appropriate recommendations made to referring person/agency |

yes__ no __ n/a __

-- Evaluation met the needs of the client/referring person/agency

yes__ no __ n/a __

-- Follow-up services recommended as appropriate

All areas of psych-social history assessed.

Check yes when:

1. **All blanks are completed in the Psycho-Social Intake.**

Check no when:

1. **Any blank is left incomplete in the Psycho-Social Intake.**

Diagnosis appropriate.

Check yes when:

1. **The data in the client's chart matches his or her diagnosis.**

Check no when:

1. **The data in the client's chart does not match his or her diagnosis (e.g. someone displaying daily stressors is diagnosed with major depression).**

Testing administered appropriately.

Check yes when:

1. **The four mandatory tests (HTP, Bender Gestalt, WRAT, DAF) are given and any other tests given that fit the needs of the client.**
2. **Or an explanation of why tests were not administered is noted in record.**

Check no when:

1. **Any of the four mandatory tests are not given and when a client displays a clear need to be administered any further tests and are not given those tests.**

Check n/a for:

1. **Any situations not stated in the previous guidelines.**

Client received appropriate testing for purpose of formal evaluation.

Check yes when:

1. **A client being evaluated is administered appropriate tests in accordance with their needs.**

Check no when:

1. **A client being evaluated is not administered appropriate tests or is administered tests out of accordance with their needs.**

Check n/a when:

1. **A client is not being seen for purposes of an evaluation.**

Number of sessions appropriate for type of evaluation.

Check yes when:

1. **The number of sessions is appropriate according to the intensity of the client's situation (e.g. a client with questionable mental functioning may require additional sessions).**

Check no when:

1. **The number of sessions is inappropriate according to the intensity of the client's situation.**

Check n/a when:

1. **A client is not being seen for purposes of an evaluation.**

Appropriate recommendations made to referring person/agency.

Check yes when:

1. Some type of recommendation has been made to the person or agency.

Check no when:

1. No recommendations are made to the person/agency.

Check n/a for:

1. Any situations not stated in the previous guidelines/not a formal evaluation.

Evaluation met the needs of the client/referring person/agency.

Check yes when:

1. The evaluation answered all of the referral questions.

Check no when:

1. The evaluation did not answer all of the referral questions.

Check n/a when:

1. A client is not being seen for purposes of an evaluation.

Follow-up services recommended as appropriate.

Check yes when:

1. Some kind of follow-up service is recommended or it is explained that no such service is necessary.

Check no when:

1. No follow-up service is recommended and there is no explanation of why.

Check n/a when:

1. A client is not being seen for purposes of an evaluation.

C. Counseling and Psychotherapy Services (complete only if Counseling/Psychotherapy services were provided) (34)

Appropriate ISP completed (20)

- | | |
|-------------|---|
| yes__ no __ | -- Appropriate assessment tools used prior to treatment |
| yes__ no __ | -- All Axis completed on Diagnosis |
| yes__ no __ | -- No multiple/incompatible diagnosis |
| yes__ no __ | -- No rule out diagnosis carrying for many months |
| yes__ no __ | -- Do diagnosis and treatment plan match |
| yes__ no __ | -- Diagnosis supported by clinical data |
| yes__ no __ | -- Client strengths addressed |
| yes__ no __ | -- Client needs addressed |
| yes__ no __ | -- Client abilities addressed |
| yes__ no __ | -- Client preferences addressed |
| yes__ no __ | -- Treatment goals realistic |
| yes__ no __ | -- Observable/measurable assessment of goals |

- yes__ no __ -- Resource/Responsible staff identified
- yes__ no __ -- Frequency of contact appropriate
- yes__ no __ -- Expected target date appropriate for identified goal
- yes__ no __ -- Client involved in the formation of plan
- yes__ no __ -- Plan follows progress
- yes__ no __ -- Do comments clearly reflect period's progress
- yes__ no __ n/a __ -- Identification of any mental status changes
- yes__ no __ n/a __ -- Modifications of treatment plan identified

Termination issues addressed appropriately (9)

- yes__ no __ n/a __ -- Clear summary of treatment results
- yes__ no __ n/a __ -- Changes in behavior in relation to problems noted
- yes__ no __ n/a __ -- Description of problems unresolved
- yes__ no __ n/a __ -- Reasons for closing case
- yes__ no __ n/a __ -- Termination issues addressed
- yes__ no __ n/a __ -- Linkage/referrals made
- yes__ no __ n/a __ -- Effort made to re-engage
- yes__ no __ n/a __ -- Client response to termination noted
- yes__ no __ n/a __ -- Aftercare treatment relevant to identify needs of client

Transfer issued addressed appropriately (5)

- yes__ no __ n/a __ -- Reason for transfer
- yes__ no __ n/a __ -- Transfer discussed with client
- yes__ no __ n/a __ -- Client involved in decision
- yes__ no __ n/a __ -- Client response to transfer decision
- yes__ no __ n/a __ -- Termination issues addressed (from specific clinician)

Appropriate tests and assessment tools given case information.

Check yes when:

1. Tests and assessments match the information given in the case file and given prior to initiating treatment.

Check no when:

2. Tests and assessments do not match the information given in the case file.

All Axes completed on Diagnosis.

Check yes when:

1. All five axes have some kind of explanation (even if one does not apply, none should be written).

Check no when:

1. Any of the five axes are left without some kind of explanation.

No rule out diagnosis carrying for many months.

Check yes when:

1. The rule out diagnosis does not appear on more than one treatment plan without explanation in comments for why.

Check no when:

1. The rule out diagnosis does appear on more than one treatment plan.

Do diagnosis and treatment plan match.

Check yes when:

1. The treatment plan is set up so that it will, or has in the past; treat the client's condition.

Check no when:

1. The treatment plan is not set up to treat the client's condition.

Diagnosis supported by clinical data.

Check yes when:

1. All data sets are present.

Check no when:

1. All data sets are not present.

Client strengths/needs/abilities and preferences addressed.

Check yes when:

1. At least one client strengths/needs/abilities/ and preferences have been listed in the ISP.

Check no when:

1. One or more client strengths/needs/abilities/and preferences are left blank on the ISP.

Treatment goals realistic.

Check yes when:

1. Goals can be expected to attain by the client (do not accept words like *always*, *never*, *eliminate*, *100%*, *etc.*).

Check no when:

1. Goals are too strict and cannot realistically be attained by the client.

Observable/measurable assessment of goals.

Check yes when:

1. Goals are assessed in an objective way, or a way in which another therapist could measure (not subjectively like *good*, *improved*, etc.).

Check no when:

1. Goals are assessed subjectively, or a way in which another therapist could not measure.

Resource/Responsible staff identified.

Check yes when:

1. Any staff working with or helping with the client is identified on the form.

Check no when:

1. Any staff working with or helping with the client is not identified on the form.

Frequency of contact appropriate.

Check yes when:

1. The number of sessions is compatible with the diagnosis.

Check no when:

1. The number of sessions is *incompatible* with the diagnosis.

Expected target date appropriate for identified goal.

Check yes when:

1. The target date is reasonably realistic to the goal, diagnosis, and treatment conditions and is after the start date.

Check no when:

2. The target date is not reasonably realistic to the goal, diagnosis, and treatment conditions or is not after the start date.

Client involved in the formation of plan.

Check yes when:

1. The client fills something out besides their signature or an explanation by the clinician reflecting the participation of the client in the production of the ISP.

Check no when:

2. The client does not fill something out besides their signature and no explanation by the clinician reflecting the participation of the client in the production of the ISP is absent.

Plan follows progress.

Check yes when:

1. The progress of the client has been documented in the plan.

Check no when:

1. The progress of the client has not been documented in the plan.

Do comments clearly reflect period's progress.

Check yes when:

1. The progress of the client has been described in objective terms.

Check no when:

1. The progress of the client was not described.

Identification of any mental status changes.

Check yes when:

1. Some report of mental status is documented from session to session in the case notes.

Check no when:

1. No report of mental status is documented from session to session in the case notes.

Check n/a for:

1. Any situations not stated in the previous guidelines.

Modifications of treatment plan identified.

Check yes when:

1. The treatment plan has been modified to treat what is happening now, up-to-date with the changes in the client's life and condition and an explanation of the changes in the treatment plan is provided.

Check no when:

1. The treatment plan has not been modified to treat what is happening now, out-of-date with the changes in the client's life and condition.

Check n/a for:

1. Any situations not stated in the previous guidelines.

COMMENTS _____

D. Medication/Somatic Services (complete only is medication/somatic services were provided) (38)

- | | |
|-------------|---|
| yes__ no __ | - Did client complete appropriate intake procedure (completed Diagnostic Assessment) |
| yes__ no __ | -Were services provided by an appropriate person as outlined in ODMH 5122-23-04 |
| yes__ no __ | -Was the client seen within 30 days of referral for this service |
| yes__ no __ | -Were services provided in a face-to-face fashion |
| yes__ no __ | -Did the client receive education concerning: |
| yes__ no __ | -the potential benefits of taking medication |
| yes__ no __ | -the potential side-effects of taking medication |
| yes__ no __ | -the potential risks of treatment and of refusing treatment |
| yes__ no __ | -the means for monitoring potential side-effects/aversive reactions |
| yes__ no __ | -the appropriate action if they encounter a medication crisis situation or need to discuss their medication |

Appropriate ISP completed (14)

- | | |
|-------------|--|
| yes__ no __ | -- Appropriate tests and assessment tools given case information |
| yes__ no __ | -- All Axis completed on Diagnosis |
| yes__ no __ | -- Do diagnosis and treatment plan match |
| yes__ no __ | -- Diagnosis supported by clinical data |

- yes__ no __ -- Client strengths addressed
- yes__ no __ -- Client needs addressed
- yes__ no __ -- Treatment goals realistic
- yes__ no __ -- Observable/measurable assessment of goals
- yes__ no __ -- Resource/Responsible staff identified
- yes__ no __ -- Frequency of contact appropriate
- yes__ no __ -- Expected target date appropriate for identified goal
- yes__ no __ -- Client involved in the formation of plan
- yes__ no __ -- Plan follows progress
- yes__ no __ -- Do comments clearly reflect period's progress
- yes__ no __ -- All systems addressed
- yes__ no __ n/a __ -- Description of progress since last session
- yes__ no __ n/a __ -- Identification of any mental status changes
- yes__ no __ n/a __ -- Modifications of treatment plan identified

Termination issues addressed appropriately (9)

- yes__ no __ n/a __ -- Clear summary of treatment results
- yes__ no __ n/a __ -- Changes in behavior in relation to problems noted
- yes__ no __ n/a __ -- Description of problems unresolved
- yes__ no __ n/a __ -- Reasons for closing case
- yes__ no __ n/a __ -- Termination issues addressed
- yes__ no __ n/a __ -- Linkage/referrals made
- yes__ no __ n/a __ -- Effort made to re-engage
- yes__ no __ n/a __ -- Client response to termination noted
- yes__ no __ n/a __ -- Aftercare treatment relevant to identify needs of client

Transfer issues addressed appropriately (5)

- yes__ no __ n/a __ -- Reason for transfer
- yes__ no __ n/a __ -- Transfer discussed with client
- yes__ no __ n/a __ -- Client involved in decision
- yes__ no __ n/a __ -- Client response to transfer decision
- yes__ no __ n/a __ -- Termination issues addressed (from specific clinician)
- yes__ no __ n/a __ -- Services coordinated with appropriate staff

- yes__ no __ n/a __ -Documentation of Medication changes on *Medication Summary Form*
- yes__ no __ n/a __ -Appropriate laboratory tests performed
- yes__ no __ n/a __ -Issue of self-administering medications discussed with client and decision reviewed every 90 days

Appropriate laboratory tests performed.

When administering substances that require “level” or pre-administration of labs, there should be evidence of these tests in the chart.

COMMENTS _____

E. CSP Services (complete only if CSP Services were provided) (30)

- yes__ no __ --Did client complete appropriate intake procedure (completed Diagnostic Assessment)
- yes__ no __ -- Were services provided by an appropriate person as outlined in ODMH 5122 23-04
- yes__ no __ -- Was the client seen within 10 days of referral for this service
- yes__ no __ -- Were services provided according to ISP
- yes__ no __ -- Is CSP listed in the goals
- yes__ no __ -- Are CSP goals appropriate
- yes__ no __ -- Do comments clearly reflect period’s progress
- yes__ no __ n/a __ -- Were services provided in the client’s natural environment 75% of time
- yes__ no __ n/a __ -- When transportation occurred, it was done for clinically necessary reasons
- yes__ no __ n/a __ -- Were the CSP activities driven by client need as perceived by the client
- yes__ no __ n/a __ -- Was client able to access CSP services when needed
- yes__ no __ n/a __ -- Was the client able to be linked to appropriate community resources
- yes__ no __ n/a __ --Description of progress since last session
- yes__ no __ n/a __ -- Identification of any mental status changes
- yes__ no __ n/a __ -- Modifications of treatment plan identified
- yes__ no __ -- Do diagnosis and treatment plan match

Termination issues addressed appropriately (9)

- yes__ no __ n/a__ -- Clear summary of treatment results
- yes__ no __ n/a__ -- Changes in behavior in relation to problems noted
- yes__ no __ n/a__ --Description of problems unresolved
- yes__ no __ n/a__ -- Reasons for closing case
- yes__ no __ n/a__ -- Termination issues addressed
- yes__ no __ n/a__ -- Linkage/referrals made
- yes__ no __ n/a__ -- 2 Documented efforts made to re-engage if premature termination
- yes__ no __ n/a__ -- Client response to termination noted
- yes__ no __ n/a__ -- Aftercare treatment relevant to identify needs of client

Transfer issues addressed appropriately (5)

- yes__ no __ n/a__ -- Reason for transfer
- yes__ no __ n/a__ -- Transfer discussed with client
- yes__ no __ n/a__ -- Client involved in decision
- yes__ no __ n/a__ -- Client response to transfer decision
- yes__ no __ n/a__ -- Termination issues addressed

Do comments clearly reflect period's progress.

Check yes when:

1. **Progress is clearly documented on the form and all services required are addressed.**

Check no when:

1. **One of the two or both are missing; progress documentation and services required documentation.**

Reason for transfer.

Check yes when:

1. **The reason for the transfer to CSP is documented in a case note and in the transfer form.**

Check no when:

1. **The reason for the transfer is not documented in either a case note or transfer form or both.**

Transfer discussed with client.

Check yes when:

1. **The discussion of a transfer to CSP with the client is documented in a case note and in the transfer form.**

Check no when:

1. **The discussion of a transfer with the client is not documented in a case note or transfer form or both.**

Client involved in decision.

Check yes when:

1. The client is notified of a transfer *as soon as possible*.
2. The client's involvement is documented in a case note and in the transfer form.

Check no when:

1. The client's involvement in the transfer is not documented in a case note or transfer form or both.

Client response to transfer decision.

Check yes when:

1. Some kind of client response is documented in a case note and/or transfer form.

Check no when:

1. Some kind of client response is not documented in a case note or transfer form or both.

Termination issues addressed.

Check yes when:

1. Issues involving a new therapist is discussed with the client being transferred and the discussion is documented in a case note and/or transfer form.

Check no when:

1. A discussion with the client involving issues with a new therapist is not documented in a case note or transfer form or both.

COMMENTS _____

F. Utilization review (6)

- | | |
|-------------|---|
| yes__ no __ | -- Client's admission to treatment is appropriate |
| yes__ no __ | -- Client received only services authorized by governing authority |
| yes__ no __ | -- Client received services as recommended |
| yes__ no __ | -- Client involvement consistent with customary and reasonable practice |
| yes__ no __ | -- Length of service appropriate to diagnosis |
| yes__ no __ | --Length of service consistent with agency standards |

COMMENTS _____

TOTAL # YES _____ TOTAL # POSSIBLE (YES + NO) _____

% CORRECT (# YES/TOTAL # POSSIBLE) _____

ADDITIONAL COMMENTS _____