Linda Perez
Project Director,
Safe Schools/Healthy Students
PAJARO VALLEY UNIFIED
SCHOOL DISTRICT

2005

Integrated Mental Health Services:

Assessment and Screening Tools

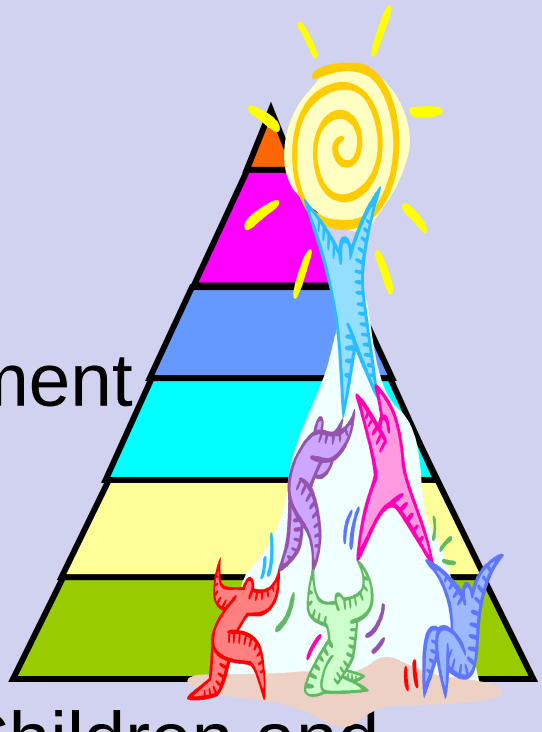
PAJARO VALLEY UNIFIED SCHOOL DISTRICT

- Located in Southern Santa Cruz County, along the central coast of California
- Primarily an agricultural community
- Approximately 20,000 students in the district
- The student population is over 78% Latino
- 70% speak a language other than English at home
- One in five children live in poverty
- 70% of families qualify for free or reduced lunches

CHALLENGES

- NCLB Pressures
- Confidentiality - Protecting Privacy - Information Sharing
- Lack of Common Language between MH and Education
  - Different Ideas, Different Approaches
- Turf Issues
  - Deciding who is the best provider to deliver services
- Maintaining Partner Relationships
- Fragmented Funding Sources
  - No consistent funding stream
  - Funding changes
  - Staff changes
- Sustainability – Maintaining services that were developed with Federal Funds

WHAT WORKS:



MAKING THE COMMITMENT TO:

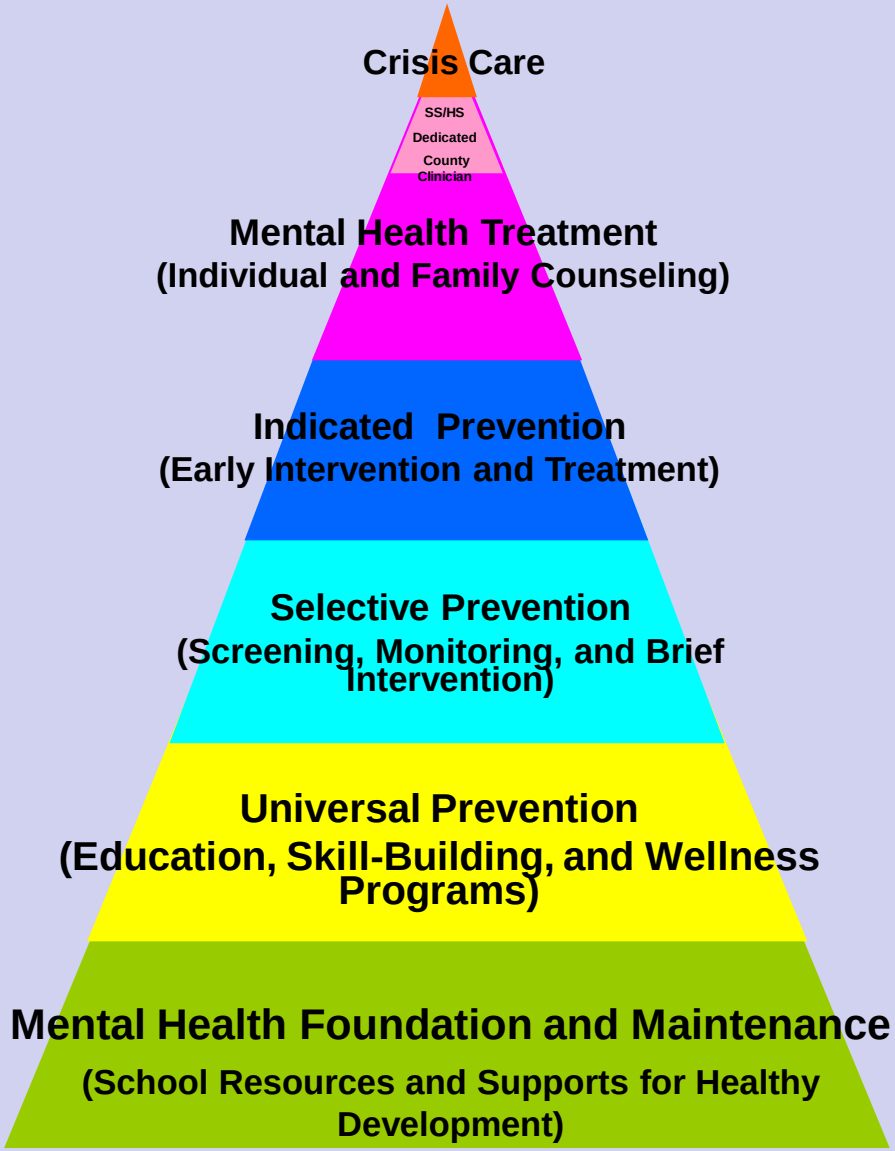
- Resources
- Ongoing Training and Staff Development
- Evidence Based Practices
- Evaluation
- Social Marketing, Sharing Outcomes
- Sharing Resources for the Good of Children and Youth
- Working through Partner Tensions and Problems
- Minimize Duplication and Fragmentation

What Also Works:

- State Support - Medicaid Reimbursement


Integrated Mental Health Services

Pajaro Valley Unified School District Integrated Mental Health Services



- Mental Health Emergency Response Team
- Suicide Hotline
- Criminal Justice Interventions

- Safe Schools/Healthy Students Dedicated County Clinician
- Probation Team and Wrap-Around Services
- AB 3632 SDC-ED Mental Health Services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Supportive Intervention Services (SIS)
- Supportive Adolescent Services (SAS)
- Safe Schools/Healthy Students Counseling

- Secondary Student Assistance Program
- Seven Challenges Insight/Prevention Groups
- Drug Medi-Cal Minor Consent Services
- Kids Korner Elementary Student Assistance Program
- Student Study Teams
- School Psychologist

- Seven Challenges Insight/Prevention Groups
- Primary Intervention Program (EMHI)
- Families and Schools Together (FAST)
- Primary Care Provider Referrals
- Conflict Resolution Teams

- Youth Development
- School Health Curriculum
- Bullying and Other Prevention Programs
- Parent Education and Involvement Programs
- School Nurses

- Classroom Teachers
- Guidance Counselors and Academic Support Programs
- Parent Involvement
- School Safety Personnel
- After School Programs
- Sports, Arts, and Extra Curricular Activities

ASSESSMENT, SCREENING, AND REFERRAL TOOLS

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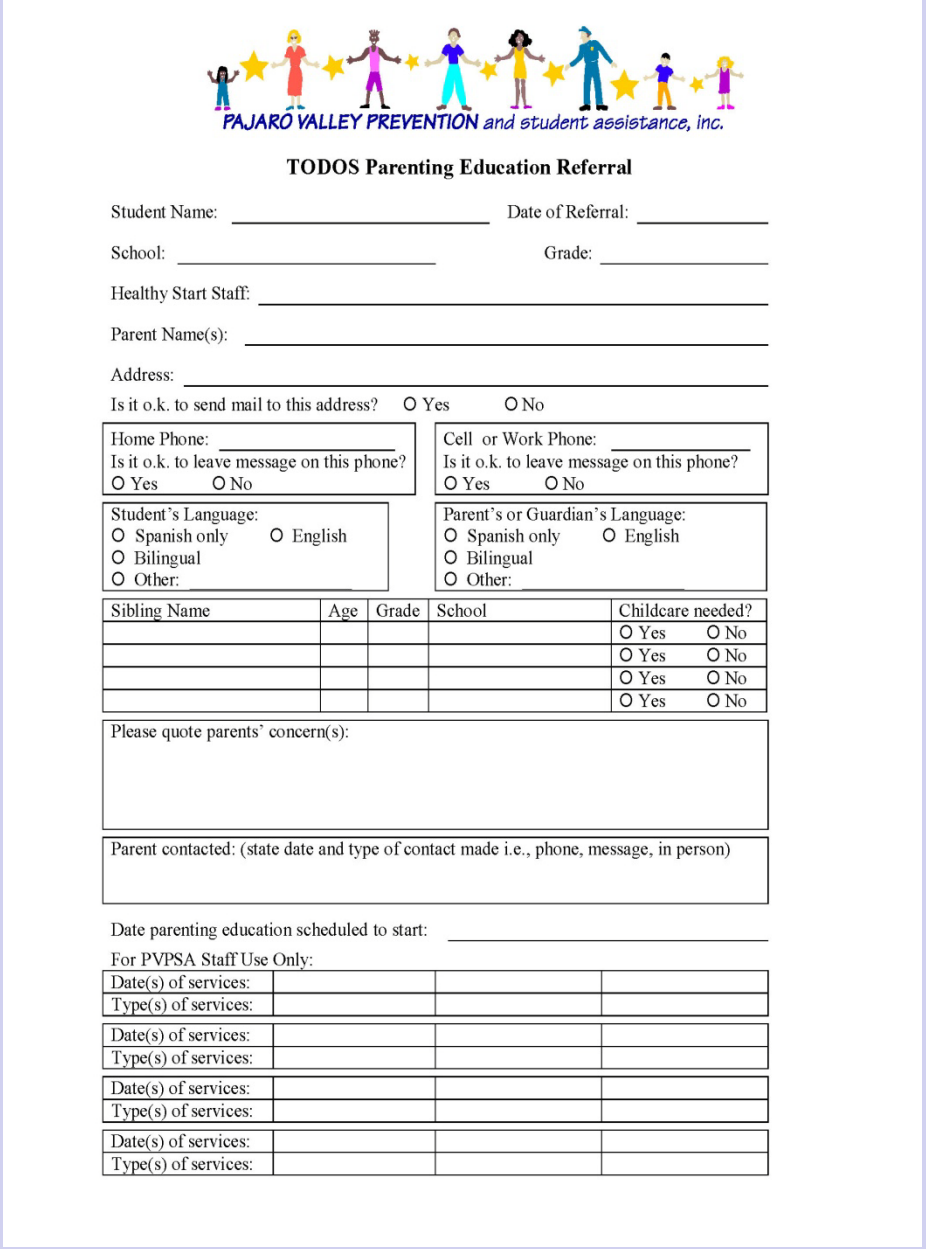
PARENTING EDUCATION REFERRAL



PAJARO VALLEY PREVENTION and student assistance, inc.

TODOS Parenting Education Referral

Student Name: _____ Date of Referral: _____

School: _____ Grade: _____

Healthy Start Staff: _____

Parent Name(s): _____

Address: _____

Is it o.k. to send mail to this address? O Yes O No

Home Phone: _____
Is it o.k. to leave message on this phone?
O Yes O No

Cell or Work Phone: _____
Is it o.k. to leave message on this phone?
O Yes O No

Student's Language:
O Spanish only O English
O Bilingual
O Other: _____

Parent's or Guardian's Language:
O Spanish only O English
O Bilingual
O Other: _____

Sibling Name	Age	Grade	School	Childcare needed?
				O Yes O No
				O Yes O No
				O Yes O No
				O Yes O No

Please quote parents' concern(s):

Parent contacted: (state date and type of contact made i.e., phone, message, in person)

Date parenting education scheduled to start: _____

For PVPSA Staff Use Only:

Date(s) of services:			
Type(s) of services:			
Date(s) of services:			
Type(s) of services:			
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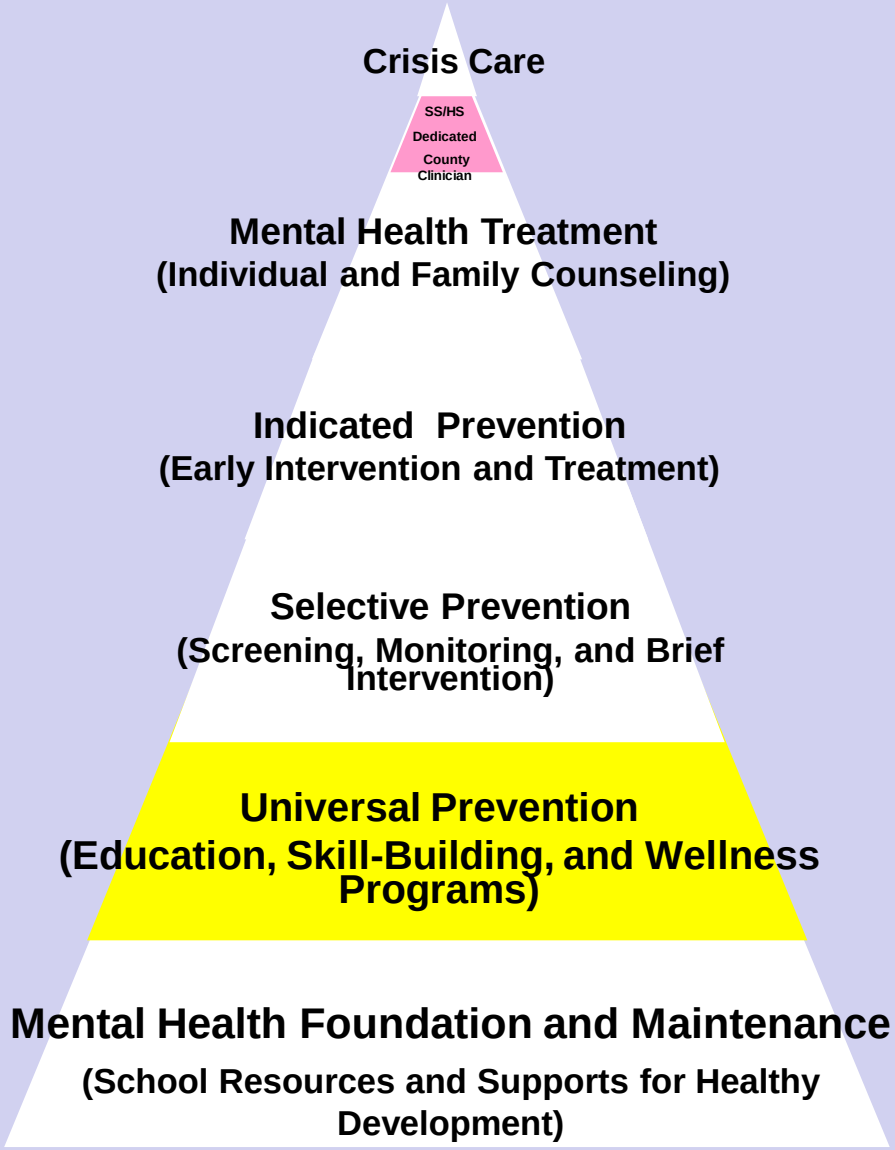
Date(s) of services:			
Type(s) of services:			

Pajaro Valley Unified School District Integrated Mental Health Services



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FAST SELF-REFERRAL FORM

Safe Schools/Healthy Students
PRESENTS:

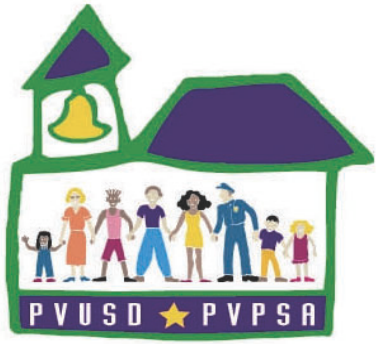
FAST
Families & Schools Together

You are invited to attend a parent education program where your family will find a safe and fun place to strengthen your relationships.

Through several activities held at your child's school, your family builds a supportive network with other families and school staff.

Our weekly activities include sharing a meal, creating a family project, singing, exercises in communication and identifying feelings, and spending time together as a family.

Join our FAST program held at Ann Soldo Elementary School in October.



Safe Schools ★ Healthy Students

Pajaro Valley Prevention & Student Assistance, Inc.
335 East Lake Avenue
Watsonville, CA 95076
Phone: (831) 728-6300
E-mail: gina.cole@pvpsa.org
carlos.campos@pvpsa.org
Fax: (831) 728-6963

————————(Please detach and return to your child's teacher)————————

YES! We are interested in learning more about how to be involved in the **FAST Program** at **Ann Soldo Elementary School!**

CHILD'S NAME _____ GRADE _____

TEACHER _____ ROOM _____

PARENT'S NAMES _____

PARENT'S CONTACT PHONE NUMBER _____

Safe Schools/Healthy Students
PRESENTA:

FAST
Familias Y Escuelas Juntas

¡Ayude a sus hijos a ser sobresalientes!
FAST es un programa que ayuda a los padres a que mejoren sus relaciones con su familia, con otros padres, con los maestros de sus hijos y con la comunidad en general.

Durante ocho semanas ofrecemos actividades tales como cena familiar, crear un proyecto familiar, cantar, ejercisios en la communicacion y como identificar los sentimientos, al igual que compartir tiempo juntos como familia. ¡Todo es gratis!

Lo invitamos a ser parte de este programa de FAST que ofreceremos en la escuela Ann Soldo el mes de Octubre.

Safe Schools ★ Healthy Students

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335 East Lake Avenue
Watsonville, CA 95076
Phone: (831) 728-6300
E-mail: gina.cole@pvpsa.org
carlos.campos@pvpsa.org
Fax: (831) 728-6963

————————(Por favor recorte y regrese la parte de abajo a la maestra)————————

¡SI! Deseamos participar en el programa FAST en la escuela primaria Ann Soldo.

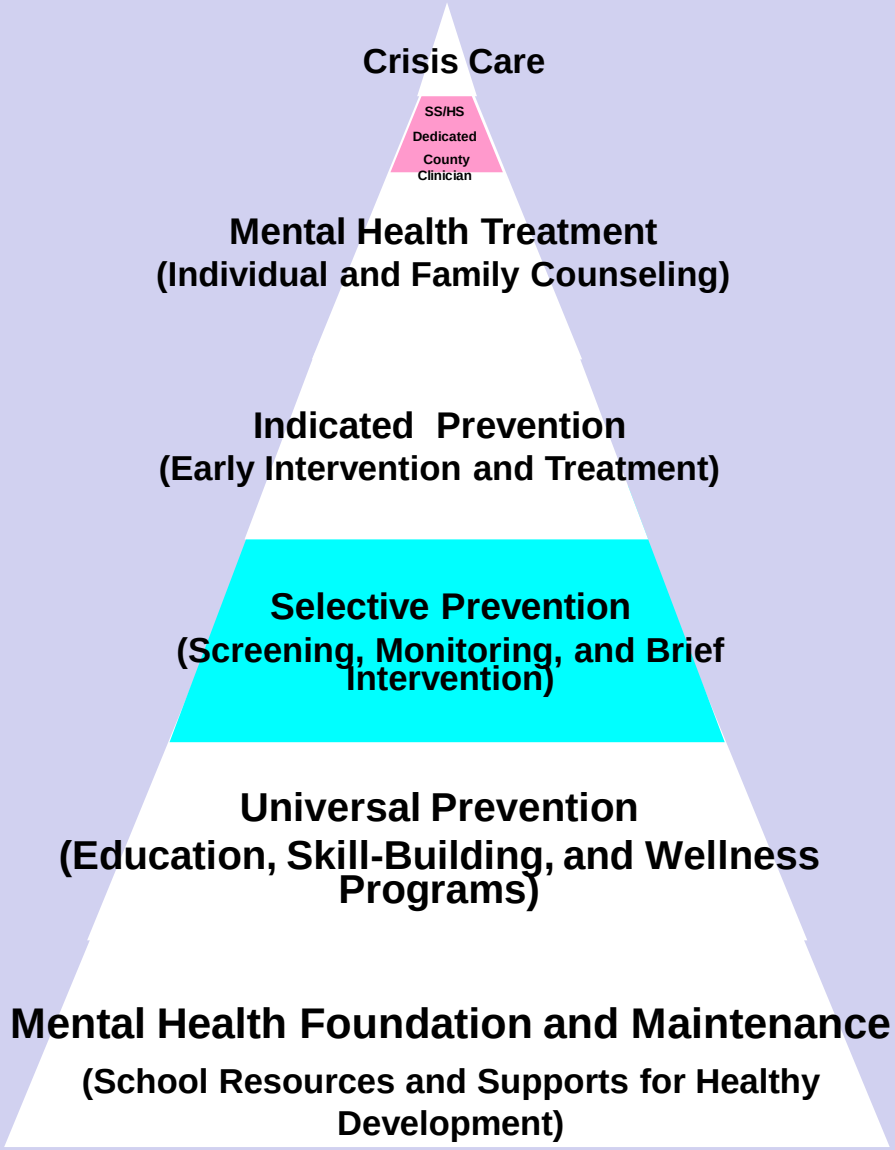
NOMBRE DE HIJO/A _____ GRADO _____

MAESTRA/O _____ SALON _____

NOMBRE DEL PADRE _____

NUMERO DEL TELEFONO _____

Pajaro Valley Unified School District Integrated Mental Health Services



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PRIMARY INTERVENTION OBSERVABLE BEHAVIOR REFERRAL

Safe Schools ★ Healthy Students

PVUSD ★ PVPSD

PIP *Confidential* Observable Behavior *REFERRAL* Form

Student _____--__ Grade ___ Room ___ Date_____

Instructions:

- Rate students for each of the following behaviors.
- Fold, staple, and place in ***Kids' Korner*** box.

		Never		Sometimes		Frequently
1	Other children seek child out to involve her/him in activities.	1	2	3	4	5
2	Plays or talks with children for extended periods of time.	1	2	3	4	5
3	Invites peers to play or share in activities.	1	2	3	4	5
4	Compromises with peers when situation calls for it.	1	2	3	4	5
5	Appropriately copes when feeling threatened.	1	2	3	4	5
6	Can accept not getting his or her own way.	1	2	3	4	5
7	Stops to think of consequences before acting.	1	2	3	4	5
8	Copes appropriately with frustration.	1	2	3	4	5
9	Able to concentrate in the classroom.	1	2	3	4	5
10	Produces work of acceptable quality given his/her skill level.	1	2	3	4	5
11	Has good work habits.	1	2	3	4	5
12	Consistently attends school.	1	2	3	4	5
13	Able to adjust to changes in routine.	1	2	3	4	5
14	Seeks to follow direction from adults.	1	2	3	4	5
15	Tells truth in difficult situations.	1	2	3	4	5
16	Appropriately cares for own health and safety.	1	2	3	4	5
17	Able to trust others.	1	2	3	4	5
18	Self confident.	1	2	3	4	5
19	Level of worry appropriate to situation.	1	2	3	4	5
20	Cheerful.	1	2	3	4	5

Family Background Information

- ☐ Housing concerns or frequent moves
- ☐ Divorce/separation
- ☐ Recent death or loss
- ☐ Unemployment/disability
- ☐ Lives with someone other than parent.
- ☐ Concern regarding alcohol/drug use.
- ☐ Suspected child abuse/neglect.
- ☐ Medical problems.
- ☐ Domestic violence.
- ☐ New to school

Current Related Services Received

- ☐ SST
- ☐ Resource Specialist
- ☐ Special class
- ☐ School Psychologist
- ☐ Speech Therapist
- ☐ GATE
- ☐ Migrant
- ☐ CPS
- ☐ Other services: _____

_____

_____

_____

_____

Parent has been notified of this Referral to **PIP PROGRAM** **Yes** **No**

Other information and a positive comment about the student.

_____

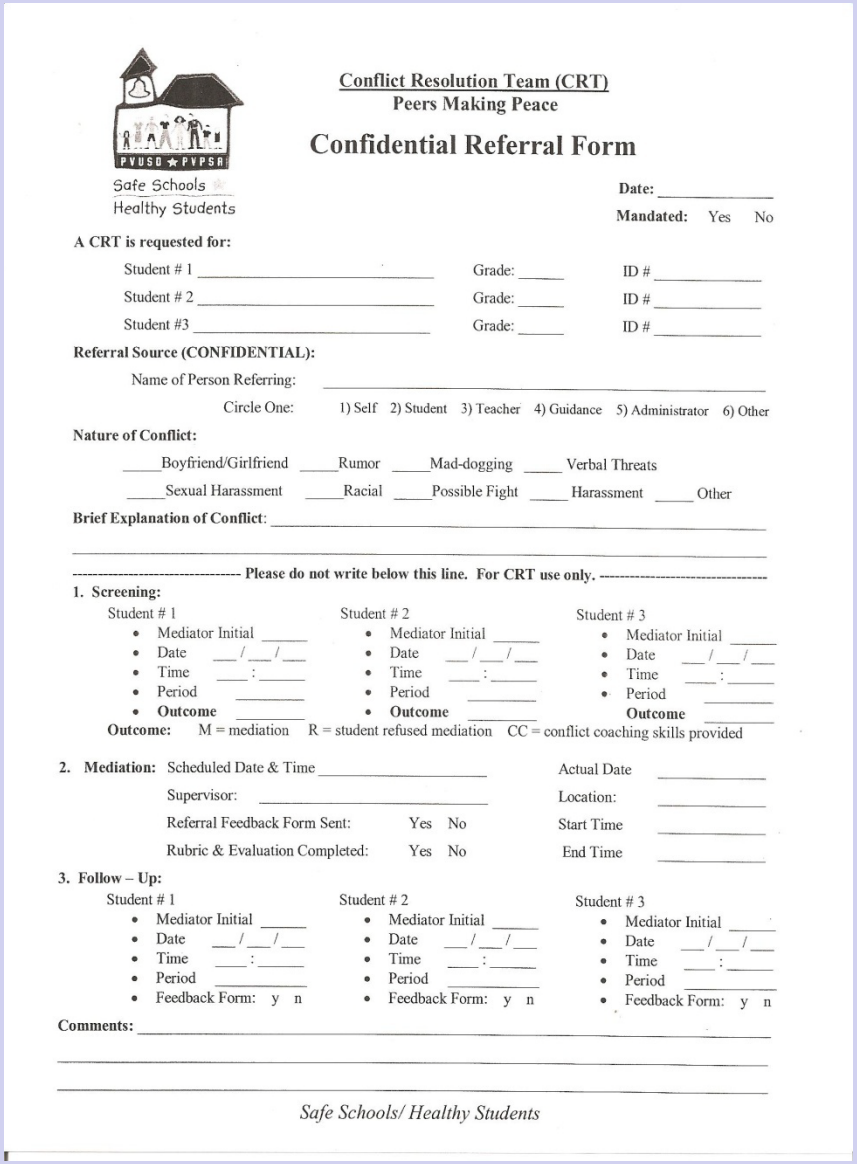
_____

_____

_____

_____

CONFLICT RESOLUTION REFERRAL



PVUSD ★ PVPSA
Safe Schools ★ Healthy Students

Conflict Resolution Team (CRT)
Peers Making Peace

Confidential Referral Form

Date: _____

Mandated: Yes No

A CRT is requested for:

Student # 1 _____ Grade: _____ ID # _____

Student # 2 _____ Grade: _____ ID # _____

Student #3 _____ Grade: _____ ID # _____

Referral Source (CONFIDENTIAL):

Name of Person Referring: _____

Circle One: 1) Self 2) Student 3) Teacher 4) Guidance 5) Administrator 6) Other

Nature of Conflict:

_____Boyfriend/Girlfriend _____Rumor _____Mad-dogging _____ Verbal Threats

_____Sexual Harassment _____Racial _____Possible Fight _____ Harassment _____ Other

Brief Explanation of Conflict: _____

_____

---------- **Please do not write below this line. For CRT use only.** ----------

1. Screening:

Student # 1
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____
- **Outcome** _____

Student # 2
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____
- **Outcome** _____

Student # 3
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____

Outcome _____

Outcome: M = mediation R = student refused mediation CC = conflict coaching skills provided

2. Mediation: Scheduled Date & Time _____ Actual Date _____

Supervisor: _____ Location: _____

Referral Feedback Form Sent: Yes No Start Time _____

Rubric & Evaluation Completed: Yes No End Time _____

3. Follow – Up:

Student # 1
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____
- Feedback Form: y n

Student # 2
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____
- Feedback Form: y n

Student # 3
- Mediator Initial _____
- Date ___/___/___
- Time ____:_____
- Period _____
- Feedback Form: y n

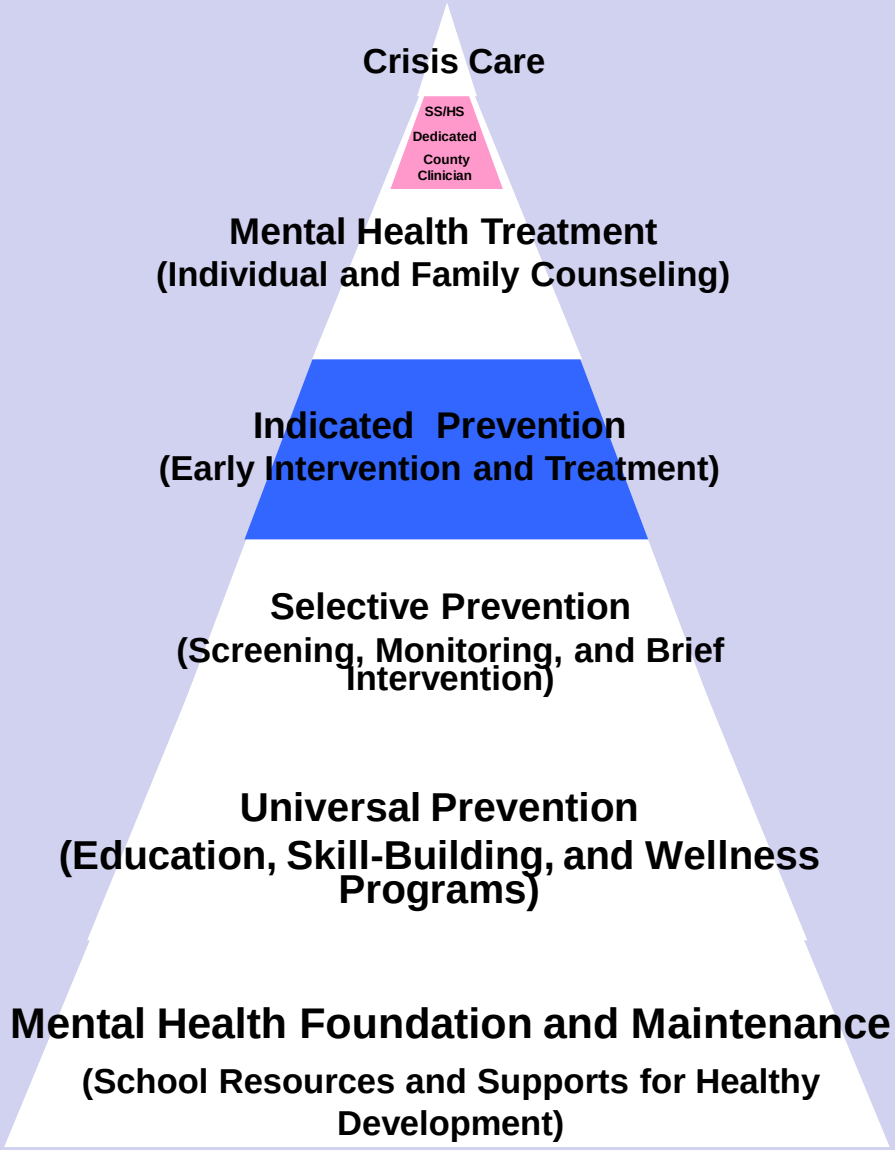
Comments: _____

_____

_____

Safe Schools/ Healthy Students

Pajaro Valley Unified School District Integrated Mental Health Services



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- Multi-Disciplinary Team
- Kids Korner Elementary Student Assistance Program
- Student Study Teams/ School Psychologist

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- Families and Schools Together (FAST)
- Primary Care Provider Referrals
- Conflict Resolution Teams

- School Health Curriculum
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- School Nurses

- Classroom Teachers
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- Parent Involvement
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KIDS KORNER OBSERVABLE BEHAVIOR REFERRAL

PAJARO VALLEY PREVENTION and student assistance, inc.

Kids' Korner
Observable Behavior Referral Form

CONFIDENTIAL

Students will NOT be seen in Kids' Korner or other PVPSA Student Assistance Program without the signed consent of one parent.

Teacher has:
- ❑ Spoken with parent.
- ❑ Sent consent to parent.
- ❑ Received consent.

INSTRUCTIONS:

1. Check the behavior(s) that this student is exhibiting. Indicate your major concern with an extra check.
2. Fold, staple and place in the KIDS' KORNER box. Completion signifies your concern.

Student: _____ Grade: ____ Date: _____

Room # ____ Person Referring: _____

Primary Language: _____

√ *Behavior Signs*

- ❑ Difficulty concentrating.
- ❑ Persistent absenteeism.
- ❑ Poor grades and/or failure to turn in homework.
- ❑ Sudden behavior changes (quiet and moody or acting out).
- ❑ Signs of neglect or physical and sexual abuse. Avoids being touched, fearful of going home.
- ❑ Compulsive behaviors (overeating, overachieving, smoking, chemical abuse, stealing, lying about the obvious).
- ❑ Shy and withdrawn from other children.
- ❑ Quarrelsome and uncooperative with teachers and classmates.
- ❑ Constant health problems (headaches, stomachache, wetting or soiling pants).

√ *Psychological Signs*

- ❑ Low self-esteem
- ❑ Anxiety
- ❑ Self-destructive
- ❑ Poor coping skills
- ❑ Unreasonably fearful
- ❑ Sad and unhappy
- ❑ Difficulty adjusting to changes in routine
- ❑ _____

√ *Family Background Information*

- ❑ Housing concerns
- ❑ Divorce/separation
- ❑ Recent death
- ❑ Unemployment/disability
- ❑ Lives with someone other than parent
- ❑ Concern regarding alcohol/drug use
- ❑ Suspected child abuse/neglect
- ❑ Family medical problems
- ❑ Domestic violence
- ❑ _____
- ❑ _____

√ *Current Related Services Received*

- ❑ SST
- ❑ Resource Specialist
- ❑ Special Class
- ❑ School Psychologist
- ❑ Speech Therapist
- ❑ GATE
- ❑ Migrant
- ❑ CPS
- ❑ Other services (please specify)

_____

√ *Strengths*

- ❑ Verbal
- ❑ Auditory
- ❑ Academics
- ❑ Kinesthetic
- ❑ Athletic
- ❑ Friendship
- ❑ Caring
- ❑ Helpful
- ❑ Responsible
- ❑ _____

Other information and a <u>positive</u> comment about the student

_____

_____

_____

MDT REFERRAL

MDT Referral Form

WE WANT TO RESPOND TO THIS REFERRAL AS QUICKLY AS POSSIBLE. INCOMPLETE REFERRAL FORMS WILL RESULT IN UNNECESSARY *DELAYS* FOR A STUDENT IN NEED.
***PLEASE* HELP US BY COMPLETING *as much* INFORMATION *as possible* BELOW:**

Name of Student _____ D.O.B. ___/___/___ Date of Referral: ___/___/___

School _____ Grade _____ ID# _____

MDT Rev. Date: _____
To:
O FSA
O YS
Wats __
HYP __
O PVPSA
D&A __
O SSHS
O CC
O SIT
O Other: _____ _____

Referring Person: _____
Position:
- O _____ Teacher
- O School Nurse/Health Clerk
- O Office, Custodial, Security Staff
- O Coach
- O Counselor
- O Administrator
- O Other: _____

Is it OK to inform the student that you made the Referral?
- O Yes
- O No

Student Participates in the ***Migrant Ed*** Program?
- O Yes
- O No
- O Don't Know

Student's *Language*: O Spanish only
- O English O Bilingual Sp/Engl.
- O Other: _____

Parents or Guardian's Primary *Language*:
- O English O Spanish
- O Other: _____

HS:mch Version 3.04 07/28/09

Parent(s) or Guardian's Names:
- O Mother: _____
- O Father: _____
- O Guardian: _____

Student lives with: Address: Telephone Numbers:
- O Mother _____ (H)_____ (W/C)_____
- O Father _____ (H)_____ (W/C)_____
- O Guardian _____ (H)_____ (W/C)_____
- O Currently homeless (Please provide *as much information as possible*, i.e., "kicked out of the house," staying with relatives, living on the street, staying in a shelter, "didn't like" foster care home, etc.):

_____
_____

O Student wants (agrees to/is seeking) counseling.
MARK ONE: Student O consents O declines to give permission to contact his/her parent
If parent/guardian **has not been contacted**, *please* state reason why not: _____
O Student *does not want* parent involved **and** subject is *pregnancy/sex*, drugs/alcohol, physical/sexual abuse.
(circle one) or _____

******* STUDENT'S HEALTH INSURANCE *******
(This information is *crucial* for prompt assignment of student to health &/or counseling services).
- O Medi-Cal
- O Healthy Families
- O Healthy Kids
- O Private Insurance (Plan Name) _____ (Blue Cross, RF Kennedy…)
  Policyholder's name, if known (typically a parent): _____
- O Student Does Not Know: **O** if s/he has health insurance or not **O** name of the Insurance Plan

Student's Regular Doctor or Clinic:
- O _____ Doctor's Name or Practice Group (i.e., Pediatric Med Grp, Capitola Peds
- O Salud Para La Gente O Clinica del Valle O Planned Parenthood
- O Other: _____
- O Student O Does Not Know If S/he has a Doctor
- O Maybe has a Doctor; s/he (a) doesn't remember name; (b) it has been a long time since his/her last office visit

Please describe the Reason for the Referral:
_____
_____
_____

Also, please check all items below that apply:

Health Needs:
- O Physical Exam
- O Dental Care
- O Pregnancy
- O Frequent physical complaints / visits to School Health Office
- O Supervision for medication compliance
- O Sudden weight loss/gain
- O Fatigue/sleepiness
- O Unexplained injuries
- O Other Health (please specify)

Social Needs:
- O Recent loss (Death/divorce)
- O Economic/housing problems
- O Family conflict/concerns
- O Substance abuse – student
- O Substance abuse – member(s) of family
- O Suspected gang involvement
- O Domestic violence
- O Recent immigrant
- O Other: (please specify)

Behavior Observed:
- O Withdrawn
- O Anxious/fearful
- O Hostile/aggressive/fighting
- O Low self-image
- O Self-Destructive/Suicidal
- O Sexual acting-out
- O Steals or destroys property
- O Apathy/low motivation
- O Runaway/homeless/"couch surfing" **(** SIT **)**
- O Other: (please specify)

Educational Needs: O refer to school psychologist for possible need for assessment
O refer to school administration for possible need for SST meeting

Agencies or services involved, previously & currently. **Please mark all known &/or that apply**:
O School Health Office/Nurse O School Psychologist O SELPA: circle all that apply: had SST/ has IEP/in SDC or RSP
O Guidance Counselor O Safe Schools/SAP Counselor O SARB'd O **Healthy Start/Teen Resource**: i.e.FSA
O Foster Care ** **SIT**** O PVPSA Drug & Alcohol O TAM (Teen-Aged Moms) Cath Charities, Youth Svcs, Defensa

DRUG MEDI-CAL PSYCHOSOCIAL ASSESSMENT

PAJARO VALLEY PREVENTION and student assistance, inc.

DMC Psychosocial Assessment

Name: _____ **D.O.B.** _____

Student's Identifying Information (including developmental functioning and mental status): _____

Interests/Activities: _____

Peer Relationships: _____

Educational Functioning & Goals: _____

Employed? _____

Legal History/Status: *Please include information about probation, upcoming court date, number of arrests in the last 6 months & number of days in Jail/Juvenile Hall in the last 6 months if applicable.*

History of Abuse/Neglect: _____

History of Self-Destructive Behaviors & Medical a/o Psych. Hospitalizations:
Also include dates and duration of any ER visits in the last 60 days if applicable

Family System Description: _____

Problem Summary/Precipitant: (include referral source and mandated): _____

PAJARO VALLEY PREVENTION and student assistance, inc.

DRUG USE HISTORY

Has student ever used needles? Yes No If yes, how often in the last month?: _____

Has student ever participated in a needle exchange program? Yes No

Ever had any drug treatment? Yes No What type of treatment?: _____

Name of treatment program: _____ Dates: _____

Did student complete the program? Yes No

What did she/he find helpful about the program?: _____

List any prescribed medications past and/or present (include dosage and times/day): _____

Family history of drug/alcohol use: Father: _____ Mother: _____

Siblings: _____

Grandparents: specify maternal/paternal _____

Other: _____

Self Evaluation: _____

Student's Drug Use:

Type of Drug	Age of 1st Use	Frequency of Use

Type of drugs (enter code in table above): Heroin (01), Alcohol (02), Barbiturates (03), Other sedatives/hypnotics (04), Methamphetamine (05), Other amphetamines (06), Other stimulants (070, Cocaine/crack (08), Marijuana/hashish (09), Other hallucinogens (10), Tranquilizers (Benzodiazepines) (11), Other tranquilizers (12), Non-prescription methadone (13), Other opiates & synthetics (14), Inhalants (15), Over the counter drugs (16), Other (specify) (17), None (18)

Frequency of Use (enter code in table above): None past month (1), 1-3 times past month (2), 1 – 2 times a week (3), 3 to 6 times a week (4) Daily (5)

Usual Route of Administration for each drug indicated above:

Oral: …… Smoking: ……

Inhalation: ……Injection (IV or Intramuscular): ……

Other: ……

Completed by (signature and title): _____ Date: _____

STUDENT ASSISTANCE PROGRAM OBSERVABLE BEHAVIOR REFERRAL

Observable Behavior Referral Form – Student Assistance Program

Name of Student_____

D.O.B.____/____/_____ Grade_____ ID# _____

Referral Date____/____/_____ Referred By_____

Is it OK to inform student you made the referral? ☐ YES ☐ NO

Student's Language: ☐ Spanish Only ☐ English ☐ Bilingual (Spanish/English)

Parent or Guardian Name_____Telephone _____

Parent or Guardian Address_____

Has parent(s) or guardian been informed of referral? ☐ YES ☐ NO If no, Why not:_____

Please attach a copy of the students' ☐ Class Schedule AND ☐ Emergency Card

Nature of Concern: ☐ Drug/Alcohol ☐ Harm to Self or Others ☐ Behavior

☐ Attendance ☐ Academics ☐ Other_____

Reason for Referral _____

_____

Health Needs:	**Social Needs:**	**Observed Behaviors:**
☐ Physical Exam	☐ Recent Loss (Death/Divorce)	☐ Withdrawn
☐ Dental Care	☐ Economic/Housing Problems	☐ Decrease in Academic Performance
☐ Pregnancy	☐ Family Conflict/Concerns	☐ Anxious/Fearful
☐ Frequent Physical Complaints Or Visits to Health Office	☐ Substance Abuse – student	☐ Hostile/Aggressive/Fighting
☐ Supervision for Medication Compliance	☐ Substance Abuse – family	☐ Low Self-Esteem/Image
☐ Weight Loss/Gain	☐ Suspected Gang Involvement	☐ Self Harmful/Suicidal
☐ Fatigue/Sleepiness	☐ Domestic Violence	☐ Sexual Acting Out
☐ Unexplained Injuries	☐ Recent Immigrant	☐ Steals or Destroys Property
☐ Other_____	☐ Other_____	☐ Apathy/Low Motivation
	_____	☐ Runaway/Homeless

Please complete and return to PVPSA counselor's mailbox. Thank You.

C:\Documents And Settings\ADMINISTRADOR\My Documents\A_SS HS\COUNSELING\COUNSELING FORMS\SAP Observable Behavior Referral 2.Doc

Pajaro Valley Unified School District Integrated Mental Health Services

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SS/HS SCHOOL BASED MENTAL HEALTH COUNSELING SCREENING pg 1&2

Safe Schools Healthy Students

Confidential Secondary School Screening for SS/HS MH Counseling

Date _____ Counselor _____ School _____

Address _____

Contact number(s) _____ ❒ New ❒ Re-entry

DOB _____ Grade _____ ❒ Male ❒ Female

Ethnicity ❒ White ❒ Hispanic ❒ Asian ❒ African-American
❒ Filipino ❒ Pacific Islander ❒ Native American ❒ _____

Referral Source

- ❒ Mandatory
- ❒ Teacher
- ❒ Self
- ❒
- ❒ SAP counselor
- ❒ School counselor
- ❒ Other school staff
- ❒ Law enforcement
- ❒ School administration
- ❒ Parents
- ❒ Nurse
- ❒ Juvenile Court
- ❒ Agency
- ❒ _____

Reason for Services

- ❒ Withdrawn, depressed, sad/grief
- ❒ Acting out, angry
- ❒ Sexuality concerns
- ❒ Non-compliance with school rules
- ❒ TAOD using behavior
- ❒ Alcohol/drug use in family
- ❒ Evaluation
- ❒ Peer
- ❒ Conflict resolution
- ❒ Authority
- ❒ Divorce
- ❒ Health-eating disorder
- ❒ Neglect
- ❒ Domestic violence
- ❒ Pregnancy
- ❒ Suicidal
- ❒ Gang
- ❒ Individual
- ❒ Friends
- ❒ Family
- ❒ Harassment
- ❒ _____

Reason for Referral

- ❒ Attendance
- ❒ Grades
- ❒ _____
- ❒ Classroom behavior
- ❒ Physical symptoms

Services Provided/Offered

- ❒ Screening _____
- ❒ Group counseling _____
- ❒ Family contact _____
- ❒ Parent support group _____
- ❒ _____
- ❒ Individual counseling _____
- ❒ Support group _____
- ❒ Insight group _____
- ❒ CPS report _____

Referral Out

- ❒ Defensa de Mujeres
- ❒ Parent Center
- ❒ Catholic Services
- ❒ Alateen
- ❒ 12 Step
- ❒ Santa Cruz Community Counseling Center
- ❒ Youth Services
- ❒ Alanon
- ❒ NA
- ❒ _____

Family History/Constellation _____

Health History/Medication/Allergies _____

Friends and Relationships _____

School Experience _____

Interest and Activities _____

Job _____

Legal History _____

Weight/Food Issues _____

Previous counseling Kids' Korner/SAP _____

Suicidal ❒ ideation ❒ plan ❒ means ❒ opportunity ❒ attempts

EPSDT ASSESSMENT PG 1&2* (*abbreviated form)

EPSDT Assessment

Student Name: On Social Security_____ _____AKA _____

DOB _____ **Location:** _____ **Social Security #** _____ **Student #** _____

I. Sources of information:

Referred by:

Teacher _____ Principal Assist. principal Self Mother Father Other _____

Assessment Information from: (circle all relevant sources)

Teacher Principal Assist Principal Student Mother Father Other _____

II. Identifying data:

Age___ Grade __ **Sex:** M F **Ethnicity:** Hispanic White Other _____ **Pref lang:** English Spanish

Name (family/guardians)	Age	Relationship	Address	Phone	Occupation	Lang
		Mother				
		Father				

Physician (Psychiatrist) _____ **Legal Consent by:** (9 if parent)____

Episode open date _____ **Legal Status Code** - always use: W60000 for Episode Opening

Target pop: 300(CPS referral) ~ 502 (Probation) ~ 3632 (School, Special ed) ~ Other SED (All others)

Factors affecting mental health: Substance Abuse ~ Developmental disabilities ~ Physical disorders

Diagnosis must include at least one diagnosis shown in bold type.
Indicate Principal diagnosis with "P" and secondary with "S."
"Diagnosis deferred" and RO not acceptable diagnosis. Clinician may indicate for own use.

USUALLY FIRST DIAGNOSED IN CHILDREN:

Mental retardation Axis II
- 317 Mild
- 318.0 Moderate
- 318.1 Severe
- 318.2 Profound
- 319 Unspecified severity

Learning Disorders
- 315.00 Reading
- 315.1 Mathematics
- 315.2 Written expression
- 315.9 Learning Disorder NOS

Motor Skills Disorder
- 315.4 Developmental Coord.

Communication Disorders
- 315.31 Expressive language
- 315.39 Phonological
- 307.0 Stuttering
- 307.9 Communication NOS

Pervasive Developmental Disorders
- 299.00 Autistic
- **299.80 Rhett's**
- **299.10 Childhood disintegrative**
- **299.80 Asperger's**
- **299.80 Pervasive dev. NOS**

Attention-Deficit and Disruptive Behavior
- **314.01 ADHD**
- **314.00 ADD**
- **319.9 AD/HD NOS**
- **312.8 Conduct (specify child or adolescent onset)**
- **313.81 Oppositional defiant**
- **312.9 Disruptive behavior NOS**

Feeding and Eating Disorders of infancy or early childhood

Tic disorders

Elimination disorders
- **787.6 Encopresis w/ constip.**
- **307.7 Encopresis w/o constip.**
- **307.6 Enuresis (noct, diurnal)**

Other disorders of infancy, childhood, or adolescence
- **309.21 Separation anxiety**
- **313.23 Selective mutism**
- **313.89 Reactive attachment**
- **307.3 Stereotypic movement**
- **313.9 NOS**

USUALLY FIRST DIAGNOSED IN ADULTS:

Mental disorders due to a general medical condition not elsewhere classified.

Substance-related disorders

Schizophrenia and other psychotic

Depressive disorders (partial list)
- **300.4 Dysthymic (early, late, atypical)**

Bipolar disorders

Anxiety disorders (partial list)
- **300.23 Social phobia**
- **300.3 OCD**
- **309.81 PTSD (acute, chronic, delayed)**
- **300.02 Generalized anxiety**

Somatoform disorders

Fictitious disorders

Dissociative disorders

Gender identity disorders

Sexual dysfunctions

Eating disorders

Sleep disorders

Impulse-control disorders not elsewhere

Adjustment disorders
- **309.xx Adjustment**
- **0. Depressed, .24 Anxiety, .28 Mixed**
- **.3 Conduct disturb, .4 Mixed emot/cond**
- **.9 Unspecified (specify acute/chronic)**

Personality disorders Axis II (Antisocial disorder does not qualify for services)

Psychological factors affecting medical condition

Medication-induced movement disorders

OTHER DIAGNOSES:

Relational problems
- V61.9 Related to mental/medical
- V61.20 Parent-child
- V61.1 Partner
- V61.8 Sibling
- V62.81 NOS

Problems related to abuse or neglect
- 995.5 Child victim of neglect, or abuse

V71.09 No Diagnosis on Axis II

Axis IV _____

Axis V (GAF): Current _____

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SC COUNTY CHILDRENS MH SCREENING AND INTAKE

COUNTY OF SANTA CRUZ
CHILDREN'S MENTAL HEALTH
SCREENING AND INTAKE

MH STAFF USE ONLY
CASE #:

If Screening, complete *sections ONE, TWO, THREE* and *TEN* only. For face-to-face complete ENTIRE form.

SECTION ONE: CLIENT INFORMATION

Date:____/____/____ Social Security #:_____-_____-_____ Dominant Language: Parent_____ Child_____

Child's Name:_____ D.O.B.:_____ Age:_____ Sex:____ Ethnicity:_____

Birthplace (City & State):_____ School:_____ Spec. Ed. Highest grade completed:_____

Referral Source-Name:_____ Agency:_____ Phone: (____)_____

Current Therapist/Psychiatrist:_____ Phone: (____)_____

Present Placement-Address:_____ Phone: (____)_____

Present Living Arrangement: Group Home Foster Home Parent/Guardian Redwoods Other:_____

Parenting Arrangement: Two Parents/One Home Two Parents/Two Homes Single Parent (primarily) Other:_____

Custody Status: Both Parents Mother Father Guardian Ward Unknown Other:_____

Parent/Guardian:_____ Relationship:_____

Address:_____ Phone:_____

County of Residence:_____

Legal Consent: Parent 300 (Dependent) 602 (Ward) Adoption Agency Guardian Other:_____

Financial Status: Medi-Cal Insurance Other:_____ _____
(Legal Guardian's County of Residence)

SECTION TWO: CURRENT RISK FACTORS

Rate the current applicable risk factors and presenting problem behaviors using the scale below.
Severity Rating Upon Entry: 1=Mild 5=Severe

Criminal activity (formal/informal probation/uncited criminal activity)	Sexual abuse or Hx	Tantrums/out of control	Poor Social Skills
Unstable living situation putting client at risk of placement	Physical abuse or Hx	Oppositions/defiant	Frequent lying
Gang Involvement	Suicidal thoughts	Runaway/curfew problems	Assualtive behavior
School problems (SARB referrals, falling grades, serious behavior)	Suicidal plan	Cruel to animals	Hyperactive/distractible
Substance abuse causing functional impairment in living skills	Suicidal attempt	Sexual acting out	Depressed/Withdrawn
History of placement or hospitalization during past year	Suicidal Hx	Aggressive (verbal/physical)	Enuretic/encopretic
Psychotic Symptomatology (hallucinations/delusions)	Self injury	Other:_____	

Rate overall risk of out-of-home placement (Referral Source Rating): **High Medium Low**

Further comments regarding risk factors and current emotional & behavioral problems (include multi-agency involvement, if known). PLEASE PRINT LEGIBLY.

SECTION THREE: CLIENT STRENGTHS

List personal strengths of child and/or family which may assist in treatment.

SECTION FOUR: SPECIAL SERVICES REQUESTED

Check if applicable.

STAR	Probation OP	GROW/PARK	Social Services OP (SIS/SAS)
Other SED	Intensive Family Support Services	School OP	Day Treatment
Court Assessment	TBS	Medication	Access Team

Please estimate date without Mental Health Services:_____

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MHE 611 / Rev 2.27.02

SECTION FIVE: PSYCHIATRIC HISTORY/PERTINENT BACKGROUND INFORMATION

Summarize developmental, psychosocial, psychiatric and medical issues. Include placement history, family constellation, etc. Attach court reports, if possible. PLEASE PRINT LEGIBLY.

Medical History:

Substance Abuse History:

SECTION SIX: MEDICATION(S)

#1_____ Start Date:_____ Dosage:_____ Prescribing MD:_____

#2_____ Start Date:_____ Dosage:_____ Prescribing MD:_____

SECTION SEVEN: MENTAL HEALTH EXAM

Hallucinations/Visions:_____

Appearance:_____ Behavior:_____

Mood/Affect:_____ Speech/Thought:_____

Orientation:_____ Judgment:_____

Memory:_____ Insight:_____

Other:

SECTION EIGHT: CLINICAL SUMMARY

PRIMARY PRESENTING PROBLEM:

In summary, if denying services, be specific about rationale (does not meet medical necessity, not at risk of out-of-home placement, etc.):

SECTION NINE: DSM IV DIAGNOSIS

Axis I: Primary_____ #_____ Secondary_____ #_____

Axis II:_____ #_____ Axis III:_____

Axis IV:_____ Axis V:_____

Target Population: HRA PROB 3632 Other SED Overall risk of out-of-home placement (*Assessor's Rating*): High Medium Low
Rate overall severity of mental health condition: Mild Moderate Severe

SECTION TEN: DISPOSITION

A. Level of Mental Health needs identified:
I. No Mental Health needs identified. II. Uncomplicated Mental Health needs that can be met with outpatient counseling.
III. SED*-but low/no risk of out of home placement (has needs for system approach and has full scope Medi-Cal).
IV. SED-at risk or in need of out of home placement or hospitalization. V. Referral to Primary Care Physician.

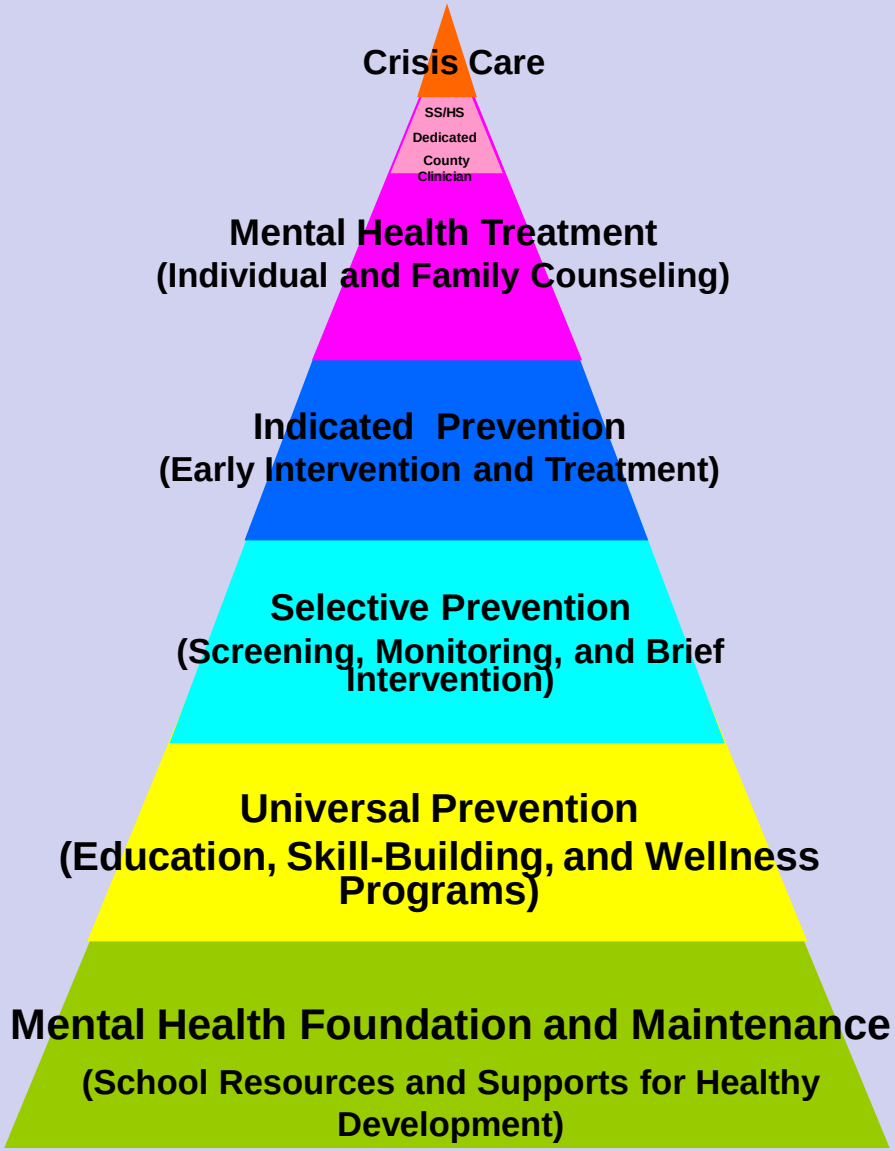
B. Services required to treat individual (check all that apply):

Level of Care				Services required to treat individual (check all that apply)				
Inpatient	Group Home	Ther. Foster Home	Foster Care	OUTPATIENT TREATMENT	Community Referral		Access Panel Provider	
					YSOPN	YSOPS	YSGROW	
Relative/Parents Home		Self/Friends			YSOTHR	YSYWKS	PARCTN	PARCTS
				SOC Children's MH	HRA	PROB	SCHOOL	DAYT
STAR	TYLER	YSATL	UCDT	OTHSED	FAMSUP	COURT	PARKDT	UCTBS
				FQHCN	FQHCS			

C. Comments regarding Disposition:

Name/Title:_____ Date:_____

Pajaro Valley Unified School District Integrated Mental Health Services



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Ongoing Quality Assurance for Integrated Mental Health Services

- Interventions are monitored and improved as needed
- Staff at all levels have appropriate knowledge and skills for their roles and functions (continued professional development).
- Cultural and linguistically competent services and interventions are in place
- Services are coordinated and integrated (No Silos!)
- Appropriate legal considerations are addressed

Safe Schools ★
Healthy Students