

## Outpatient Integrated Assessment Requirements

### 1. Presenting Problem Summary

1. **Reason for the assessment:** initial, annual, change of clinical status update, etc.
2. **Reason for Referral:** Presenting problems, current symptoms, behavioral and functional needs; what brings them in for treatment. This should be more than “My mom made me come” or the PO sent them in. We want to see what is happening for this person. You might have to ask more questions to get the real reason behind the referral. We want to know what the presenting problem is that brought them in for treatment. Ex. I have been having trouble in school and my mom made me come. I need get into fights; have trouble getting my work done, etc... My PO sent me because I got arrested for meth and if I don't get help I will go to jail and lose my child. This is not the place to put DSM criteria that goes in the interpretive summary.
3. **Current Symptoms:** Indicate the psychiatric symptoms and behaviors the client is experiencing
  - a. Severity of each: how do these symptoms impact their daily life
  - b. Frequency of each: how often do they experience symptoms
  - c. Onset: when did they first start experiencing these symptoms
  - d. Duration of each: how long do the symptoms last, do they ever go completely awayThis section should be a picture of what is happening in this person's life, a summary of their mental health/substance use history, and what they want to see change. You can begin to develop your clinical formulation of the person based on the information gathered in this section. You can expand on the presenting problem and go more in-depth in their history and what life looks like right now.
4. We need enough bio, psycho, social information to support the diagnosis and support the need for treatment. This is where the individual's story begins to develop.

### 2. Social History Summary

1. **Indicate any relevant information assessed in the social history assessment**
  - a. **Living situation:** with who, satisfied, safe, secure
  - b. **Educational history:** hx of disabilities, vocational hx, need of employment help, do sx interfere with employment
  - c. **Military history:** have they served in the military
  - d. **Health:** picture of overall health, tobacco use, eating disorder
  - e. **Family history:** any developmental issues growing up, speech problems, brain injuries; pertinent family hx of mental health or substance use/abuse; Family or Origin captures what it was like growing up in their family and what it looks like now
  - f. **Abuse history:** this can be documented in family history and again in more detail in the trauma section. Complete the addendum if they disclose a trauma hx and are willing to discuss it
  - g. **Legal issues:** this information can be further explored as to how that affects their current involvement in treatment.

### 3. Medical/Medication Summary

1. **List current and past Medications**
  - a. Dosages & efficacy of each
  - b. Compliance with taking meds
  - c. Level of assistance needed in taking meds
2. **Indicate all medical conditions (including PCP)**

4. **Behavioral Health Summary**

1. **Indicate prior TX** This is **all** treatment, outpatient and inpatient for both MH and SUD
  - a. Indicate the type of treatment ex. Outpatient treatment
  - b. Indicate the location and results of that treatment (used to help determine what has worked in the past and what has not), include the name of the provider and agency
2. It is important to capture a history of a person's mental health and obtain records when possible.
  - a. Look to see if this is their first time in treatment, do they have a history of prior hospitalizations, etc.

5. **Substance Abuse/Gambling Summary**

1. **Indicate any abused substances/gambling issues and include:**
  - a. Frequency of usage
  - b. History of usage
  - c. Potential of withdrawal
2. **Regardless of the age of the individual**, it is important to address the substance use questions. It is appropriate to indicate no substance use but you must ask the question. For a young child we might capture substance use in the family history which might indicate the child has been exposed to it either prenatally or throughout their life. We do not want to assume there is no substance use just because they are young.
3. **Complete an ASAM when recommended based on use.**
  - a. Be sure you address this in the clinical formulation as to how substance use affects their mental health.
  - b. Be sure to be descriptive in dimensions, not just low, med, high risk; support reason

6. **Mental Status Summary**

1. **Results of Mental Status Exam** (orientation, mood, affect, speech, appearance, thought content, sociability, recall memory and coping ability).
  - a. Please add any additional comments to help clarify if needed. This provides the reader with a picture of the persons presentation at that moment and can compare in the future as needed to show progress or concerns

7. **Risk Assessment./Safety concerns Summary**

1. **Indicate any assessed risks/safety concerns** (suicidal, homicidal, violence, harm to property)
  - a. Please use the comments section to elaborate on the answers, indicate if the person has a previous history, if they have current thoughts or plans
2. **If the individual presents with current or past risk with a moderate or high score, complete the Risk Assessment Addendum**
3. Indicate the clinician's actions to address the identified risks in the comment section and if a safety plan was completed and put in place
4. Assess and indicate if there is a family history of suicide.

## 8. Social/Life Goals

### 1. **Social and Environmental Factors/Natural Supports**

- a. **Friendships/Social/Pets/Peer Supports/ Natural Supports:** Please indicate the type of supports the individual has in their life and include anything or anyone they consider a support. It is helpful to put a number such as 3 close friends they can call on, please list first names when possible.
- b. **Meaningful Activities:** Include anything the individual states as a meaningful activity for them, this can include hobbies, interests, community involvement, or other interests
- c. **Community Supports/Self Help Groups:** Include any activities the individual is involved in within the community they consider a support. This could be church groups, support groups such as AA, NA, grief recovery support groups, etc...
- d. **Religion/Spirituality:** This can include anything the individual states as their spiritual belief or higher power. It does not have to be limited to organized religion. It is whatever the individual indicates
- e. **Important features of your cultural identity:** This is not limited to race or ethnicity. This can be whatever the individual states is their cultural identity. Ask what is their role and expectations in their life and culture. Get to what is important to them in their daily life and how they fit into that culture

### 2. **Life Goals, Strengths, Abilities, and Barriers:** use the individual's own words when possible

- a. **Life Goals:** This is what they want to get out of life. It may not be reflective of treatment goals but we want to capture in here what they want out of life and where they see themselves in the future so we can help them achieve those goals
- b. **Strengths:** This might be difficult for some individuals as they might not be able to recognize their strengths or talents. Ex maybe a good friend, determined, good supports, desire to learn, dependable, etc...
- c. **Barriers to Success:** These can include transportation, desire to continue current life style, lack of supports, mental health symptoms get in the way, substance use, anything they identify as difficulties in meeting their goals in life
- d. **Past and Present Success in Achieving Desired Goals:** What has worked in the past and can work currently to reach the goal. What goals have they achieved and can they apply those skills to current goals

## 9. Prioritized Problems/LOC/Treatment Recommendations

1. **Prioritize all problems.** These should be the specific problems assessed that will be the focus of treatment. This is where you put assessed needs not services or interventions but rather distressing symptoms, maladaptive behaviors, functional deficits, support deficits, etc. that prevent the individual from assuming desired life goals.

- a. Ex. Debilitating depressive symptoms that result in isolation; problems controlling anger; repeated relapses with drugs and alcohol; challenges with ADL skills that interfere with individual's ability to integrate into the community; lack of social supports to help in recovery.

2. Indicate if the identified need is active, person declined, deferred, or referred.

3. Indicate the client's assigned level of care

- a. Indicate what treatment recommendations are being made at this time, i.e. Individual counseling, medication management, substance use treatment

10. **DSM5/ICD 10 Diagnosis and the criteria met for the diagnosis**

Using the ICD 10 codes and DSM 5 criteria, indicate the presenting concerns in order of priority. In addition to mental health and substance use diagnosis, please address environmental or situational factors such as unemployment, health concerns, homeless, etc. **Be sure to indicate sub types and specifiers in the diagnosis when required.**

11. **Clinical Formulation/Interpretive Summary**

1. **Do not cut and paste the concerns and presenting problems** this is a summary of the entire assessment and treatment needs. Briefly describe the client and provide a succinct narrative summary which includes specific diagnostic criteria from the DSM that justifies both the diagnoses and medical necessity of treatment along with the origin of the presenting problem, the severity, and factors contributing to its continuation, where the problem occurs and whether it is short or long term. Include a brief summary of the individual's motivation for treatment and natural supports. This is where you summarize the information to justify the diagnosis and document the medical necessity for the treatment and services you are recommending using the DSM 5 guidelines and language to support your diagnosis.
2. Indicate any specific functioning and/or environmental issues assessed and give examples, use quotes from the individual
3. If you identified a substance use issue during the assessment be sure you capture how that affects their mental health
4. When an assessment determines the presence of co-occurring substance use and mental health disorders, or any significant risk to health and safety, all providers must document referral and further assessment, planning, and intervention from an appropriate professional, either with the same provider or with a collaborative community partner
5. Include all treatment recommendations and referrals such as if you are referring to substance use treatment, medication management, etc. This is where you put what types of treatment they would benefit from i.e. Individual therapy, groups, medication assessment
6. Include if there is a history of trauma and was it considered in the diagnosis.