**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?YesNo 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: