**County of San Diego Mental Health Services**

**MCRT ASSESSMENT**

**Client Name:       Case #:**       **Assessment Date:**

**Program:       \*SubUnit:**

Type of Contact: [ ]  Telephone [ ]  Face-to-Face [ ]  Unable to Contact [ ]  Telehealth

 [ ]  Refused MCRT Services

Insurance? [ ]  No [ ]  Yes [ ]  Unknown

(If Yes, check all that apply)

 [ ]  Medi-Cal

 [ ]  Medicare

 [ ]  Private Insurance/ VA/ Tricare

Does client meet criteria for continued MCRT Services: [ ]  Yes [ ]  No [ ]  Refused Services

If No or refused; explain rationale as to why client did not meet criteria (Does not meet medical necessity, does not meet level of referral, client is currently physically injured, client has a weapon, there is a current medical emergency, if there an active crime occurring, client is actively violent, and other potential reasons):

**Reason(s) for Referral (check all that apply):**

**[ ]** Suicidal Ideation [ ]  Grave Disability [ ]  Psychotic Symptoms [ ]  Abuse

[ ]  Other

If other, explain:

Referral Party Name:       Relationship to Client:

Referral Phone:

**Referral Party Type:**

Choose an item.

**If other, specify:**

Information provided by referral party:

Is the client under 18? [ ]  Yes [ ]  No Client’s Age Today:       Date of Birth:

If client is under 18 provide name and phone of guardian/parent:

Safety Alerts (check all that apply):

[ ]  Command Hallucinations

[ ]  Hx mult hosp call Dr. Nesbit 619-692-8838

[ ]  Other

[ ]  Hx of program shopping for control substance

[ ]  Hx of near lethal suicide attempts

[ ]  Hx of Tarasoff

[ ]  Unconnected Client

[ ]  Hx of violence towards staff

 Description:

Does client have a current open mental health assignment in the EHR? **[ ]** Yes **[ ]** No  **[ ]** Unknown

If yes, include open assignments here:

Is client on Conservatorship? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does Client have Regional Center involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have CWS involvement? [ ]  Yes [ ]  No [ ]  Unable to Assess

Region service provided in: [ ]  Central [ ]  North Central [ ]  East

 [ ]  South [ ]  North Inland [ ]  North Coastal

**\*PRESENTING PROBLEM:** *(A summary of your clinical assessment. It should include: how you became involved with client, scene overview, client report, 3rd party report, justify 5150 or lack thereof. Name/age/ethnicity/gender/language spoken/living situation/circumstances for the referral/precipitating event(s)/current symptoms and behaviors (intensity, duration, onset, frequency) impairments in life functioning caused by the symptoms/brief description of current treatment/organizations, or groups involved/strengths/support):*

\*This contact is related to which of the following:

[ ]  Mental Health

[ ]  Substance Use

[ ]  Co-Occurring

Is client currently taking medications (prescribed or over the counter): [ ] Yes [ ] No [ ]  Unknown

List Medications:

Is client receiving treatment for any medical conditions: [ ] Yes [ ] No [ ]  Unknown

Describe:

Does the client have a Primary Care Physician: [ ] Yes [ ] No [ ]  Unknown

If no, has client been advised to seek primary care: [ ] Yes [ ] No

Primary Care Physician:       Phone Number:

Behavioral Health Treatment within the last 12 months *(check all boxes that apply)*:

[ ]  Outpatient [ ]  Inpatient [ ]  Residential Withdrawal Management [ ]  MCRT [ ]  ER/ED [ ]  PERT [ ]  Crisis House [ ]  CSU/ESU [ ]  WIAC/JWC [ ]  MAT Program [ ]  Outpatient SUD [ ]  Residential SUD [ ]  Hx of difficulty connecting/sustaining OP MH services [ ]  Multiple contacts with higher level of care [ ]  Other:

History of Behavioral Health Treatment (Describe relevant past psychiatric/SUD history):

Behavior toward Interview(er) and/or others present (check all that apply):

 [ ]  Culturally congruent [ ]  Cooperative [ ]  Uncooperative [ ]  Sensitive [ ]  Guarded/Suspicious [ ]  Distractable [ ]  Resistant [ ]  Confrontational

[ ]  Argumentative [ ]  Belligerent/hostile/aggressive [ ]  Silly [ ]  Demanding [ ]  Demeaning [ ]  Overly Dramatic [ ]  Excessive/inappropriate display of anger/aggression [ ]  Other

Provide details for any item addressed above:

**SCHOOL INFORMATION:**

Is client currently in school? [ ]  Yes [ ]  No [ ]  Refused/Unable to Assess

Current School:

If Other:

Current Grade Level:

Does client have an IEP or 504 Plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

Educationally Related Mental Health Services? [ ]  Yes [ ]  No [ ]  Unable to Assess

History of behavioral problems in school? [ ]  Yes [ ]  No [ ]  Unable to Assess

Does client have a history of truancy, [ ]  Yes [ ]  No [ ]  Unable to Assess

suspensions or expulsions?

History of bullying? [ ]  Yes [ ]  No [ ]  Unable to Assess

History of being bullied? [ ]  Yes [ ]  No [ ]  Unable to Assess

Victim of violence/abuse? [ ]  Yes [ ]  No [ ]  Unable to Assess

Has a preoccupation with violence? [ ]  Yes [ ]  No [ ]  Unable to Assess

Violent drawings/writings? [ ]  Yes [ ]  No [ ]  Unable to Assess

Media research on explosives, weapons,

terrorist sites, school shootings? [ ]  Yes [ ]  No [ ]  Unable to Assess

Has intended victims? [ ]  Yes [ ]  No [ ]  Unable to Assess

Stalking behavior? [ ]  Yes [ ]  No [ ]  Unable to Assess

School violence plan? [ ]  Yes [ ]  No [ ]  Unable to Assess

If any yes answers, occurring either at home or school, explain:

**SOCIAL CONCERNS**:

Peer/Social Support [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Substance use by peers [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Gang affiliations [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Family/community support system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

Religious/spirituality [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

\*Justice system [ ]  No [ ]  Yes [ ]  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Specify plan intent and ability to carry out the plan:

Previous attempts or past suicidal behaviors? [ ]  Yes [ ]  No [ ]  Unknown/Refused

Describe:

\*Has the client had suicidal ideation in the past 12 months? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Explain:

\*Are the client’s current/recent behaviors possibly creating a danger to self (things to consider: non-suicidal self-injurious behavior, method, severity, frequency, remote vs ongoing)?

[ ]  Yes [ ]  No [ ] Unknown/Refused

\*Explain:

\*Access to weapons/explosives? [ ]  Yes [ ]  No [ ] Unknown/Refused

\*Describe:

\*Current Violent/Homicidal Ideation Towards Others? [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Specify plan, intent and ability to carry out the plan:

\*Has the client had violent/homicidal ideation towards others in the past 12 months?

 [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Explain:

\*Does the client have past behavior of violence (Things to consider: toward property or animals, toward people, domestic violence, anti-social, intimidation, predatory, restraining orders?

 [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Describe:

\*Identified Victim(s)? [ ]  No [ ]  Yes \*Tarasoff Warning Indicated? [ ]  No [ ]  Yes

Reported To:       Date:

\*Were there multiple victims identified? [ ]  No [ ]  Yes

\*Victim(s) name and contact information *(Give victim information, time/date, and method of notifying the victim. Provide the Tarasoff warning details):*

\*Is the client’s Current/recent behavior possibly creating a danger to others? [ ]  Yes [ ]  No [ ]  Unknown/Refused

 \*Describe:

\*Gravely Disabled? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

*(Explain why client did or did not meet criteria. Be very specific and clear. Gravely disabled is the inability to procure and/or utilize food, clothing, and/or shelter).*

\*Describe:

\*Current Abuse or Domestic Violence: [ ]  Yes [ ]  No [ ]  Unknown/Refused

\*Describe situation:

\*Child/Adult Protective Services Notification Indicated and reported? [ ]  Yes [ ]  No

\*History of Trauma? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

 \*Describe:

Recent Substance Use? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

 Describe:

Justice System Involvement? [ ]  Yes [ ]  No [ ]  Unknown/Refused to answer

 If yes, describe recent arrests, probation, sex offender information, ect:

**OUTCOME/DISPOSITION**

Describe Factors Increasing Risk (What are the barriers to client being successful in the community, why is MCRT being utilized?):

Describe Protective Factors/Strengths: (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.):

Safety Plan/Describe Outcome, Including Plan (Details of safety plan. What criteria did the client meet? Referrals offered? Include if client refused the referrals. Tarasoff details):

Disposition Level (*Note: CSU, WIAC, STARTS are considered a lower level of care*):

 [ ]  Higher Level of Care [ ]  Lower Level of Care [ ]  Stabilized in the Field

**Higher level of care** = Jail and Inpatient Psychiatric Hospitalization

**Lower level of care** = Transports to crisis residentials (includes withdrawal management, etc.), CSU, urgent walk-in centers or MH or SUD outpatient clinics

**Stabilized in the field** = Review of protective factors & BHS resources, linkage

\*Referred to: *Check all that apply*

[ ]  ACL, 211, Other Community Support [ ]  PEI Program [ ]  PCP/FQHC [ ]  SDCPH

[ ]  Crisis Residential (MH) [ ]  Outpatient (SUD) [ ]  Residential (SUD) [ ]  TBS [ ]  Other

[ ]  ACT Program [ ]  CAPS [ ]  Case Mgmt. Program [ ]  Clubhouse

[ ]  FFS Hospital [ ]  FFS Individual Provider [ ]  Mental Health Res Treatment Facility

[ ]  OP Clinic [ ]  ADS [ ]  Hospital/ER [ ]  No Referral [ ]  Jail

[ ]  Specialty Mental Health Services [ ]  ESU [ ]  CAC [ ]  NCCIRT

[ ]  Juvenile Hall [ ]  Withdrawal Management [ ]  Other Community Services [ ] WIAC/JWC

[ ]  CSU [ ]  Regional Center Services

If Other, specify:

**CARE COORDINATION:**

Which of the following providers were contacted by the Clinician? (check all that apply):

**[ ]** Outpatient Treatment Provider [ ]  Psychiatrist [ ]  School Representative

[ ]  Probation Officer [ ]  CWS Worker [ ]  APS worker [ ]  Regional Center

[ ]  LECC/Other LE agencies [ ]  Conservator’s Office [ ]  Residential Treatment Provider [ ]  Other [ ]  Not Applicable

For any item indicated, provide documentation as to the nature of the contact or why not applicable:

**Signature of Staff Completing Assessment:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Time

Printed Name:       CCBH ID number: