COURSE 3C - BEYOND THE YELLOW LEGAL PAD!
BIOPSYCHOSOCIAL AND RISK ASSESSMENT OF CHILDREN AND ADOLESCENTS: FROM ETHICS TO PRACTICE TO THE COURTROOM

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Many clinicians approach assessment and diagnosis in an expedient manner – oftentimes gathering just enough information in written form to confirm that there is a behavioral health problem, and that the client meets the criteria of the admitting agency or practice. There are good reasons for this expedience, of which we are all familiar – including the pressure of too little time during any given day to accomplish myriad activities . . . the fact that we are required to gather so much data and complete so many forms which are in keeping with our contractors' requirements [which verge upon the voluminous and sometimes the ridiculous], etc..

Furthermore (and here lies the trap), most of us who have been doing this type of work for a while rest easily on the dual assumptions that (1) "we know it when we see it", and (2) "we therefore don't need a standardized format" upon which to gather the data which are required to arrive at accurate diagnosis(es) and treatment planning. Based upon these two assumptions, we oftentimes 'assess on the fly' - meaning *'without preplanning and structure' and 'according to the needs of the moment'.*

What we are missing here is that, in doing so (assessing on the fly, and failing to follow a standardized WRITTEN protocol), we leave ourselves in an untenable position from an *ethical, legal, professional, and risk perspective – no matter how many years we have been in this business*.

Even if no issues related to the case ever see the inside of a courtroom, there is truly a danger that we will 'miss something important'. Or we may fail to address an issue that seems inconsequential, but which has the potential to become 'the elephant in the room'. In the process of 'missing' or passing over some detail about the individual's history or functional status, there is the very real risk that we will misdiagnose him or her – or that we will fail to include an important issue in the treatment plan – both of which may come back to haunt us.

There is also a danger that we will see one particular diagnosis rise to the surface as being 'The One' – and thus ignore or fail to recognize or address another significant diagnostic issue – possibly resulting in a 'case failure', an adverse incident, or civil and ethical repercussions.

Aside from the potential for clinical embarrassment if we make errors in the write-up of an assessment interview or an error in the diagnosis(es), most clinicians do not give much thought to the potential for legal, ethical or other professional repercussions which might result from these routine activities. Nor do they see the development of a treatment plan as a potential for trouble.

Furthermore, it's a common assumption that if an assessment (any assessment), treatment plan (any treatment plan), and any reasonable diagnosis are "in the chart" that all is well. Local Program Managers may even be auditing internally from that perspective. But this, too, has the potential for trouble. Think: 'Professional Competence' . . . 'Ethics' . . . 'Scope of Practice'.

***Professional Competence* and *Scope of Practice* are two areas which are inherently included in the RULES of ETHICAL PRACTICE for almost every behavioral health license, nationwide.**

- **Please Note: Except for inappropriate sexual relationships with clients, *at a national level the most common ethical violations* involve professionals who operate**

  (1) outside of their 'Professional Competence Level,' (i.e., they are judged to be NOT PROFESSIONALLY COMPETENT to perform a given service such as Assessment, Diagnosis, or Treatment – sometimes referring to specific modalities of treatment or specific diagnoses – and/or to treat clients with particular disorders) or

  (2) outside the 'Scope of Practice' of his or her license (i.e., doing something of a professional nature with a client that their state license doesn't allow them to do, such as working with people with a certain diagnosis, performing certain psychological tests, or independently assessing persons with SUD – Substance Use Disorder without specified training in addiction).

The determination of 'Professional Competence' includes several things, including whether or not you are QUALIFIED to provide the services. In civil and criminal courts (and within most State licensing boards) 'QUALIFIED' means that we have specialized *training* and *demonstrated skill* in the assessment and treatment of a particular disorder and/or in the provision of a specific type of treatment or intervention, AND that we are working within the Scope of Practice for our license.

But simply working within your Scope of Practice is NOT enough to be PROFESSIONALLY COMPETENT.

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Example: A counselor with a certain license may be LEGALLY authorized to do Family Therapy, i.e., it's within her Scope of Practice . . . BUT she has never had specialized training or supervision in Family Therapy, and so she is NOT QUALIFIED to provide the service. Furthermore, if she is involved in an adversarial proceeding or if there is a critical incident or negative outcome involving a family she is working with, depending upon the situation, she may be determined to be PROFESSIONALLY INCOMPETENT – and may be sanctioned by her board or may come out on the losing end of a lawsuit. This has obvious ramifications for her reputation, employment, and licensure.

Is That All? No. Don't Forget the Ethical Requirement to 'Act In the Best Interest of the Client'. Some practitioners think that 'acting in the best interest of the client' simply means that we are not acting in our OWN best interest. [Like, admitting someone into a particular program instead of another program that he really needs, simply because it will help get the census in that program up.]

But that's not all there is to 'Best interest'. Best interest of the client – among other things – looks at whether or not our assessment, diagnosis and treatment of the client was consistent with the 'prevailing standards of care' and the 'best practices' for assessment and treatment of individuals who have essentially the same characteristics and current needs as the client in question.

In other words, did our actions with THIS client or THESE clients COMPARE WELL with the procedures and approaches which are widely recognized to be appropriate and effective, when treating patients who have the same diagnostic and functional characteristics? The sources to which our actions are compared include experts in the field, professional publications, the DSMs 4 and 5, State regulations, etc.

And how would anyone KNOW what we were doing, and when, and why, and how? They look at the client's treatment record, starting with

- the original assessment and any UPDATES,
- the original diagnosis(es) and any UPDATES, and
- the original treatment plan and any UPDATES
- Progress Notes and other notations within the treatment record, made by you *and others on the treatment team, including Case Managers and physicians*.

These things – when taken in the context of the *entire treatment record*, INCLUDING timely modification of the treatment approach in response to CHANGES in the CONDITION of the client – can reveal either competent treatment or grounds for civil action and licensure sanctions.

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This course is offered by *CEU By Net* because we know these issues to be real – based upon our years in local and State level administration, our experience in auditing records under State and Federal mandate and within private consultation contracts, and our participation in Death Reviews and Critical Incident reviews. It has been our pleasure to see inspiring work performed by many competent professionals. It has also been our opportunity to see tragedy 'up close and personal' within these contexts.

This course is an attempt to enhance awareness of the critical need to utilize a 'formal, written Biopsychosocial Assessment with a STRUCTURED format', when we admit a child or adolescent client into a treatment program or practice – and the relationship of this type of assessment process to

(1) Ethicality,

(2) Our personal LEGAL, CIVIL, and LICENSURE vulnerability, and

(3) The risk of ADVERSE OUTCOMES or CRITICAL INCIDENTS of any sort, with its professional repercussions.

With this in mind, please read on.

Thorough CLINICAL ASSESSMENT of a client's history, behavior, emotions, and functionality is a critical process, if we are to do effective Diagnosis, Treatment Planning and Treatment Intervention. This is true whether we are dealing with young or middle age adults, geriatric individuals, or children and adolescents.

We need to explore the individual's historical and current issues, behavioral and social functioning, any medical issues which might be present which could potentially complicate matters, and his or her mental status, in order to know how to approach the treatment process in a way that makes sense. Simply 'looking at obvious SYMPTOMS' and listening to the client's REPORT of problems is NOT ENOUGH. And there can definitely be LEGAL and ETHICAL repercussions if we neglect to cover several vital areas.

Assessment and diagnosis can be especially challenging with children and adolescents because they oftentimes screen thought content from adults – and they may be resistant to anyone whom they perceive as an authority figure (and certainly that may include someone whom they perceive as a 'shrink'). There are also confidentiality issues – particularly with adolescents – in terms of what is to be shared with parents. And there are sensitive developmental issues. And social issues and experiences. And parental issues. And so on!

Bottom line, assessment of children and adolescents is more challenging than assessment of adults [*unless* the adult is of an advanced age]. Why is this? The functioning of children and adolescents is significantly affected by multiple complicated and thorny issues which are a function of their unique stage in life.

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Such issues include parental relationship issues, shifting developmental and sexual status, educational issues, and social experiences. We are also dealing with 'third parties' here – parents or other caretakers – who may be cooperative or not, and may or may not be an active part of the problem.

In this course we have endeavored to identify the most essential and critical pieces of KNOWLEDGE about a young client's psychiatric, emotional, behavioral, functional, familial, and addictive history – information which we should collect during a STRUCTURED ASSESSMENT, if we are to adequately diagnose and treat the child or adolescent.

How much of an issue is 'assessment,' in the grand scheme of the total treatment process? It's 'major'. 'Assessment' is probably the most common form of service delivered by any type of treatment facility, to mental health and addiction clients. Why? Because virtually *everyone* who meets basic criteria for admission is *assessed* – whereas *not all* are accepted for treatment.

- And yet, despite its common occurrence, this professional function (ASSESSMENT) is perhaps the most susceptible to clinical problems. Why? *There are specific clinical, social, and historical areas which must be assessed if a valid diagnosis is to be given, and yet some of these may be skipped, even by quite competent professionals.* Why?

  One common explanation is that 'time' was a limiting factor. The intake process may be rushed. There may be an intention to 'come back to this later' – but it never happens due to intervening priorities. And limited funds to deliver services is a factor, too – after all, 'time' is 'money'.

- However, over the years we have found that the ***primary reason*** for a critical gap in a Biopsychosocial Assessment is this: The clinician ***was not using a standardized (or structured) assessment protocol*** – they were just 'winging it' – oftentimes 'on the fly' – with a limited structure and a 'yellow legal pad'.

  The direction that the interview takes with a client under these circumstances may then not cover all the essentials, as was intended at the start of the session. The assessment may become sidetracked from the planned progression, and so may fail to cover some important social or functional areas which would impact diagnosis and the details of the treatment plan.

- But also, if a provider hasn't had much experience in the area of 'RISK MANAGEMENT' (i.e., what it is, why we need it, how it protects us ethically and legally), he or she may be unaware of the importance of pursuing particular lines of questioning, from a RISK and LEGAL perspective.

  Thoroughness of assessment is indeed a RISK MANAGEMENT and ETHICAL ISSUE. Licenses can be retained or lost, financial livelihoods can be secured or placed in jeopardy, and professional reputations can be enhanced or ruined . . . depending upon how we as clinicians handle the risky business of ASSESSMENT.

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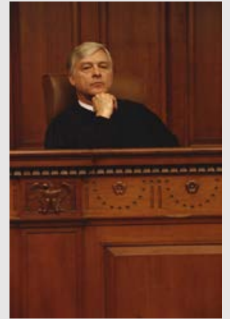

For example, let's say that a professional fails to explore a particular area of a client's problems, issues, and history during the ASSESSMENT. And, say, the client later experiences an adverse treatment event or outcome that can be *associated with that area which was not pursued during assessment.* What may the RESULT be, for the professional? He or she can be sued in a civil court of law – accused of failure to perform his or her professional responsibilities, and subsequently may be found to be PROFESSIONALLY NEGLIGENT. This can be very costly to the professional in terms of monetary damages, and may even become a licensure review issue.

Therefore, in this course we present two very different types of 'child and adolescent assessments':

(1) a quick, structured RISK ASSESSMENT rating scale for use in crisis situations involving potential-for-harm, which will provide good protection for you in an adverse legal or ethics-related challenge, and

(2) a structured, comprehensive BIOPSYCHOSOCIAL ASSESSMENT PROTOTYPE, which covers the assessment 'essentials', needed to carry you forth safely into the treatment process – INCLUDING a Mental Status Exam.

And at the end of this course, we give you a copy of each of these prototype assessment documents in Adobe format with no security restrictions, which you can copy, paste, distribute and modify as you see fit.

You may also download this Course 3C document to your computer, for personal future review – with the understanding that this material is copyrighted and proprietary, i.e., not to be copied and distributed to others, published, or used for monetary gain without the express written permission of the author (Marsha Naylor, MA, LPC – CEU By Net, Pendragon Associates LLC).

Important point here: Obviously, a provider may CHOOSE TO SKIP or shorten certain areas of our prototype Biopsychosocial Assessment, which we are presenting as part of this course material, for various internal or philosophical reasons. But what we have presented here is, we think, a 'thesaurus' or 'focused list of topics' which can be used to guide a program's or practice's clinical evaluation of its clients.

We think of the Biopsychosocial Assessment protocol as a 'CHECKLIST' which contains some crucial bits of inquiry, to guide DIAGNOSIS and assess the NEED FOR TREATMENT – and we have developed it with a keen eye geared to RISK MANAGEMENT and LEGAL and ETHICAL SAFEGUARDS.

Who can do what? There is a psychosocial history section in the Biopsychosocial Assessment, and also a Clinical Interview section. The 'history section' can be done by anyone who has appropriate education and has been properly trained to gather information related to the client's social, behavioral, medical, educational, and addictive experiences and prior treatment. A license is not typically required to do this.

However, the issue of who is allowed to perform the **Clinical Interview portions of a Biopsychosocial Assessment** – and certainly who can perform an **Assessment of Acute Risk** – is usually defined by the State, through 'Scope of Practice' for the various behavioral health licenses.

The '*clinical interview*' portions of the Biopsychosocial Assessment and the Risk Assessment are typically conducted only by persons licensed to assess and diagnose (i.e., whose Scope of Practice includes assessment and diagnosis). This would include LPCs or other Counselors, LMSW-ACP, LCSW and other Social Workers, LMFTs, psychologists, certified psychiatric nurse practitioners, or physicians.

Licensed Chemical Dependency Counselors and Certified Addiction Professionals are oftentimes allowed to perform all parts of assessments with clients who present with a SUD. In such situations, they would likely bring in or consult with a licensed mental health professional about mental health issues.

Because of 'who-can-do' limitations and permissions, we have DIVIDED the format of our Biopsychosocial Assessment into two separate sections: The first section (Section A) may be performed by any competent individual who has been appropriately trained to gather and record HISTORICAL biological, medical, social, psychiatric, and behavioral data.

The second section of our prototype assessment (Section B) is the 'CLINICAL INTERVIEW' section which typically requires a licensed or certified individual who has been clinically trained in assessment and diagnosis, who can then

- INTEGRATE the HISTORY with the CURRENT FUNCTIONAL and MENTAL STATUS DATA, resulting in a
- CLINICAL SUMMARY, with
- One or more mental health and/or addiction DIAGNOSES, and
- RECOMMENDATIONS FOR TREATMENT including immediate ACTIONS to be taken if the client is judged to be potentially at risk for harm to self or others.

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Problematic Issues We See In Client Records, Related To Assessment

1. **Failure to recognize co-occurring disorders.** We want to emphasize that one of the primary failings of practitioners when assessing children and adolescents is this: When it is clear that the youth has two or more **CO-OCCURRING DISORDERS** (i.e., both mental health and SUDs), the assessor may nevertheless neglect to recognize and deal with the SUDs issues, when affixing diagnoses and developing a treatment plan. In such situations, there should be at least two (2) or more diagnoses in the completed Assessment document – one or more for the substance use issue AND one or more for the mental health issue (when such co-occurring disorders exist). It is generally true that where there is no diagnosis assigned to a known disorder, nothing happens to address the problem.

   - Even when the co-occurring disorders are recognized within the content of the initial assessment, and both a mental health and a SUDs diagnosis are affixed, it oftentimes appears that this information was written down and then filed away – *and never read again.* The SUDs issues simply don't appear in the ongoing chart – UNTIL a SUDs-related adverse incident occurs. The treating professional then has no valid defense for having neglected the known-but-ignored disorder.

   In this situation, the assessment and the entire client record have proven to be ***internally inconsistent***. Depending upon the seriousness of the adverse incident, adversaries and regulatory entities may then hand the professional a 'go straight to jail' card! [So to speak.]

2. **Failure to address one or more affixed diagnoses in the treatment plan.** We oftentimes find that even though all demonstrable diagnoses are documented in the assessment, when it comes to the development of the TREATMENT PLAN, we may see only ONE issue addressed – with no explanation as to why the second diagnosis was not addressed. And typically, with children and adolescents, it is the SUBSTANCE USE DISORDER (SUD) that is not addressed in the treatment plan.

   When serving as an external auditor following an adverse drug-related incident, on numerous occasions we have found that an adolescent with a Substance Use Disorder and, say, a serious addiction to cocaine or hallucinogens, is receiving treatment ONLY for his or her depression or bipolar disorder or oppositional defiant disorder.

   - Although it is true that depression, bipolar disorder, attention deficit disorder or various personality disorders oftentimes are the attention-grabbing issues in youth who have substance abuse issues, it is typically a mistake to not address the SUDs issues in the Treatment Plan – from both a CLINICAL perspective and a RISK MANAGEMENT perspective.

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Scenario: If the youth has been assessed to have substance use issues, and if he or she eventually has a substance-related serious adverse incident or adverse treatment outcome, we are in far better shape as licensed professionals if we have addressed the substance use issue in the Individual Treatment Plan (ITP).

If we have failed to address the SUDs issue, we are subject to allegations of PROFESSIONAL NEGLIGENCE – which is both an ETHICS ISSUE and a LEGAL LIABILITY ISSUE. This is true even if the adverse event occurs AFTER he or she has been discharged from the treatment program – sometimes years later.

3. Failure to make the Assessment a 'working document' involving UPDATES.

The assessment of a client is *an ongoing process* – NOT simply a one-time event*. The assessment of a client's status and needs is NOT simply a pro forma activity that you do once at admission, and then file away in the back of the chart, never to be seen again.*

'Assessment' is the foundation upon which we assess the needs and progress of the individual. One of the strongest principles of the assessment process is this: The Biopsychosocial Assessment should be the '*basis'* of the ITP and also *a 'working ongoing guide'* for treatment as it unfolds.

The assessment therefore needs to be periodically UPDATED to reflect the course of treatment – if only in an abbreviated format.

NOTE: Think of it like this, when reviewing a clinical record: We should see the important findings of an *ongoing assessment process* reflected everywhere we look in a client's treatment record – i.e., in treatment plans, and in progress notes, and in the rational for medication prescriptions and med changes, and in requests for authorization to deliver services, and in the discharge notations.

Scenario: Assume that you are an internal auditor reviewing a clinical record in which an adolescent makes a serious suicide attempt. The family is suing both the counselor and the Treatment Center for professional negligence. There will be repercussions for the responsible professionals if

- In multiple places within the chart, you find yourself confused about 'what's what' . . . unclear about what happened to this issue or that issue which was identified in the Biopsychosocial Assessment or elsewhere, but not followed up in the Treatment Plan or in Progress Notes.
- Toward the end of the treatment record, you stumble across a comment in a Progress Note which refers to the "adolescent's history of self-abuse, including cutting". You can't find any previous mention of this – not in the assessment or in the treatment plan. You ask, 'When did they first learn about that self-abuse issue? It sounds like it was going on for a while. Where is that problem addressed in the treatment plan?'

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- And then, 'What did the staff DO when the child's teacher reported signs of suicidal ideation to the receptionist – and the mother reported to the counselor that he's been browsing the internet for deadly chemicals? Where is the documentation of follow-up?

- **And of great importance: 'I don't see where they *changed the treatment plan* to deal with those high risk situations, as they came to light. And I don't see any significant follow-up in the progress notes, either.'**

In such a case there is both a PROFESSIONAL COMPETENCE issue and an ETHICS issue (both involving failure to take action in the best interest of the client). And it is also a Risk Management Issue, i.e., an apparent failure to ensure CONTINUITY in clinical record documentation as issues were identified, leading up to the suicide attempt. *All of this will come back to haunt the providers*.

What's considered to be the worst failing of all, from an ETHICAL, COMPETENCE, LEGAL, AND RISK MANAGEMENT perspective? It's when we see evidence in a client's treatment record that he or she is deteriorating or is potentially at risk of harming self or others . . . where it is ALSO clear (through lack of relevant documentation to the contrary) that the assessing and treating staff did not follow up as the situation came to light . . . that they apparently did nothing of significance to RESPOND to the indicators of trouble or to assure the welfare of the client. Appropriate response would have included such things as obtaining a psychiatric exam or an inpatient assessment, and implementing a special interim treatment plan, and notifying others who can take appropriate action to safeguard the child. We have seen this too many times, as an external auditor in the wake of an adverse (often fatal) incident.

4. And yes, we do see INEFFECTIVE ASSESSEMENT and DOCUMENTATION SYNDROMES, in the work of otherwise competent, experienced professionals!

For example, there's **'THE PASSIVE REPORTER'** Syndrome – His or her assessments are simply 'reporting' what the consumer or family member SAYS about the issues and problems – failing to express *their own clinical observations and professional conclusions*. Those days of passive reporting are over! We must be clear about what we (ourselves) perceive, and must make clear clinical statements about our professional impressions, which should result in one or more diagnoses.

And there's **'THE INCOHERENT ASSESSMENT'** Syndrome, where nothing in the assessment ties together – where there are inherently contradictory and confusing statements with no explanation of the conflict. For example, in one section the assessor states in the 'behavior' section that school personnel have no concerns about the child's behavior or functioning, when we clearly see in the 'why child is

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here' section that he has been expelled from Alternative School. (Yes, we really have seen that type of thing in many charts we have audited.)

And there's **'THE POORLY DOCUMENTED LEVEL OF CARE'** Syndrome – deadly, if your charts are audited by an insurance company or another plan manager who is paying for a certain Level of Care (LOC), and they see (based upon what you have documented in the client's record) that you are providing something LESS than the authorized LOC for which they are paying. **Even *more* problematic, if there is an adverse outcome or critical incident, and the indicated LOC and the delivered LOC do not appear to match, based upon what you have documented in the record.**

It's an **apparent inconsistency** in 'LOC Need' vs. 'LOC Delivered' that sometimes raises questions about competency. Is there an *'inconsistency'* between (a) the findings within both the original ASSESSMENT and any UPDATE assessments which call for a certain LOC, and (b) the LOC which you appear to be providing, and/or (c) an inconsistency between a shift in the client's status, and how the professional has responded to the shift in terms of what he or she is now doing to address it?

This latter situation (c) applies whether the shift in functioning is improved OR regressed. **Either way, *we should see documentation that the LOC delivered to the client has changed along with the client's status.***

- And if you are relying on insurance or contract funds to pay the bill, the Biopsychosocial Assessment findings should be *consistent with the criteria for the <u>Level of Care which you are requesting</u>.* NOTE: If the insurance company has denied your request for a certain level of care, you must CLEARLY DOCUMENT the resulting disparity between 'LOC Need' vs. the 'LOC Approved'.

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Bottom line here, if there are internal inconsistencies in the documentation seen within the client's record, this spells trouble and suggests a lack of professional competence – and perhaps ethics violations if the situation results in failure to act in the best interest of the client. The Biopsychosocial Assessment must be <u>internally consistent</u> – within *itself* and with the REST of the client's chart.

- Example: We don't want to read in one part of the Assessment that the child gets along well with peers and has no SUDs issues, and in another section of the Assessment, read that he has been expelled twice in the past year for using illicit drugs on campus and for fighting with peers.

  Likewise, we don't want to see in the current ITP that Skills Training in peer relationships is not needed, while in the Progress Notes we find that the youth has once again been suspended from school and is now in Alternative Education.

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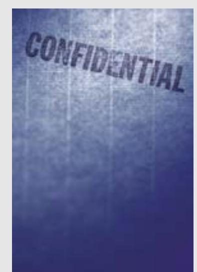
- **How to handle shifts in client functioning?** As the condition of the client shifts, an abbreviated UPDATE ASSESSMENT should be entered into the record along with an UPDATED treatment plan AND evidence that you have IN FACT followed through with the modified plan of care. The RESPONSE of the client to the shift in his treatment plan is also essential – including response to any changes in the medication regimen.

Remember this: It is a cardinal 'rule' of auditors and the court system that if it is not written down or otherwise documented, 'it didn't happen.' Too many times, professionals will respond responsibly to a client's deterioration but they fail to make that clear in the record. In the event of an adverse incident, there is no defense. Licenses and financial assets can be lost for 'failure of the professional to respond in keeping with prevailing standards of care' – even if he or she did respond, but simply didn't document it.

Scenario: We should never see a treatment record of a typically withdrawn, depressed 14 year old adolescent, in which we see a brief notation made by a case manager which reports that he has been suspended from school for aggressive, defiant behavior, in which he 'punched out' a peer and was sent to Alternative Education … followed by two weeks with no notations made by anyone …. followed by two counseling 'no-show' notations … followed by a routine 30 day prescription refill authorized by the responsible psychiatrist with no notations that he or she is aware of new problems …. followed by a notation 10 days later, that the mother called to report that the child has shot himself and a peer on the school grounds.

The ethical and legal issues should be clear to you here, if you see a treatment record like this. It raises disturbing questions about Continuity of Care . . . as well as questions about professional ethics and competency as it pertains to the welfare of the client and failure to deliver services consistent with the prevailing standard of care.

A lack of DOCUMENTATION – with no evidence of an ongoing ASSESSMENT of the client's status and needs, and no evidence of an appropriate RESPONSE from the professionals involved – is definitely problematic if 'push comes to shove'. Did the professionals involved in this case actually intervene in places where there are major gaps in the documentation – but just didn't write it down? Did they actually do an Update Assessment when things started to fall apart? If so, where is it? Without documentation, there is no verification. Without verification, questions of professional competency remain – as does the risk of ethical and legal repercussion.



5. ***A Word About Confidentiality and Assessment of Minors***

- When a MINOR CHILD [or a person who is NOT CAPABLE of providing informed consent] is the client, the assessor must consider the ethical principle of 'Welfare of The Client' in all issues involving confidentiality of information vis-à-vis disclosure to the

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parent or legal representative. For example, in some cases it is may well be in the best interest of the minor client to share certain information confided during the assessment with the legal guardian (such as when the child is placing himself or others in danger). In other situations, it may be in the best interest of the minor client (particularly with adolescents) to NOT share some information with the parent . . . such as details of a non-harmful personal relationship between a female teen and a male peer . . . and if allowed and supported by State law, a minor female's independent decisions about abortion or birth control.

- We also wish to emphasize the importance of careful and sensitive exploration of potential LGBT orientation or gender identity issues, when assessing adolescents [LGBT = Lesbian, Gay, Bisexual, or Transgender]. *Attention to LGBT issues is recognized as crucial to the responsible assessment of minors, given the high rate of serious suicide attempts reported for LGBT youth which far exceeds the incidence in non-LGBT youth.*

NOTE: A licensed or certified professional who is competent (read: trained) to conduct clinical interviewing with children and adolescents should routinely explore this issue with minor clients and young adults*, regardless of the presence or absence of overt indicators that the client may have sexual orientation or gender identity issues.* The Suicide Prevention Resource Center in Newton, MA states that we should "Assume that clients or students could be any sexual orientation or gender identity and respond accordingly."

That being said, providers must also be aware that the 'coming out' process is an important and difficult one regardless of age, and particularly so for adolescents and young adults. Many LGBT individuals spend years working through the issues related to coming out (both to themselves and to others) – reason being, that even with mature adults, there can be a significant amount of *internalized* homophobia that must be personally worked through before individuals can feel safe in coming out to others.

Given these cautions, the 'coming out' process with LGBT adolescents has become an urgent matter for mental health professionals and educators, because of increasingly overt confrontation by adolescent peers which evolves to 'sex-based harassment'. Bullying has become rampant in some communities, having gone 'viral' by virtue of the internet. LGBT youth are oftentimes primary targets, and clinical sensitivity to these issues is essential.

Some of our clients ask why we have included these comments about the need to address LGBT issues in a Biopsychosocial Assessment. Aside from our sense of *professional responsibility* to draw attention to this high-risk issue, there are now multiple Federal, State, and local Civil Rights laws and ordinances which prohibit 'discriminatory harassment' – applicable to sex-based harassment of both adolescent and adult individuals. This includes harassment of students based upon their actual or perceived sexual orientation.

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These laws *require assertive action* by adults who become aware of sex-based harassment, particularly within school populations. School personnel are required to immediately investigate the circumstances including interview of all those involved, to take prompt action to halt the harassing behaviors, to protect the harassed youth, to eliminate a hostile environment, to work toward effective solutions, AND when harassment persists, to consider filing a formal grievance with the school district and contacting the U.S. Department of Education's Office for Civil Rights and the U.S. Department of Justice's Civil Rights Division.

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OVERVIEW OF ASSESSMENT CONTENTS

1. The Assessment of Acute Risk **2. The Biopsychosocial Assessment**

Overview of the 'Assessment of Acute Risk': This brief 'risk assessment' screening process is to be performed (1) as a short-term, interim alternative to the full Biopsychosocial Assessment, WHEN the client is UNABLE to respond adequately to the assessment situation due to ACUTE psychiatric disturbance or emotional upset, or (2) whenever there is reason to believe that an individual may be at ACUTE RISK of harming himself or someone else.

The Assessment of Acute Risk (or 'Risk Assessment') seeks to clarify these issues:

(a) The basis for the perception that there is a risk (i.e., does a parent or a teacher fear that harm is imminent, but there is no clinical support for this fear?), and

(b) If there is a risk of harm, how serious is the risk from a clinical perspective, and

(c) What shall we do as an immediate measure, from a RISK MANAGEMENT perspective?

NOTE: As a risk management issue, emergency Risk Assessments should be performed by a licensed professional whenever possible. If an adverse outcome or critical event occurs (e.g., client attempts suicide or hurts someone else), a licensed professional is in a better position to say to the court (and a jury, if that's involved) that, "In my best professional judgment as a licensed practitioner, I did not believe that the client was in fact a danger to herself or others, based upon the following findings . . ."

Risk Assessment (Assessment of Acute Risk) has the following components:

- Primary Reason for Admission or Treatment
- Assessment Of Suicide Potential
- Assessment Of Homicide Potential
- Interim Recommendations

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Special Notation: Performing an Assessment of Acute Risk is NOT THE TIME to simply accept at face value what the client or others tell you, about whether or not the client is indeed contemplating suicide or harm to others. You are expected to use your best professional and clinical judgment here, to integrate ALL of the information (***including your own impressions***) into a responsible conclusion. You do not disregard the statements of others – but you carefully EVALUATE what you hear and act accordingly.

This is also *not* the time to 'flip a coin' if uncertain. Call on a trusted colleague if possible – and if that's not possible, it's better to err on the side of caution. Many adverse incidents have occurred in treatment situations where 'caution' was not the assessor's watchword, much to the regret of all.

And the worst failing of all, from a RISK MANAGEMENT perspective? To see evidence in a client's treatment record that he or she is deteriorating or is at risk of harm to self or others, where it is ALSO clear that the assessing and treating staff did LITTLE or NOTHING to intervene.

When there is an indication that a client is deteriorating or is otherwise at risk of harm to self or others, we should see in the record that there has been an appropriate RESPONSE and FOLLOW-THROUGH from the treating professional(s) . . . such as obtaining an inpatient assessment, implementing a special interim treatment plan, scheduling and ensuring that there is a timely appointment for a medication re-check, making sure that any medication orders are filled, and/or notifying others who can take appropriate action.

We have seen a failure to follow through in such scenarios too many times, as an external auditor in the wake of an adverse (and often fatal) incident. A 'death review' in a treatment program or practice can have many implications – LEGALLY, ETHICALLY, and FINANCIALLY.

Overview of Contents of the Biopsychosocial Assessment

The assessment may include but is not limited to the following historical, functional, and clinical areas, regardless of the format in which an agency or program or practice constitutes its assessments:

- Relevant Family History
- Relationships and Cultural Influences
- Developmental milestones – any unusual noted
- Significant Biomedical History – *including the name of the consumer's Primary Care Physician (PCP)* if she/he is a Medicaid a recipient, or otherwise has a family physician.

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- Educational And Employment History
- Legal Issues
- Sexuality History and LGBT Issues, as relevant
- Psychological and Behavioral Functioning, *including Mental Status Exam* [Note: We describe the Mental Status Exam (MSE) below. This is the portion of the exam that most likely will require a licensed professional to perform]
- Complete History of Chemical Abuse or Dependency [To be performed only by a professional who has training, experience, or licensure/certification in Addiction Diagnosis and Treatment]
- Perceived Strengths and Weaknesses
- Presence of any co-occurring mental health and addiction diagnoses [which requires specialized planning and services to address these issues, and which may involve an outside provider – for example, if the assessing entity provides mental health services but not addiction services, or vice versa]
- Diagnostic Impression, Clinical Formulation, Recommendations for additional assessment or studies as appropriate, and Recommendations for Treatment Modality. [Requires a licensed individual to perform this function.]

The Mental Status Examination and Clinical Formulation. In order to arrive at a final diagnosis, 'mental status' and other crucial issues (such as LGBT-related safety and social issues) must be assessed. The assessment addresses the following clinical and historical areas, regardless of the format in which the network agency constitutes its assessments:

- presenting problem
- referral source
- onset of symptoms
- duration of symptoms
- past outpatient management (with which facility, physicians, frequency, reason for treatment)
- brief previous psychiatric and medical history
- mental status exam of psychiatric functioning
    - attitude-general appearance

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    - mood-affect
    - content of thought and speech
    - perception
    - motor behavior
    - sensorium
    - memory
    - judgment and insight
    - intellectual functions
- assessment of any LGBT issues, with an eye to identification of any protections which are needed to ensure emotional and cultural safety for the youth
- statement of potential for risk of suicide or harm to others (and if affirmative, a formal Risk Assessment must be done to determine criticality and need for emergency intervention)
- abuse / neglect and bullying / harassment issues – and specific actions which may be indicated
- any special issues such as sexual activity, use of protection, pregnancy, etc.
- diagnostic impression and brief formulation of consumer's illness
- preliminary treatment plan, which includes:
    - frequency of individual, group, or other therapy
    - medications
    - special consumer management issues
    - special work-up and tests

SPECIALIZED SUPPLEMENTAL ASSESSMENT INFORMATION

A Word About Supplemental Assessments: We recognize that the type of 'treatment setting' oftentimes dictates the thoroughness of an assessment, and also may determine required content. For example, admission to a residential treatment or detox or

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inpatient treatment program will likely require a NURSING ASSESSMENT and a PHYSICAL ASSESSMENT. Such intensive settings oftentimes also will require a PSYCHOLOGICAL ASSESSMENT (testing for intelligence and personality factors), a PSYCHIATRIC ASSESSMENT (by a psychiatrist, most often to determine psychotropic medication needs), or an ACTIVITY ASSESSMENT (which looks at skills, talents, interests and aptitudes – including physical abilities and limitations, work patterns and availability of leisure time, motivation and preferences for various activities.) We have included material at the end of this course related to these assessments.

We have also included material related to the 'Abnormal Involuntary Movement Scale' (AIMS) Assessment, which is a good idea to perform regularly for patients who are taking some forms of antipsychotic medication. Why? This is a Risk Management issue! There have been many lawsuits filed and won because an individual was taking antipsychotic medication and contracted a permanent involuntary move (IM) disorder. Careful routine assessment of whether or not the patient was showing any signs of IM could have prevented this serious disability. 'New generation' antipsychotic medications are not as prone to result in involuntary movement disorders, but potentially can do so, in some individuals.

In summary:

- Although outpatient treatment programs generally would not require assessment in most of these specialized areas (except for the AIMS and the psychiatric assessment by a psychiatrist, if the program provides medication management), we have included the content for such assessments, for purposes of thoroughness.

- You will find narrative related to the content of these supplemental assessments at the end of the course materials, following the prototype of the 'Assessment of Acute Risk' form.

Please note that there will be some questions on the quiz for this course which come directly from the ASSESSMENT FORMATS themselves.

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Notice: *Aside from the prototype assessment formats (which you are free to download, modify, and use at will, from the links you will see at the end of this course)*, this Course 3C from CEU By Net is NOT to be used for any purposes other than your personal CE activity on this website. This is a copyrighted document, protected by USA and International LAW. You have CEU By Net's permission to view it strictly for your own personal educational use – but not for training of or sharing with others. However, re the Prototype Forms: Use them as you please.

BIOPSYCHOSOCIAL ASSESSMENT
PROTOTYPICAL EXAMPLE

We feel that it is easier to communicate the flow and tone of an assessment by presenting an EXAMPLE for the CEU participant to examine, rather than attempt to convey these details through pure narrative. The following format provides a good example of a COMPLETE Biopsychosocial Assessment. Providers might choose which sections they wish to include in their standard assessment format – bearing in mind the issue of 'RISK MANAGEMENT' as to what information is essential to collect.

Using content from this prototype, you may also structure YOUR OWN assessments for use during 'Brief Assessment' vs. 'Comprehensive Assessment', according to your needs. A significant portion of your quiz questions will relate to information on this prototype assessment.

NOTE TO ALL USERS: At the end of this study material, you may DOWNLOAD AND SAVE our free-standing copyrighted 'Biopsychosocial Assessment' forms for your personal use in your own clinical work. You will find one Biopsychosocial format for TEXAS' participants, and one for GENERAL USE by other professionals) . . . as well as the 'Assessment of Acute Risk' form. They are in a PDF format (Adobe). These forms are PROTOTYPES. You may extract from or modify the forms as needed, if you have appropriate software that will allow you to modify pdf documents. The content of these forms is also suitable for inclusion in an automated client records system. There are no restrictions in terms of copying, pasting, or modification of these two forms. However, with regard to the use of the content of this training presentation (Course 3C), please note the copyright statement at the top of this page, and its restrictions.

***** Optional Resource Materials for Providers in Texas and Other States *****

For Texas professionals who are familiar with the Texas Resilience and Recovery program, the Child and Adolescent Needs and Strengths (CAN) initiative, the Uniform Assessment (UA) program and the implementation of the 'Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services' (previously known only as CA-TRAG – **Texas Recommended Assessment Guidelines): You will find a specialized TRR-TRAG-related ASSESSMENT FORMAT developed by CEU By Net which you may access and download through a link** *at the end of this course*. **This specialized assessment format is very similar to the regular assessment format which we present on the following pages . . . but it includes additional material which integrates Service Package recommendations (Level of Care) into the assessment, and related items.**

For ALL Providers: If you want to learn more about the Utilization Management Criteria used in connection with the State of Texas' Child and Adolescent treatment programs (which are based upon Assessment and Treatment validation studies and norms from Ohio and other nationally recognized resources), CLICK here to download, or copy and paste this URL for later use. NOTE: Your browser may insist that you SAVE the document to your computer first and then open it from there.

http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589972582

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Client Name

Date of Assessment

Date of Birth of Client

Other Information

PART A1. REASON FOR SEEKING TREATMENT AT THIS TIME

1. Please make a brief statement of what circumstance has ***precipitated*** this child's admission to services AT THIS TIME, i.e., ***"why now?"*** IN ADDITION: ***If there are major life issues*** which are currently impacting this child or adolescent at this time (*such as*, but not limited to pregnancy or being the parent of a child or infant, or recent or pending incarceration or probation for a juvenile or felony offense, or a terminal illness of the child or caretaker, or parental divorce, or death of a parent or sib or other close relationship) ***briefly identify those major life issue(s) here.***

2. **PRESENTING ACUITY:** *By professional clinical standards*, is this child presenting for treatment in an Emergent Situation – either Emergency or Clinically Urgent?

☐ Y ☐ N

Are immediate actions necessary to protect the safety of the child or others, with or without prior authorization from the HMO or other contractor?

☐ Y ☐ N

If yes, what actions are you taking immediately?

3. **KNOWN ALLERGIES:** Is consumer ALLERGIC to any known thing – ESPECIALLY MEDICINE AND FOODS? YES ☐ NO ☐. If yes, specify 'what'.

NOTE: If consumer is allergic to any medicine or food, this must be posted prominently on the front of the client record, in RED.

PART A2. HOUSEHOLD CIRCUMSTANCES AND MAJOR LIFE EVENTS

1. Is/Was consumer raised mainly by a parent, or someone else?

2. Is child living 'at home' with natural parent or primary historical caretaker? ☐YES ☐NO If no, when did child leave home, and under what circumstances, and with whom is s/he living now?

3. What type of dwelling is consumer living in? Describe consumer's immediate neighborhood and characteristics (socioeconomic level, high crime area, low- or mid-income, etc.):

4. How many times has consumer moved in the past two years? If often, why?

5. List all immediate family members and parental equivalents, below, and indicate the following information for each. If any family members are deceased or elsewhere, be sure to list below, and indicated "deceased" or "in prison", etc..

Name	Age	Relation-ship	Where Resides

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6. PAST TRAUMAS OR RECENT CHANGES: Have there been any major life traumas or recent major changes within the family (e.g., a divorce, abandonment, incarceration of parent or child, death of a loved one or friend, serious injury, life threatening illness, etc.)? If yes, describe.

7. Has anyone in consumer's family ever attempted/committed suicide? ☐YES ☐NO If YES, who and when and by what means:

8. Is there a history of mental illness or substance abuse in the child's immediate family (parent, grandparent, sibling, or other with whom child has lived)? And if so, who and what?

9. CPS ISSUES – Child Protective Services Activity

   (1) Has this child ever been removed from home due to CPS involvement? ☐YES ☐ NO If YES, why?

   (2) What was tried to keep the child in the home, e.g., outpatient treatment, treatment for parent(s)?

   (3) Is CPS currently involved with the family?

   ☐ YES ☐ NO

   If YES, what is the nature of the CPS involvement and the length of time involved? CPS's plan for the family? Name and telephone number of CPS caseworker?

10. Describe client's / family's perception of any significant changes expected in the coming year (e.g., will child or family be moving, will there be a divorce, will a parent return from prison, will child have to change schools due to family issues, etc.?).

PART A3. RELATIONSHIPS, CULTURAL INFLUENCE , RELIGIOUS ISSUES

11. How does consumer rate his/her relationships with the following?

	Excellent.	Good	Fair	Poor
With parent(s) or LAR	☐	☐	☐	☐
With spouse /signif other	☐	☐	☐	☐
With siblings	☐	☐	☐	☐
With teachers or boss	☐	☐	☐	☐
With friends/peers	☐	☐	☐	☐
With non-parent relatives	☐	☐	☐	☐
With authority figures	☐	☐	☐	☐

12. Is youth active in any formal or informal social groups and extracurricular activities that involve others his/her age?.

13. 'Running with the wrong crowd'?

14. Any gang activity?

15. Does child seem to lack constructive friendships with age appropriate peers?

16. Does child feel that his peers like him, or does he feel rejected by them?

17. Does child appear to be socially isolated, preferring or doing things mainly by himself? If so, HOW LONG has this been going on?

18. Based upon information that you have gathered, does this child appear to feel rejected by one or both parents or caretaker(s)? Describe.

19. How does the parent or caretaker *[or, for married or cohabiting teens, their significant other]* rate this consumer's relationships with the following?

	Excellent	Good	Fair	Poor
With parent(s) or LAR	☐	☐	☐	☐
With spouse /signif other	☐	☐	☐	☐
With siblings	☐	☐	☐	☐
With teachers or boss	☐	☐	☐	☐
With friends/peers	☐	☐	☐	☐
With non-parent relatives	☐	☐	☐	☐
With authority figures	☐	☐	☐	☐

10. Does the parent or caretaker describe negative personal feelings about child? ☐ YES ☐ NO. If yes, when did these feelings start, and how strong do they appear to be?

11. Is family or caretaker seemingly supportive of treatment at this time? ☐YES ☐NO

12. Is there history or impression that suggests the family might undermine/interfere with consumer's treatment and/or recovery? ☐YES ☐NO If YES, in what way?

13. Is consumer active in religious activities? ☐ YES ☐ NO Any specific denomination? If not active, does consumer consider him/herself to be a religious person? ☐ YES ☐ NO

    Are there any special cultural or religious issues which may affect this client's treatment? ☐ YES ☐ NO If YES, what?

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PART A4. BIOMEDICAL & DEVELOPMENTAL HISTORY, and BEHAVIORAL HEALTH ISSUES AT HOME

1. General physical description including hygiene and dress:

   Consumer's height Consumer's weight
   Any evidence of eating disorder including obesity or malnutrition? ☐ YES ☐NO If YES, describe:

2. Is consumer's physical development normal for his or her age? ☐ YES ☐ NO If NO, in what way?

3. Any significant change in weight and/or eating patterns over the past year? ☐ YES ☐NO Specify:

4. Eyes (color) Hair (color) Scars or other distinguishing features?

5. When was the last time consumer had a MEDICAL HISTORY AND PHYSICAL EXAM? (date).
   What lab tests were done?

   Any negative ('needs attention') findings with exam?

   Name of physician or clinic.

   Also, are you now obtaining a release of information to communicate with physician on an ongoing basis?

   ☐ YES ☐ NO If no, why not?:

6. Is the consumer experiencing any disturbance in sleeping patterns? *For example, sleeping too much, too little, nightmares, night terrors, bed wetting, etc.* ☐YES ☐NO
   If YES, explain:

7. Describe any medical condition which requires regular attention.

8. Relevant Birth and Developmental Information:

   - *Developmental milestones*

     Sat alone:
     Single words:
     Toilet trained:
     Walked alone:
     Sentences:
     Social:

   - Pregnancy Planned? ☐YES ☐NO Mother's feelings about pregnancy:

   - Was pregnancy full term or premature? Full Term ☐ Premature ☐ And if premature, how many months was pregnancy?

   - Was delivery normal/without incident? ☐YES ☐NO And if NO, what complications were there during delivery?

9. Health of birth mother and birth father?

10. If not living with birth parents, health of current caretakers?

11. List any previous hospitalizations or extended outpatient treatment of the youth for **MEDICAL (physical health)** problems.

12. **PROBLEM BEHAVIOR AT HOME AND IN NEIGHBOR-HOOD:**

    Do the parent(s) or caretaker(s) report that their MAJOR CONCERNS about this child relate to **EXTERNALIZING BEHAVIORS** (such as hyperactivity, aggression, disruptive behavior, oppositional behaviors, refusal to follow rules and directions, resistance to authority, juvenile delinquency, substance abuse, etc.)? ☐ YES ☐ NO
    If YES, describe specific behaviors below.. Include **HOW LONG** these behaviors have been occurring.

    Do the parent(s) or caretaker(s) report that their MAJOR CONCERNS about this child relate to **INTERNALIZING BEHAVIORS** (depression, anxiety, withdrawn behaviors, isolation, crying, sad affect, feelings of inadequacy, anger and frustration, sleep and eating disturbance, and other clinical indicators of depression or anxiety)? ☐ YES ☐ NO (***Be specific.*** Also include HOW LONG these behaviors have been occurring.)

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13. **Do the parents or caretakers report behaviors and symptoms that are bizarre or suggest that a psychotic process is going on?** ☐ YES ☐ NO If YES, please describe here, including how long these behaviors have been occurring. **(*Be specific.*)**

14. Behavioral Health Treatment. Has child had any formal treatment (other than meds) for his or her behavioral health problems? ☐ YES ☐ NO

List any previous inpatient, residential or outpatient treatment for behavioral health problems, in TABLE below. NOTE: MEDICATIONS are described in table #15 below.

In caretaker's opinion, was child/family helped by these past treatments which you have listed on Table below? ☐ YES ☐ NO Which things were most helpful vs. those that were least helpful?

WHERE / WHO / WHAT?	ADM. DATE	D/C DATE	REASON FOR BEHAVIORAL HEALTH TREATMENT

15. Identify *current and past* medications prescribed by a physician for medical and psychiatric problems.

NAME OF MEDICATION	MEDICATION FOR WHAT?	DOSAGE	FREQUENCY	PAST OR PRESENT?	WHEN STARTED AND STOPPED?	RESPONSE?

NOTE: If individual has taken psychotropic medications to control symptoms, which medications have been the most effective? Least effective?

Any negative side-effects with any of these meds? (Identify and describe side-effects here.)

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PART A5. EDUCATIONAL AND VOCATIONAL HISTORY

1. Is consumer currently in school – or if summertime, is consumer planning to return to school next term?

   ☐ Y ☐ N

   Current grade level, or grade entering in the Fall (if this is summertime)?

   What is the highest grade or degree consumer has completed?

   Current or most recent school?

   School attending next term?

2. Is this child currently receiving any D or F (failing or at risk of) grades? ***If YES,*** which grades are D or F?

   Has there been any significant change in grades over the past year? ☐ YES ☐ NO If YES, what change?

3. Has child now or has s/he ever been in a 'special class' for emotional or learning difficulties?
   ☐ YES ☐ NO ***If YES***, when?

   And was/is it for emotional (SED) or for learning problems?

   What grades did/does child usually earn IN HIS/HER SPECIAL CLASSROOM SETTING (if has been in such a class)?

4. Ever suspended from any school? ☐YES ☐ NO
   If YES**, when, where, for what type of behavior?**

5. Ever placed in In-School Suspension or In-School Disciplinary Classes or Study Hall? ☐ YES ☐ NO
   If YES**, when, how often, and for what type of behavior?**

6. Ever been in an Alternative / Behavior School or equivalent?

   ☐YES ☐NO ***If YES,*** **when, how many times, for what duration, and for what specific behaviors?**

7. Ever expelled from any school? ☐YES ☐NO
   If YES**, details of when, where, for what behavior?**

8. If NO to Questions 4, 5, 6, and 7, has the child been asked to leave the classroom due to a behavior problem? ☐YES ☐ NO ***If yes, why?***

9. Does child have a history of truancy, and if so, extent of the problem (how often truant)? ☐ YES ☐ NO ***If YES,*** describe.

10. Any evidence of school phobia or anxiety?
    ☐ YES ☐ NO ***If yes, what evidence?***

11. *According to School Representatives*, what is the MAIN CONCERN of the school system or counselors or teachers about this child's behavior and functioning?

12. If expelled or dropped out of school, does youth have any plans to return to school for completion of a GED or graduation? ☐YES ☐NO If yes, what? If no, why?

13. How does *consumer* rate *himself* as a student or employee, on a scale of 1 to 10, with 10 being excellent?

14. How does *caretaker/parent* rate child as a student or employee, on a scale of 1 to 10, with 10 being excellent?

15. Does the school counselor or School System know that the consumer is applying for treatment?
    ☐YES ☐NO Are you now obtaining a consent for release of information to and from the ISD?
    ☐YES ☐NO If NO, why not?

16. If adolescent: Is child currently employed? ☐ Y ☐ N Describe job history, including number of hours per week, history of holding job(s):

17. Ever fired from any job? ☐YES ☐NO

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PART A6. CHILD'S LEGAL HISTORY AND OTHER FAMILY ISSUES (INCLUDING FINANCIAL OR OTHER LEGAL PROBLEMS)

1. Has consumer ever been arrested? ☐YES ☐ NO If YES, complete the table at (5) below.

2. Is consumer currently on probation, deferred adjudication, or parole, and for what? ☐ YES ☐ NO [Refer to number(s) assigned to item(s) in the table below that relate to probation, deferred adjudication, or parole]

If YES, what is consumer's understanding of the terms of his/her probation/parole?

3. County of probation: Probation Ends:

Does the probation or parole officer know consumer is in treatment? ☐YES ☐NO If not, why not?

4. Probation or Parole Officer:

Phone Number:

5. List of ALL charges or adjudications (specify which status, in OUTCOME)

CHARGE	DATE	OUTCOME
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

END OF SECTION 'A'

Note: If Section A has been completed by someone other than the individual who completes Section B, please summarize any critical issues of which the Section B completer should be aware, and sign and date below.

Name (print): ____ **Date:** _____________

Signature and credentials: ____

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SECTION B.

The assessing clinician is expected to thoroughly review all of the historical information and presenting issues documented in Section A (which may have been collected by another individual), and then integrate this information with his/her clinical findings and observations, to arrive at a DIFFERENTIAL DIAGNOSIS and summary conclusions.

CLINICAL INTERVIEW

Including the Mental Status Exam

I. IDENTIFICATION / AGE / PRESENTING DESCRIPTION

II. CHIEF PRESENTING COMPLAINT PER PREVIOUS 'SECTION A' MATERIAL

III. PSYCHIATRIC HISTORY PER CLINICAL INTERVIEW

1. Psychotropic Medicine -
2. Outpatient Treatment -
3. Hospitalization / Residential -
4. Past Diagnoses -
5. Substance Abuse -
6. Tobacco -
7. Caffeine –
8. Known allergies especially medications and food –

IV. MENTAL STATUS

- ❑ Appearance:
- ❑ Dress hygiene grooming:
- ❑ Orientation: person, place, time and situation:
- ❑ Mood:
  - ❑ Affect:
  - ❑ Insight:
- ❑ Judgment:
- ❑ Intelligence:
- ❑ Attention:
- ❑ Concentration:
- ❑ Memory:
- ❑ Speech:
- ❑ Thought Process:

1. Is there evidence that this youth is socially withdrawn and/or isolated and/or a target of bullying, whether upon interview or by history? ☐YES ☐NO If YES, which?
2. Depressed or anxious, whether upon interview or by history? ☐YES ☐NO If YES, which?
3. Exhibiting psychotic features or those of bipolar disorder, whether upon interview or by history? ☐ YES ☐NO If YES, what?
4. Any evidence of self-abuse from any source (e.g., cutting, burning, etc.)? ☐YES ☐NO If YES, what?

V. LGBT ISSUES - Assessment of LGBT issues [LGBT = lesbian, gay, bisexual, or transgender. Note: 'Transgender' is NOT a sexual orientation; it refers to persons whose gender identity and/or expression is inconsistent with cultural norms for their biological sex.

Based upon careful clinical exploration: ☐There are no atypical sexuality issues. ☐This youth identifies with an L, B, G, or T orientation. If so, which? ____ ☐ This youth is qu*estioning or exploring* the nature of his/her sexual orientation or gender identity. ☐ He/she feels that he/she is being ostracized, excluded, harassed, or discriminated against because of these issues. ☐ Is at risk of (or considering) suicide **NOTE: If any of these apply, please provide details and assessment of protections which are needed to ensure emotional and cultural safety for the youth, on next page.**

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V.. **Continued here:**

VI. POTENTIAL FOR SUICIDE OR DANGER TO OTHERS

1. Is there information, **from any source**, that the consumer may be contemplating suicide? ☐ YES ☐ NO If YES, please summarize, below and complete and attach an **'Assessment of Acute Risk'.**

IS RISK ASSESSMENT ATTACHED? ☐ YES ☐ NO

If no Risk Assessment form is available, describe the nature of the suicide risk and the need for immediate intervention, below, with brief mention in the Clinical Summary.

2. Is there information, from any source, that the consumer may be contemplating homicide or serious bodily harm to another person? ☐YES ☐NO If YES, please summarize below and complete and attach an **'Assessment of Acute Risk'.**

IS RISK ASSESSMENT ATTACHED? ☐ YES ☐ NO

If no Risk Assessment form is available, describe the nature of the risk of harm to others and the need for immediate intervention below, with mention in the Clinical Summary.

Substance Abuse Screening, next page.

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V. SUBSTANCE ABUSE SCREENING

1. Does consumer admit to use of alcohol or drugs or other illicitly used substances?

   ☐YES ☐NO

2. Is consumer reported to have emotional or social/behavioral problems which are (or appear to be) *associated with chemical abuse or dependency*?

   ☐ YES ☐ NO If YES, please explain:

3. Has consumer ever had or does s/he now have a communicable disease which may be associated with drug use or substance use behaviors (i.e., herpes, hepatitis, tuberculosis, gonorrhea, syphilis)?

   ☐ YES ☐ NO If yes, place X beneath past or present, and enter disease information

PAST	PRESENT [Communicable Disease]	WHAT?
☐	☐	
☐	☐	
☐	☐	

4. Is consumer currently complaining of or experiencing any physical health problems which *might conceivably be associated with* drug or alcohol use (for example, headaches, stomach aches, high blood pressure, dental, AIDS, blood disorder, loss of appetite, joint pain?) ☐ YES ☐ NO If YES, describe:

5. Has consumer ever experienced any of the following problems with drinking/using? Check which:

☐Tremors ☐Blackouts ☐Flashbacks

☐Hangovers ☐Seizures ☐Hallucinations ☐DT's

☐Nervousness ☐ Other

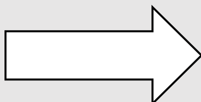
Details of such physiological events:

6. Are there any indications WHATSOEVER, from ANY SOURCE, OR from your own clinical judgment, that this consumer may has or may have substance abuse or dependency issues? ☐ YES ☐ NO

Other Notes Related to Possible Abuse of Substances, noted here:

If NO, proceed on to Section VI, Abuse and Neglect.

But if YES . . .



If YES, please be specific in the space above about the predominant indicators, and from what source, and then proceed on to the following page subsection 7, completing the Drug Usage grid and the additional questions.

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7. **DETAILED HISTORY OF DRUG USAGE (Section V continued)**

	AGE BEGAN	HOW LONG USED (DATES IF KNOWN)	ANY PERIODS OF NOT USING	ROUTE	FREQ.	AMOUNT	LAST DOSE OR USE
ALCOHOL							
AMPHETAMINE							
BARBITURATES							
CNS Depressants							
MARIJUANA							
NARCOTICS							
HALLUCINOGEN							
COCAINE							
INHALANTS							

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	AGE BEGAN	HOW LONG USED (DATES IF KNOWN)	ANY PERIODS OF NOT USING	ROUTE	FREQ.	AMOUNT	LAST DOSE OR USE
OVER-THE-COUNTER							
OTHER SUBSTANCES							

8. Has there been any change in tolerance (i.e., the amount it takes to achieve a certain effect from alcohol or drug)? If YES, please explain:

9. Does consumer think there is any difference between what his/her ethnic or family group taught about drinking and using, and what the rest of society or the peer group teaches?

   ☐ YES ☐ NO

   If YES, please explain:

10. Has consumer participated in any support groups before? (Check)

    ☐ AA ☐ NA ☐ CA ☐AlAnon

    ☐ NarAnon ☐ Other

    How many times attended, or how long?

11. Was anything "missing" from his/her support group experience? ☐ YES ☐ NO

    If YES, please explain:

12. What effect has consumer's drinking / using had on his/her social relationships or activities?

13. Does s/he/she have friends who are recovering or do not drink/use? ☐ YES ☐ NO

14. Is there any information that consumer's parents, grandparents, siblings, other relatives, or spouse or significant other have/had psychological or emotional or CD-related problems? ☐ YES ☐ NO If YES, what?

15. Does consumer feel that alcohol/drug use has caused problems in how he/she behaves sexually?
☐ YES ☐ NO

If YES, please explain:

16. Does the total of gathered information related to substance use indicate that an addiction or substance use DIAGNOSIS is appropriate?

☐ YES ☐ NO If YES, specify WHICH DIAGNOSIS(ES), here:

END OF SUBSTANCE ABUSE ASSESSMENT

If SA Assessment is not completed by person who does the Clinical Interview, please specify who:

Print name ______________________________

Signature, Credentials:

________________________________Date_____

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VI. ABUSE OR NEGLECT RELATED ISSUES

1. Based upon all available information and clinical interview, has consumer been (or does it appear that consumer has been) abused or harassed in any of the following ways?

   Physically ☐ Emotionally / Mentally ☐

   Sexually ☐ ☐ Bullied or Harassed

   Specifics:

2. Ever abused or bullied or harassed others?

   ☐YES ☐NO

   If yes, how?

3. Ever abused animals? ☐YES ☐NO

   If yes, details:

VII. SPECIAL ISSUES

1. Is youth sexually active? ☐YES ☐NO

   If YES, how many partners thus far?

   If YES, uses protection? ☐YES ☐ NO

2. If YES, does he/she believe that his/her parents or caretakers know that he/she uses protection?

   ☐YES ☐NO If YES, do they approve or assist him/her in obtaining protection?

3. If sexually active: If not limited to a monogamous “adult” relationship, does consumer feel that his/her sexual contacts are the result of

   ☐ impulse, or
   ☐ curiosity, or
   ☐ desire to please others, or
   ☐ "addictive" habitual pattern

4. If female, is there any possibility that the individual is pregnant? ☐ YES ☐ NO If YES, basis, or date baby is due?

5. Family: Strengths and weaknesses

6. Child: Strengths and weaknesses

7. Clinician: Strengths and weaknesses

VIII. DIAGNOSTIC IMPRESSION

Axis I

1. PRIMARY:

2. SECONDARY:

3. TERTIARY:

Axis II:

Axis III:

Axis IV:

A. Problems with primary support group ☐
B. Problems related to the social environment ☐
C. Educational problems ☐
D. Occupational problems ☐
E. Housing problems ☐
F. Economic problems ☐
G. Problems with access to health care services ☐
H. Problems related to interaction with the legal system/crime ☐
I. Other psychosocial and environmental issues ☐

Axis V: CURRENT GAF:

Estimated Highest Past Year:

Estimated Lowest Past Year:

IX. SPECIAL SERVICE RECOMMENDATIONS?

- Does consumer meet criteria for a particular program, service category or service package? ☐ Y ☐ N if Yes, what?

- Is consumer MEDICALLY UNSTABLE with a Bipolar Disorder or other psychosis, so that he/she must be considered for an intensive service package or program? ☐Y ☐N ☐Pending psychiatric assessment by physician

- Does this consumer need immediate crisis intervention in a psychiatric inpatient treatment facility? ☐ YES ☐ NO ☐ Pending psychiatric assessment by psychiatrist

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X. CLINICAL FORMULATION

Please write a Clinical Summary of this child's status, based upon the information contained in Sections A and B of this assessment. For multiple diagnoses: Please explain your rationale for assigning 'primary' vs. 'secondary' to each diagnosis.

Please formulate the major issues which need to be addressed FIRST, and if any major functionality issues are to be left un-addressed in the treatment plan at this time, please explain WHY. If this child has a Bipolar Disorder, Psychosis, or related disorder, and is NOT medically stable, please formulate a prognosis for achieving stability and within what timeframe, based upon available data and history of treatment thus far.

Finally, please identify the CASE MANAGEMENT issues which you consider to be the most pressing at the moment.

Clinical Assessment Completed By: (print): ___________________ Date of Assessment _______

Signature, credentials: _______________________________ Date signed ___________

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THE ASSESSMENT OF ACUTE RISK
PROTOTYPICAL EXAMPLE

SCREENING FOR INDICATORS OF ACUTE RISK

Note: To be performed prior to routine Biopsychosocial Assessment *when a potential client presents with indicators that suicidality or intent to kill or inflict serious bodily harm to self or others may exist.* Also may be used as a free-standing risk assessment at any time when such indicators arise after admission, or when an admission decision must be made but there is insufficient time to perform a full Biopsychosocial Assessment prior to the admission.

Client Name

Date of Assessment

Date of Birth of Client

Primary Reason for Admission or Treatment:

Assessment of Suicide Potential

1. Is there information, from <u>any source</u>, that the consumer may be contemplating suicide? ☐ Yes ☐No If YES, what is the source?

2. Does consumer admit to current suicidal ideation? ☐ Yes ☐ No If YES, please answer the remainder of this section:

   a. For how long has consumer been considering suicide? ☐ hours ☐ days ☐ weeks ☐ months ☐years

   b. Is there a contemplated method? ☐ Yes ☐ No If YES, describe method:

   ____

   ____

   c. Is the method readily available to consumer? ☐ Yes ☐ No

   d. How detailed is the plan?

   VERY VAGUE VERY DETAILED

   1 ....2.........................3.........................4.........................5.......................... 6

   e. Has consumer begun to prepare for suicide? ☐Yes ☐No What steps has consumer taken to prepare?

   ____

   ____

   f. How lethal is the consumer's method?

   LOW LETHALITY HIGH LETHALITY

   1 ....2.........................3.........................4.........................5.......................... 6

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3. If consumer denies suicidal ideation, but **OTHER SOURCES** indicate the possible presence of such, provide a summary of the information provided by the source:

4. ***Previous suicidality information:*** Is there a report of past suicide ideation or act? ☐Yes ☐No If YES: How many previous attempts or gestures? _________ When was *most recent* attempt/gesture? _________ And the *most serious*? _________

   Method?

   ____

   ____

   a. How lethal was the consumer's method in this/these past act(s)?

   LOW LETHALITY HIGH LETHALITY

   1 ....2.........................3.........................4.........................5.......................... 6

   b. What prevented the consumer from completing the most recent suicide attempt/gesture?

   ____

   ____

5. Based upon *all available data*, in the clinician's professional opinion, how lethal is consumer's current suicide status?

   LOW LETHALITY HIGH LETHALITY

   1 ....2.........................3.........................4.........................5.......................... 6

6. Immediate Clinical Recommendations for this area:

Assessment of Potential For Homicide Or Serious Bodily Harm To Others

1. Is there information, from any source, that the consumer may be contemplating homicide or serious bodily harm to another person? ☐Yes ☐No If YES, what is the source?

2. Does consumer admit to current or recent homicidal ideation or desire to inflict serious bodily harm to another? ☐Yes ☐No YES, please answer the remainder of this section:

   a. When or for how long has consumer been considering homicide or bodily harm to others? ☐hours ☐days ☐weeks ☐months ☐years

   b. Contemplated target and method? ☐Yes ☐No If YES, who is the target and what is the method?

   ____

   ____

   c. Is the method readily available to consumer? ☐Yes ☐No Method:

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d. How detailed is the plan?

VERY VAGUE VERY DETAILED

1 ....2.........................3.........................4.........................5.......................... 6

e. Has consumer begun to prepare for the homicide or bodily harm action? ☐Yes ☐No
If YES, what steps has consumer taken to prepare?

____

____

f. How lethal is the consumer's method?

LOW LETHALITY HIGH LETHALITY

1 ....2.........................3.........................4.........................5.......................... 6

3. If consumer denies homicidal ideation, but other sources indicate the possible presence of such, provide a summary of the information provided by the source:

4. **Information about previous risk of harm to others:** Is there a report of past intent or action to harm others? ☐Yes ☐No If YES, complete the following:

   a. Methods and dates of previous homicide attempts, serious attempts to harm, or threats of such: How many previous attempts or threats? ____ When was *most recent* attempt or threat? _______ And the *most serious*? _______

   Method?

   ____

   ____

   b. How lethal was the consumer's method in previous attempts or threats?

   LOW LETHALITY HIGH LETHALITY

   1 ....2.........................3.........................4.........................5.......................... 6

5. Based upon *all available data*, in the clinician's professional opinion, how lethal is consumer's current potential for homicide or serious bodily harm to others?

   LOW LETHALITY HIGH LETHALITY

   1 ....2.........................3.........................4.........................5.......................... 6

6. Recommendations in this area, and actions to be taken immediately:

_______________________________________ _____________

Assessing Clinician, credentials **Date**

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THE SUPPLEMENTAL ASSESSMENTS

A. MOVEMENT SCALE (A.I.M.S.) ASSESSMENT

The Abnormal Involuntary Movement Scale (A.I.M.S.) Assessment is a simple screening device for the early detection of tardive dyskinesia which may develop in consumers exposed to antipsychotic medications over a prolonged period of time. Since there is no known, consistently effective treatment for tardive dyskinesia, prevention and early detection are critical. The A.I.M.S. Assessment is to be done by a physician upon admission and then each 90 days thereafter, for persons taking neuroleptic medications, including adolescents. Registered Nurses (RN) who have been trained in the A.I.M.S. Assessment may examine and rate the consumer using the A.I.M.S. Scale.

B. PSYCHOLOGICAL EVALUATION

A psychological assessment obtains psychometric and projective data on intellectual and personality functioning, as well as evaluates cognitive, neurological, affective and visual-motor functioning. Psychological evaluations and assessments are performed only by a licensed psychologist, *and authorization for performance is requested of the managed care company only when such assessment is crucial to the differential diagnosis of the consumer's condition.* Some examples of clinical justification for assessment include the following:

- differentiating between an organic, drug-induced psychosis and schizophrenia or other major mental illness
- differentiating between a mental illness diagnosis and mental retardation
- differentiating between a progressive cognitive decline (dementia) and major depression

Typically, assessments of children and adolescents which differentiate between mental retardation or borderline intellectual conditions and mental disorder, and assessments of learning disorders, may be obtained through the local public school system, or through requesting a special educational planning meeting though the school system.

C. NURSING ASSESSMENT

Comprehensive nursing assessments may be performed at the request of the managed care company, sometimes as a precursor to admission into

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a special program such as inpatient treatment or residential care. These assessments typically include mental status review and complete drug and alcohol history. Other areas of assessment typically included in nursing assessments are the following:

- physical description of the consumer
- known allergies
- activities of daily living
- legal status
- dietary habits (including ethnic or cultural preferences)
- general mental orientation
- nursing assessment of physical systems
- precipitating factors of hospitalization
- typical sleep patterns
- family situation
- educational needs
- special precautions and restrictions.

D. ACTIVITY ASSESSMENT

The activity assessment may be performed in the context of participation in special programs such as residential or day treatment for psychiatric or substance abuse issues, and may not be separately billable.

The assessment includes information regarding the consumer's past and present functionality, skills, talents, interests and aptitudes – including physical abilities and limitations, work patterns and availability of leisure time, motivation and preferences for various activities. The activity assessment must consider the psychiatric status and history when designing a plan of activity participation, in that each activity in which the consumer participates must coordinate with therapeutic goals.

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E. PHYSICAL ASSESSMENT

This is not a standard behavioral health or substance abuse modality, but may be performed in the context of participation in special programs such as residential or day treatment for psychiatric or substance abuse issues. When performed by the Primary Care Physician or equivalent, the physical assessment of the consumer's medical needs is typically covered by the HMO contractor providing physical health care, or through other means. Physical assessments should be performed by a board-certified or board-eligible physician, and typically include the following:

- gross neurological assessment;
- gross speech, hearing and language examination;
- gross dental examination.

The medical history should include a drug and alcohol history, review of all systems, and all medical/surgical treatments. Laboratory testing may be ordered by the physician and may include a complete blood count, biochemical profile, STD serology and urinalysis.

Proceed to Next Page!

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http://www.ceubynet.com/media/course_3c/assessment_of_acute_risk_form.pdf

http://www.ceubynet.com/media/course_3c/biopsychosocial_assessment_form.pdf

For those working with Texas' TRR and CAN programs, see the *link below*, for a 'tweaked' version of the C and A Biopsychosocial Assessment. The difference between the first two assessments (above) and the third assessment (below), is that the third assessment makes provisions for identifying diagnosis(es) as 'internalizing' vs. 'externalizing' disorders, with an eye to selecting a Skills Training approach *vs*. a Cognitive Behavioral Therapy (CBT) approach, if appropriate.

http://www.ceubynet.com/media/course_3c/biopsychosocial_assessment_form_for_texas_trag.pdf

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