

County of Sonoma – Superior Courts
Mental Health Diversion Court
Universal Treatment Participation & Progress Report

You have been identified as a healthcare provider who is providing services to someone who has been granted Mental Health Diversion Court in Sonoma County, California. In order for participants to remain eligible for Mental Health Diversion Court, all clients must provide a written report about their progress in treatment prior to each appearance in Mental Health Diversion Court. In an attempt to support healthcare providers with providing this information, a Universal Progress Report is now available for use. Thank you for taking a few moments to complete this report.

➤ **Please complete sections # 1-3.**

Section #1:

Client Information

Client Name:	
Today's Date:	
Treatment Provider Name:	
Treatment Provider Title:	
Treatment Provider Agency Name:	

Section #2:

Since my client's last appearance in Mental Health Diversion Court, I believe he/ she/ they are: (select one of the three following options):

- Satisfactorily meeting the requirements of their treatment plan (engaged in treatment, attending appointments regularly, keeps in touch with provider, making progress towards treatment goals, etc.).
- Partially meeting the requirements (attendance at treatment is not consistent, engagement is limited, making some progress but could be increased, etc.).
- Not compliant with the treatment plan or not attending treatment.

Section #3:

Based on my knowledge, I believe selections below best describe my client's efforts in following through with the recommended treatment plan for Mental Health Diversion Court:

Please check all that apply:

Yes/ No/ Unsure/ N/A

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending all psychiatry and/ or primary care appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is taking all medications as prescribed. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending all individual counseling appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending all scheduled case management appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending all classes or group counseling appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending all scheduled appointments for outpatient substance use treatment. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is attending sobriety support meetings. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is abstaining from alcohol, cannabis, and all other illicit substances. If no, please specific which substances:
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is testing negative on all toxicology screens.
If no, please specific which substances: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is maintaining employment, volunteer work, attending classes, or pursuing a job training program. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is maintaining suitable housing and/ or following through with referrals to enter into stable housing in the community. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Printed Name of Provider/Clinician

Signature & License of Provider/Clinician

Date:
