

UM/OUTCOME EVALUATIONS/ MEASURES

NOTE: Outcome evaluation/measure tools are obtained by contacting CASRC via email at soce@casrc.org or via phone at 858-966-7703 ext 3508. Questions regarding data collection and data entry into the DES/SOCE should also be directed to CASRC for the Children's programs. For the Adult programs outcome evaluation/measures are obtained by contacting HASRC.

MENTAL HEALTH SERVICES

2014

CHILDREN'S PROGRAMS

- WHEN:** OPTIONAL: For clients 16 years or older, within 30 calendar days of opening the client's assignment according to age (see "On Whom"). When client has been in the System of Care, the evaluation form should be requested from the prior provider. If the evaluation is not received prior to the thirty days, a new evaluation shall be completed.
- ON WHOM:** All clients age 16 years or older, including those already in the Children's Mental Health System of Care. The evaluation form must be updated at age 17, 17 1/2, 18 and yearly thereafter until client is discharged from Children's Mental Health System of Care.
- COMPLETED BY:** Client shall complete the evaluation, and when needed staff may assist the client in completing the form.
- MODE OF COMPLETION:** Youth Transition Self-Evaluation form (MHS-624) and filed in the hybrid chart.
- REQUIRED ELEMENTS:** Complete all prompts. The following five life domains are rated by circling a 1 to 5 or non applicable scale:
Health / Mental Health,
Social Skills,
Daily Living Skills,
Financial, and
Educational /Vocational.
Staff must address any item/s that result in a score of less than 3 by a written comment in the "Action" section of the form.
- NOTE:** The Youth Transition Self-Evaluation form may be imported from previous assignments or other providers.

Please read each of the following LIFE DOMAIN statements and circle the answer that sounds the most like you:

HEALTH/MENTAL HEALTH	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to keep my mental health services, or get them going again.	1	2	3	4	5	N/A
2. I know how to get a copy of my file if I need one.	1	2	3	4	5	N/A
3. I know what problems I have and how to get the help I need.	1	2	3	4	5	N/A
4. I know how to find a therapist or doctor and how to make an appointment.	1	2	3	4	5	N/A
5. I know the names of the medicines I take.	1	2	3	4	5	N/A
6. I know and can say why I take the medicines.	1	2	3	4	5	N/A
7. I know how to get more of my medicine so I don't run out.	1	2	3	4	5	N/A
8. I know how to get help if I have a problem with drugs or alcohol.	1	2	3	4	5	N/A
9. I know what taking illegal drugs, alcohol or smoking can do to my body.	1	2	3	4	5	N/A
10. I can explain the side effects my medicines can cause.	1	2	3	4	5	N/A
11. I show appropriate self-control.	1	2	3	4	5	N/A
12. I know some things I can do to deal with stress.	1	2	3	4	5	N/A
13. I know how I can prevent pregnancy & sexually transmitted diseases.	1	2	3	4	5	N/A
ACTIONS/COMMENTS: _____						

SOCIAL SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. During my free time, I find something to do that doesn't get me into trouble.	1	2	3	4	5	N/A
2. I have positive free time activities that I enjoy.	1	2	3	4	5	N/A
3. I am involved in group activity (sports, youth group, etc.).	1	2	3	4	5	N/A
4. I can explain how I am feeling.	1	2	3	4	5	N/A
5. I can handle things that make me mad without yelling, hitting, or breaking things.	1	2	3	4	5	N/A
6. I talk over problems with friends/family.	1	2	3	4	5	N/A
7. I am willing to have my family or friends help me.	1	2	3	4	5	N/A
8. I have friends my own age.	1	2	3	4	5	N/A
9. I know how to be polite to others.	1	2	3	4	5	N/A
10. I am able to introduce myself to new people.	1	2	3	4	5	N/A
11. I know how to be a good listener, and ask questions when I need to understand better.	1	2	3	4	5	N/A
12. I know some ways I could help others who live near me.	1	2	3	4	5	N/A
13. I can explain my own cultural background.	1	2	3	4	5	N/A
ACTIONS/COMMENTS: _____						

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DAILY LIVING SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know who to call if there is an emergency.	1	2	3	4	5	N/A
2. I keep my teeth and body clean.	1	2	3	4	5	N/A
3. I know how to do my own laundry.	1	2	3	4	5	N/A
4. I keep my room clean.	1	2	3	4	5	N/A
5. I know how to buy things at the grocery store.	1	2	3	4	5	N/A
6. I know how to cook my own meals.	1	2	3	4	5	N/A
7. I know what foods I should eat to keep me healthy.	1	2	3	4	5	N/A
8. I know how to get a driver's license or California I.D.	1	2	3	4	5	N/A
9. I know how to use buses or other public transportation.	1	2	3	4	5	N/A
10. I can give somebody directions to where I live.	1	2	3	4	5	N/A
11. I can take care of myself if I am sick or get hurt, and I know where to get help.	1	2	3	4	5	N/A
12. I know how to get something fixed at home if it is broken.	1	2	3	4	5	N/A
13. I know what could be unsafe in my home and how to fix it.	1	2	3	4	5	N/A
14. I know how to find a place to live.	1	2	3	4	5	N/A
ACTIONS/COMMENTS: _____						

FINANCIAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to manage my money so I can always pay my bills.	1	2	3	4	5	N/A
2. I know how to write a check, use a credit card or a debit card, and I know how to pay by cash and get the right change back.	1	2	3	4	5	N/A
3. I know how to decide what to buy first if I want several things and don't have enough money for everything.	1	2	3	4	5	N/A
4. I can explain the good & bad points of buying on credit.	1	2	3	4	5	N/A
ACTIONS/COMMENTS: _____						

EDUCATIONAL/VOCATIONAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know what helps me learn new things.	1	2	3	4	5	N/A
2. I know what I like to do.	1	2	3	4	5	N/A
3. I know what I am good at doing.	1	2	3	4	5	N/A
4. I know what my educational goals are.	1	2	3	4	5	N/A
5. I know how to meet my educational goals.	1	2	3	4	5	N/A
6. I know what kind of job or career I would like to have.	1	2	3	4	5	N/A
7. I can explain the education and/or training needed for my career options.	1	2	3	4	5	N/A
8. I can find out what kinds of activities/classes an organization offers.	1	2	3	4	5	N/A
9. I know coming to work on time every day is very important, and I can do it.	1	2	3	4	5	N/A
10. I get my work done on time.	1	2	3	4	5	N/A
11. I follow directions from my supervisor/teacher.	1	2	3	4	5	N/A
ACTIONS/COMMENTS: _____						

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

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YOUTH TRANSITION SELF-EVALUATION

Por favor lea cada una de las siguientes afirmaciones sobre los diferentes ASPECTOS DE LA VIDA y marque con un círculo la respuesta que le parezca más cercana a lo que usted sabe o hace:

SALUD FÍSICA / MENTAL	No, no sé	Sé un poco			Sí, sí sé	N/A
1. Sé cómo conservar mis servicios de salud mental o cómo reactivarlos.	1	2	3	4	5	N/A
2. Sé cómo obtener una copia de mi expediente si lo necesito.	1	2	3	4	5	N/A
3. Sé los problemas que tengo y cómo conseguir la ayuda que necesito.	1	2	3	4	5	N/A
4. Sé cómo buscar a un terapeuta o a un médico y sé como hacer una cita con él o con ella.	1	2	3	4	5	N/A
5. Sé los nombres de los medicamentos que tomo.	1	2	3	4	5	N/A
6. Sé y puedo decir porqué tomo los medicamentos.	1	2	3	4	5	N/A
7. Sé cómo volver a surtir mis medicamentos para que no me falten.	1	2	3	4	5	N/A
8. Sé cómo obtener ayuda si tengo problemas de alcohol o de drogas.	1	2	3	4	5	N/A
9. Sé lo que le puede pasarle a mi cuerpo si fumo, consumo alcohol y/o drogas controladas.	1	2	3	4	5	N/A
10. Puedo explicar los efectos secundarios de los medicamentos que tomo.	1	2	3	4	5	N/A
11. Demuestro tener el autocontrol adecuado.	1	2	3	4	5	N/A
12. Sé de algunas cosas que puedo hacer para manejar el estrés /la tensión.	1	2	3	4	5	N/A
13. Sé cómo puedo prevenir el embarazo y las enfermedades de transmisión sexual.	1	2	3	4	5	N/A
ACCIONES/COMENTARIOS: _____						

CAPACIDAD PARA INTERACTUAR CON LOS DEMÁS	No, no sé	Sé un poco			Sí, sí sé	N/A
1. En mi tiempo libre busco hacer cosas que no me metan en problemas.	1	2	3	4	5	N/A
2. En mi tiempo libre realizo actividades positivas que disfruto.	1	2	3	4	5	N/A
3. Formo parte de actividades en grupo (deportes, grupos juveniles, etc.)	1	2	3	4	5	N/A
4. Puedo explicar cómo me siento.	1	2	3	4	5	N/A
5. Puedo manejar situaciones que me enojan, sin necesidad de gritar, pegar o romper cosas.	1	2	3	4	5	N/A
6. Hablo de los problemas con mi familia y mis amigos.	1	2	3	4	5	N/A
7. Estoy dispuesto(a) a que mi familia o mis amigos me ayuden.	1	2	3	4	5	N/A
8. Tengo amigos de mi misma edad.	1	2	3	4	5	N/A
9. Sé comportarme educadamente con los demás.	1	2	3	4	5	N/A
10. Soy capaz de presentarme yo solo a personas que no conozco.	1	2	3	4	5	N/A
11. Sé cómo escuchar y sé hacer preguntas cuando quiero entender mejor algo.	1	2	3	4	5	N/A
12. Sé cómo ayudar a las otras personas que viven cerca de mí.	1	2	3	4	5	N/A
13. Puedo explicar mi formación cultural.	1	2	3	4	5	N/A
ACCIONES/COMENTARIOS: _____						

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CAPACIDAD PARA SOBREVIVIR	No, no sé	Sé un poco			Sí, sí sé	N/A
1. Sé a quién llamar en caso de una emergencia.	1	2	3	4	5	N/A
2. Mantengo mi cuerpo y mis dientes limpios.	1	2	3	4	5	N/A
3. Sé cómo lavar mi ropa.	1	2	3	4	5	N/A
4. Mantengo limpio mi cuarto.	1	2	3	4	5	N/A
5. Sé cómo comprar cosas en la tienda de comestibles.	1	2	3	4	5	N/A
6. Sé cómo preparar mis comidas.	1	2	3	4	5	N/A
7. Sé los alimentos que debo consumir para mantenerme sano(a).	1	2	3	4	5	N/A
8. Sé cómo sacar una licencia para conducir o una credencial de identificación de California.	1	2	3	4	5	N/A
9. Sé cómo transportarme en autobuses y en otro tipo de transporte público.	1	2	3	4	5	N/A
10. Puedo dar instrucciones sobre cómo llegar al lugar en donde vivo.	1	2	3	4	5	N/A
11. Puedo cuidarme a mi mismo(a) si estoy enfermo(a), y sé dónde conseguir ayuda.	1	2	3	4	5	N/A
12. Sé cómo componer algo en casa si está descompuesto.	1	2	3	4	5	N/A
13. Sé lo que puede ser peligroso en la casa y cómo eliminar el peligro.	1	2	3	4	5	N/A
14. Sé cómo buscar vivienda.	1	2	3	4	5	N/A
ACCIONES/COMENTARIOS: _____						

FINANZAS	No, no sé	Sé un poco			Sí, sí sé	N/A
1. Sé cómo manejar mi dinero para poder pagar siempre mis cuentas.	1	2	3	4	5	N/A
2. Sé cómo escribir un cheque, usar tarjeta de crédito o de débito, y sé cómo pagar en efectivo y recibir el cambio correcto.	1	2	3	4	5	N/A
3. Sé decidir que debo comprar primero cuando hay varias cosas que deseo y no suficiente dinero para todas.	1	2	3	4	5	N/A
4. Puedo explicar lo bueno y lo malo de comprar a crédito.	1	2	3	4	5	N/A
ACCIONES/COMENTARIOS: _____						

EDUCACIÓN / PROFESIÓN	No, no sé	Sé un poco			Sí, sí sé	N/A
1. Sé qué es lo que me ayuda a aprender cosas nuevas.	1	2	3	4	5	N/A
2. Sé lo que me gusta hacer.	1	2	3	4	5	N/A
3. Sé para lo que soy bueno.	1	2	3	4	5	N/A
4. Sé cuáles son mis metas de educación.	1	2	3	4	5	N/A
5. Sé cómo alcanzar mis metas de educación.	1	2	3	4	5	N/A
6. Sé el tipo de trabajo o de carrera que deseo tener.	1	2	3	4	5	N/A
7. Puedo explicar la educación y/o el entrenamiento que se necesita para las carreras que deseo seguir.	1	2	3	4	5	N/A
8. Puedo averiguar que tipo de actividades o de clases ofrece una organización.	1	2	3	4	5	N/A
9. Sé que llegar a tiempo al trabajo es muy importante, y yo puedo hacerlo.	1	2	3	4	5	N/A
10. Termino mi trabajo a tiempo.	1	2	3	4	5	N/A
11. Sigo las instrucciones de mi supervisor / profesor.	1	2	3	4	5	N/A
ACCIONES/COMENTARIOS: _____						

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YOUTH TRANSITION SELF-EVALUATION

Xin caùc baïn vui loøng ñoïc caùc khung döôùi ñây vaø khoanh troøn caâu naøo dieãn taù ñuùng nhaát con ngôôøi cuõa baïn

SÖÜC KHOEÛ/SÖÜC KHOEÛ TAÂM THAÀN Chaéc chaén N/A	Khoàng , Khoàng chuùt naøo				Vaâng, Phaàn naøo	
	1	2	3	4	5	N/A
1. Toái bieát giöõ nhöõng dòch vuï taâm thaàn, hoaëc tieáp tuïc trôu laïi nhaän nhöõng dòch vuï naøy.	1	2	3	4	5	N/A
2. Toái bieát caùchlaáy baùn sao cuõa hoà sô toái neáu toái caàn.	1	2	3	4	5	N/A
3. Toái bieát toái bò ñau gì vaø tìm ñoïc söi giuùp ñôõ khi caàn.	1	2	3	4	5	N/A
4. Toái bieát tìm chuyeân vieân trò lieäu hoaëc baùc só vaø bieát saép xeáp buoái heïn.	1	2	3	4	5	N/A
5. Toái bieát teân nhöõng thöu thuoác toái uoáng.	1	2	3	4	5	N/A
6. Toái bieát vaø toái coù theå noùi taïi sao toái uoáng thuoác.	1	2	3	4	5	N/A
7. Toái bieát caùch coù theå thuoác uoáng ñeå khoûi bò heát thuoác.	1	2	3	4	5	N/A
8. Toái bieát tìm söi giuùp ñôõ neáu toái nghieän caàn sa hay nghieän röõu.	1	2	3	4	5	N/A
9. Toái bieát vieäc gì seõ xaây ra cho theå xaùc toái khi toái duøng nhöõng loaïi ma tuøy baát hôïp phaùp, khi uoáng röõu hoaëc huùt thuoác laù.	1	2	3	4	5	N/A
10. Toái coù theå giaûi thích phaûn öùng phuï do thuoác toái uoáng.	1	2	3	4	5	N/A
11. Toái coù thaùi ñoä töï chuù ñuùng luùc.	1	2	3	4	5	N/A
12. Toái bieát moät soá ñieàu toái coù theå laøm ñeå giaûi quyeaát söi caêng thaúng.	1	2	3	4	5	N/A
13. Toái bieát caùch ngaên ngôøa thuï thai vaø caùc beäähnh truyeàn nhieãm tình duïc.	1	2	3	4	5	N/A
BIEÁN PHAÛP/NHAÀN XEÛT: _____						

Vaâng KYÕ NAËNG GIAO TEÁ chaén N/A	Khoàng, Khoàng chuùt naøo				Phaàn naøo		Chaéc
	1	2	3	4	5		
1. Trong luùc roäi raõnh, toái tìm vieäc ñeå laøm ñeå khoûi sa vaøo nhöõng baát traéc.	1	2	3	4	5	N/A	
2. Toái coù thì giøø raõng rang ñeå tham gia nhöõng sinh hoaït maø toái thích.	1	2	3	4	5	N/A	
3. Toái coù tham gia sinh hoaït nhòum (theå thao, nhòum treù, vaân vaân...).	1	2	3	4	5	N/A	
4. Toái coù theå giaûi thích caûm nhaän cuõa toái.	1	2	3	4	5	N/A	
5. Toái coù theå giaûi quyeaát nhöõng vieäc khieán toái töüc giaän maø khoâng phaûi la heùt, ñaùng ñaám, hay ñaáp beå ñoä ñaïc.	1	2	3	4	5	N/A	
6. Toái thaùo luaän nhöõng vaán ñeå khoâng oån vôi baïn be/ø gia ñình toái.	1	2	3	4	5	N/A	
7. Toái saùn saøng ñeå gia ñình vaø baïn beø giuùp toái.	1	2	3	4	5	N/A	
8. Toái coù nhöõng ngôôøi baïn cuøng tuoái.	1	2	3	4	5	N/A	
9. Toái bieát cõ xöù leä ñoä vôi moïi ngôôøi.	1	2	3	4	5	N/A	
10. Toái coù theå giöuù thieäu chính toái vôi nhöõng ngôôøi	1	2	3	4	5	N/A	

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môi quen.						
11. Tôi biết làm một người chăm chú nghe, và nhớ các câu hỏi khi tôi muốn hiểu rõ hơn.	1	2	3	4	5	N/A
12. Tôi biết một vài cách để giúp những người khác sáng tạo hơn.	1	2	3	4	5	N/A
13. Tôi có thể giúp người khác nâng cao cuộc sống.	1	2	3	4	5	N/A
BIỂU PHẠM/NHẬN XÉT: _____						

KỸ NĂNG SỐNG MÃNG NGƯỜI Chắc chắn N/A	Không, Khoảng chút nào					Vâng, Hoàn toàn
		1	2	3	4	5
1. Tôi biết gọi ai khi cần giúp đỡ.	1	2	3	4	5	N/A
2. Tôi giỏi sắp xếp và quản lý thời gian.	1	2	3	4	5	N/A
3. Tôi biết cách tổ chức quán ăn.	1	2	3	4	5	N/A
4. Tôi giỏi phỏng vấn sắp xếp.	1	2	3	4	5	N/A
5. Tôi biết mua sắm ở tiệm tạp hóa.	1	2	3	4	5	N/A
6. Tôi biết tìm kiếm các bữa ăn cho tôi.	1	2	3	4	5	N/A
7. Tôi biết phải ăn thức ăn nào để khỏe mạnh.	1	2	3	4	5	N/A
8. Tôi biết cách lái xe hay thuê chèo mình ra ngoài Cali.	1	2	3	4	5	N/A
9. Tôi biết dùng xe buýt hay phương tiện giao thông công cộng khác.	1	2	3	4	5	N/A
10. Tôi có thể chờ đợi cho người ta nhận lời tôi có người.	1	2	3	4	5	N/A
11. Tôi có thể tổ chức sự kiện khi tôi buồn hay bỏ lỡ, và tôi biết nên làm gì để tìm sự giúp đỡ.	1	2	3	4	5	N/A
12. Tôi có thể sống chung với những thú cưng như chó khi nó bỏ nhà, gây ồn.	1	2	3	4	5	N/A
13. Tôi biết những việc nào an toàn ở nhà và biết cách sửa chữa.	1	2	3	4	5	N/A
14. Tôi có thể tìm một nơi để ở.	1	2	3	4	5	N/A
BIỂU PHẠM/NHẬN XÉT: _____						

TÀI CHÁNH Chắc chắn N/A	Không, Khoảng chút nào					Vâng, Hoàn toàn
		1	2	3	4	5
1. Tôi biết cách sử dụng tiền bạc nên tôi có thể trả tiền các hóa đơn.	1	2	3	4	5	N/A
2. Tôi biết cách viết 1 cái check, dùng tiền tín dụng hay tiền mặt, và tôi biết cách trả bằng tiền mặt và lấy tiền số tiền thừa lại.	1	2	3	4	5	N/A
3. Tôi biết quyết định mua cái gì trước trong số những thứ tôi cần và tôi biết tôi không nên mua cái gì.	1	2	3	4	5	N/A
4. Tôi có thể giúp người khác làm việc và bắt lỗi khi mua đồ.	1	2	3	4	5	N/A
BIỂU PHẠM/NHẬN XÉT: _____						

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YOUTH TRANSITION SELF-EVALUATION

HOÏC VAÁN/ naøo	NGHEÀ Chaéc chaén	NGHIEÄP N/A	Khoâng Khoâng chuùt naøo				Vaâng, Phaàn	
1.	Toâi bieát nhöõng gì giuùp toâi hoïc hoûi ñieàu môûi.		1	2	3	4	5	N/A
2.	Toâi bieát toâi thích laøm gì.		1	2	3	4	5	N/A
3.	Toâi bieát toâi gioûi laøm vieäc gì.		1	2	3	4	5	N/A
4.	Toâi bieát muïc ñích cuûa vieäc hoïc vaán.		1	2	3	4	5	N/A
5.	Toâi bieát caùch ñaït ñöôïc muïc ñích hoïc vaán cuûa toâi.		1	2	3	4	5	N/A
6.	Toâi bieát toâi thích ngheà gì, vieäc gì maø toâi muoán laøm.		1	2	3	4	5	N/A
7.	Toâi coù theå giaûi thích hoïc vaán vaø huaán luyeän caàn phaûi coù ñeå cho toâi chöïn löa ngheà nghieäp.		1	2	3	4	5	N/A
8.	Toâi coù theå tìm ra caùc lôùp vaø sinh hoaït maø caùc hoâi ñoaøn cung caáp.		1	2	3	4	5	N/A
9.	Toâi bieát ñi laøm vieäc ñuùng gioø moãi ngaøy raát quan troïng, vaø toâi coù theå laøm ñöôïc.		1	2	3	4	5	N/A
10.	Toâi xong coâng vieäc ñuùng gioø.		1	2	3	4	5	N/A
11.	Toâi laøm theo lôøi chæ daãn cuûa giaùm ñoác / thaøy coâ giaùo cuûa toâi.		1	2	3	4	5	N/A
BIEÁN PHAÛP/NHAÂN XEÛT: _____								

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

County of San Diego - CMHS

Client: _____

InSyst #: _____

Program: _____

YOUTH TRANSITION SELF-EVALUATION

يرجى أن تقوم بقراءة كافة البيانات الحياتية الواردة أدناه و قم بتحديد الإجابة التي تنطبق عليك:

الصحة البدنية/الصحة النفسية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف كيف يمكنني الحفاظ على خدمات الصحة النفسية التي أستحصل عليها، أو كيفية إستعادتها مرة أخرى.	1	2	3	4	5
2. أعرف كيف يمكنني الحصول على نسخة من ملفي إن إحتجت إلى ذلك.	1	2	3	4	5
3. أعرف المشاكل التي أعاني منها، و أعرف كيف يمكنني أن أحصل على المساعدة.	1	2	3	4	5
4. أعرف كيف يمكنني أن أجد طبيباً أو معالجاً و كيف يمكنني أن أطلب موعداً.	1	2	3	4	5
5. أعرف أسماء الأدوية و العقاقير التي أتناولها.	1	2	3	4	5
6. أعرف و أستطيع أن أقول الأسباب التي تدفعني لتناول الأدوية و العقاقير.	1	2	3	4	5
7. أعرف كيف يمكنني الحصول على المزيد من الدواء أو العقار كي لا ينفذ.	1	2	3	4	5
8. أعرف كيف يمكنني الحصول على المساعدة إن كانت لدي مشاكل في تناول الكحول أو المخدرات.	1	2	3	4	5
9. أعرف تأثير تناول المخدرات أو الكحول أو التدخين على جسدي.	1	2	3	4	5
10. أعرف كيف أشرح الأعراض الجانبية للعقاقير و الأدوية التي أتناولها.	1	2	3	4	5
11. يظهر علي تحكم جيد بالنفس.	1	2	3	4	5
12. أعرف بعض الطرق التي تساعدني على التغلب على الضغط النفسي.	1	2	3	4	5
13. أعرف كيف يمكنني أن أتجنب الحمل أو الإصابة بالأمراض المنتقلة عن طريق الجنس.	1	2	3	4	5
الإجراءات و التعليقات:					

القدرة الإجتماعية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. خلال وقت فراغي، أجد شيئاً أقوم به لا يسبب لي المشاكل.	1	2	3	4	5
2. لدي نشاطات إيجابية في وقت فراغي أستمتع بالقيام بها.	1	2	3	4	5
3. أشارك بالفعاليات و الأنشطة الجماعية (الرياضة، المجموعات الشبابية، الخ).	1	2	3	4	5
4. أستطيع أن أشرح أحاسيسي.	1	2	3	4	5
5. أستطيع أن أتعامل مع الأمور التي تغضبني من دون صراخ أو ضرب أو تكسير.	1	2	3	4	5
6. أتحدث عن مشاكلي مع عائلتي و أصدقائي.	1	2	3	4	5
7. أرغب بأن يقوم كل من عائلتي و أصدقائي بمساعدتي.	1	2	3	4	5
8. لدي أصدقاء من نفس عمري.	1	2	3	4	5
9. أعرف كيف أكون مؤدياً في التعامل مع الآخرين.	1	2	3	4	5
10. أستطيع أن أقدم (أعرف) نفسي لأشخاص لم ألتقيهم من قبل.	1	2	3	4	5
11. أعرف كيف أكون مستمعاً جيداً، و كيف أقوم بطرح الأسئلة عندما أحتاج لفهم شيء ما بشكل أفضل.	1	2	3	4	5
12. أعرف بعض الطرق التي تجعلني أساعد بها الآخرين الذي يعيشون بقربي.	1	2	3	4	5
13. أستطيع أن أشرح خلفيتي الثقافية.	1	2	3	4	5
الإجراءات و التعليقات:					

County of San Diego - CMHS

Client: _____

InSyst #: _____

Program: _____

مهارات الحياة اليومية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف بمن يجب عليّ الإتصال في الحالات الطارئة.	1	2	3	4	5
2. أحافظ على نظافة أسناني و جسدي.	1	2	3	4	5
3. أعرف كيف أقوم بغسل ملابسي.	1	2	3	4	5
4. أحافظ على غرفة نومي نظيفة.	1	2	3	4	5
5. أعرف كيف أشتري الأشياء من محلات البقالة و المتاجر.	1	2	3	4	5
6. أعرف كيف أحضر طعامي.	1	2	3	4	5
7. أعرف أنواع الطعام التي يجب عليّ تناولها للحفاظ على صحتي.	1	2	3	4	5
8. أعرف كيف يمكنني الحصول على إجازة قيادة المركبات في كاليفورنيا أو على هوية إثبات الشخصية.	1	2	3	4	5
9. أعرف كيف أستخدم حافلة نقل الركاب (الباص) و وسائل النقل العامة الأخرى.	1	2	3	4	5
10. أستطيع أن أدل شخص آخر على محل سكني.	1	2	3	4	5
11. أستطيع أن أعني بنفسني إن كنت مريضاً أو مصاباً كما و أعرف أين يمكنني الحصول على المساعدة.	1	2	3	4	5
12. أعرف كيف يمكنني إصلاح الأشياء في المنزل إن تعطلت.	1	2	3	4	5
13. أعرف ما هي الأشياء التي قد تكون خطيرة في المنزل و أعرف كيف أقوم بتجنب خطرها.	1	2	3	4	5
14. أعرف كيف يمكنني أن أجد مكان لأسكن فيه.	1	2	3	4	5
الإجراءات و التعليقات:					

الشؤون المالية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف كيف أدير أموالي و أستطيع أن أقوم بدفع فواتيري بإستمرار و إنتظام.	1	2	3	4	5
2. أعرف كيف أقوم بكتابة صك (شيك) و أعرف كيف أستعمل بطاقات الإئتمان و البطاقات المصرفية، كما إنني أعرف كيف أقوم بالدفع نقداً و الحصول على باقي الحساب بشكل مضبوط.	1	2	3	4	5
3. أعرف كيف أقرر أن أشتري شيئاً ما قبل الأشياء الأخرى إن كنت أحتاج لعدة أشياء و لا أملك المال الكافي لشرائها جميعاً.	1	2	3	4	5
4. أستطيع أن أشرح إيجابيات و سلبيات إستخدام بطاقات الإئتمان.	1	2	3	4	5
الإجراءات و التعليقات:					

التعليم و التدريب المهني	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف مالذي يمكن أن يساعدني على تعلم أشياء جديدة.	1	2	3	4	5
2. أعرف مالذي أحب القيام به.	1	2	3	4	5
3. أعرف الأشياء التي أجد القيام بها.	1	2	3	4	5
4. أعرف ما هي أهدافي الدراسية.	1	2	3	4	5
5. أعرف كيف أحقق أهدافي الدراسية.	1	2	3	4	5
6. أعرف ما هي المهنة التي أرغب بالقيام بها.	1	2	3	4	5
7. أستطيع أن أشرح إحتياجات دراستي أو تدريبي المهني من أجل المهنة التي أرغب بالقيام بها.	1	2	3	4	5
8. أستطيع أن أعرف ما هي النشاطات و الدروس التي تقدمها مؤسسة ما.	1	2	3	4	5
9. أعرف أن الحضور للعمل في موعده أمر ضروري و أستطيع القيام بذلك.	1	2	3	4	5
10. إنهي واجبات عملي في موعدها.	1	2	3	4	5
11. أتبع توجيهات مديري في العمل أو مدرسي.	1	2	3	4	5
الإجراءات و التعليقات:					

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

County of San Diego - CMHS

Client: _____

InSyst #: _____

Program: _____

YOUTH TRANSITION SELF-EVALUATION

- WHEN:** Children’s Mental Health provider is unable to make a routine or successful referral to Adult Mental Health services.
- ON WHOM:** Any client turning 18 years (or older) who is assessed by a current Children’s Mental Health provider to be a candidate for Adult Mental Health services. This form is only to be completed when a direct referral to Adult Mental Health services has not been successful.
- COMPLETED BY:** Staff providing services.
- MODE OF COMPLETION:** Transitional Youth Referral Plan form (MHS-605) and filed in the hybrid chart.
- REQUIRED ELEMENTS:** This is a three part process:
Section I – completed by the referring Children’s Mental Health provider
Section II – completed by the Regional Program Coordinator/Designee
Section III – Completed by Regional Program Coordinator /Designee only when the linkage is not successful

TRANSITIONAL YOUTH REFERRAL PLAN

(SEE TRANSITIONAL AGE YOUTH REFERRAL POLICY AND PROCEDURE 01-01-114 FOR MORE DETAILS)

Section I (completed by Children’s program with attached referral packet and releases)

Staff Name: _____ Date: _____
Referring Program: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email: _____

Client’s Name: _____ Birth Date: _____
Client’s Address: _____
Phone Number: _____
Insurance Status: _____
Current Diagnosis: _____

Services currently receiving: _____
Services needed from Adult Mental Health System of Care: _____

I have attempted to refer to the following Adult Mental Health Programs unsuccessfully (include all attempts and outcome);

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____

Other Comments: _____

SECTION II (completed by RPC / designee & provided to Children's provider who initiated request)

Regional Program Coordinator's (RPC) Response:

- deny services because client does not meet medical necessity criteria
- youth 18 and over; an assessment will be requested from an adult provider agreeable to the client and family (see specifics below)
- other (see specifics below)

Program referred to: _____
 Staff Name/Contact: _____
 Phone Number: _____ Fax Number: _____

RPC / Designee's Name: _____ Date: _____
 Phone Number: _____ Fax Number: _____
 Email: _____

Date response was forwarded to referring party: _____

.....

SECTION III (Completed by RPC when the linkage is not successful. RPC shall coordinate an initial meeting with a multidisciplinary team within two weeks of the initial referral.)

Date of initial meeting: _____

Multidisciplinary Team Members Names and Signatures: _____

Transition Plan Recommendation: _____

Individual to follow up on Plan: _____
 Phone Number: _____ Fax Number: _____
 Email: _____

Date copy of completed form sent to original children's referral source: _____

Youth accepted plan: Yes No Other: _____

(when "no" an alternative shall be identified & same procedure followed)

County of San Diego Health and Human Services Agency (HHSA) Mental Health Services Policies and Procedures MHS General Administration			
Subject:	Transition Age Youth Referral	No:	01-02-212 Formerly: 01-01-114
Reference:	Mental Health (MH) Youth Transition Service Plan, July 2000	Page:	1 of 3

PURPOSE:

To support system of care practice by establishing a process for the transition of clients from County and contracted Children’s Mental Health Services (CMHS) when routine referrals have been unsuccessful.

POLICY:

Provide a collaborative process between CMHS and Adult/Older Adult Mental Health (A/OAMH) Services when routine referrals have been unsuccessful to determine an appropriate referral disposition for youth in CMHS who are attaining 18 years (or older in some cases, i.e., AB2726) and who may need continued care in the A/OAMH System of Care.

BACKGROUND:

Youth receiving mental health services in the Children’s Mental Health System of Care and who are reaching 18 years of age may require system coordination to successfully transition to the Adult System of Care. To provide integrated services; the following procedure is established when routine referrals have been unsuccessful.

PROCEDURE(S):

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the Children’s System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:
 - Referral Form/Cover Letter,
 - 650 Children’s Mental Health Assessment and most recent update,
 - Current Five Axis Diagnosis,
 - Youth Transition Evaluation,
 - Mental Status conducted by psychiatrist within the last 45 days,
 - Physical Health Information,
 - Medication Sheet,
 - Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS)Plan,
 - Psychological testing done within past year (if available),
 - Individual Education Plan and Individual Transition Plan,

Approved Date:	Approved:
1/25/10	Alfredo Aguirre’s Signature on File
	Director, Mental Health Services/Designee

County of San Diego
Health and Human Services Agency (HHSA)
Mental Health Services
Policies and Procedures

MHS General Administration

Subject: **Transition Age Youth Referral**

No: **01-02-212**

Page: **2** of **3**

- Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday), and
 - Any self evaluations recently given to youth.
2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.
 3. The MHPC will review the packet to determine medical necessity according to Title 9 and the Service Eligibility Policy for the Adult/Older Adult System of Care (to include AB2726 referrals).
 4. If the client does not meet medical necessity criteria (or AB2726 criteria), then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will be requested from an adult provider agreeable to the client and family. If the assessment indicates a Medi-Cal beneficiary doesn't meet medical necessity criteria, a Notice of Action Assessment (NOA-A) will be issued, advising him/her of his/her rights to appeal the decision.
 5. If a transition plan is agreed upon, the client's CMHS Case Manager or Care Coordinator will attempt to link the client with the targeted service.
 6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary team within **two weeks** of the initial referral that will include relevant persons that may include, but are not limited to, the following:
 - Youth,
 - Support System (parent, social worker, family members),
 - Children's Mental Health Case Manager and/or Therapist,
 - Current Psychiatrist,
 - Chief of Children's Outpatient Services (or designee),
 - MHPC
 - Adult/Older Adult Case Management Contracting Officer's Technical Representative (COTR) if applicable, or designee,
 - Probation Officer (if applicable), and
 - Educational/Vocational Specialist.
 7. Team will review services and options and create a transition plan, complete the Transition Age Youth Referral Plan form, including all signatures. The Care Coordinator will include a copy of the Transition Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified and same procedure followed.

ATTACHMENT(S):

A - [Transition Age Youth Referral Form](#)

B - [Transition Age Youth Referral Plan](#)

County of San Diego
Health and Human Services Agency (HHSA)
Mental Health Services
Policies and Procedures

MHS General Administration

Subject: **Transition Age Youth Referral**

No: **01-02-212**

Page: **3** of **3**

SUNSET DATE:

This policy will be reviewed for continuance on or before November 30, 2012.

AUTHOR/CONTACT ON 11/23/09:

Virginia West

CHILD AND ADOLESCENT MEASUREMENT SYSTEM
(CAMS) - PAPER

2014

- WHEN:** Provided to caregivers of youth aged 5 – 18+ and to youth 11 and up upon admission, at the authorization/UM cycle, and upon discharge.
- NOTE:** Questions and to obtain tools as well as direction for data entry – contact CASRC
soce@casrc.org
858-966-7703 ext 3508
- ON WHOM:** Clients opened to identified Units/SubUnits.
- COMPLETED BY:** Parent/guardian and client and enter score into DES/COSE – these scores are not entered into the EHR.
- MODE OF COMPLETION:** CAMS tools and report summaries. Raw data is entered into the DES/SOCE and summary report is generated. File tools and reports in the hybrid chart.
- REQUIRED ELEMENTS:** All elements should be completed.
- NOTE:** Medication only cases are exempt from completing CAMS.

Client ID Number

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Instructions: Think about the things you do and how you feel. Fill in the circle that best describes you.

	Never ₁	Sometimes	Often
1. I help others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have 2 or more friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I understand the consequences of my behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have an interest in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I have good relationships with adults outside my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I am confident (not easily embarrassed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I have a good relationship with my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I am able to concentrate/pay attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I am able to plan and organize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I participate in activities (sports, arts, hobbies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I take responsibility for tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I handle criticism well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Instructions: Think about your behavior over the Last Two Months. Fill in the circle that best describes you.

	No ₀	Yes ₁
1. Had contact with police	<input type="radio"/>	<input type="radio"/>
2. Used alcohol	<input type="radio"/>	<input type="radio"/>
3. Ran away	<input type="radio"/>	<input type="radio"/>
4. Used illegal drugs	<input type="radio"/>	<input type="radio"/>
5. Attempted suicide/hurt self	<input type="radio"/>	<input type="radio"/>
6. Set fires	<input type="radio"/>	<input type="radio"/>
7. Cruel to animals	<input type="radio"/>	<input type="radio"/>
8. Hurt or cut myself.	<input type="radio"/>	<input type="radio"/>

Instructions:

Think about your behavior and whether it has caused problems for you. Fill in the circle that is most like you.

How often has your behavior caused problems in each of the following areas?

	Never ₁	Sometimes ₂	Often ₃	Almost Always ₄
1. Home and family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. School	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Friendships with peers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Leisure (free time) activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. How long have you had problems?

Less than a month	1 - 3 months	4 - 6 months	7 - 12 months	13 - 17 months	18 - 24 months	More than two years
<input type="radio"/> ₁	<input type="radio"/> ₂	<input type="radio"/> ₃	<input type="radio"/> ₄	<input type="radio"/> ₅	<input type="radio"/> ₆	<input type="radio"/> ₇

Instructions: Think about your life and how you are feeling about the future. Fill in the circle that best describes you.

	Never ₁	Sometimes ₂	Often ₃
1. I am happy with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have what I need in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My life is going well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have all the support from my family or friends that I need	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I am able to accomplish the things I want to do in my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I feel good about what's going on in my life right now	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I wish my life was different than it is right now	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I am able to do the kinds of things that other kids my age can do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. There are people I can count on to help me out if I need it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I have more stress and pressure in my life than I can handle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- WHEN:** Completed by clinicians upon admission, at the authorization/UM cycle, and upon discharge. To be used by Children's programs only.
- NOTE:** Clinicians are expected to complete certification on the rating system tool prior to utilizing the tool through the website at:
<http://outcomes.fmhi.usf.edu/cfars.cfm>
- Questions – contact CASRC
soce@casrc.org
858-966-7703 ext 3508
- ON WHOM:** Clients opened to identified Units/SubUnits.
- COMPLETED BY:** Clinician.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record. Additionally, this data must be entered into the DES/SOCE.
- REQUIRED ELEMENTS:** All elements should be completed.
- For each category, a level of severity (1-9) must be marked, along with the adjectives or phrases that describe the child's symptoms or assets.
- NOTE:** Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

Client Name: _____

Case #: _____

Date: _____

*Program Name: _____

San Diego County Mental Health Services Children's Functional Assessment rating Scale-CFARS

Copyright held by University of South Florida, John C. Ward, Jr., PhD

Type of Assessment:

- Admission
- 3 Months
- 6 Months
- 9 Months
- # Of Months
- School Based
- Discharge
- Admin. Discharge

Admission Date: _____

Problem Severity Ratings

Use the scale below to rate the child/youth's current [last three weeks] of severity for each category.

A rating from 1-9 is required for each major category. Check as many symptoms as indicated under each major category.

1	2	3	4	5	6	7	8	9
No problem	Less than Slight	Slight Problem	Slight to Moderate	Moderate Problem	Moderate to Severe	Severe Problem	Severe to Extreme	Extreme Problem
*Depression				*Anxiety				
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Happy	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Anxious/Tense	<input type="checkbox"/> Calm	<input type="checkbox"/> Guilt			
<input type="checkbox"/> Sad	<input type="checkbox"/> Hopeless	<input type="checkbox"/> Lacks Energy / Interest	<input type="checkbox"/> Phobic	<input type="checkbox"/> Worried/ Fearful	<input type="checkbox"/> Anti-Anxiety Meds			
<input type="checkbox"/> Irritable	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Anti-Depression Meds	<input type="checkbox"/> Obsessive/Compulsive	<input type="checkbox"/> Panic				
*Hyper activity				*Thought Process				
<input type="checkbox"/> Manic	<input type="checkbox"/> Inattentive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Illogical	<input type="checkbox"/> Delusional	<input type="checkbox"/> Hallucinations			
<input type="checkbox"/> Sleep Deficit	<input type="checkbox"/> Overactive / Hyperactive	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Ruminative	<input type="checkbox"/> Command Hallucination			
<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Relaxed	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Derailed Thinking	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Intact			
<input type="checkbox"/> ADHD Meds	<input type="checkbox"/> Anti-Manic Meds		<input type="checkbox"/> Oriented	<input type="checkbox"/> Disoriented	<input type="checkbox"/> Anti-Psych Meds			
*Cognitive Performance				*Medical / Physical				
<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Low Self-Awareness	<input type="checkbox"/> Acute Illness	<input type="checkbox"/> Hypochondria	<input type="checkbox"/> Good Health				
<input type="checkbox"/> Poor Attention/Concentration	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> CNS Disorder	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Need Med./Dental Care				
<input type="checkbox"/> Insightful	<input type="checkbox"/> Concrete Thinking	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Poor Nutrition	<input type="checkbox"/> Enuretic/ Encopretic				
<input type="checkbox"/> Impaired Judgment	<input type="checkbox"/> Slow Processing	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stress-Related Illness				
*Traumatic Stress				*Substance Use				
<input type="checkbox"/> Acute	<input type="checkbox"/> Dreams/Nightmares	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Drug(s)	<input type="checkbox"/> Dependence				
<input type="checkbox"/> Chronic	<input type="checkbox"/> Detached	<input type="checkbox"/> Abuse	<input type="checkbox"/> Over Counter Drugs	<input type="checkbox"/> Cravings/Urges				
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Repression/Amnesia	<input type="checkbox"/> DUI	<input type="checkbox"/> Abstinent	<input type="checkbox"/> I.V. Drugs				
<input type="checkbox"/> Upsetting Memories	<input type="checkbox"/> Hyper Vigilance	<input type="checkbox"/> Recovery	<input type="checkbox"/> Interfere w/Functioning	<input type="checkbox"/> Med. Control				
*Interpersonal Relationships				*Behavior in "Home" Setting				
<input type="checkbox"/> Problems w/Friends	<input type="checkbox"/> Diff. Estab./ Maintain	<input type="checkbox"/> Disregards Rules	<input type="checkbox"/> Defies Authority					
<input type="checkbox"/> Poor Social Skills	<input type="checkbox"/> Age-Appropriate Group Participation	<input type="checkbox"/> Conflict w/Sibling or Peer	<input type="checkbox"/> Conflict w/Parent or Caregiver					
<input type="checkbox"/> Adequate Social Skills	<input type="checkbox"/> Supportive Relationships	<input type="checkbox"/> Conflict w/Relative	<input type="checkbox"/> Respectful					
<input type="checkbox"/> Overly Shy		<input type="checkbox"/> Responsible						
*ADL Functioning (Not Age Appropriate In:)				*Socio-Legal				
<input type="checkbox"/> Handicapped	<input type="checkbox"/> Communication	<input type="checkbox"/> Self Care	<input type="checkbox"/> Disregards Rules	<input type="checkbox"/> Offense/Property	<input type="checkbox"/> Offense/Person			
<input type="checkbox"/> Permanent Disability	<input type="checkbox"/> Hygiene	<input type="checkbox"/> Recreation	<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Probation/Parole	<input type="checkbox"/> Pending Charges			
<input type="checkbox"/> No Known Limitations	<input type="checkbox"/> Mobility		<input type="checkbox"/> Dishonest	<input type="checkbox"/> Use/Con Other(s)	<input type="checkbox"/> Incompetent to Proceed			
			<input type="checkbox"/> Detention/ Commitment	<input type="checkbox"/> Street Gang Member				
*Select: <input type="checkbox"/> Work <input type="checkbox"/> School				*Danger to Self				
<input type="checkbox"/> Absenteeism	<input type="checkbox"/> Poor Performance	<input type="checkbox"/> Regular	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Current Plan	<input type="checkbox"/> Recent Attempt			
<input type="checkbox"/> Dropped Out	<input type="checkbox"/> Learning disabilities	<input type="checkbox"/> Seeking	<input type="checkbox"/> Past Attempt	<input type="checkbox"/> Self-Injury	<input type="checkbox"/> Self-Mutilation			
<input type="checkbox"/> Employed	<input type="checkbox"/> Doesn't Read/Write	<input type="checkbox"/> Tardiness	<input type="checkbox"/> "Risk-Taking" Behavior	<input type="checkbox"/> Serious Self-Neglect	<input type="checkbox"/> Inability to Care for Self			
<input type="checkbox"/> Defies Authority	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Suspended						
<input type="checkbox"/> Disruptive	<input type="checkbox"/> Terminated/ Expelled	<input type="checkbox"/> Skips Class						
*Danger to Others				*Security/ Management Needs				
<input type="checkbox"/> Violent Temper	<input type="checkbox"/> Threatens Others	<input type="checkbox"/> Home w/o Supervision	<input type="checkbox"/> Suicide Watch					
<input type="checkbox"/> Causes Serious Injury	<input type="checkbox"/> Homicidal Ideation	<input type="checkbox"/> Behavioral Contract	<input type="checkbox"/> Locked Unit					
<input type="checkbox"/> Use of Weapons	<input type="checkbox"/> Homicidal Threats	<input type="checkbox"/> Protection from Others	<input type="checkbox"/> Seclusion					
<input type="checkbox"/> Assaultive	<input type="checkbox"/> Homicide Attempt	<input type="checkbox"/> Home w/Supervision	<input type="checkbox"/> Run/Escapes Risk					
<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Accused of Sexual Assault	<input type="checkbox"/> Restraint	<input type="checkbox"/> Involuntary Exam/ Commit.					
<input type="checkbox"/> Does not appear dangerous to Others	<input type="checkbox"/> Physically Aggressive	<input type="checkbox"/> Time-Out	<input type="checkbox"/> PRN Medications					
		<input type="checkbox"/> Monitored House Arrest	<input type="checkbox"/> One-to-One Supervision					

Signature of Staff Member Obtaining Information: _____

Printed Name: _____ Anasazi Staff ID: _____ Date: _____

Signature of Staff Entering Information (If different from above): _____

Printed Name: _____ Anasazi Staff ID: _____ Date: _____

EYBERG CHILD BEHAVIOR INVENTORY (ECBI) - PAPER

2014

- WHEN:** Completed for youth under the age of 5 upon admission and discharge.
- NOTE:** Questions and to obtain tools as well as direction for data entry – contact CASRC
soce@casrc.org
858-966-7703 ext 3508
- ON WHOM:** Clients opened to identified Units/SubUnits.
- COMPLETED BY:** Parent/guardian and scored by clinical staff providing service and enter score into DES/SOCE – these scores are not entered into the EHR.
- MODE OF COMPLETION:** ECBI tool. Data is entered into the DES/SOCE. File tool in the hybrid chart.
- REQUIRED ELEMENTS:** All elements should be completed.

UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION
Outpatient Treatment & Case Management Programs
Children's Programs Only

2014

WHEN:	<p>Prior to an outpatient client reaching the end of the initial 13 sessions included individual sessions or up to 18 family or group only included sessions from the date the assignment was opened at the Unit/SubUnit. Subsequently, the Utilization Management (UM) Authorization shall be completed prior to the expiration of the previous UM Authorization.</p>
ON WHOM:	<p>All outpatient and case management clients meeting above requirements who are clients receiving individual, group or family therapy. This excludes medication management, CMBR only, unplanned services such as Crisis Intervention (CI), plan development, evaluation of records, report preparation, TBS, psychological testing (for those programs approved to do testing); collateral (contact with significant others such as teachers, PO, CWS, and parent). Paraprofessional rehabilitative services (R-individual, R-group, R-family). Rehabilitative services provided by a clinician are included services.</p> <p>Clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program).</p>
COMPLETED BY:	<p>Request form may be completed by:</p> <ul style="list-style-type: none">Physician,Licensed/Waivered Psychologist,Licensed/Registered/Waivered Social Worker,Licensed/Registered/Waivered Marriage Family Therapist,Licensed Professional Clinical Counselor, orLicensed Psychiatric Technician, orRegistered Nurse.Trainee,Mental Health Rehab specialist,Rehab staff, orParaprofessional <p>The program sets co-signature requirements.</p> <p>The UM Authorization shall be approved by a licensed or waived clinician. The clinician member authorizing the sessions cannot be the same as the staff who submitted the UM form.</p>
MODE OF COMPLETION:	<p>Legibly handwritten, typed, or word-processed on Utilization Management Authorization form.</p>
REQUIRED ELEMENTS:	<p>Staff requesting services outline the date of initial admission in the program, type of services offered by program, current planned session frequency per month, number of additional sessions requested and any additional comments. A five-axis diagnosis shall be completed. Note if family is involved in treatment, and if youth or family are requesting</p>

UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION
Outpatient Treatment & Case Management Programs
Children's Programs Only

2014

continuation of service. Check off any concurrent interventions treatment client is involved with, and any prior hospitalizations.

Staff requesting services complete the Current Client Functioning (CFARS) section. Complete rationale for additional service/s need.

Staff requesting services beyond the initial 13 sessions must summarize the Eligibility Criteria for the appropriate request (post initial 13 sessions or post 26 sessions).

Staff requesting services identify all the proposed treatment modalities with the planned frequency. The expected outcome and prognosis follows. The requesting staff then outlines the actual requested number of treatment sessions to continue providing services after the initial 13 session mark or the previous UM authorization (for those requests past the 26 sessions).

The requesting staff attaches Client Plan (with or without the client's and guardian's signature) proposals/changes/additions, and then prints, signs, and dates the request. (NOTE: the Client Plan does need to be signed in order to continue beyond the initial 13 sessions). Each program determines co-signature requirements for the authorization request form. **CLIENT PLAN PROPOSALS/CHANGES/ADDITIONS MUST BE SUBMITTED WITH THE UM REQUEST FORM.** Once the UM request is approved the proposed changes/additions must be incorporated in to the Client Plan using either the review function or by rewriting a new Client Plan (revise is not acceptable for this process) within the EHR.

The UM representative identifies the approved number of sessions post the 13 session mark or the previous UM authorization up to an additional 13 sessions. The UM representative selects the appropriate box indicating if the request was approved, reduced, or denied. UM representative may outline any comments or suggestions to the requesting staff. Retroactive authorization is not acceptable (the program must contact the COTR when a client has no UM in place to cover claims). The UM representative completing the review prints name, signs, and dates the form. The UM approval must be completed by a licensed clinician only.

BILLING:

Utilization Management is a non-billable activity. Therefore, there is no billing for preparation of the UM form or for the UM review time spent on the case. UM is an administrative function.

**UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION
CYF - Outpatient Treatment**

Client Name:	Client #:	Program:
ADMISSION DATE:	DIAGNOSIS:	
CURRENT SERVICES & FREQUENCY:	Axis I: Primary: Code:	
<input type="checkbox"/> MHS <input type="checkbox"/> MHS-R <input type="checkbox"/> CM <input type="checkbox"/> Meds	Secondary: Code:	
sessions per month	Axis II:	
Does youth/family request additional services?	Axis III:	
Y <input type="checkbox"/> N <input type="checkbox"/> Explain:	Axis IV:	
	Axis V: Current: Highest in last 12 months:	

Psychiatric Hospitalizations: Y N (Provide relevant history):

Other Services Client Receiving:

See CFARS dated: at Admission or UM Cycle CURRENT CFARS Reviewed: YES NO

RATIONALE FOR ADDITIONAL SERVICES:

Program is on a COR approved UM Cycle exception. Exception is for session cycle OR months cycle (written exception on file).

New Client Plan was completed prior to UM request and reviewed by UM Committee (client/family input/signatures may be pending UM Approval)

ELIGIBILITY CRITERIA: UM CYCLE POST INITIAL 13 SESSIONS

Client continues to meet Medical Necessity and demonstrates benefit from services

- Consistent participation
- CFARS – Impairment Rating guideline of 5
- Client meets criteria for Pathways to Well-Being Enhanced Services

Client meets the criteria for SED based upon the following:

As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas (check)

- Self-care and self- regulation
- Family relationships
- Ability to function in the community
- School functioning

AND One of the following occurs:

- Child at risk for removal from home due to a mental disorder
- Child has been removed from home due to a mental disorder
- Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

- acute psychotic features,
- imminent risk for suicide
- imminent risk of violence to others due to a mental disorder

ELIGIBILITY CRITERIA – UM CYCLE POST 26 SESSIONS (Requires COR approval)

Client has met the above criteria as indicated AND Meets a minimum of one continuing **current** Risk Factor related to child’s primary diagnosis:

- Child has been a danger to self or other in the last two weeks
- Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks
- Child’s behaviors are so substantial and persistent that current living situation is in jeopardy
- Child exhibited bizarre behaviors in the last two weeks
- Child has experienced trauma within the last two weeks

Proposed Treatment Modalities: <input type="checkbox"/> Family Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Collateral Services <input type="checkbox"/> Case Management/Brokerage <input type="checkbox"/> Individual Rehab <input type="checkbox"/> Medication Services Pathways to Well-Being (Katie A. Subclass Only) <input type="checkbox"/> Intensive Care Coordination <input type="checkbox"/> Intensive Home Based Services	Planned Frequency: per month per month per month per month per month per month per month per month per month	Expected Outcome and Prognosis: <input type="checkbox"/> Return to full functioning <input type="checkbox"/> Expect improvement but less than full functioning <input type="checkbox"/> Relieve acute symptoms, return to baseline functioning <input type="checkbox"/> Maintain current status/prevent deterioration	REQUESTED NUMBER OF TREATMENT SESSIONS <input type="text"/> REQUESTED NUMBER OF MONTHS (for programs under written COR approval) <input type="text"/>
--	--	--	--

PROGRAM LEVEL REVIEW: ADDITIONAL UM CYCLE

Requesting Staff's Name, Credential & Signature: _____ **Date:** _____

of Sessions/Time Approved: _____ Request Approved Request Reduced Request Denied

UM Clinician's Name: _____ Signature/Credentials: _____ Date: _____

Committee Members Names and Credentials: _____

Comments: _____

COR LEVEL REVIEW – UM CYCLE POST 26 SESSIONS:

of Sessions/Time Approved: _____ Request Approved Request Reduced Request Denied

DATE: _____ COR Name and Credentials: _____ (attach written COR approval) (NOA-B may be required for Medi-Cal Clients)

Retroactive Authorization (attach written COR approval): DATE Approved: _____

Approved Time Frame: _____ COR Name and Credentials: _____

ADULT PROGRAMS

Recovery Markers Questionnaire (RMQ)-Paper

2014

- WHEN:** Completed by client at assessment and every 6 months, and at discharge.
- ON WHOM:** All Adult clients opened to outpatient and case management programs.
- COMPLETED BY:** Client. If clients require assistance with their RMQ's, staff can help them complete the assessments. Ideally this would be done by a peer or volunteer but any staff could assist.
- MODE OF COMPLETION:** Printed out on paper to be completed by client and entered online by program staff. Online website to print out form and enter results: <https://homs.ucsd.edu/login.aspx>
- REQUIRED ELEMENTS:** All elements should be completed.

Recovery Markers Questionnaire (RMQ)

DATE:

		/			/				

CLIENT CASE #:

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STAFF ID #:

--	--	--	--	--	--	--	--	--	--

UNIT/SUB-UNIT:

				/					
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For each of the following questions, please fill in the answer that is true for you now.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My living situation is safe and feels like home to me.	<input type="radio"/>				
I have trusted people I can turn to for help.	<input type="radio"/>				
I have at least one close mutual (give-and-take) relationship.	<input type="radio"/>				
I am involved in meaningful productive activities.	<input type="radio"/>				
My psychiatric symptoms are under control.	<input type="radio"/>				
I have enough income to meet my needs.	<input type="radio"/>				
I am not working, but see myself working within 6 months.	<input type="radio"/>				
I am learning new things that are important to me.	<input type="radio"/>				
I am in good physical health.	<input type="radio"/>				
I have a positive spiritual life/connection to a higher power.	<input type="radio"/>				
I like and respect myself.	<input type="radio"/>				
I am using my personal strengths skills or talents.	<input type="radio"/>				
I have goals I'm working to achieve.	<input type="radio"/>				
I have reasons to get out of bed in the morning.	<input type="radio"/>				
I have more good days than bad.	<input type="radio"/>				
I have a decent quality of life.	<input type="radio"/>				
I control the important decisions in my life.	<input type="radio"/>				
I contribute to my community.	<input type="radio"/>				
I am growing as a person.	<input type="radio"/>				
I have a sense of belonging.	<input type="radio"/>				
I feel alert and alive.	<input type="radio"/>				
I feel hopeful about my future.	<input type="radio"/>				
I am able to deal with stress.	<input type="radio"/>				
I believe I can make positive changes in my life.	<input type="radio"/>				
My symptoms are bothering me less since starting services here	<input type="radio"/>				
I deal more effectively with daily problems since starting services here	<input type="radio"/>				

	Yes	No
I am working part time (less than 35 hours a week)	<input type="radio"/>	<input type="radio"/>
I am working full time (35 or more hours per week)	<input type="radio"/>	<input type="radio"/>
I am in school	<input type="radio"/>	<input type="radio"/>
I am volunteering	<input type="radio"/>	<input type="radio"/>
I am in a work training program	<input type="radio"/>	<input type="radio"/>
I am seeking employment	<input type="radio"/>	<input type="radio"/>
I am retired	<input type="radio"/>	<input type="radio"/>
I regularly visit a clubhouse or peer support program	<input type="radio"/>	<input type="radio"/>

YOUR INVOLVEMENT IN THE RECOVERY PROCESS: Which of the following statements is most true for you?

<input type="radio"/> I have never heard of, or thought about, recovery from psychiatric disability
<input type="radio"/> I do not believe I have any need to recover from psychiatric problems
<input type="radio"/> I have not had the time to really consider recovery
<input type="radio"/> I've been thinking about recovery, but haven't decided yet
<input type="radio"/> I am committed to my recovery, and am making plans to take action very soon
<input type="radio"/> I am actively involved in the process of recovery from psychiatric disability
<input type="radio"/> I was actively moving toward recovery, but now I'm not because: _____
<input type="radio"/> I feel that I am fully recovered; I just have to maintain my gains
<input type="radio"/> Other (specify): _____

Client could not complete because: language refused unable other (please specify): _____

- WHEN:** Completed by clinicians at assessment, every 6 months and at Discharge
- ON WHOM:** All adult clients opened to Outpatient and Case Management programs.
- COMPLETED BY:** Clinician or Case Manager.
- MODE OF COMPLETION:** Online questionnaire. Printed copy can be printed out and kept in the hybrid chart. Online website: <https://homs.ucsd.edu/login.aspx>
- REQUIRED ELEMENTS:** All elements should be completed.

Recovery Scale: IMR Clinician Version

DATE:

		/			/				

STAFF ID #:

						/			

CLIENT CASE #:

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UNIT/SUB-UNIT:

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1. Progress towards personal goals: In the past 3 months, s/he has come up with...

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No personal goals	A personal goal, but has not done anything to finish the goal	A personal goal and made it a little way toward finishing it	A personal goal and has gotten pretty far in finishing the goal	A personal goal and has finished it

2. Knowledge: How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

<input type="radio"/>				
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in my mental health treatment: How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her mental health treatment?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time and they really help with his/her mental health

4. Contact with people outside of my family: In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)

<input type="radio"/>				
0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week

5. Time in Structured Roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

<input type="radio"/>				
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/wk

6. Symptom distress: How much do symptoms bother him/her?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptoms really bother him/her a lot	Symptoms bother him/her quite a bit	Symptoms bother him/her somewhat	Symptoms bother him/her very little	Symptoms don't bother him/her at all

7. Impairment of functioning: How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptoms really get in his/her way a lot	Symptoms get in his/her way quite a bit	Symptoms get in his/her way somewhat	Symptoms get in his/her way very little	Symptoms don't get in his/her way at all

8. Relapse Prevention Planning: Which of the following would best describe what s/he knows and has done in order not to have a relapse?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written a plan and has shared it with others

9. Relapse of Symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year

NOTE: Complete at Intake and 6 Month Treatment Plan Update

This form can be entered into HOMS at <https://homs.ucsd.edu> or faxed confidentially to (858) 622-1795.

Recovery Scale: IMR Clinician Version

DATE:

		/			/				

CLIENT CASE #:

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STAFF ID #:

UNIT/SUB-UNIT:

						/			

10. Psychiatric Hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year

11. Coping: How well do you feel your client is coping with his/her mental or emotional illness from day to day?

<input type="radio"/>				
Not well at all	Not very well	Alright	Well	Very well

12. Involvement with self-help activities: How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly

13. Using Medication Effectively: (Don't answer this question if his/her doctor has not prescribed medication). How often does s/he take his/her medication as prescribed?

<input type="radio"/>				
Never	Occasionally	About half the time	Most of the time	Every day

___ Check here if the client is not prescribed psychiatric medications.

14. Impairment of functioning through alcohol use: Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol use really gets his/her way a lot	Alcohol use gets in his/her way quite a bit	Alcohol use gets in his/her way somewhat	Alcohol use gets in his/her way very little	Alcohol use is not a factor in his/her functioning

15. Impairment of functioning through drug use: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug use really gets in his/her way a lot	Drug use gets in his/her way quite a bit	Drug use gets in his/her way somewhat	Drug use gets in his/her way very little	Drug use is not a factor in his/her functioning

Please complete the following items if the client is being seen for his/her follow-up treatment planning.

Since the last formal treatment plan update of six months ago...	Yes	No	N/A (no goal on client's plan)
16. has the client demonstrated progress towards achieving his/her employment goal ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. has the client demonstrated progress towards achieving his/her housing goal ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. has the client demonstrated progress towards achieving his/her education goal ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- WHEN:** Completed by clinicians at assessment and every 6 months thereafter.
- NOTE:** Completed by outpatient clinics only. Not completed by Case Management programs or residential programs.
- ON WHOM:** Clients opened to identified Units/SubUnits.
- COMPLETED BY:** Clinician.
- MODE OF COMPLETION:** Hand-written.
- REQUIRED ELEMENTS:** All elements should be completed.

Milestones of Recovery Scale (MORS)

Date: Client Case # Staff ID #

Unit Subunit

Please select the number that best describes the current (typical for the last two weeks) milestone of recovery for the client listed above. If you have not had any contact (face-to-face or phone) with the client in the last two weeks, do not attempt to rate the client.

- 1. Extreme risk
- 2. High risk/not engaged
- 3. High risk/engaged
- 4. Poorly coping/not engaged
- 5. Poorly coping/engaged
- 6. Coping/rehabilitating
- 7. Early Recovery
- 8. Advanced Recovery

- 1. Extreme risk – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
- 2. High risk/not engaged- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
- 3. High risk/engaged – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.
- 4. Poorly coping/not engaged – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or

jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

- 5. Poorly coping/engaged – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
- 6. Coping/rehabilitating – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing non-disabled roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be testing the employment or education waters, but this group also includes individuals who have retired. That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
- 7. Early Recovery – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
- 8. Advanced Recovery – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

- WHEN:** Completed by case manager or clinician at admission and annually thereafter.
- NOTE:** Completed by Case Management, ACT and FSP programs only.
- ON WHOM:** Clients opened to identified Units/SubUnits.
- COMPLETED BY:** Case Manager or Clinician.
- MODE OF COMPLETION:** Hand-written.
- REQUIRED ELEMENTS:** All elements should be completed.

LOCUS WORKSHEET VERSION 2010

Rater Name _____ Date _____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

<p>I. Risk of Harm</p> <p><input type="checkbox"/> 1. Minimal Risk of Harm Criteria _____</p> <p><input type="checkbox"/> 2. Low Risk of Harm Criteria _____</p> <p><input type="checkbox"/> 3. Moderate Risk of Harm Criteria _____</p> <p><input type="checkbox"/> 4. Serious Risk of Harm Criteria _____</p> <p><input type="checkbox"/> 5. Extreme Risk of Harm Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p>IV-B. Recovery Environment - Level of Support</p> <p><input type="checkbox"/> 1. Highly Supportive Environment Criteria _____</p> <p><input type="checkbox"/> 2. Supportive Environment Criteria _____</p> <p><input type="checkbox"/> 3. Limited Support in Environment Criteria _____</p> <p><input type="checkbox"/> 4. Minimal Support in Environment Criteria _____</p> <p><input type="checkbox"/> 5. No Support in Environment Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p>II. Functional Status</p> <p><input type="checkbox"/> 1. Minimal Impairment Criteria _____</p> <p><input type="checkbox"/> 2. Mild Impairment Criteria _____</p> <p><input type="checkbox"/> 3. Moderate Impairment Criteria _____</p> <p><input type="checkbox"/> 4. Serious Impairment Criteria _____</p> <p><input type="checkbox"/> 5. Severe Impairment Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p>V. Treatment and Recovery History</p> <p><input type="checkbox"/> 1. Full Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 2. Significant Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 4. Poor Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 5. Negligible Response to Treatment Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p>III. Co-Morbidity</p> <p><input type="checkbox"/> 1. No Co-Morbidity Criteria _____</p> <p><input type="checkbox"/> 2. Minor Co-Morbidity Criteria _____</p> <p><input type="checkbox"/> 3. Significant Co-Morbidity Criteria _____</p> <p><input type="checkbox"/> 4. Major Co-Morbidity Criteria _____</p> <p><input type="checkbox"/> 5. Severe Co-Morbidity Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p>VI. Engagement</p> <p><input type="checkbox"/> 1. Optimal Engagement Criteria _____</p> <p><input type="checkbox"/> 2. Positive Engagement Criteria _____</p> <p><input type="checkbox"/> 3. Limited Engagement Criteria _____</p> <p><input type="checkbox"/> 4. Minimal Engagement Criteria _____</p> <p><input type="checkbox"/> 5. Unengaged Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p>IV-A. Recovery Environment - Level of Stress</p> <p><input type="checkbox"/> 1. Low Stress Environment Criteria _____</p> <p><input type="checkbox"/> 2. Mildly Stressful Environment Criteria _____</p> <p><input type="checkbox"/> 3. Moderately Stressful Environment Criteria _____</p> <p><input type="checkbox"/> 4. Highly Stressful Environment Criteria _____</p> <p><input type="checkbox"/> 5. Extremely Stressful Environment Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p>Composite Score</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 150px;"></div> <p>Level of Care Recommendation</p> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 150px;"></div>

- WHEN:** Completed by clinicians at admission and every 6 months thereafter as long as the client continues to have a substance related goal in his/her client plan.
- ON WHOM:** Clients opened to identified Outpatient clinics, Case Management, and ACT programs, when client has an active substance related treatment plan goal in his/her client plan.
- COMPLETED BY:** Clinician or Case Manager.
- MODE OF COMPLETION:** Hand-written.
- REQUIRED ELEMENTS:** All elements should be completed.

Substance Abuse Treatment Scale - Revised (SATS-R)

From *Integrated Treatment for Dual Disorders* by Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox. Copyright 2003 by The Guilford Press: New York.

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is 6 months. The clinician will document in a progress note what level was chosen and the justification for the choice. The clinician will provide the names, dates, and scores to the Program Manager monthly.

1. **Pre-engagement.** The person (not yet a client) does not have contact with a case manager, mental health counselor or substance abuse counselor, and meets criteria for substance abuse or dependence.
2. **Engagement** The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.
3. **Early Persuasion.** The client has regular contacts with a case manager or counselor; continues to use the same amount of substances, or has reduced substance use for less than 2 weeks; and meets criteria for substance abuse or dependence.
4. **Late Persuasion.** The client has regular contacts with a case manager or counselor; shows evidence of reduction in use for the past 2-4 weeks (fewer drugs, smaller quantities, or both); but still meets criteria for substance abuse or dependence.
5. **Early Active Treatment.** The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.
6. **Late Active Treatment.** The person is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 1-5 months.
7. **Relapse Prevention.** The client is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 6-12 months.
8. **In Remission or Recovery.** The client has not met criteria for substance abuse or dependence for more than the past year.

Initial Level: ____

Client Plan Update: ____

Client Plan Update: ____

Date_____

Date_____

Date_____

Clinician/Title

Clinician/Title

Clinician/Title

County of San Diego
Health and Human Services Agency
Mental Health Services

SUBSTANCE ABUSE TREATMENT SCALE - REVISED
July 1, 2005

Client: _____

MR/Client ID #: _____

Program: _____