

ASSESSMENTS

GATHERING INFORMATION AND FORMULATING
IT INTO A COHERENT PICTURE OF THE CLIENT
AND HIS OR HER CIRCUMSTANCES

SOWK 486: Theories of Practice I
Heritage University Fall 2020
Jacob Campbell, LICSW



AGENDA

- Diagnostic Assessments
- Screening Tools
- DSM-5
- Documentation
- Mini Mental Status Exams

An aerial photograph of an ancient city, likely Mayan or Aztec, featuring a central temple complex on a hilltop. The city is built on a grid of stone walls and courtyards, with a dense network of structures. The lighting is dramatic, with strong shadows and highlights, suggesting a sunset or sunrise. The sky is dark, and the overall tone is sepia or golden-brown.

Complex Interplay

Complex Social Institutions

Person's functioning

THE MULTIDIMENSIONALITY OF ASSESSMENT

PRIORITIES IN ASSESSMENT

- What does the client see as his or her primary concerns or goals?
- What (if any) current or impending legal mandates must the client and social worker consider?
- What (if any) potentially serious health or safety concerns might require the social worker's and client's attention?



DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION

ETHICAL CONSIDERATIONS REGARDING CLINICAL WORK

- **Who gives diagnoses?**
- **Students roles in understanding clinical practice**

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

DSM-5

AMERICAN PSYCHIATRIC ASSOCIATION

USING THE DSM

- **Common language**
- **Billing**
- **Research**

PROBLEMS WITH THE DSM

- Not strengths based
- Possible loss of personal freedom
- Lifelong labeling
- Variance of diagnoses among professionals

(Shackle, 1985)

DSM SECTIONS

- Diagnostic criteria
- Subtypes/specifiers
- Recording procedures
- Diagnostic features
- Associated features supporting diagnosis
- Prevalence
- Development and course
- Risk and prognostic factors
- Specific culture, gender, and age features
- Functional consequences of the specific diagnosis
- Differential diagnosis
- Comorbidity



EMPHASIZING STRENGTHS IN ASSESSMENTS

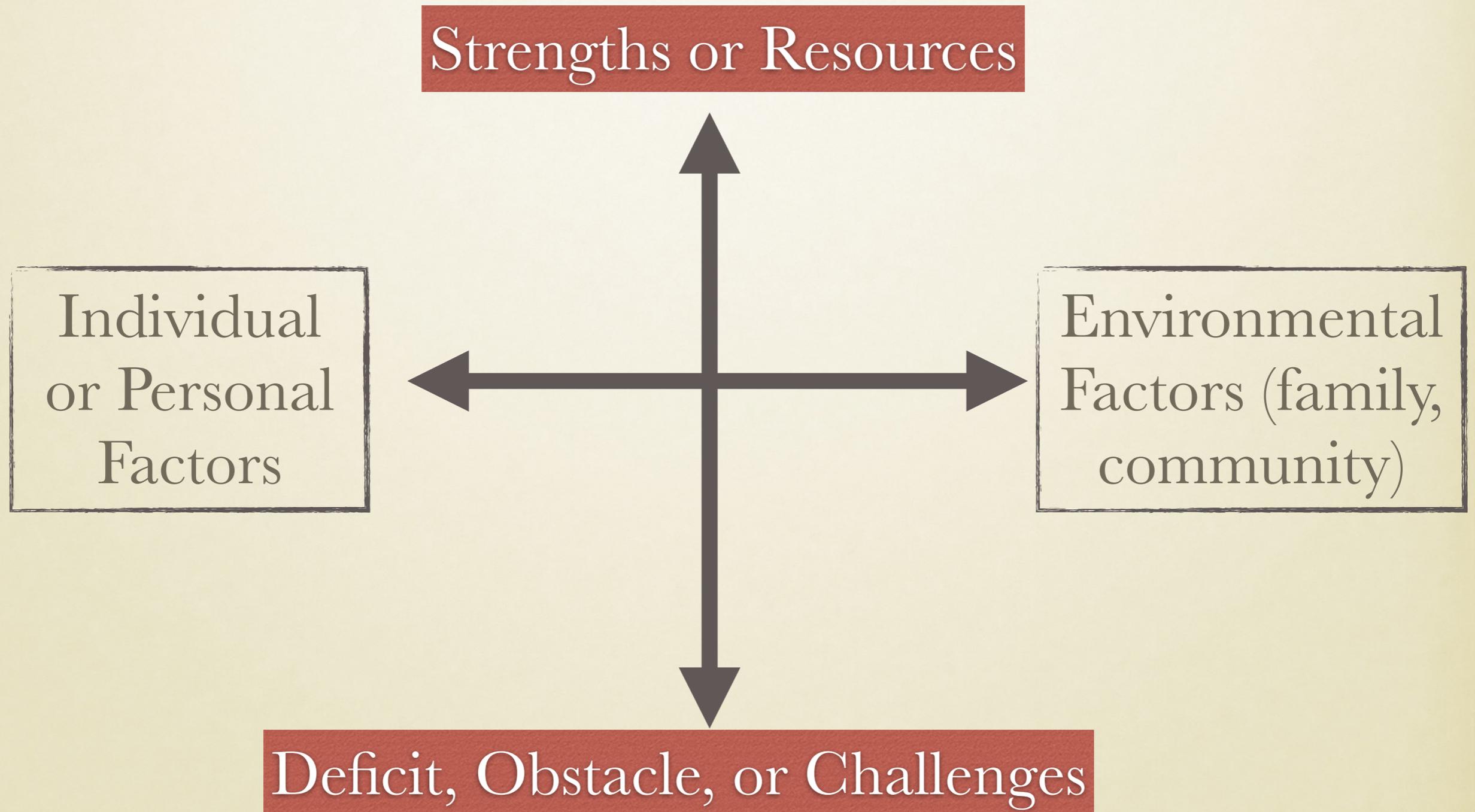
Give pre-eminence to the client's
understanding of the facts

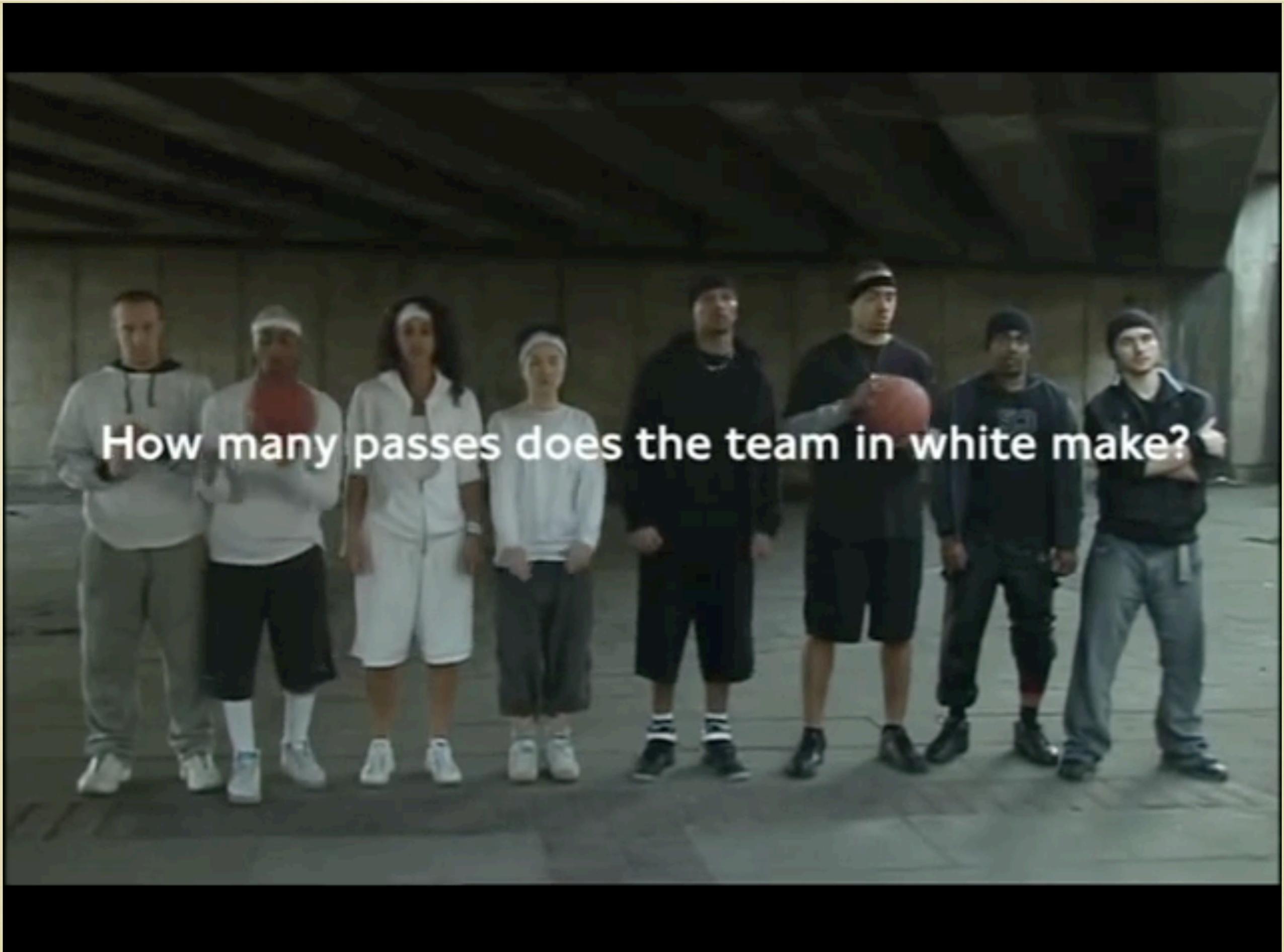
Discover what the client wants

Assess personal and environmental strengths
on multiple levels



FRAMEWORK FOR STRENGTHS IN ASSESSMENT





CONDITIONS SURROUNDING TROUBLING BEHAVIORS

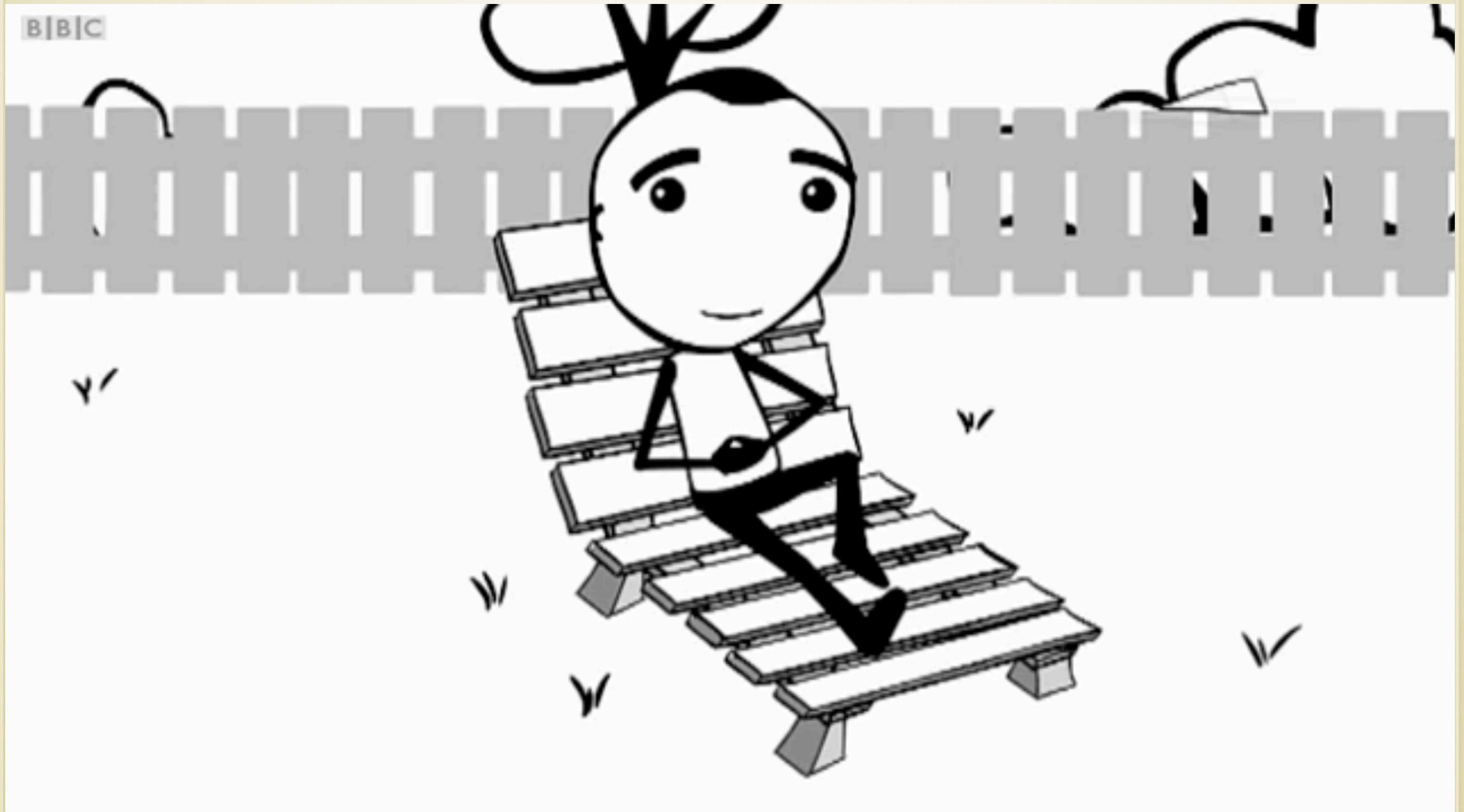


SOURCES OF INFORMATION FOR ASSESSMENTS

- Background sheets or other intake forms
- Interview with clients
- Direct observation of nonverbal behavior
- Direct observation of interaction
- Collateral information
- Tests or assessment instruments
- Personal experiences of the practitioner



MANAGING STRESS - BBC



PERCEIVED STRESS SCALE

For each question choose from the following alternatives:

0 - never 1 - almost never 2 - sometimes 3 - fairly often 4 - very often

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and stressed?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. In the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that happened that were outside of your control?
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

PERCEIVED STRESS SCALE

1. Reverse your scores for questions 4, 5, 7, and 8. On these 4 questions, change the scores like this: 0 = 4, 1 = 3, 2 = 2, 3 = 1, 4 = 0.
2. Add up your scores for each item to get a total.

Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress.

- Scores ranging from 0-13 would be considered low stress.
- Scores ranging from 14-26 would be considered moderate stress.
- Scores ranging from 27-40 would be considered high perceived stress.

The Perceived Stress Scale is interesting and important because your perception of what is happening in your life is most important.

Consider the idea that two individuals could have the exact same events and experiences in their lives for the past month. Depending on their perception, total score could put one of those individuals in the low stress category and the total score could put the second person in the high stress category



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

add columns + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

| | | |
|--|----------------------|-------|
| 10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | _____ |
| | Somewhat difficult | _____ |
| | Very difficult | _____ |
| | Extremely difficult | _____ |

Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over half the days | Nearly every day |
|--|-----------------|--------------|--------------------|------------------|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| <i>Add the score for each column</i> | + | + | + | |
| Total Score (<i>add your column scores</i>) = | | | | |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.



| | | |
|--|--|---|
| Client Name (First Middle and Last): <input type="checkbox"/> Adult <input type="checkbox"/> Youth | | Date: <input type="checkbox"/> Client Refused to Answer Questions |
| Client Phone Number: | Client Date of Birth: | Social Worker Name: |
| Client Address: | CAMIS Person ID: Race/Ethnicity: | Social Worker Phone Number: |
| <input type="checkbox"/> Client referred for assessment <input type="checkbox"/> Mental Health <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Co-occurring | <input type="checkbox"/> Client currently receiving service <input type="checkbox"/> Mental Health <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Co-occurring | <input type="checkbox"/> CP investigation and Assessment <input type="checkbox"/> Family Voluntary Services <input type="checkbox"/> Family Reconciliation Services <input type="checkbox"/> Family Dependency Services <input type="checkbox"/> CHET |
| Global Appraisal of Individual Needs-Short Screener (GAIN-SS) <i>The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.</i> | | |
| Mental Health Internalizing Behaviors (IDScr 1): | | |
| During the past 12 months, have you had significant problems... | | |
| a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. when something reminded you of the past, you became very distressed and upset? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. with thinking about ending your life or committing suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| IF TWO OR MORE YES ANSWERS REFER TO MENTAL HEALTH, except IF POSITIVE ON (e) for suicide, REFER TO DMHP (Designated Mental Health Professional) or CRISIS LINE | | |
| Mental Health Externalizing Behaviors (EDScr 2): | | |
| During the past 12 months, did you do the following things two or more times? | | |
| a. Lie or con to get things you wanted or to avoid having to do something? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Have a hard time paying attention at school, work or home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Have a hard time listening to instructions at school, work or home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Been a bully or threatened other people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Start fights with other people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| IF TWO OR MORE YES ANSWERS REFER TO MENTAL HEALTH | | |
| Substance Abuse Screen (SDScr 3): | | |
| During the past 12 months did... | | |
| a. you use alcohol or drugs weekly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| IF TWO OR MORE YES ANSWERS IN SUBSTANCE ABUSE OR CO-OCCURRING (Substance Abuse AND Mental Health) REFER TO CDP or SUBSTANCE ABUSE TREATMENT PROVIDER | | |
| Client Signature to Release Screen Results: | | Date: |



PMHNP



**Psychiatric Mental Health
Nurse Practitioner**

Examples of Screener Forms

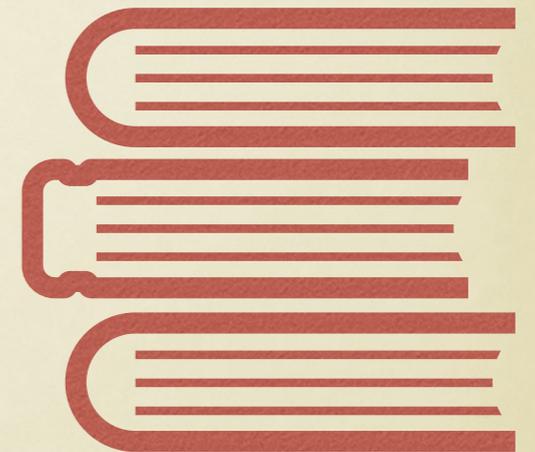
IN CLASS TEACH BACK ACTIVITY

About 5 to 10 minutes next week

- Suicide Risk Assessment (pp. 230-234)
- Assessing Aggression (pp. 236-237)
- Assessing Environmental Systems (pp. 237-241)
- Assessing Biophysical Functioning (pp. 218 - 224)



Provide Info



Group Discussion



HOW I WRITE MY NOTES

A LOOK INTO THE
MADNESS



GENERAL COMPONENTS OF A MENTAL STATUS EXAM

- General appearance
- Behavior
- Thought process and content
- Affect
- Impulse control
- Insight
- Cognitive functioning
- Intelligence
- Reality testing
- Suicidal or homicidal ideation
- Judgment



GENERAL APPEARANCE

Use of mobility device

Posture and gait

Build

Meticulous Self-neglect

Grooming

Garish

Skillfully applied

Outstanding features Disabilities

Physical characteristics

Immaculate Important physical features

Fashionable **Dress**

Unconventional

Appearance



GENERAL APPEARANCE

Ingratiating Guarded

Passive Hostility Seductive Manipulative

Sullen **Attitude and Interpersonal Style** Playful

Uncooperative Inappropriate boundaries

Demanding Contemptuous Withdrawn



GENERAL APPEARANCE

Flat Liable Bland
Facial expression

Awkward

Motor retardations Motor hyperactivity

Mannerism Posturing Tics and twitches

Tension Severe akathisia Rigid Agitated

Behavior and Psychomotor activity

Hyperactive Tardive dyskinesia

Combative Seated quietly

GENERAL APPEARANCE

Impoverished

Pressured Perseveration Dysarthria

Speech and Language Neologisms

Monotonous Stereotypy Accented

Emotional Aphasia Wernike's aphasia

Global aphasia Broca's aphasia



EMOTIONS

Full range of affect

Affect Broad Constricted

Congruent with mood Anhedonic

Appropriate Emotional withdrawal

Flat Blunted Labile

Terminal insomnia Euphoric Euthymic

Sleep Middle insomnia Expansive **Mood** Anxious

Initial insomnia Hypersomnia Clients description



COGNITIVE FUNCTIONING

Lethargy Oriented Times Four

**Orientation and level
of consciousness**

**Attention and
concentration**

Coma Stupor Obtundation

Transient global amnesia

Amnesia Retrograde amnesia

Anterograde amnesia

Memory

Registration Retention Retrieval Head Injuries

Short term memory Long term memory

COGNITIVE FUNCTIONING

Memory Testing

Ability to Abstract and
Generalize

Information
Intelligence

THOUGHTS AND PERCEPTION

Somatic delusions

Nihilistic delusions Thought content

Thought Content Delusions Bizarre behavior

Delusional guilt Grandiose delusions Ideas of reference

Ideas of inference Magical thinking Distortions

Suspiciousness Paranoid delusions

Thought withdrawal Thought insertion

Thought broadcasting

Hallucinations Illusions

Disordered Perceptions

Dearealization Depersonalization



THOUGHTS AND PERCEPTION

Loose association Perseverative Racing thoughts

Conceptual disorganization Neologism

Overvalued **Thought Process** Tangentiality

Distractable Spontaneous Clang association

Goal directed Incoherent Illogical Flight of ideas

Circumstantial blocking Impoverished



THOUGHTS AND PERCEPTION

Somatic preoccupations

Preoccupations Phobias

Obsessions Compulsions

Suicidality,
Homicidality,
Impulse control

Insight and
Judgment

