Child/Adolescent ESP Comprehensive Assessment

The Child/Adolescent ESP Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served, up to the age of 21, who present for emergency behavioral health services by an Emergency Service Program's Mobile Crisis Intervention Team. For MassHealth enrolled transitional aged youth, this form must be used. For other transitional age youth, agencies will need to decide whether to use this form or the adult assessment form.

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Data Field	Identifying Information
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Organization Name:	Record your agency's name.
Record Number	Record your agency's established identification number for the person.
DOB	Record the person's date of birth
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Date Field	**Custody**
Custody	Check all boxes that reflect the current custody arrangement for the youth. If applicable, include the DCF Caseworker's name. Complete Legal status Addendum if person needs a guardian.
Is there a need for a Legal Guardian, Rep Payee, or Conservatorship?	Check the appropriate box and provide comments regarding the need for a Legal Guardian, Representative Payee, or Conservatorship if needed. If *yes*, complete the Legal Status Addendum.
Referral Source	Indicate the referral source, including name, role, organization and telephone number. Indicate if anyone is accompanying the person, and if yes, the name, relationship and phone number. Indicate whether the parent/guardian(s) or family member was available to participate in this assessment and intervention. If no, please explain.
Data Field	**Presenting Concerns**
What Occurred to Cause the Person to Seek Services Now	Use the person's/family's own words to document the reason the person is asking for help. Also, include the reason the person was referred for services, from the referent's point of view. This should be a concise but complete description of why the person is seeking help now. Include troublesome symptoms, behaviors and/or problems affecting day-to-day functioning, relationships and work. Additional useful information may come from any readily available sources such as schools, hospitals, police departments, or your agency's records.
Precipitating Factors (Note Symptoms, Behavioral and Functioning Needs, parent/guardian/care giver's response to youth's behavior) include what has the person has done in this instance and/or previously to cope and stabilize, coping skills resources and supports the person wants to use right now)	In identifying crisis precipitants, include: psychiatric, educational, social, familial, legal/court related and environmental factors. Record symptoms, behavioral and functioning status and needs at home, school and community as reported by the person served and/or parent/guardian. Be sure to include what the person has done in this instance and/or in pervious instances to cope with the situation and stabilize. Include what coping skills, resources and supports the person wants to use now to help. Examples: "I can't sleep"; "They (my probation officer) said I had to come here"; "I got fired"; "I keep getting into these bad relationships and I don't know what to do". Include parent, guardian, caregivers response to the youth's behavior. Discuss and note what the person can identify and would like to try now to address the precipitants, help them cope, and stabilize. What has been helpful to them when they have been in crisis in the past? What would be helpful to them now? Examples "I just want someone to listen and I think I can calm down," "I need help thinking this through then I think I'll be able to go home," "It helps to talk to my friend but she's out of town" "Last time I wouldn't go to the crisis stabilization program but this time I might." "I think its my meds but my doctor/clinic won't return my call."
Risk Management/Safety Plan: Does the person have a risk management Safety Plan?	Indicate if the person has a Risk Management Safety Plan. If yes, indicate how it was used during this encounter by checking all that apply. If no, complete the Risk Management/Safety Plan form for youth.
If person is a MassHealth enrolled youth up to age	If he/she referred to Mobile Crisis Intervention (MCI) Services by Intensive Case Coordination (ICC) indicate ICC team's assessment, interventions used, and ICC

21 and is in ICC:	intervention and disposition recommendations. If he/she was self- referred to MCI or referred to MCI by another source: Contact ICC immediately to obtain information and coordinate services. In these cases, the MCI is expected to be the first responder, and to coordinate their response with the ICC team.
Data Field	**Family**
Family	Attach Genogram/ Ecomap if completed. Record each household member's name, his/her relationship to the person served and his/her age. **Examples: Mother, Father, sister, family friend, foster brother/sister, step-parent.** Record the household's street address if different from the address listed on the Personal Information form. Record all other significant family members and others not residing in household currently. Record significant history regarding family functioning. Record current status of family functioning.
Data Field	**Collaterals Involved and/or Contacted**
Contact, Contact Name, Telephone, Date and Time, results	Complete each section indicating the person's collateral involvement and document contacts. Indicate date and time of your contact with the collateral contact and the results of your discussions. Under "Other" be sure to include any state agency involvement. Coordinating with other service providers in the person's life is a vital component of the ESP Assessment. Indicate in "results" including which providers where reached and informed of the person's involvement with ESP services, information and treatment recommendations gathered, and coordination of services.
Date Field	**Living Situation**
What is the person's current living situation	Check the box (or boxes) to indicate what the person's current living situation is. You are not required to check off one box under each category (i.e., person's home, residential care/treatment facility, other).
Person's Home	Check if person served currently rents or owns his/her home. If person does not currently reside in independent housing, leave blank and complete the next section.
Residential Care/Treatment Facility	Check if person served is in one of these living situations. If person owns or rents an independent living situation but currently resides in residential care or a treatment facility, complete this and the previous section.
Other	Check appropriate current living situation if not already noted above.
Contact name and phone Number	If a situation in o*ther* is checked, note here the contact name and phone number of the person/facility with whom the person served is living.
At Risk of Losing Current Housing	Check *yes* or *no*. If yes, provide comments that illustrate the situation.
Satisfied with Current Living Situation	Check y*es* or *no*. If yes, provide comments that illustrate the situation.
Comments	Add comments about the person's current living situation as necessary.
Data Field	**Medical/Physical**
Allergies	List all known food, medication and environmental allergies for the person. Note drug sensitivities. If no allergies/drug sensitivities are known, check *No known allergies* and skip to next section.
Significant History Regarding Physical Health Reported (include asthma, obesity, diabetes)	**The health history is based on the person's self report and not based on a physical examination from a qualified healthcare professional.** Summarize, based on person's self report, physical health history including chronic conditions, or dental issues. If there are significant health issues and an exam has been conducted by a qualified healthcare professional, then check *Refer to Attached Physical Health Assessment* and complete or include that document to provide necessary details.
Current Status of Medical/Physical	**The current status of medical/physical functioning is based on the person's self report and not based on a physical examination from a qualified healthcare professional.**

Functioning Reported, include current physical complaints.	Summarize, based on the person's self report, his/her current physical functioning, including complaints that may interfere with the person's functioning or ability to attend and benefit from treatment.
Does the person or guardian request immediate medical evaluation	**Indicate if the person or the guardian requests an immediate medical evaluation and indicate the reason they are requesting this evaluation.**
Date Field	**Developmental**
Significant History Regarding Developmental Functioning	Record significant history regarding developmental functioning. Include information regarding prenatal history, developmental milestones, any disruptions in achievement of developmental tasks, or other pertinent information regarding development. **Examples: Child did not walk until age 2 ½; child was unable to successfully separate from mother to attend preschool.** Record current status of developmental functioning.
Current Status of Developmental Functioning	Record current status of developmental milestones achieved or delays in attainment.
Date Field	**Substance Use / Addictive Behavior History**
Does person report a history of, or current, substance use/addictive behavior concerns?	At a minimum, a basic screening instrument (e.g. CAGE, MAST, DAST) should be employed in addition to person's self report and information available from other sources. If there are no substantial indications for substance use or addiction problems past or present check *No* and skip to the next section. If *yes*, complete the Substance Use/Addictive Behavior History Addendum.
Data Field	**Mental Health Service History**
None Reported	If None Reported, skip to the Health Summary section
Mental Health Treatment	Check all boxes that apply.
Type of Service	Record the type of service received; be as specific as possible. **Examples: Inpatient, Partial Hospitalization Program (PHP), Outpatient Group.**
Dates of Service	Record the approximate date range of service.
Reason	Record the reason that person received treatment. **Example: Depression**
Name of Provider / Agency	Record the name of the provider and/or agency.
Completed?	Check if person completed the originally planned service. **Example: Check *No* if person discharged himself against team's recommendations**
Past/Current Diagnoses	Record all past/current psychiatric diagnoses known by the person, significant others, former clinician(s) or identified in former records. This is not an attempt to formulate a diagnosis, only information gathering. Identify the source(s) of the information. **Examples: The person, hospital records, primary support person, case manager etc.**
Summary of Current Mental Health Functioning/Symptoms:	Describe, in summary, the person's current mental health functioning and/or symptoms.
Data Field	**Current Medication Information** (Include All Non-Psych Meds/Prescription/OTC, Herbal)
Medication	Record current psychiatric and non-psychiatric medications, by a licensed prescriber or self-prescribed, as well as over the counter and/or herbal medications and supplements. If the client does not know the name of the med the information should still be completed – under name of medication list unknown and then list all other information client remembers – this is especially important for current meds.
Rationale/Condition	Indicate the symptoms or diseases for which the medication was/is used.
Dosage / Route / Frequency	Record the dosage for each medication taken by the person. It is suggested that dosage be recorded as unit/time of day. **Example: 50 mg @ 9AM, 10 cc @ 5 PM and 20cc @ 8PM.**
Reported Side-effects	Record any reported side-effects. Document the degree of distress the person experienced or experiences due to each side-effect.
Adherence	Check the box that best indicates if the person takes the medication as prescribed or

(WA = With Assistance)	suggested, or if the person needs assistance to adhere to the medication regimen.
Prescriber	Record the name of the physician or other licensed prescriber who prescribed the listed medication.
Comments on Medications	Note which medications have been tried in the past indicating which ones have worked well or not. Record relevant comments, including reasons for discontinuation of the medication, why person doesn't take meds as prescribed, side-effects and any specific medications the person would like to avoid taking in the future.
Data Field	**Trauma History**
No Self Reported History of Abuse/Violence	If the person reports no history of abuse/violence, check this box and continue to the next section.
Multiple Fields: Physical Abuse; Domestic Violence/ Abuse; Elder Abuse; Community Violence*; Physical Neglect; Verbal/Emotional Abuse; Sexual Abuse/Molestation; Military Trauma; Other Trauma; Witness to Violence; Witness to MH/SA issues of household members	For each traumatic event, indicate if the person was the victim or perpetrator and describe specifics of trauma in the comments section to the right. Note if experience was single event or sustained over time. *Example: Gang violence
Current Involvement by	Check the box(es) that apply. Add comments if necessary.
Additional Mandated Report Required?	If the person reports any activity that requires interviewer to report to an oversight agency, check the box(es) that apply. Add comments if necessary.
Data Field	**Mental Status Exam**
Mental Status Examination	Avoid judgmental perceptions. Take into account cultural differences. • Think of creating a picture of the person served so that anyone reading the results of the exam would be able to clearly perceive the person just as you do. • Assessment items are "in the moment", in other words as the person presents to you at the present time. There are other sections of the assessment form that address historical information.
Appearance	Check appropriate boxes to describe physical appearance, taking into account culture and age of person.
Eye Contact	Check boxes that apply.
Build	Check boxes that apply.
Posture	Check boxes that apply.
Body Movement	Check boxes that apply.
Behavior	Check boxes that apply.
Speech	Check boxes that apply.
Emotional State-Mood	Sustained internal emotional state of a person. This describes the typical, more consistent emotional state of the person. Examples: Typical Mood is balanced and WNL; Mood is typically subdued; Mood is typically anxious and irritable. Check boxes that apply.
Emotional State-Affect	External expression of present emotional content. This describes the emotional state presently observed or described. Examples: Person describes inability to sleep through the night (sleep disturbance), loss of appetite (appetite disturbance), irritability over the past three weeks; Person appears somewhat elated (inappropriate), describes lack of fatigue although has not slept for three nights (sleep disturbance). Check boxes that apply.
___Constricted	Feelings demonstrated are subdued and do not appear to present the full range usually seen in people of this culture (cultural expectations are vital considerations in this area).
___Flat	No feeling states are demonstrated.
___Inappropriate	Demonstrated feelings do not match with subject discussed (e.g. laughing while discussing a trauma experience).

___**Changeable**	Demonstrated feelings shift rapidly from one state to another. Called changeable on the form.
___**Full Range**	Demonstrates a full range of feelings.
___**Panic attacks or symptoms**	Person describes recent anxiety/panic symptoms including: shortness of breath, rapid breathing/hyperventilating, extreme discomfort with crowds or open places, sweatiness or dizziness.
___ **Sleep disturbance**	Person describes recent difficulties sleeping including generally reduced or increased sleep, difficulties falling asleep (longer than 1 hour), and difficulties remaining asleep, early morning awakening or no perceived need for sleep for longer than a day.
___ **Appetite disturbance**	Person describes marked changes in appetite including but not limited to incessant hunger or lack of hunger for more than 1-2 days.
Facial Expression	Check boxes that apply.
Perception	
___ WNL	If there are no perceptual disturbances, check here
___Illusions	A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices.
___Depersonalization	An alteration in the perception or experience of the self. The person will describe feeling as though he/she is "not really there" , detached from or feeling as though he/she is an outside observer to his/herself or as if in a dream.
___De-realization	An alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical).

Hallucinations	Hallucinations are perceptions with a compelling sense of reality but occurs in the absence of stimuli. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination.
___Auditory	Usually described as voices. To assess, ask the individual, "Do you ever hear anyone talking but cannot tell where the voice is coming from?" If they answer yes, ask if he/she can tell what the voice is saying and he/she can identify the voice.
___Visual	Visual hallucinations are usually only experienced by individuals who have ingested an illicit drug or drug overdose, or someone who has experienced a head injury. It is important to ask the person served to describe the visual hallucination and under what circumstances it occurs.
___Olfactory	A hallucination involving the perception of odor, such as of burning rubber or decaying fish. This is usually a symptom of a neurological disorder or brain injury.
___Gustatory	A hallucination involving the perception of taste (usually unpleasant). This is usually a symptom of a neurological disorder or brain injury.
___Tactile	A hallucination involving the perception of being touched or of something being under one's skin. This is more typical in substance dependent individuals (especially alcoholics) who are detoxifying. The most common tactile hallucination is the feeling that bugs are crawling under the skin.
___Command**	Command hallucinations are voices telling someone to do something dangerous or harmful (e.g. "kill him").
Thought Content	
Delusions	Beliefs in things that are not true (e.g. "Aliens have planted a sensor in my head").
___None reported	No observable evidence of delusions or delusions are denied.
___Grandiose	Thoughts of exaggerated and somewhat improbable status or success: "Mattel is going to buy my game and I'll make millions."
___Persecutory	"People are trying to kill me."
___Somatic	Physical complaints in the absence of any real cause. Fear that stomach pains are cancer even after a doctor has examined him/her and found no health problem.
___Illogical	"My neighbors are throwing away babies in the trash. I can hear them at night."
___Chaotic	"The world is going to end on New Year's Day."
___Religious	"I am the second coming."
Other Content	
___Preoccupied	Person appears to be lost in thought, engrossed or absorbed to such a degree that communication with others is compromised.
___Obsessive	Persistent and disturbing intrusive thoughts, ideas or feelings.
___Guarded	Statements, ideas, responses are brief and person appears reluctant to provide details

	or information.
___Phobic	Exaggerated fear inexplicable to the person (e.g. airplane flight, spiders, heights).
___Guilty	Focused on unrealistic self-blame.
___Ideas of reference	"Those people standing together over there are talking about me."
___Thought broadcasting	"I can make those people think what I am thinking."
___Thought insertion –	"Those people are sending their ideas to me."
Self Abuse Thoughts	Take care to differentiate between thoughts of self abuse/self harm behaviors and suicidal actions.
___None reported	No acknowledgment or evidence of thoughts of self harm behaviors.
___Cutting**	Thoughts of any type of scratching or cutting that draws blood or damages the skin or a body part
___Burning**	Thoughts of putting hot objects, including open flames in contact with any part of the body so as to damage the skin or a body part.
___Other self mutilation**	Thoughts of pulling out hair, damaging eyes , etc.

Suicidal Thoughts	
___None reported	Person denies thoughts of taking his or her life.
___Intent	Person admits to seriously considering taking his or her life. This goes beyond feelings of hopelessness or frustration.
___Plan	Person describes a viable, actual plan to take his or her life.
___Means	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. stock-pile of pills, gun).
Aggressive Thoughts	
___None reported	Person denies thoughts of harming another person.
___Intent	Person admits to seriously considering harming another person. This goes beyond feelings of anger or frustration.
___Plan	Person describes a viable, actual plan to harm another person.
___Means	Person has in his/her possession the object or objects necessary to complete his/her plan (e.g. knife, gun).
**	**Checking any item with ** requires an immediate risk and/or lethality assessment.**
Thought Process	
___WNL	Within Normal Limits) - Thoughts are clear, logical and easily understood.
___Incoherent	Thoughts, words or phrases are joined together without a logical or meaningful connection or relevance, and are not understandable despite repeated attempts to explain.
___Circumstantial	Pattern of speech in which the person is not able to respond directly to a question but will provide a lot of related information.
___Decreased thought flow	Responses and statements are slow and have a paucity of details.
___Blocked	The person has consistent difficulty responding to questions. Answers or statements are either very brief and appear difficult to produce or there are no responses at all.
___Flight of ideas	A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.
___Loose	A disturbance of thinking shown by speech in which ideas shift from one subject to another that is unrelated or minimally related to the first. The speaker gives no indication of being aware of the disconnectedness, contradictions, or illogicality of speech. To assess for loose thinking, ask the person to explain a proverb. For example, "People who live in glass houses shouldn't throw stones". An example of loose thinking would be: "If you don't punch holes in the top, everyone dies."
___Racing	Demonstrates rapid thinking that is not necessarily bizarre or unusual but thought production is faster than most people typically demonstrate.
___Increased thought flow	Responses and statements are rapid and rich with detail.

___Concrete	To assess for concrete thinking, ask the person to explain a proverb. For example, "People who live in glass houses shouldn't throw stones". An example of concrete thinking would be: "Rocks break glass."
___Tangential	A question or statement will prompt a response that begins with one subject and ends with an entirely different subject only vaguely related to the first subject, if at all.
Intellectual Functioning	
___WNL	No apparent deficits in intellectual functioning.
___Lessened fund of common knowledge	Ask: "Who is the President of the United States?" "Who was President before him or her?"
___Short attention span	Person demonstrates difficulty staying on topic or attending to a task.
___ Impaired concentration	Person is distracted from basic tasks
___Impaired calculation ability	Ask the person to count backwards from 100 by 7's.

Intelligence Estimate	This can be an estimate only in the absence of any accepted intelligence tests or information from other sources. Keep in mind that some psychiatric disorders (depression) can negatively impact IQ scores. Intelligence is generally accepted to be a person's capacity to absorb information and solve problems.
___MR	IQ under 70 on the Wechsler scale.
___Borderline	IQ from 70-79 on the Wechsler scale.
___Average	IQ from 90-109 on the Wechsler scale. (80-89 is considered "low average").
___Above average	IQ above 110 on the Wechsler scale.
___No formal testing	Note if there is no record of formal testing of intellectual functioning (e.g. MMPI)
Orientation	
___WNL	Check here if the person can correctly respond to the following questions about person, time and place.
Disoriented to:	
___Person	Does the person know his/her correct name, age and some facts about his/her life.
___Time	Does the person know what time and day it is (within a few hours and days).
___Place	Does the person know where he or she is?
Memory	
___WNL	Check here if the following three areas are responded to sufficiently.
Impaired:	
___Immediate recall	At the beginning of the assessment interview, tell the person you are going to state three objects that you will ask him or her to recall later in the interview. Use three basic objects such as tree, car and floor. After 10-15 minutes, ask the person to tell you what the three items were that you asked him/her to remember from the beginning of the interview.
___Recent memory	Can the person tell you what they had for breakfast or what he/she did first thing this morning?
___Remote memory	Can the person describe events form his/her childhood or in the past?
Insight	Check the most appropriate description of the person's current functioning.
Judgment	
___WNL	Decision making abilities appear intact and sufficient for day-to-day functioning.
Impaired ability to make reasonable decisions	Utilize scenarios to assess: 1. If you were in a crowded movie theatre and noticed there was a fire off to the side in a hallway, what would you do? 2. If you found a fully addressed and stamped envelope on the sidewalk, what would you do?
___Some	
___Severe	
Past attempts to Harm to	Check the all boxes that apply and comment on all past attempts.

Self or Others	

Risk Assessment

The following assessment tool is to be used if the person served has made contact with a behavioral health professional and is willing to work with us, to some degree to assess risk. If a person is fully determined to take their own life or that of another, there may be nothing a behavioral health professional can do to prevent this from occurring. The assessment of risk is complicated and is based on many interacting factors. The items in this tool are based on research and many years of practical experience. The tool is a means to gather data. This data must then be considered in its entirety before making a determination of risk.

Plan to Harm Self	***Does the person describe any plan to harm themselves?***
Means/Accessibility	If the person is stating that they have thoughts about hurting or killing themselves, do they possess the means to carry out the plan. For example, if they describe thoughts about "taking pills" to end their life, do they have in their possession the type and sufficient quantity of pills to do so? If they do not have the pills in their direct possession, can they access them without too much difficulty? (example: pick up prescriptions waiting for them at pharmacy; take roommate's meds.)
Lethality Of Means	Assess the person's lethality of the means on a range of "least likely to be lethal"(low) to "most likely to be lethal" (high). "Taking some pills" has much less chance of lethality than "shooting myself in the head with a shot-gun".
Suicidal History	At any time in the past, has the person experienced any suicidal thoughts or engaged in any self-harm behavior? Have these experiences been Ideation/threats; gestures; or an actual attempt to kill themselves. Ask: "What did you intend to have happened as a result of (the action)"
Lethality Of Attempts	If the person has at any time attempted to take his or her life, To what degree was the attempt potentially lethal (see Lethality of Means" above)
Last Attempt	If the person has made a suicide attempt, when was the last attempt? If the exact date is unknown, estimate to the best of your ability with the information available.
Family History	Note any family history of suicidal behavior including threats, attempts and actual suicides.
Plan To Harm Others	***Does the person describe any plan to harm another person?***
Means Accessibility	If the person is stating that they have thoughts about hurting or killing themselves, do they possess the means to carry out the plan. For example, if they describe thoughts about "taking pills" to end their life, do they have in their possession the type and sufficient quantity of pills to do so? If they do not have the pills in their direct possession, can they access them without too much difficulty? (example: pick up prescriptions waiting for them at pharmacy; take roommate's meds.)
Lethality Of Means	Assess the person's plan on a range of "least likely to be lethal" to "most likely to be lethal". "Punching someone" has much less chance of lethality than "shooting them with a shot-gun".
Assault History	At any time in the past, has the person experienced any assaultive thoughts or engaged in any assaultive behavior? Differentiate between a frustrated and angry person "blowing off steam" and actual assaultive planning or behavior. Ask: "If you had the chance, would you really have done this?"
Lethality Of Assaults	If the person has assaulted another person at any time, how severe were the victim's injuries? (Example: did the victim receive some cuts and bruises or end up in a hospital intensive care unit?)
Last Assault	If the person has assaulted another, when was the last incident? If the exact date is unknown, estimate to the best of your ability with the information available.
Family History	Note any family history of assaultive behavior and how often it occurred.
Arrest Record	Note if the person has ever been arrested, for any reason and if it was a single arrest or multiple arrests.
Physical Abuse Hx	Note if the person has ever been physically abused and if so, how often were the occurrences
Sexual Abuse Hx	Note if the person has ever been sexually abused and if so, how often were the

	occurrences
Substance Abuse	Note the person's use of potentially addictive substances and estimate of they appear to be a "social" user, abuser or dependent.
Sexualized Behavior	Note if the person has a history of sexually provocative speech, removing clothing, other provocative gestures, etc.
Runaway Risk	Note if the person has a history of running, and current assessment of run potential. If history, note known information such as location person runs to, contacts, etc.
Delinquent Behavior	Note if the person has a history of delinquent behavior, note the nature of the behavior and current activities.
Fire Setting	Note if the person has a history of fire setting, list specifics if known, including dates.
Gambling	Note if person has a history of gambling, Include internet gambling if appropriate.
Bullying	Note if person has a history of bullying.
Other Risk Behaviors	Note other risk behaviors.
Mental Status	**If necessary, administer the more complete mental status exam available in the Comprehensive Assessment**
Hallucinations	Note if the person reports or appears to be experiencing hallucinations. Ask: "Do you ever hear sounds or someone talking to you and you cannot tell where it is coming from?" Seek as much detail as possible. Clarify if any voices perceived are commanding the person to do something potentially harmful or if the voices are disturbing to the person.
Judgment and Reality Testing	From the information available, estimate the person's current ability to make safe decisions. Ask: "If you were in your apartment and noticed smoke coming from a crack in the ceiling, what would you do?"
Orientation	Clarify the degree to which the person is oriented toward the future. Ask: "What are you plans for next weekend?" or "Have you though about what you would like to do when you are feeling better?" A person without a future orientation is much more at risk than someone who has plans for a later time.
Interpersonal interactions	Determine the degree with which the person has meaningful contact with others. Ask: "Do you have friends? Tell me about them. How often do you see them?" An isolated person is much more at risk than someone who has meaningful contact with others in their life.
Impulsivity	From the information provided, can you determine if the person can take the time to make decisions or are they more likely to react impulsively?
Stress	Does the person describe subjective feelings of stress? What feels stressful to them? How long have they experienced this stress? Ask: "On a scale of 1-10, how would you rate this stress?"
Loss	Has the person experienced a significant loss and if so, when? Examples: spouse, parent, home, job, pet.
Physical Condition	Is the person physically healthy? Are they able to exercise regularly or have they become increasing less functional due to medical or physical problems?
Financial Stress	Does the person feel as though they have sufficient income to meet basic needs? Do they feel stressed by their financial situation? Ask: "On a scale of 1-10, how would you rate this stress?"
Living Arrangements	In their current living situation, does the person have access to other people or is the person isolated?
Support From Significant Others	Does the person have supportive others in their life? This may include spouse/partner; relative; friend; clergy. This does not include professional helpers.
Male Age Suicide	If this is an assessment of a male for suicidal behavior, note which age category the person is currently in
Homicide	If this is an assessment of a male for homicidal or assaultive behavior, note which age category the person is currently in
Female Age Suicide	If this is an assessment of a female for suicidal behavior, note which age category the person is currently in
Homicide	If this is an assessment of a female for homicidal or assaultive behavior, note which age category the person is currently in

Overall Risk Level	There is no formula to assessing Overall Risk Level. You must take into account the multiple factors and the amount of High, Medium, Low and No Risk data available. Check the box you determine fits best with the data obtained.
Comments	Provide a rationale for your determination of Risk Level
Safety/risk issues for the parent/guardian/caregiver	Indicate any safety or risk issues for the parent, guardian, and/or caregivers of the person.

Data Field	Assessed Needs Checklist Including Functional Domains
Check all Current Need Areas	Check all current need areas for the person. Each *Assessed Needs Area* addressed will tie directly to the Individualized Action Plan and constitutes the beginning of the order for treatment. *Need Areas* should be determined based on assessment areas above with emphasis on those areas that interfere with or prevent assumption or continuation of the person's self-determined valued life roles in the areas of Activities of Daily Living, Addictive Behaviors, Behavior Management, Family and Social Support, Mental Health/ Illness Management, Physical Health, Risk/Safety and Other.
As Evidenced by	Indicate the behavioral and other evidence, based on the assessments completed above, that support listing the area as an assessed need area.
Person Served Desires Change Now?	Check the box that applies. This section will be used to generate the Prioritized Assessed Needs.

Data Field	Person's Served Strengths/Capabilities/Resiliency (Skills, Talents, Interests, Aspirations, Protective Factors)
Personal Qualities	Describe the personal qualities (strengths/capabilities) that can be put in service toward the person's goals. **Examples: Intelligence, sense of humor, determination, self-knowledge, collaborative, emotional intelligence, etc.**
Daily Living Situation	Describe the person's strengths and capabilities regarding his/her daily living situation. Record the community resources available to the person. **Examples:** Lives close to needed services such as pharmacy, public transportation etc.
Financial	Describe the person's strengths and capabilities regarding his/her financial situation. Example Person's parents have had a steady source of independent income for 12 months.
Employment/Education	Describe the person's strengths and capabilities regarding his/her employment/education situation. Example: Person has done well in school for the past several months.
School, Family and Social Supports	Describe the person's school, family and social supports and how these can assist in working toward the person's goals.
Health	Describe the person's strengths and capabilities regarding his/her health. Example: Youth is physically healthy and active
Leisure/Recreational	Describe the person's strengths and capabilities regarding his/her leisure/recreational skills. Example: Youth participates in Little League sports and "feel good" for several hours after a game.
Spirituality/Culture/ Religion	Describe the person's strengths and capabilities regarding his/her spirituality, culture and/or religion. Example: Youth enjoys talking with his grandfather about growing up in China
Other	Describe any other significant strengths, abilities and/or resiliencies that will assist the person in working on toward his/her goals.
Parent/guardian caregiver strengths and resources and how they impact their ability to care for the youth's behavioral health needs.	Describe the person's parent's/guardian's/caregivers' strengths and resources and these will impact their ability to care for the youth's behavioral health needs and assist in the current situation. Example: Successfully parented 2 older children
Natural supports,	Describe the natural supports, community resources and/or professionals that can assist in stabilizing the current situation and offer on-going support to the youth and

community resources and professionals that can assist in stabilizing the current situation and offer ongoing support to the youth and parent/guardian/caregivers.	his/her parent(s), guardian(s) and/or caregivers. **Example: Good rapport with school counselor**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the person (and/or primary support person) which allows the person (and/or primary support person) to express his/her desired treatment, support preferences and priorities. Record the prioritized service preferences for the full range of behavioral health and community-based rehabilitative services, and environmental support services available, as identified by the person (and others involved with the person) based on the areas covered in the Assessed Needs. Include the person's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the person, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the person's preferences for activities focused on increasing his/her power and control over his/her life and future.

Data Field	Intervention and Stabilization
Therapeutic Interventions Delivered, including solution-focused crisis counseling and brief interventions that address behavior and safety	Describe the specific therapeutic interventions and crisis counseling provided during the crisis assessment and stabilization service to assist the person and parent/caregiver, and address behavior and safety. Examples: Helped Rebecca in identifying times of the day that she feels less suicidal (identifying "exceptions"). Through this process, Rebecca identified that she is suicidal at bedtime but that she rarely had these feelings during other times of the day. Through the use of a simple rating scale, Rebecca discovered that though she has thoughts of suicide that scare her (4 out of 5) she has a very low belief that she would actually harm herself (1 out of 5). Rebecca expressed a new understanding that having thoughts of suicide was not the same as being in danger of dying. Rebecca was then able to identify three techniques that she would use when having thoughts in her head that she does not like: 1. She will remind herself that that she is not in danger and that the thoughts are a habit of thinking that she has developed, 2. She will ask for her mom to assist by providing coaching and support, and 3. Each morning she will chart how successfully she mastered her thinking. Assisted Rebecca in including these strategies in her risk management / safety plan. This intervention increased her feeling of safety and her comfort, and that of her parents, with remaining at home tonight with a plan for the clinician to meet with them in the home at 8:00 tomorrow morning to assess how Rebecca is doing. Helped Henry and his mother identify the period of time each day when Henry (per his perspective) feels like he gets into the most trouble and when his mother (from her perspective) feels Henry most often misbehaves. They both identified the period between 3:00 (home from school) and 5:00 (dinnertime) as most problematic. Asked each to identify what is most important to them to accomplish during that period. Henry said he wants to be able to play and his mother said she wants him to do his homework while she cooks dinner and does other household chores. Henry and mother were asked to think of a solution that would allow all of those things to occur. They agreed that from 3:00 to 4:00, he would do his homework and she would offer coaching and assistance. From 4:00 to 5:00, Henry will have a dedicated hour to play and his mother will have an hour to prepare dinner and do other chores. Henry and his mother agreed to a 2-day test period to see how well the plan is working. Clinician will call them at 5:00 for the next two days to check in.
Person's Response to Interventions	This section should address BOTH: • The person's response to the intervention - Include evidence the person participated in the evaluation and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills.

	• Progress towards goals and objectives - Include an assessment of how the session has moved the person closer, further away, or had no discernable impact on meeting the identified goal(s) and objective(s) of this crisis intervention. Examples: Keisha and her father both actively participated in the crisis intervention and each had a chance to hear the other person's perspective. Keisha's father said that he understands that it is helpful to Keisha if she can have time by herself to regain control when she is feeling angry. They both are comfortable with her using her bedroom as a place to regain control. Keisha agrees that if her father has any concerns about her safety that he will knock on her door and if she does not answer he will enter the room. Keisha agrees to talk to her father following these 'time outs' to let him know she is feeling better and to resolve any differences. These agreements were incorporated into the risk management / safety plan. Derek had witnessed a fiery car accident a week earlier. Clinician gave written information to Derek and his parents about the normal signs and symptoms that people usually experience after a very abnormal and scary event. In reviewing the materials, Derek was excited to see that "startles easily," "difficulty falling asleep" and "reliving the event" were on the list because he had been concerned he was "going crazy," and he got in trouble at school for falling asleep at his desk. Clinician shared that most kids start to feel better after a few days and then things usually get a little bit better each day. Derek's parents voiced relief that the symptoms did not suggest something worse and asked if clinician would call Derek's teacher and explain what he has been experiencing. Derek , his parents and clinician agree that the crisis has stabilized, Derek and his parents voice understanding that he seems to be experience uncomfortable, but not abnormal symptoms. If the symptoms do not improve in the next two weeks or if one or more symptom becomes too uncomfortable, Derek's parents will seek treatment from a trauma-trained clinician, and/or call the ESP MCI team again if they feel it is urgent. Juan, his mother and clinician all agree that Juan's behavior is in much better control and that hospitalization is not necessary. However, Juan's mother voices concern that once the MCI team leaves that Juan's behaviors will escalate again. As part of the crisis stabilization plan, Juan, his mother and team agreed to the following: 1. A follow-up meeting in the home with the clinician and family partner in 24 hours to review progress and address any concerns with the risk management / safety plan, and 2. Family Partner will return to the home while Juan is at school (the next day) to talk to Juan's mother about the difficulty she is having with the school and to identify resources and supports
Stabilization Activities	Describe the specific stabilization activities delivered to the person during this intervention. Example: Family Partner met with Tuan's mother to review what has occurred since the crisis intervention one day earlier. Tuan's mother reports that she has been pleased that Tuan appears to be comfortable using his risk management / safety plan and that they have not had any arguments during the past 24 hours. Tuan's mother shared concern about calling the school to schedule a conference. Family Partner actively listened to Tuan's mother's long-standing frustration with the school and affirmed the challenge of parenting a child who has not had school success. Family Partner and Tuan's mother discussed strategies for requesting the meeting and offered to accompany her if Tuan's mother thought that would be useful. The stabilization plan targeted the hour before school each day because this is the period of time when Tuan begins to get stomach aches and makes threats to kill herself if she is forced to go to school. Clinician and Family Partner arrived at the home 90 minutes prior to the time Tuan leaves for school. Clinician supported and coached Tuan as he attempted to use the techniques identified during the crisis intervention a day earlier. Family Partner supported and coached mother in new techniques designed to aid Tuan in getting to school. When Tuan's mother took Tuan to school, clinician and family partner followed and continued to offer support until Tuan went successfully to class.
Data Field	**Clinical Formulation - Interpretive Summary**
This Clinical Summary is Based Upon Information Provided By	Check the box(es) that apply.
Interpretive Summary	This section should reflect the person's status, and your plan, after the ESP has

	provided crisis intervention and stabilization activities as reflected in the previous section. Do not duplicate the information provided earlier in this document. Instead, provide a brief narrative summary and analysis that blends the findings and opinions of the interviewer(s) and the preferences of the person/family into a concise synthesis. Describe the origin of the presenting problem(s), severity and factors contributing to its continuation, where the problem occurs (home, work, in community) and whether it is short or long term. Describe the significance of the problem(s) in the person's cultural and developmental context. Summarize the person's motivation for treatment and support, readiness for change, potential barriers to change and preferred learning style(s). Finally, assess person's strengths and assets in the areas of personal qualities, daily living situation, financial assets and insurance coverage, work and education, social support, recreation/leisure skills, and spirituality/religion that can be leveraged to make progress toward the person's goals. Follow agency policies and procedures to determine who should complete the Interpretive Summary.
Data Field	**Diagnosis**
General Instructions: Diagnosis	This section is used to record all current diagnoses that will provide the documented support for the medical necessity of services that will be provided for the person. Diagnoses can be recorded in either ICD CM codes and narrative, or DSM codes and narrative. Check the applicable box at the top of the Diagnosis section to indicate if you are using ICD or DSM codes. ICD CM Codes: List codes in appropriate order using ICD coding conventions. Next to each code, complete a narrative description of the code from the ICD CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. DSM Diagnostic Codes: List codes next to appropriate Axis designation using DSM coding conventions. Up to two Axis I and Axis II diagnoses can be recorded. All five axes can be recorded in this section. Next to each code, complete a narrative description from the DSM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode.
Check Primary	Check the primary diagnosis.
Axis I, II, III, IV, V	
Code	Indicate the ICD or DSM numerical or alphanumerical code.
Narrative Description	List the narrative description of the code in either DSM or ICD terminology.
Data Field	Further Evaluations Needed
Further Evaluations Needed	Check the box(es) that best identify additional assessment(s) needed for the person (if any).
Data Field	**Was Outcomes Tool Administered?**
Was outcomes tool administered?	Note if a standardized outcomes tool was administered for this person. This may include the TOP, Basis-24, CANS. or other instruments.

Data Field	Prioritized Assessed Needs as Evidenced by
Prioritized Assessed Needs to be addressed at the next level of care, as Evidenced by	The information for this section comes from the Assessed Needs Checklist, regardless of whether or not the person desires change at the current time. Identify and record *Assessed Needs* of the person/family The clinician, person served and others involved with the person, including family as indicated, will collaborate to identify and prioritize needs. These identified needs will be considered the basis for subsequent treatment goals and/or objectives and all recommendations and needs will be geared toward improving the functioning of the person in life roles or reducing the symptoms of his/her illness**.** **Examples: Address a specific precipitant (specify) to this crisis; address a specific medication issue (specify); Decrease symptoms of depression; learn**

	anger management strategies; improve personal hygiene; develop Wellness and Recovery Action Plan (WRAP) to decrease likelihood of psychiatric relapse; learn pain management skills; improve medication management skills; reduce suicidal ideation; improve social skills; reduce dissociation; learn stress management skills; improve sleep hygiene skills; increase personal safety skills; obtain a specific evaluation (specify); arrange a specific aftercare service (specify), etc. Assess all Recommendations/Needs as ACTIVE, PERSON DECLINED, DEFERRED, or REFERRED OUT. Include rationale for all Declined, Deferred and Referred Recommendations/Needs.
Person Declined/Deferred/Referred Rationale(s)	Describe reasoning behind worker's decisions to defer work on any high priority assessed needs. Also provide reasoning behind decisions by person served to decline or defer a recommendation at this time.
Data Field	**Disposition Details**
Collateral Details	Indicate where information was gathered from; check all that apply. Indicate the person(s) responsible for Personal Safety Check, Medical Clearance if needed, Psychiatric consult and/or Section 12 Authorization, if applicable.
Current Safety Assessment	Check all that apply.
Level of Care/Indicated Service Recommendations	Check all that apply. Note regarding ICC: "Intensive Care Coordination is a care coordination service available to MassHealth enrolled youth up to age 21 with Serious Emotional Disturbance. It is not a treatment service. While a referral to ICC will be appropriate for many youth who utilize MCI services, it is not appropriate to expect that ICC will provide continued crisis stabilization or other urgent treatment services. In most cases of unlinked youth, it will be appropriate to refer to both ICC and one or more direct services, such as FST/in home therapy or outpatient services."
Diversion alternatives discussed	Report all alternatives to recommended LOC identified and discussed with the consumer and family if appropriate. Document why those diversionary services were not accessed.
For any MassHealth enrolled youth up to the age of 21 who will remain in the community (ie: not be admitted to a 24 hour level of care other than Community Crisis Stabilization),	Document the MCI Team's plan for the provision of crisis stabilization services for up to 72 hours? Include type and frequency of contacts and services as well as roles. The MCI team ensures that families have established a connection with the services and supports identified through the MCI assessment and intervention. MCI remains involved with the youth and his/her parent/guardian/caregiver(s) until aftercare services are established and work has begun with the identified aftercare providers. If the youth is admitted to a Community Crisis Stabilization program, the MCI provider facilitates access and stays involved for up to 72 hours, working with the CCS provider and family to support the youth in returning to the community.
Informed person and parent/guardian/caregiver of availability of the ESP's MCI services if needed in the future.	It is important to educate utilizers of ESP/MCI of the availability of this service on a mobile basis as well as the ESP's community based location, especially if the current ESP/MCI intervention was provided in the hospital emergency department setting. If you did not do so, explain.

Data Field	Staff Signatures
Provider – Print Name/Credential and title	**Legibly print** name and credential(s)of person completing the Comprehensive Assessment.
Date	Next to each signature record the date of the signature.
Supervisor – Print	If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.

Name/Credential (if needed)	
Date	Next to each signature record the date of the signature.
Provider Signature	**Legible signature** of person completing the Comprehensive Assessment.
Date	Next to each signature record the date of the signature.
Supervisor Signature (if needed) see also MDT requirements for day treatment and signatures.	If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.
Person's Signature Recommended if appropriate)	Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.
Date	Next to each signature record the date of the signature.
Parent/Guardian Signature (Recommended)	Signature of the person's parent or guardian agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.
Date	Next to each signature record the date of the signature.
Next Appointment / Date /	Record the next appointment for the person including date
MD Signature	This is a requirement for Opiate Treatment Programs