Clinical Assessment Training for Behavioral Health Services

For use with:

* BHS Yearly Refresher Quiz

*Clinical Assessment Orientation Test

Competency Assessment of Inquiry and Pre-Admission Assessment

Purpose:

- In the field of behavioral health, one of the most important decisions is whether or not a client is appropriate for the services they are seeking or that others are seeking on their behalf. This particular decision has an impact on the legal, medical, and patient rights dimensions of the program's operation.

Expectations:

- It is expected that a member of the staff qualified for assessments can pass this competency prior to being allowed to complete assessments independently. Once the competency is passed, the individual will need to be supervised in the assessment process and also pass that competency prior to performing the assessments without supervision. Passing is equivalent to 100% correctness on the examination and meeting all expectations in all areas on the assessment competency portion.

Admission Criteria for Inpatient Mental Health Admissions

Severity of Illness

a. **Danger to self**

Recent suicide attempt, recent gesture with history of attempts

i. Persistent suicidal ideas, especially with plans
ii. Persistent self-mutilating acts
iii. Self-destructive behaviors
iv. Inability to provide basic needs for food/shelter (such as in severe cognitive impairment)
v. Bizarre social behavior endangering reputation, assets, relationships, or
vi. Presence of command hallucinations

b. **Danger to others**

i. Threats to harm a specific individual
ii. Threats to harm someone as yet identified
iii. Brandishing lethal weapons or possession of weapons in an emotionally disturbed state
iv. Escalating behavior suggestive of impending aggressive outbursts and with a history of such
v. Significant damage to property
vi. Presence of command hallucinations
vii. Recent aggressive outbursts

a. Impaired activities of daily living (ADL)

i. Not eating—weight loss
ii. Not sleeping or hypersomnia
iii. Not bathing, dressing, etc.
iv. Inability to carry out basic functions such as child care, paying bills, or preparing meals

b. Cognitive distortions

i. A majority of their behaviors are influenced by delusions/hallucinations
ii. Command hallucinations of harm to self/others
iii. Evidence of responding to internal stimuli
iv. Misinterpreting, paranoia
v. Grandiosity
vi. Ideas of Reference

Conducting the Assessment

Mental Status Exam

a. **Presenting problem**: in a quotation if possible and how this problem affects them
   i. Why did they pick today to come in?
   ii. Who brought them or who called EMS?

b. **Presenting appearance**
   i. Includes chronological and apparent age, ethnicity, apparent height and weight (average, stocky, healthy, petite), any physical deformities (hearing impaired, injured and bandaged right hand)
   ii. Basic Grooming and Hygiene, dress and whether it was appropriate attire for the weather
   iii. Gait and Motor Coordination (awkward, staggering, shuffling, rigid, trembling with intentional movement or at rest), posture (slouched, erect), any noteworthy mannerisms or gestures

Conducting the Assessment (Continued)

c. Cognition

i. Thought processing: continuity of thought, coherence, blocking, attention span

ii. Presence or absence of hallucinations and what type, duration, etc.

iii. Orientation: do a Mini Mental Status Exam if indicated for the elderly or if needed to determine decision-making capacity.

d. Language

i. Speech (normal rate and volume, pressured, slow, accent, enunciation quality, loud, quiet, impoverished)

ii. Expressive Language (no problems expressing self, circumstantial and tangential responses, difficulties finding words, misuse of words in a low-vocabulary-skills way, misuse of words in a bizarre-thinking-processes way, echolalia or perseveration, mumbling)

iii. Note if English is not primary language here and comment on their command of the language

iv. Receptive Language (normal, able to comprehend questions, difficulty understanding questions)

Conducting the Assessment (Continued)

e. **Eye contact:** makes, avoids, seems hesitant to make eye contact

f. **Behavioral Approach: d**istant, indifferent, unconcerned, evasive, negative, irritable, depressive, anxious, sullen, angry, assaultive, exhibitionistic, seductive, frightened, alert, agitated, lethargic, needed minor/considerable reinforcement and soothing

Suicidal/Homicidal States

**Note, these should be asked together, then return to ask for clarification of each

- ✓ How long have they felt this way, what stopped them from acting on these feelings, a plan if any, have they tried to harm themselves in the past
- ✓ Any past gestures, self mutilation and when these occurred
- ✓ For homicidality is there a target, plan of assault, past history of violent behavior, property destruction, etc.
- ✓ Be sure to document this information in the appropriate blanks of the assessment form and then to the admission database
- ✓ Ask about any family history of completed suicide or if a person close to them recently committed suicide

Suicide Risk/Safety Planning

Factors that increase suicide risk

- Physical illness, particularly chronic pain, or a terminal illness diagnosis
- Family history of psychiatric illness, particularly suicide attempts or completion
- Presence of firearms in the home
- Lack of support or sense of isolation
- A history of trauma or abuse
- Present use/addiction to drugs and alcohol
- Lack of health care, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

Suicide Risk/Safety Planning (Continued)

Safety Plan creation

- It is important to establish a basic safety plan for patients that are released from the emergency room or medical floors
- A patient can be given a formal safety plan written out in collaboration with a mental health crisis worker or BHS staff or they can be given a resource card and verbalize what they would do in the event of a crisis. It is always desirable to include a friend or family member as well in the safety plan when possible.
- In the least, a safety plan should be documented to include the referral sources given (with at least three), what they would do/whom they would call/where they would go if their symptoms would worsen or if they would become unsafe, who else was involved in their safety plan, and also to document if you gave them our Jameson BHS resource card.

Problems that can Exacerbate the Person's Impairments

a. Drug and alcohol use

i. What do they use, how often, and date of last use should be recorded as best as possible.
ii. What is their drug of choice?
iii. Presence/absence of withdrawal, past blackouts, seizures, alcohol DTs
iv. Family history of use
v. Past treatment and approximate dates for both inpatient and outpatient
vi. Length of sobriety
vii. Document results of drug screen and alcohol level

b. History of Abuse

i. Physical abuse: Ask who and when. Is this still active?
ii. Sexual abuse: Ask but do not pressure client to disclose. They can answer yes without giving details---do not attempt to process abuse or prior memories with clients as assessment is not psychotherapy.
iii. Verbal/emotional abuse: ask who, when and if it still occurs
iv. If not assessed or the client is unable to be assessed in such a way, document this.

Other Problems…

a. Problems and coping

i. What are the current stressors?
ii. What coping skills do they use/ is there an absence of coping?
iii. How is their insight into these problems?
iv. Are these problems that related to them personally or are they problems of other persons in their lives?

b. Occupational issues

i. Do they work? Why not?
ii. Have they been missing work or terminated recently?

c. Medical problems

i. Who is their PCP? Have they seen them recently?
ii. Do they have medical diagnoses?
iii. Any recent changes affecting mood, etc?
iv. Excessively high/low blood sugars?
v. Sepsis, urinary tract infections?
vi. Head injuries?
vii. Oxygen levels? Do they use c-pap or other?

Assessment Skills

Tips for Crisis Intervention

- **Be empathetic:** do not be judgmental of the person's feelings or actions. They are real to the client even if they are not reality based.
- **Clarify messages:** listen to what is really being said. As reflective questions, such as repeating the feeling words used by the client when talking to them, do not fake attention.
- **Respect personal space:** stand about three feet from the person, invading personal space can escalate situations or cause discomfort.
- **Be aware of your body position**: standing eye-to-eye and toe-to-toe sends a confrontational message, positioning slightly at an angle is more supportive and safer.
- **Permit verbal venting**: allow the individual to verbalize and release feelings.
- **Avoid reacting emotionally**: remain calm, rational and professional. How you respond will directly affect the individual.
- **Evacuate from potentially dangerous situations**: do not attempt to handle dangerous situations on your own, leave to get assistance. Use intervention only if a serious threat is imminent.
- **Ignore/redirect challenge questions**: when an individual challenges your position, authority, training, etc, redirect their attention to the issue at hand, answering these questions often only fuels the power struggle and can escalate the situation.
- **Keep your non-verbal cues non-threatening**: be aware of your body language, movement, and tone of voice. Maintain a supportive, attentive, therapeutic stance, convey empathy and understanding.

Additional screening questions for gathering symptomology

- ✓ About sleep: How are you sleeping? Do you have trouble falling asleep, staying asleep, waking up?
- ✓ About energy level: How is your energy level though the day; do you have enough energy to get things done?
- ✓ How is your appetite? How do you feel most days?
- ✓ Are there things that worry you a lot? Have you ever felt an intense fear or worry that something bad would happen to you? Are there specific things that frighten you? (Indicative of anxiety)
- ✓ Do you ever feel the need to do something over and over until it's perfect? Are there certain things you sometimes feel compelled to do over and over? Are there ever thoughts that you just can't get out of your head? (Symptoms of compulsions and obsessions)
- ✓ Have you ever felt someone was reading your mind or making you think things? Have you eve r felt your mind was playing tricks on you? Have you ever had a dream that was so intense and real, you weren't sure if you were asleep or awake? (Delusions and hallucinations)
- ✓ Do you think your eating habits are unusual? What is your weight now? What is the most and least you've weighed? Are you concerned about your weight? (Screening for possible eating disorders)
- ✓ Do you ever find yourself suddenly doing something before you have really had a chance to think about it? Do you ever do things you had decided not to do, and don't know why? Does money "burn a hole in your pocket"? (Checking for impulsivity)
- ✓ Have you ever had so much energy you couldn't sit still? That you didn't need to sleep for days at a time? (Assessing for mania)

Working with People with Delusions

- ✓ It is helpful to establish a trusting, interpersonal relationship. Assure the person that they are safe. Center on the patient as a person, rather than on the need to control symptoms.

- ✓ Identify the content and type of delusion. Assist in understanding the patient and the purpose that the delusion serves. Clarify as needed

- ✓ Assess concrete ways the delusion interferes with functioning. Assess the areas of the person's life that can no longer be managed, controlled or participated in. Ask the person if they have taken actions based on their delusions.

- ✓ Assess the frequency, duration and intensity of the delusion. Fixed delusions are endured over time, fleeting delusions are those that are not part of the person's baseline thinking.

Barriers to Working with People with Delusions

- ✓ Do not become anxious with the individual. Anxiety leads to annoyance, anger and a possibility of not treating the individual fairly.
- ✓ Do not attempt to prove the person wrong or attempt to explain their delusion with logical reasoning.
- ✓ Do not reinforce the delusion by pretending the delusion is real especially as way to gain the cooperation of the individual.
- ✓ Be consistent, an intervention plan must be adhered to by the whole staff, inconsistent approaches interfere with the person's attempt to define reality.
- ✓ Do not become incorporated into the delusional system, this will cause great confusion for the person and make it impossible to establish therapeutic boundaries.

Mood Assessment

For persons not displaying symptoms of depression, a different set of symptoms and functioning can be assessed.

- **Hypomania:**
  - Feels health is good; tend to ignore wellness care, racing thoughts, increased energy
  - Sexual indiscretions, attempts to control interactions, mildly obtrusive and demanding
  - Over spending, feels others move too slow
  - Overly confident, feels on top of the world, difficulty with anger, inappropriate laughter
  - Wears out support systems, accesses community resources inappropriately

- **Mania:**
  - Need for only 4-6 hrs of sleep per day, concentration difficult, flight of ideas, pressured speech
  - Decreasing ability to manage anger
  - Wants to control others, very demanding, blames others for problems
  - Unable to complete tasks, starts numerous things but cannot finish them, overly talkative, increased use of make up, extreme change in appearance
  - Use of religious or spiritual beliefs to control others, needs help to access community resources, may not realize help is needed

Mood Assessment Continued

- **Elation**
  - Needs 3 hours or less of sleep, presence of word salad, delusions of grandeur, hostile if you disagree
  - Unable to cooperate, unable to tolerate limit setting
  - Doesn’t want help of any kind
  - Socially inappropriate, sexually promiscuous
  - Delusions may be intense religious/spiritual beliefs
  - Safety risks are imminent

Vocabulary Necessary for Conducting Assessments

Abstract thinking: the capacity to formulate concepts and to generalize

Affect: range of expression of feelings

Apathetic: showing lack of interest, indifference, or lacking feeling.

BCM/Blended Case Manager: A clinician assigned to a client that is meant to help them learn to function at a higher capacity or remain in the community by accessing or linking services, learn advocacy, teaching time management, budgeting, problem solving and commutation skills

BHRS

Behavioral Health Rehabilitation Services (BHRS) is a service that promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural settings through focusing on his/her individualized strengths and needs .

Services include psychological evaluation, Therapeutic Staff Support (TSS), Mobile Therapy (MT), and Behavioral Specialist Consultant (BSC) services. The BSC, a member of the treatment team, primarily provides assessment, program design, and monitoring rather than direct therapy. The MT provides intensive therapeutic services to a child and child's family in home, school or community settings. TSS provides one-on-one service. For instance, the child's therapist may instruct a child in how to take turns using cards, a worksheet, games, checklists, scripts and other strategies. The TSS may then prompt the child to practice that skill in natural settings such as circle-time, recess or during a play date. This instruction may occur in-home and be practiced there and at some point with other children. The TSS takes data and records treatment notes to measure the child's progress toward independent use of the skill. The BSC regularly reviews these notes to adjust treatment and goals as needed.

Vocabulary Necessary for Conducting Assessments

Blocking: difficulty in recollection, or interruption of a train of thought or speech due to emotional factors usually unconscious

Compulsions: repetitive stereotyped behaviors that patients feel they must perform in a ritualistic fashion even though they are consciously aware of the irrationality and absurdity of the behavior.

Confabulation: the more or less unconscious, defensive "filling in" of actual memory gaps by imaginary or fantastic experience, often complex, that are recounted in a detailed and plausible way as though they were factual.

Delusions: a false belief out of keeping with the individual's level of knowledge and his cultural group. The belief is maintained against logical argument and despite objective contradictory evidence.

Delusions of Grandeur: exaggerated ideas of one's importance or identity

Delusion of Persecution: ideas that one has been singled out for persecution

Delusions of Reference: incorrect assumption that certain causal or unrelated remarks or the behavior of others apply to oneself.

Echolalia: irreverent parroting of another person's words

Hallucinations: a perceptual distortion for which there is no external stimulus

Euphoria: an exaggerated feeling of physical and emotional well being not consistent with apparent stimuli or events—also seen in organic brain disease and toxic states

Flattened Affect: displaying an abnormally small range of emotional expression.

Vocabulary Necessary for Conducting Assessments

Flight of Ideas: verbal skipping from one idea to another before the last one has been concluded; the ideas appear to be continuous but are fragmentary and determined by chance associations.

Impulse control: ability to keep in check the expressions of aggressive, hostile, fearful, guilty, affectionate, or sexual impulses in situations when their expression would be maladaptive.

Inappropriate affect: Emotional expressions that are not in accord with the situation, or what is being said such as giggling when talking about a death in the family.

Insight: capacity to be aware of and understand a problem or illness and be able to review probable causes and arrive at tenable solutions.

Labile Affect: rapidly shifting emotions

Mood: sustained feeling tone that prevails over time for patients.

Neologism: a new or condensed word made up by a patient, not readily understood by others, common in schizophrenia.

Outpatient Therapy: an individualized treatment which occurs in a clinic setting or in the offices of a private practitioner and involves the interaction between a therapist and child/adolescent in order to resolve concrete problems in daily living or symptoms resulting from thoughts, feelings, interpersonal disturbances, and /or experiences.

Staff conducting the service are Master's prepared, licensed in their appropriate discipline such as Counseling or Social Work, or they may be a Psychologist.

Vocabulary Necessary for Conducting Assessments

Partial Hospitalization Program: are site-based, time-limited, intensive multi-disciplinary therapeutic programs. Appropriate referrals to this service are individuals with a DSM-IV diagnosis requiring a more intensive level of care than outpatient, but less intensive than inpatient hospitalization. Severity of presenting problems are such that the individual requires routine medical/nursing observation and behavioral intervention to maximize functioning and minimize risk to self, others and property. This level of care can be utilized as a crisis stabilization/diversion from inpatient hospitalization or as a "step-down" from a higher level of care to shorten the stay. Individuals receive psychiatric oversight and supervision to provide stabilization and treatment in a highly structured environment. The level of participation in a partial program is a minimum of 4 hours of clinical service per day with the expectation that services are provided no less than 3.5 days per week.

Phobia: marked fear reflected by intense anxiety

Preoccupations: absorption with one's own thoughts to the extent of losing contact with external reality

Psychiatric Rehab: a strength-based service that focuses on improving activities of daily living and developing education and vocational goals with the intent of maximizing the person's strengths. This is not considered psychotherapy or clinical in nature.

Vocabulary Necessary for Conducting Assessments

Residential Treatment Facilities : (RTF) services are 24-hour services for children/adolescents delivered in a licensed facility. Residents receive therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision. The focus of treatment is on stabilization and therapeutic treatment, medication management, healthcare education, life skills, interpersonal skills, education/vocational pursuits, 24-hour supervision, including nursing services, and individual and group therapies. The duration of services is based on periodic medical necessity review and the continued severity of risk that indicates a member cannot be safely treated in a less restrictive environment.

Word Salad: incomprehensible missing or meaningless words and phrases.

Mental Health Commitment Type

Voluntary Commitment (aka "a 201")

- A voluntary commitment may be appropriate for anyone 14 years of age or older who is experiencing a mental health crisis and feels that an in-patient stay is necessary for his/her safety. A person seeking treatment under Section 201 may arrive at an emergency room for an evaluation to determine the level of treatment needed. There are no hearings required during this admission and no information is submitted to the state police regarding the person's psychiatric treatment. At the time of admission, the individual will be asked to agree to give 72-hour written notice before leaving the facility if they should decide to leave against medical advice. If in-patient care is recommended, the individual must sign a 201 form and assist in developing a treatment plan with the treating facility.
- Adolescents under the age of 14 years may be admitted on a voluntary admission by a parent or legal guardian. In addition, parents or legal guardians are able to sign a 201 for an adolescent under the age of 18 years, but only if the adolescent is already in a emergency room and it is recommended by a physician.
- There is no time limit on a voluntary in-patient stay. The individual may stay as long as he/she and the medical staff believes there is a continued need for in-patient treatment.

Involuntary Commitment

Involuntary Commitment (aka “a 302”)

An involuntary commitment is an application for emergency evaluation and treatment for persons who are “dangerous” to themselves or others due to a mental illness. Dangerousness is determined based on the following criteria:

Involuntary Commitment (cont)

Involuntary Commitment (aka “a 302”)

Danger to self shall be shown by establishing that within the previous 30 days:

- The person would be unable without the care, supervision and assistance of others to satisfy his/her need for nourishment, personal or medical care, shelter or self protection or safety and that death or serious physical debilitation would occur within 30 days unless treatment was provided.
- The person has attempted suicide or the person has made threats to commit suicide and committed acts in furtherance of the threats, or
- The person has mutilated himself/herself or the person has made threats to mutilate and committed acts in furtherance of the threats.

Involuntary Commitment (cont)

Involuntary Commitment (aka “a 302”)

Danger to others shall be shown by establishing that within the previous 30 days the person has inflicted or attempted to inflict serious bodily harm on another or has threatened serious bodily harm and has committed acts in furtherance of the threat to commit harm to another.

- In every 302, a petitioner is required to sign the 302 and appear at a hearing, if necessary. A petitioner must have first-hand knowledge of the dangerous conduct.
- The petitioner may be required to testify at a hearing regarding the dangerous conduct that he or she witnessed.
- Once a 302 is authorized, the individual will be taken to an emergency room by the police or ambulance for an evaluation by a physician to determine if they need to be admitted for involuntary psychiatric inpatient treatment. If the individual is admitted, they may be kept no longer than 120 hours unless a petition for a 303, Extended Emergency Involuntary Treatment, is filed by the hospital.

Recognizing Movement Disorders

- Akathisia
  - Restlessness
  - Difficulty in sitting still
  - Strong urge to move about
  - Can be misdiagnosed as psychomotor agitation
- Dystonic Reactions
  - Abnormal posture
  - Facial grimacing
  - Abnormal eye movements
  - Involuntary muscle movements

CLOSE THIS WINDOW TO TAKE THE TEST