

*Preparing the Adult Mental Health Workforce
to Succeed in a Transformed System of Care*

Screening and Assessment:
The Basics

Module VII

NASMHPD/OTA Curriculum

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Objectives

Participants will:

1. Identify the key components and processes of screening and assessment in mental health settings
2. Understand how these functions occur and are documented
3. Describe customer service



Screening and Assessment (S & A)

- S & A are generally the first activities that an individual participates in when they are admitted into a MH agency
- A variety of mental health professionals work with the individual on Screening & Assessment. In many settings direct care staff perform important screening and assessment functions, and it is important to understand the purpose and process of these functions

Screening and Assessment

- Why? Because you need to know why the person is coming in, what do they want, what do they need, why are they there, and what you need to do to help them!



- Excellent S & A work greatly impacts the effectiveness of treatment and the efficiency of services

(National Clearinghouse on Families, 2008)

Screening and Assessment Forms

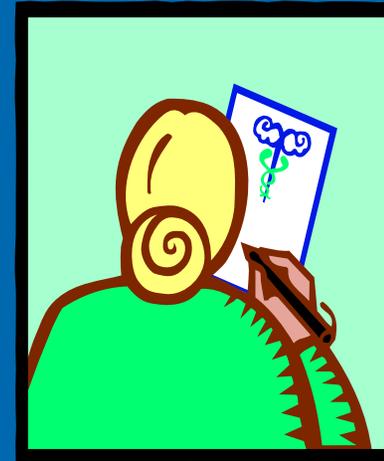
- There are a number of S & A forms available
- Most are created by the individual facility to meet their own needs
- Other settings use valid and reliable tools if these are available, such as the Beck Depression Scale or the MMPI
- A basic framework tool used in 99% of settings is the mental status assessment

The image shows a screenshot of a 'MENTAL STATUS ASSESSMENT' form. The form is titled 'MENTAL STATUS ASSESSMENT' and includes a section for 'PATIENT INFORMATION' with fields for Name, Age, Sex, Race, and Ethnicity. Below this is a section for 'MENTAL STATUS ASSESSMENT' with a table of items to be assessed. The table has two columns: 'Item' and 'Assessment'. The items listed are: 1. Orientation (Time, Place, Person), 2. Attention, 3. Memory (Recent, Remote), 4. Thought (Content, Form), 5. Affect, 6. Mood, 7. Insight, 8. Judgment, 9. Motor Behavior, 10. Speech, 11. Appearance, 12. Hygiene, 13. Grooming, 14. Posture, 15. Facial Expression, 16. Eye Contact, 17. Verbal Communication, 18. Non-Verbal Communication, 19. Overall Impression, 20. Summary.

Screening (Triage)

Work with Individuals to:

- Briefly estimate the severity of their problem
- Determine need for further assessment
- Identify life and death risks (suicidality for one)
- Depending on the facility this activity can result in the individual being referred out, being sent for further assessment, or being admitted to a facility





Screening Questions and Tools

- Screening forms are generally fairly simple and easy to use
- Cover the usual questions like name and address, age, gender, race, marital status, employment, past MH issues
- And most important, screening answers the question “what is the person’s chief complaint and why are they here now?”

(National Clearinghouse on Families, 2008)

Compassion Or Support



Sit down! When I want you to stand I'll tell you.

Screening Questions and Tools

- Screeners watch for any signs and symptoms that lead to the identification of an emergency, need for treatment and if so, what kind of treatment
- Issues such as thinking about suicide, inability to care for self, substance abuse, alterations in perceptions of reality (thinking someone is out to get them or hearing voices), or wanting to hurt someone else are very important pieces of information to know



Assessment Categories & Questions

- Assessment functions start where screening ended, or include both
- High priority issues include:
What the person wants,
identifying risk for suicide,
homicide, or aggression;
thought disorders; serious depression;
inability to care for self; dangerous behaviors
overall; general health issues; and current
medications



(Horsfall et al., 2001)

Assessment

Work with the Person to:

- Identify the person's strengths and needs
- Identify risk factors that need immediate services
- Measure the individual's usual feelings and activities (baseline) and any changes over time
- Accurately identify what kind of treatment the person needs, if any



(National Clearinghouse on Families, 2008)

Assessment Categories & Questions

Basic Information

- Demographic information
- Chief complaint
(in person's own words)
- History of any illnesses
(in last few years, what kind and what treatment?)
- Major current stressors (financial, job, housing, relationships, medical, etc?)
- Previous psychiatric history
- Level of education/literacy

A screenshot of a medical assessment form, likely a psychiatric history form. It contains various fields for patient information, including name, date of birth, and gender. There are also sections for 'Chief Complaint', 'History of Present Illness', and 'Past Medical History'. The form is filled out with text, and there are several checkboxes and dropdown menus visible.

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Appearance:** includes

Level of consciousness [LOC]:
(alert, sleepy, confused, intoxicated...)

Dress: casual, appropriate for weather,
careless, odd/eccentric, disheveled...

Grooming: clean, malodorous, kempt, unkempt



(Tasman et al., 2008)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Attitude:** Includes whether person is cooperative, hostile, evasive, threatening, or obsequious
- **Affect:** Includes restricted, expansive, blunted, flat (rare), appropriateness of mood to conversation, stability (labile or shallow), quality (silly, anxious, serious, worried)



(Tasman et al., 2008)

Assessment Categories & Questions Mental Status Examination (12 items)

- **Mood:** The underlying feeling or “affect” for most people. If you feel happy you generally look happy. Some illnesses create a separation between mood and affect
- Answers the question “How are you feeling? How has your mood been?”
- Generally written as “individual reports feeling...”
(Tasman et al., 2008)



Assessment Categories & Questions

Mental Status Examination (12 items)

- **Behavior:** Includes behavior you witness and behavior others have witnessed if you believe they are good informants

Has to do with “motor movements” such as agitation (pacing, rocking, moving feet or hands) or slowed responses seen in intoxication or severe depression or fatigue

(Tasman et al., 2008)



Assessment Categories & Questions

Mental Status Examination (12 items)

- **Speech:** Includes

Rate: rapid, slowed, pressured, hard to interrupt

Volume: loud, soft,
monotone, dramatic



Quality: fluent (well spoken), broken English, use of made up words (neologisms) or just strange (idiosyncratic)

(Tasman et al., 2008)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Thought Process:**

Goal directed

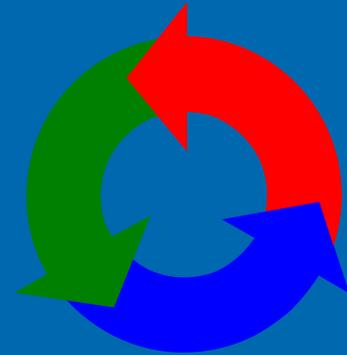
Disorganized

Loose associations (loosely related topics)

Tangential (talks around issue-does not address key question)

Circumstantial (talks around issue and takes a very long time to comes back to question)

Flight of ideas (unrelated topics)



(Tasman et al., 2008)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Thought Content:**

Major preoccupations

Ideas of reference (psychotic projection)

Delusions (beliefs not based in reality)

Thought broadcasting, insertion, or withdrawal

Suicidal or homicidal ideation including plan, intent, and ability to carry out



(Tasman et al., 2008)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Perception:**

Illusions and hallucinations (visual, auditory, olfactory, tactile, or gustatory)

Evidence of above (self-report, answer to questions, observation, responding to other stimuli)

Beliefs about above (where are they coming from, how many voices, who are they talking to, what is content?)

(*Tasman et al., 2008*)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Cognition:**

Orientation (time, place, person, situation)

Memory (objects remembered, digit span, presidents, recent events)

Concentration (serial 7's, word backwards)

Abstraction (proverb interpretation)

Similarities (how are things alike)

Computation (buying a loaf of bread, change)

(Tasman et al., 2008)

Assessment Categories & Questions

Mental Status Examination (12 items)

- **Insight:**

Person knows something is wrong, that he/she is ill, that the illness is psychiatric

- **Judgment:**

Questions providing scenarios (if you found a wallet what would you do? If you smelled smoke?)

How was the person handling their life prior to coming in?

Does behavior in the interview match stated goals and what the person wants?

Quality S&A Other Factors



If patient is very distressed or uncomfortable, all measures need to be brought to make person more comfortable/calm

Interviews... always be private, respectful, and do not interrupt the person

Family or significant others should be interviewed if an adult person consents, but the primary interview should be just the two of you

Interviewer... unbiased, kind, skilled in building rapport
(*Tasman et al., 2008*)

Exercise



Screening and Assessment: What happens next?



Screening and assessment information informs decisions about how to provide the most appropriate services and supports to the person going forward

Should be used to inform the initial treatment plan and the formal treatment plan

S & A documents should be completely filled out, legible, and as comprehensive as possible

When the interviewee is non-verbal or refuses to cooperate, the actual “observations” of S & A staff become extremely important, especially in assessing risks

Screening and Assessment: Critical Risk Factors

Screening staff may have information--whether from police, family members or others--that the person coming in (involuntarily usually) is threatening suicide or homicide against another person, and they need to pay very serious attention to this information

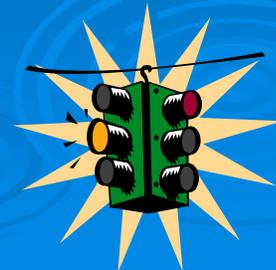
Sometimes the information is not accurate, but it is wiser to err on the side of caution unless the person being interviewed can clearly state why they have been brought to the facility and why this is wrong



Screening and Assessment: Critical Risk Factors

In most states, fair or not, a civilian can be brought to a MH treatment facility for perceived threats to harm self or others and be kept for observation against his or her will

It is also true that other people have sometimes taken advantage of this law to have family members or others taken to MH facilities for little reason. But that is not the case generally



Screening and Assessment: Critical Risk Factors

When assessing suicidal or homicidal intent
S & A staff need to explicitly determine the
following:

- Plan: Is there a plan, is it doable, is the person able?
- Goal: Death; scaring or hurting someone?
- History: Has this threat ever happened before, previous attempts, what happened then?
- Intent: How desperate is the person, why, who, when is this planned, where?
- Duty to Warn: Federal law that supercedes confidentiality when danger to another is present
- If you are worried, tell someone!

Screening and Assessment

What happens next?



Once the initial screening and assessments are done, staff confer with the person, family, supervisors and physician on-call

A decision is made on what to provide to the person seeking care, in order of priority

The choices available are dependent on what is available in terms of community mental health, available hospital resources, and the knowledge of Screening & Assessment Staff!

Screening and Assessment

What happens next?

A Comprehensive Mental Health Service System

May not always be available:

- Immediate crisis access, 24/7 (not ER's)
- Comprehensive screening and assessment, 24/7
- Crisis stabilization services (inpatient)
- Primary (medical) care...
- Social and medical Detox: SA treatment
- Intermediate/long term inpatient (state hospitals)
- Peer community run services....respite services
- Outpatient services...housing and employment



Peer-Operated Crisis Alternatives

- Peer-operated crisis facilities are designed to assist guests in diverting psychiatric distress that may lead to hospitalization
- May be able to serve individuals who have not done well in the traditional community mental health system

(People, Inc., 2008)

The Rose House

In a random survey completed in 2007, 10 people responded:

- The average respondent was able to divert a psychiatric hospitalization by utilizing The Rose House in their time of need 88.38% of the time
- 70% of the respondents have not been hospitalized for psychiatric reasons since becoming involved with The Rose House
- 70% of the respondents have had a decrease in hospitalizations since becoming involved

(People, Inc., 2008)

Screening and Assessment

Final Comments

Patients will sometimes complain that they are asked the same questions over and over. It is true and intended

Redundant questioning is important. *Getting to know a stranger* in a few hours or days is very difficult and artificial. One of the ways we try to minimize mistakes is to have multiple people ask the same questions

Okay to tell the person that this is a clinical process and a common practice. It is also fine to say that you are sorry they are having to repeat this information again!

Finally

I'm not sure it's the exact words that are most important, but rather the tone of voice, body language, and the physical environment of the verbalization. The words need to be firm but kind.

William Poole (consumer)

