A practical guide for doing initial assessments – interview, filling out form, and making chart diagnosis

Adult Initial Assessments:

2013

1) The Initial Interview

- Find everyday common ground – from the beginning assessing "mental status" without making it a formal examination
- Do some everyday self disclosure – before asking them to do so – building trust. This is getting to know each other so they're not treated by strangers and we're not treating strangers. Reduce my defensiveness – if necessary directly address things that are making me defensive, frightened, self protective so I can relax. Overt invitation for them to ask about me too.
- Explain who I am and what my purpose is and how I fit into the team
- Ask how this meeting came about - "How did you find us" or "How did we find you?"
- Ask about person centered (rather than illness centered) goals and positive rather than negative goals - "What would getting your life back on track mean?" not "What seems to be bothering you today?" – future oriented not past oriented
- Listen for a long time letting them drive the conversation
- Significant detail on current life, their ideas for improvement, look for their strengths and existing supports – lots of "respectful curiosity", reflect back / putting it together, motivational interviewing exploration, and make a few suggestions – start the idea that maybe I can be useful – most of the time this section doesn't include mental illness directly – sometimes as barriers.
- Internal reflection – how am I reacting to their story (compassion)? and "Can I feel what they're going through (empathy)? Do they have strong "dynamics" impacting the relationship this fast? – hints of childhood / trauma and past treatment experiences /projections. Do they have strong defensiveness or paranoia to avoid provoking – are power struggles emerging between us?
- "Now that I've gotten an idea what's going on with you, can we go back so I can get to know you better?" – beginning in childhood, throughout emphasizing their subjective experiences,

reactions to, and opinions about their life, looking for patterns of emotions and thinking , strengths and resilience as well as common pitfalls and barriers (engaging their self-observing and "insightful" selves – also keeping an eye out for symptom clusters - definitely include education, employment, family, relationships, homes, love, and children. Engage the hopeful part of them: "What have you been most proud of?" "What did you want to be when you grew up (and what happened to those dreams)?" "Who has taught (or given) you the most?" "Who do you look up to?" I'm looking for parts of them to ally with.

- "How does mental illness fit into all of this?" – surprisingly often their life makes sense to them and they've told a coherent story without ever really talking about mental health, substance abuse, or treatment up to this point – don't rush them to define their lives by treatment history. Emphasize "What did you think this was before you met mental health workers?" – They probably still think that. What's been helpful and not from their perspective – establishing their self-expertise and important role in collaboration. Formulate a way to incorporate mental illness and services into their self-conception and reluctance to accept destructive self- stigma. Add specific questions and rarely formal mental status exam questions to clarify diagnosis if needed

- Mop up – did the conversation include medical conditions, allergies, legal status, family history?

- Return to the present goals and plans to get life better so their left with clear hopefulness (not reassurance) – positive vision, a few steps for now, and the reason it's important enough to persist through obstacles. Include "I can see in you the strengths you're going to use to overcome this". Summary should include reinforcing Carl Roger's triad – empathy, authenticity, something to like and care about the person (usually a genuine expression of enjoying meeting them

2) Filling out the AIA form

- I'm going to read it back to them the next session, so I want to put it in words they would use and put together a formulation they'd agreed to

- This should be comprehensive enough that whenever someone new wants to get to know they're story – it's here in detail

- Other people may read this – B+C's or other "placements", other MDs or treators, Social security, DCFS, auditors, etc. – consider the possible impacts, I may need to exclude some things (especially frightening or stigmatizing things or "secrets"). This really isn't a private record.

- "Presenting problem" section – I use all paraphrased quotes of their goals and formulation

- "Illness history" section – I put the story of their life here including everything important even though some will be repeated in the next page. This is the main section I'll read back "did I get everything important?" "Did I get everything right?" This is how I'll demonstrate I really was listening and understood them
- "Impact of treatment" section – here's where I put the treatments and they're evaluation of what worked and didn't
- Second and third page – written in factual detail style – comprehensive, try to include details that I didn't see how they fit in now, they might later on
- Mental status – this is a "Baseline" picture of them. I'll likely never again spend that much time in one sitting with them – all future sessions will be compared to this one. I use the comment boxes. I don't read this page back to them.
- "Formulation" section – restate rapidly story, goals, and plans – this is the "diagnosis" / shared story I share with them – the basis for our collaboration "are we on the same page or going different directions?"
- Diagnosis – this is for formal DSM and establishing medical necessity – usually not read to them either since DSM is a very poor "shared story" tool
- Plan – these are a list of the specific services and goals that "justifies" the service plan that the PSC will do – "Did I get everything? Are those the things you want us to do to try to help you?"
- I actually un-sign the form and re-open it in the second meeting if needed to make corrections and additions in front of them, so they know I actually incorporated their feedback, so it is a collaborative document.

3) Making DSM diagnoses

- The "primary diagnosis" is to establish "target population eligibility" (major mood or psychotic disorder: Major depression, Bipolar 1 or 2, Depression NOS, Mood disorder NOS, Schizophrenia, schizoaffective, psychosis NOS) and "medical necessity" for services. Other diagnoses are optional to complete the shorthand picture
- It is not a good tool for really describing what's going on with the person or making sense of them – causality, trauma, childhood, many unapproved diagnosis are all not there along with any non-illness factors – that's what the formulation section is for.
- For the primary diagnosis I use a fairly simple decision tree:
- Are they psychotic or not? If not must be Major depression, Bipolar 1 or 2, Depression NOS or Mood disorder NOS

- If they are psychotic do they also have mood serious mood disturbances? If not it's either Schizophrenia or if I'm not sure Psychosis NOS (for example if I think the psychosis might be short lasting or due to drugs, trauma, neurological or medical conditions or "reactive"). Don't' worry about subtypes of schizophrenia – just use chronic undifferentiated type..
- If they do have mood disturbances, is the psychosis clearly secondary to the mood disturbances? If not it's schizoaffective. If yes it's depression with psychosis or bipolar with psychosis depending on if they have mania
- If they don't have psychosis do they have meet the full criteria and have "real mania"? If yes then its Bipolar 1
- If not, do they have hypomania, aggressive outbursts, "mood swings"? If yes it's either Bipolar 2 or Mood disorder NOS (for example if I think the mood disturbance might be due to substance abuse, personality disorder, trauma, "situational", neurological or medical causes)
- If only depressive symptoms do they meet the full criteria, especially do they have "vegetative symptoms"? If yes then it's Major depression
- If not, or if I think the depression might be due to something else, then it's Depression NOS
- For secondary diagnoses I put whatever else I think they have (rule out or "R/O" means I think they might have it) and that I think might be useful or a "target of treatment" at some point. Remember other people will read this.
- On axis 2, I tend to only use the full diagnosis if I'm pretty sure, otherwise I use mixed or NOS with whatever "traits". I tend to use "deferred" for if I'm not sure if there really is a personality disorder or not, not for if I don't know what kind of personality disorder it is. I have trouble being sure someone has a personality disorder while they have significant Axis 1 and/ or substance abuse that is heavily impacting their coping, relationships, and lives. Remember that putting down personality disorders, especially "borderline personality disorder" will make other people wary of them. Do I want that?

Note: an Adult Initial Assessment is not interchangeable with a social security disability assessment. That is a very different interview and form for which I have created a different long handout. I usually do not send AIA's or chart notes to social security unless specifically requested, taking the time to do another specific lengthy interview and narrative report. Doing that makes their chances of approval much higher. The same logic applies to other less common "specialized assessments" (for example, child custody fitness, legal competency, loan repayments, disabled students, HUD shelter plus eligibility). But remember that other people may use the AIA for lots of purposes I didn't predict – including SSI.