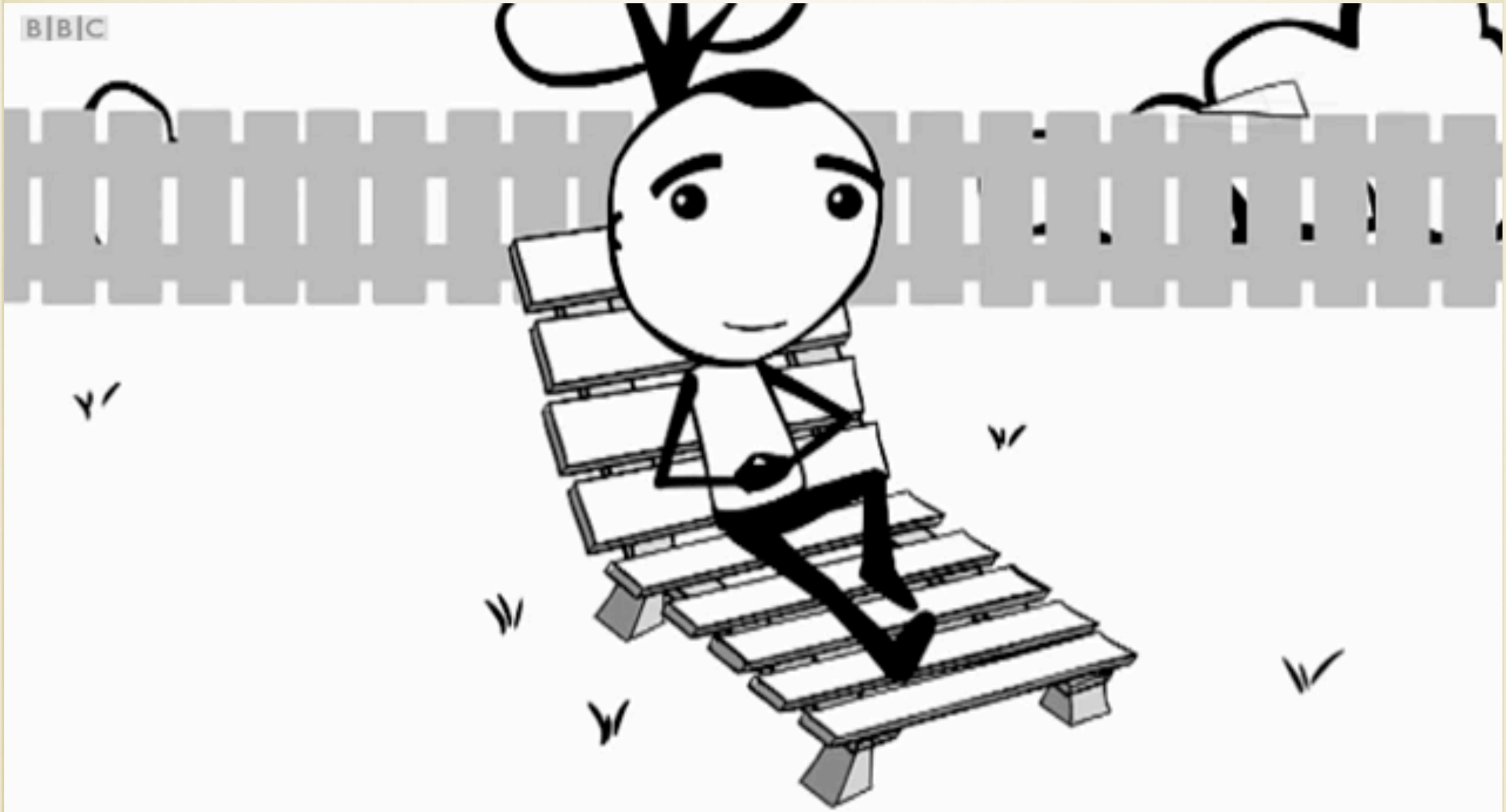
Lab Day

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 2019
Jacob Campbell, LICSW

Managing Stress - BBC



Agenda

- Screeners
- Social histories
- Genograms & Eco-maps

Stress

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 figety 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 _____

A2663B 10-04-2005

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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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 Inern Med.* 2006;166:1092-1097.

Version [GVER]: GSS-annual 2.0.1
Updated 11-17-05

Client Name (First Middle and Last): ☐ Adult ☐ Youth		Date: ☐ 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:
☐ Client referred for assessment ☐ Mental Health ☐ Chemical Dependency ☐ Co-occurring	☐ Client currently receiving service ☐ Mental Health ☐ Chemical Dependency ☐ Co-occurring	☐ CP Investigation and Assessment ☐ Family Voluntary Services ☐ Family Reconciliation Services ☐ Family Dependency Services ☐ CHET

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

*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.*

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?	☐ Yes	☐ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	☐ Yes	☐ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ Yes	☐ No
d. when something reminded you of the past, you became very distressed and upset?	☐ Yes	☐ No
e. with thinking about ending your life or committing suicide?	☐ Yes	☐ 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?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ 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?	☐ Yes	☐ 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)?	☐ Yes	☐ 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?	☐ Yes	☐ 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?	☐ Yes	☐ 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?	☐ Yes	☐ 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:**

Examples of Screener Forms from the Substance Abuse and Mental Health Services Administration

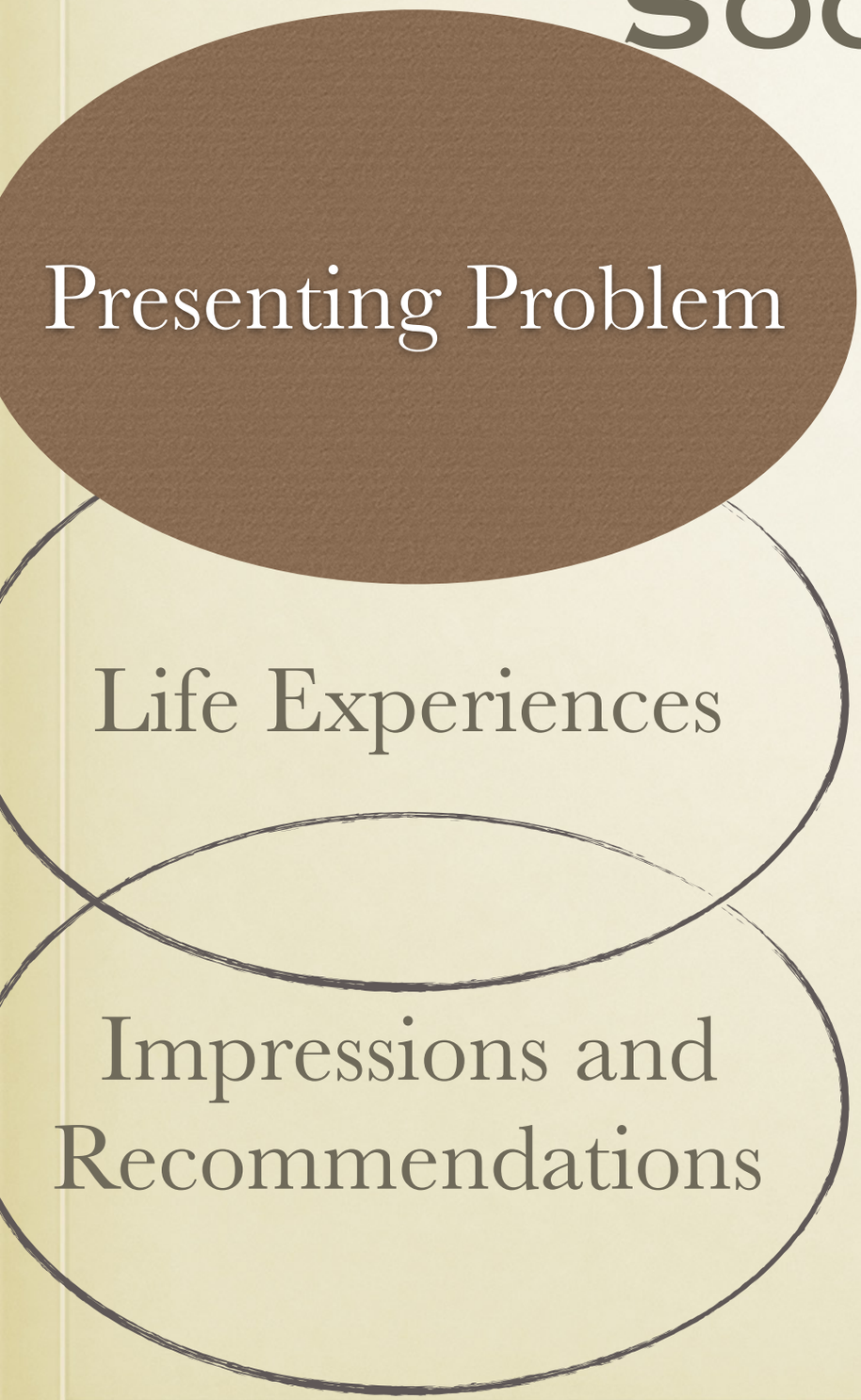
Layout of the Social History

Presenting Problem

Life Experiences

Impressions and Recommendations

Layout of the Social History



- Description and history of the presenting problem
- Introductory section

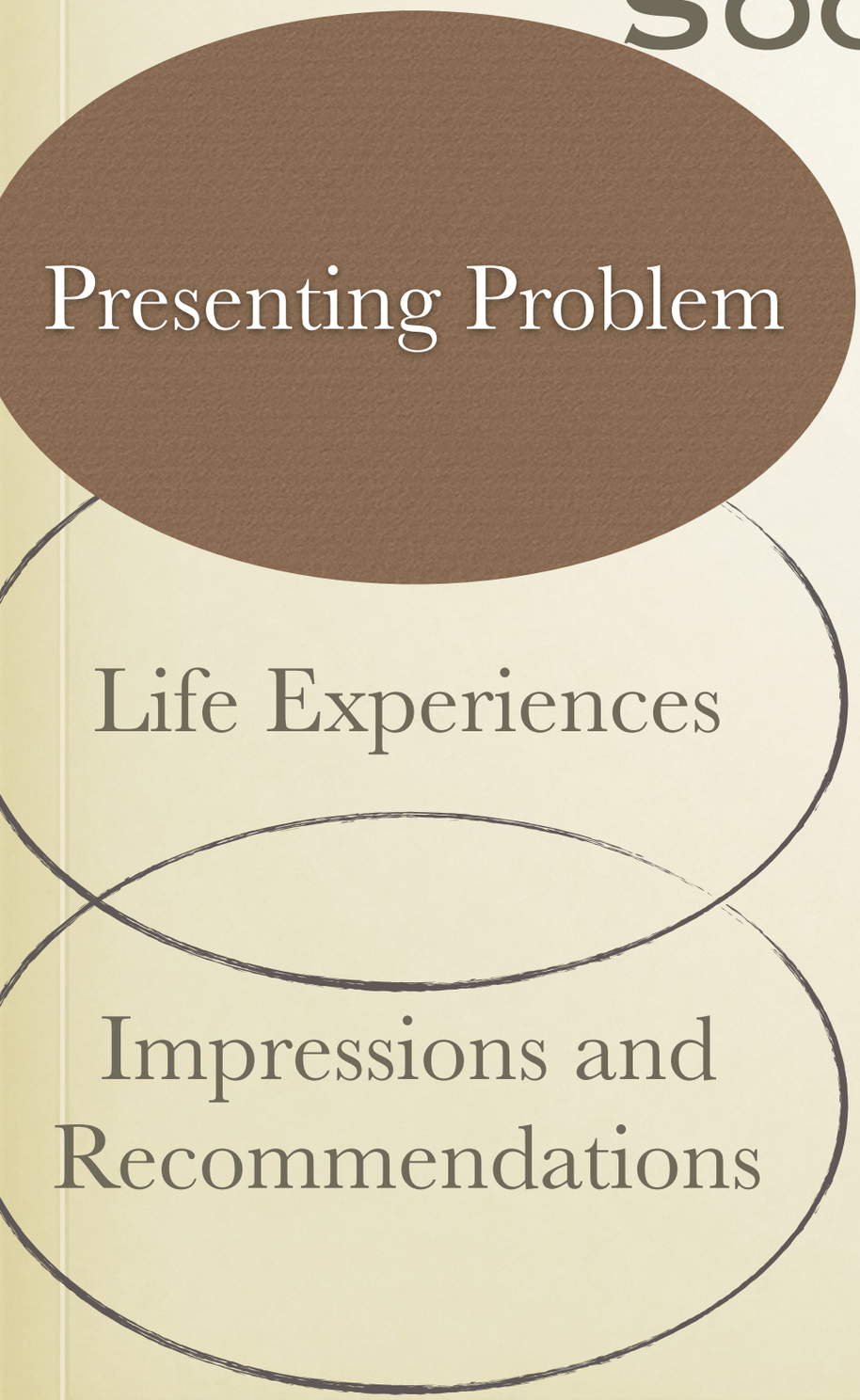
Layout of the Social History

Presenting Problem

- Description and history of the presenting problem
- Introductory section

Esmeralda, a 32 year old Hispanic married with three children female completed this mental health evaluation at the TCCH BHS Pasco office. She was accompanied by her husband and one child. Her primary language is Spanish, and the evaluation was completed in her native language. Her insurance, Medicaid, has been verified. She was referred by Crisis Response Unit after being hospitalized at Lourdes Medical Center after an attempted suicide. She presented with symptoms related to depression and anxiety.

Layout of the Social History



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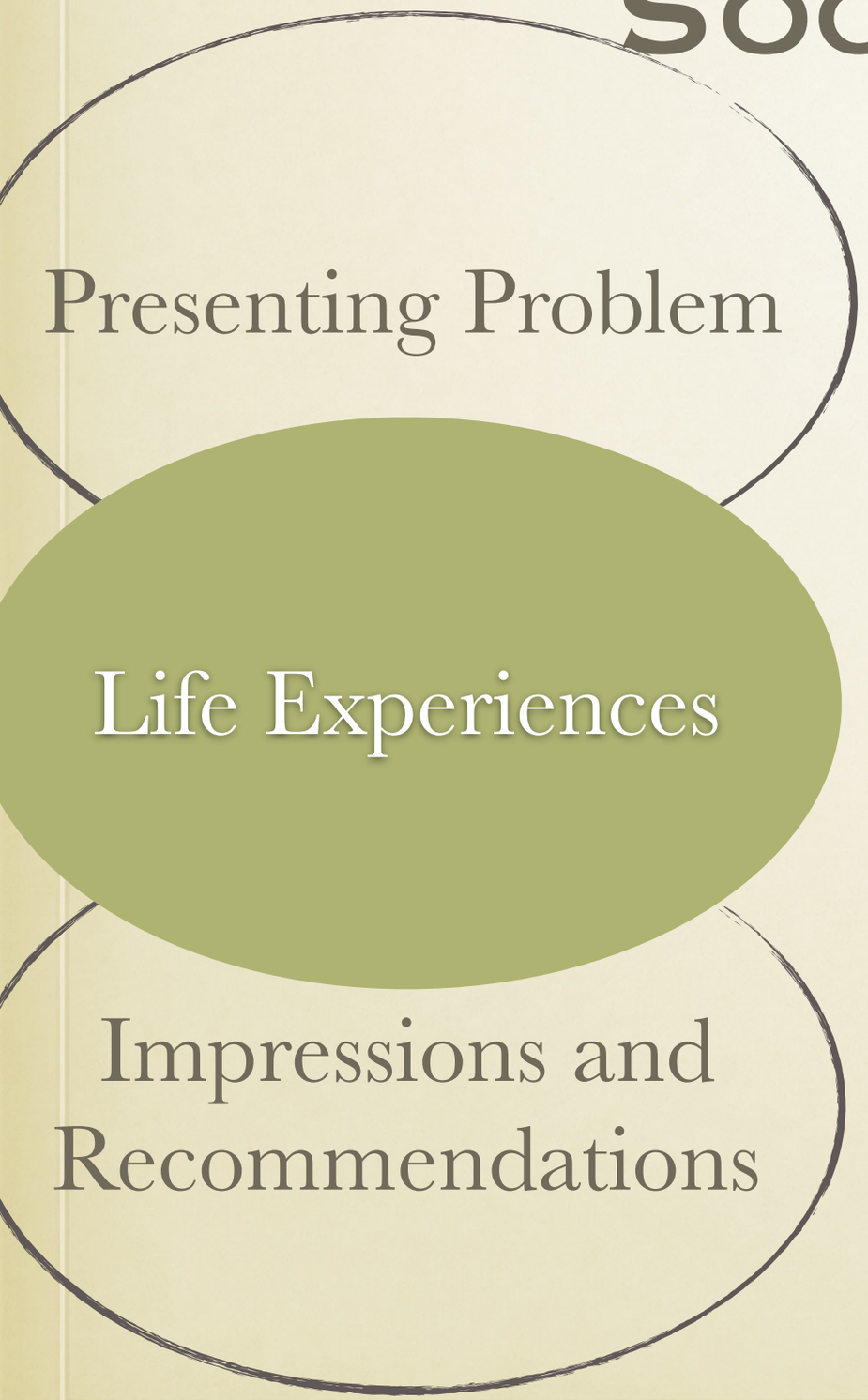
Layout of the Social History



- Family of origin
- Birth and childhood
- Marriages and significant relationships
- Current living arrangements
- Education
- Military service

Layout of the Social History

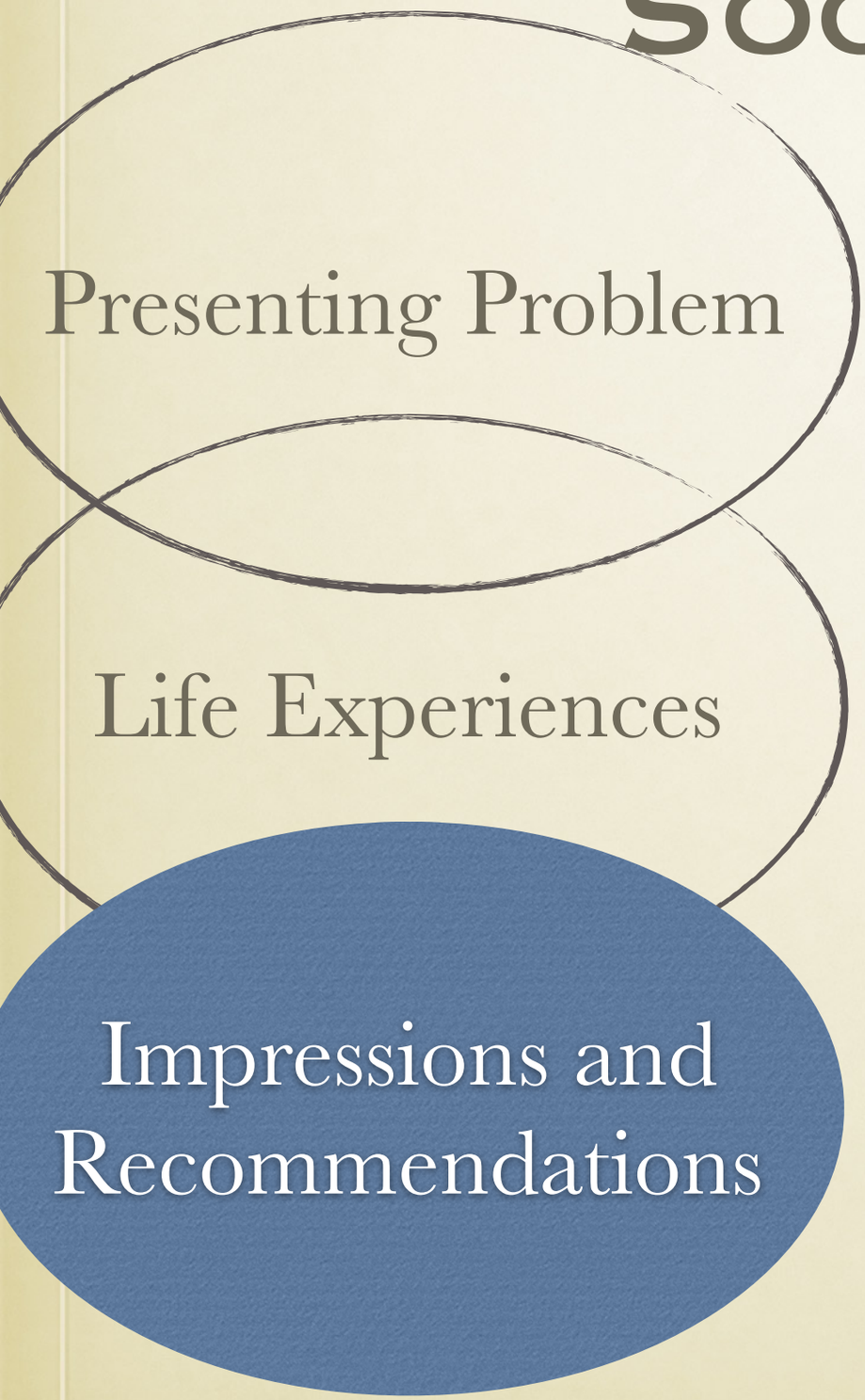
Presenting Problem

Life Experiences

Impressions and Recommendations

- Employment history
- Medical history
- Legal history
- Social and recreational interests
- Religious activities
- Client successes, strengths, and resources

Layout of the Social History



- Impressions
- Recommendations

Tri-Cities Community Health Behavioral Health Services

MENTAL HEALTH EVALUATION

Prepared by/Cred.: **Date of Intake:** **Request Of Service:**

Dimension I. Client Personal Information		
Client Name:	**Date of Birth:**	**Age:**
Gender:	**Client Ethnicity:**	
Client Place of Birth:	**Primary Language:**	**Secondary:**
Is a power of attorney needed? Yes ☐ No ☐ (If needed, explain.)		
Are legal guardianship documents needed? Yes ☐ No ☐ (If needed, explain.)		
Is there CPS involvement? Yes ☐ No ☐ (If yes, explain.)		

Dimension II. Referral & Admitting Problem
Referral Source:
Client Presenting Problem: (symptoms/length)

Dimension III: Client Treatment History, Mental Health/Psychiatric/Substance Abuse			
Name of Provider (Include dates.)	**Reason for Treatment** (e.g. CD, psych. hospital, residential, OP. Include diagnosis.)	**Medication(s) Prescribed**	**Outcome** (Successful/Unsuccessful/ AMA)

Current Substance Use:
GAIN-SS Score: ☐ **N/A**
Family/Significant Other History of Substance Use:
Is there a need for present referral to CD specialist? Yes ☐ No ☐

Dimension IV: Family/Significant Other Mental Health/Psychiatric History				
Relationship to Client	**Mental Health/ Psych History**	**Diagnosis**	**History of Suicide** (If yes, explain.)	**History of Homicide** (If yes, explain.)
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**
	Yes ☐ No ☐ Unk. ☐		**Yes ☐ No ☐**	**Yes ☐ No ☐**

Dimension V: Abuse/Neglect
Client History of Abuse/Neglect: (If abuse is reported by a client age 17 or younger, a documented CPS referral must occur within 48 hours. Call 509-737-2800.)
Dimension VI: Crisis/Risk Assessment
Client History of Suicide/Homicide: (Ideation, plan, means, attempts when/age?)
Current Crisis/Risk Assessment: (Must include current risk of suicide/homicide/risk of self-harm.)
Does a referral for provision of emergency/crisis services need to be made at this time? Yes ☐ No ☐ (If yes, identify referral provider.)
Present Treatment Need Grief/Loss Issues:
Dimension VII: Client Medical History
Has the client ever suffered from a head injury? Yes ☐ No ☐ Age: Result:
Is the client currently or recently pregnant? Yes ☐ No ☐ (If yes, how many months?) **Has the client recently given birth? Yes ☐ No ☐** (If yes, how long ago?)
Is there a Medical Advance Directive in place? Yes ☐ No ☐ (If yes, does ct wish to provide a copy?)
Medical History: (Include any/all hospitalizations and reasons.)
Client History/Presence of Chronic Infections/Diseases: (Incl. HIV, Hepatitis, treatments.) ☐ **Yes** ☐ **No** (If yes, explain.)
Client Present Healthcare Needs:
Has the primary care provider been notified? Yes ☐ No ☐ **Primary Care Provider Name:** (If no primary care provider was identified, name the provider that you are referring the client to.)
Is an EPSDT referral needed? (for anyone under age 21) ☐ **Yes** ☐ **No** **If needed, has an EPSDT letter been sent to the medical provider? ☐ Yes ☐ No ☐ N/A**
Current Medications: (Include dosage and the reason prescribed.)
Dimension VIII: Psychosocial
Family Support System:
Peer Support System:
Provider Support:
Employment/Education History:
Cultural Issues/Religious Beliefs Identified: ☐ Yes ☐ No (If yes, explain.) **Has a consult referral been made? ☐ Yes ☐ No** (If yes, what kind?)
Sexual Orientation Need(s): ☐ Yes ☐ No (If yes, explain.)
Functional Strengths/Interest of Client and/or Family:
Dimension IX: Legal Issues
Present/Past Legal Issues: (charges and dates)
Court ordered to treatment? ☐ Yes ☐ No **LRA Client? ☐ Yes ☐ No**
DOC supervision? ☐ Yes ☐ No (If so, document evidence of oral or written notification.) **Adult Parole: ☐ Yes ☐ No** (If so, document evidence of oral or written notification.) **Adult Probation: ☐ Yes ☐ No** (If so, document evidence of oral or written notification.) Name of PO: Phone Number: County:

Juvenile Court: ☐ **Yes** ☐ **No** (If so, document evidence of oral or written notification.)
Name of JPO: Phone Number: County:

Dimension X: Developmental

History of Developmental Delays/Need: (Specify.)

Present Services in Place: (i.e. 504, IEP, SSI, DDD, DVR)

Dimension XI: Environmental Need/Barriers to Treatment

Does the client have problems with any of the following? (Please check all that apply.)
☐ Housing ☐ Food ☐ Clothing ☐ Economic ☐ Employment ☐ Transportation ☐ Education
☐ Legal ☐ Social/Recreational ☐ Primary Support Network/Death or Loss ☐ ADL's
☐ Chronic Medical Condition(s)/Access to Healthcare ☐ Other Psychosocial/Environmental Problems

Current Mental Status

Appearance: . **Psychomotor Behavior:** . **Attention and Concentration:** . **Speech:** .
Thought Process: . **Orientation:** . **Memory:** . **Level of Cooperation/Relating:** .
Affect: . **Mood:** . **Thought Content:** . **Hallucinations:** . **Delusions:** .
Suicidal & Homicidal Ideation: . **Phobias:** . **Judgment:** . **Insight:** .

Admitting Diagnoses

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V: (Current GAF)

Inter-agency Services Needed

Referral to Therapy:	☐ **Yes** ☐ **No**	Referral to Case Management:	☐ **Yes** ☐ **No**
Referral to Psychiatrist:	☐ **Yes** ☐ **No**	Referral to Nueva Substance Abuse Dept.:	☐ **Yes** ☐ **No**

Clinical Summary/Recommendation for Treatment:

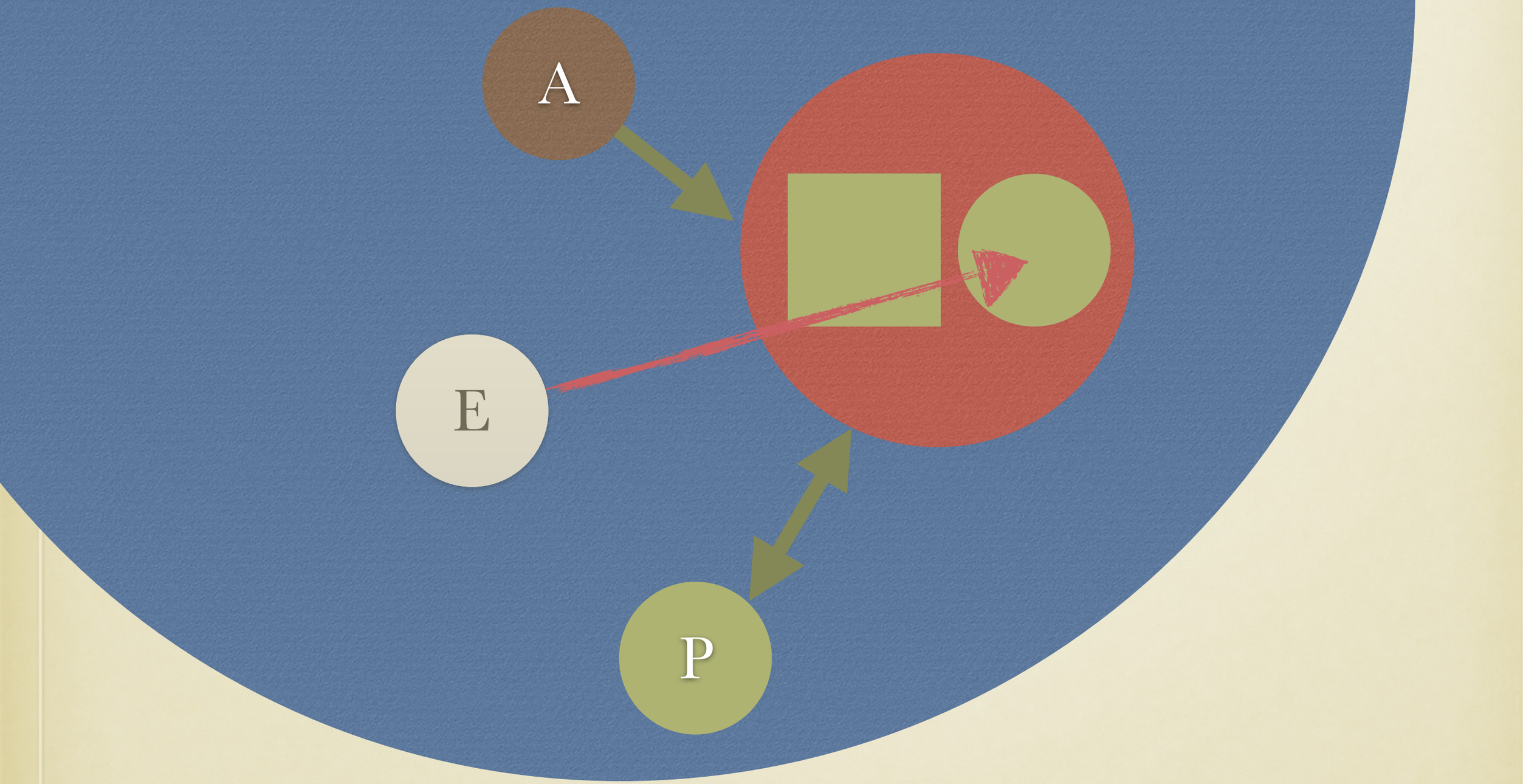
Have all releases of information been obtained for all formal/informal supports? (e.g. medical providers, legal providers, DSHS, etc.) ☐ **Yes** ☐ **No**

_____ _____
Intake Staff Signature/Cred. **Date**

Practice with Social Histories

- Family of origin
- Birth and childhood
- Marriages and significant relationships
- Current living arrangements
- Education
- Military service
- Employment history
- Medical history
- Legal history
- Social and Recreational interests
- Religious activities
- Client successes, Strengths, and resources

Family Assessments



Family Assessments