Utilizing an Approach Which Seeks to Assign an Appropriate Level of Care, Such As That Utilized in “Texas Resilience and Recovery: Utilization Management Guidelines: Child and Adolescent Services” Publication and Program

[For use by the CEU By Net participant and his or her program, as may be so desired.]

The following format provides a good example of a COMPLETE Biopsychosocial Assessment for CHILDREN and ADOLESCENTS which gathers all of the information needed to determine a Level of Care which was first addressed in the “Child/Adolescent Texas Recommended Assessment Guidelines (CA-TRAG)”, and now found in the “Texas Resilience and Recovery (TRR) Utilization Management” guidelines for children and adolescents. This prototype assessment includes a Mental Status Exam and an Addiction Assessment tool.

Per Texas DHS guidelines, the initial assessment “...is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.” This instrument developed by CEU by Net gathers this information in an organized manner. We have incorporated symptoms and behaviors which support taking either a ‘Skills Development’ approach or a ‘Counseling’ approach – although clinical judgement can result in use of both approaches. This section appears at the end of this assessment format, for your convenience.

As a successful completer of this Continuing Education course, you may use ALL OR PART of this Assessment format as you see fit.

NOTE: You may save this Biopsychosocial Assessment Prototype to your computer for your own use, and may modify it if you have software to modify pdf documents, which may include converting the document to a Microsoft Word format. At the end of the course materials, there are links to free-standing copies of all three of the documents which you see in this document. We recommend that you use those links to download a copy of any that you wish, and from there you can copy and modify. There are no security features to prevent copy and paste on those free-standing assessment instruments.

When deciding how to use this form, you may structure it as a ‘Comprehensive Assessment’ such as this, or you may design an assessment with ‘Brief Essential’ elements in mind.

CEU By Net - Pendragon Associates, LLC
http://www.ceubynet.com
PART A1. REASON FOR SEEKING TREATMENT AT THIS TIME

1. Please make a brief statement of what circumstance has precipitated this child’s admission to services AT THIS TIME, i.e., “why now?” IN ADDITION: If there are major life issues which are currently impacting this child or adolescent at this time (such as, but not limited to pregnancy or being the parent of a child or infant, or recent or pending incarceration or probation for a juvenile or felony offense, or a terminal illness of the child or caretaker, or parental divorce, or death of a parent or sib or other close relationship) briefly identify those major life issue(s) here.

2. PRESENTING ACUITY: By professional clinical standards, is this child presenting for treatment in an Emergent Situation – either Emergency or Clinically Urgent?

☐ Y ☐ N

Are immediate actions necessary to protect the safety of the child or others, with or without prior authorization from the HMO or other contractor?

☐ Y ☐ N

If yes, what actions are you taking immediately?

3. KNOWN ALLERGIES: Is consumer ALLERGIC to any known thing – ESPECIALLY MEDICINE AND FOODS? YES ☐ NO ☐ If yes, specify ‘what’.

NOTE: If consumer is allergic to any medicine or food, this must be posted prominently on the front of the client record, in RED.

PART A2. HOUSEHOLD CIRCUMSTANCES AND MAJOR LIFE EVENTS

1. Is/Was consumer raised mainly by a parent, or someone else?

2. Is child living ‘at home’ with natural parent or primary historical caretaker? ☐ YES ☐ NO If no, when did child leave home, and under what circumstances, and with whom is s/he living now?

3. What type of dwelling is consumer living in? Describe consumer’s immediate neighborhood and characteristics (socioeconomic level, high crime area, low- or mid-income, etc.).

4. How many times has consumer moved in the past two years? If often, why?

5. List all immediate family members and parental equivalents, on next page and indicate the following information for each. If any family members are deceased or elsewhere, be sure to list below, and indicated “deceased” or “in prison”, etc..

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6. PAST TRAUMAS OR RECENT CHANGES: Have there been any major life traumas or recent major changes within the family (e.g., a divorce, abandonment, incarceration of parent or child, death of a loved one or friend, serious injury, life threatening illness, etc.)? If yes, describe.
7. Has anyone in consumer’s family ever attempted/committed suicide? □YES □NO If YES, who and when and by what means:

8. Is there a history of mental illness or substance abuse in the child’s immediate family (parent, grandparent, sibling, or other with whom child has lived)? And if so, who and what?

9. CPS ISSUES – Child Protective Services Activity
   (1) Has this child ever been removed from home due to CPS involvement? □YES □NO If YES, why?

   (2) What was tried to keep the child in the home, e.g., outpatient treatment, treatment for parent(s)?

   (3) Is CPS currently involved with the family?

      □ YES □ NO
      If YES, what is the nature of the CPS involvement and the length of time involved? CPS’s plan for the family? Name and telephone number of CPS caseworker?

10. Describe client’s / family’s perception of any significant changes expected in the coming year (e.g., will child or family be moving, will there be a divorce, will a parent return from prison, will child have to change schools due to family issues, etc.).

11. How does consumer rate his/her relationships with the following?

   Excellent  Good  Fair  Poor

   With parent(s) or LAR □ □ □ □
   With spouse /signif other □ □ □ □
   With siblings □ □ □ □
   With teachers or boss □ □ □ □
   With friends/peers □ □ □ □
   With non-parent relatives □ □ □ □
   With authority figures □ □ □ □

12. Describe consumer’s participation in any formal or informal social groups and extracurricular activities that involve others his/her age.

13. ‘Running with the wrong crowd’?

14. Any gang activity?

15. Does child seem to lack constructive friendships with age appropriate peers?

16. Does child feel that his peers like him, or does he feel rejected by them?

17. Does child appear to be socially isolated, preferring or doing things mainly by himself? If so, HOW LONG has this been going on?

18. Based upon information that you have gathered, does this child appear to feel rejected by one or both parents or caretaker(s)? Describe.

19. How does the parent or caretaker [or, for married or cohabiting teens, their significant other] rate this consumer’s relationships with the following?

   Excellent  Good  Fair  Poor

   With parent(s) or LAR □ □ □ □
   With spouse /signif other □ □ □ □
   With siblings □ □ □ □
   With teachers or boss □ □ □ □
   With friends/peers □ □ □ □
   With non-parent relatives □ □ □ □
   With authority figures □ □ □ □

10. Does the parent or caretaker describe negative personal feelings about child? □ YES □ NO. If yes, when did these feelings start, and how strong do they appear to be?

11. Is family or caretaker seemingly supportive of treatment at this time? □YES □NO

12. Is there history or impression that suggests the family might undermine/interfere with consumer’s treatment and/or recovery? □YES □NO If YES, in what way?

13. Is consumer active in religious activities? □ YES □ NO

   Any specific denomination? □ □ □ □
   If not active, does consumer consider him/herself to be a religious person? □ YES □ NO

   Are there any special cultural or religious issues which may affect this client’s treatment? □ YES □ NO If YES, what?
1. General physical description including hygiene and dress:

Consumer's height         Consumer's weight
Any evidence of eating disorder including obesity or malnutrition? □YES □NO If YES, describe:

2. Is consumer's physical development normal for his or her age? □YES □NO If NO, describe:

3. Any significant change in weight and/or eating patterns over the past year? □YES □NO Specify:

4. Eyes (color)         Hair (color)       Scars or other distinguishing features?

5. When was the last time consumer had a MEDICAL HISTORY AND PHYSICAL EXAM? (date). What lab tests were done?

Any negative ('needs attention') findings with exam?

Name of physician or clinic.

Also, are you now obtaining a release of information to communicate with physician on an ongoing basis?
□YES □NO If no, why not?:

6. Is the consumer experiencing any disturbance in sleeping patterns? For example, sleeping too much, too little, nightmares, night terrors, bed wetting, etc. □YES □NO If YES, explain:

7. Describe any medical condition which requires regular attention.

8. Relevant Birth and Developmental Information:

   • Developmental milestones
     Sat alone:
     Single words:
     Toilet trained:
     Walked alone:
     Sentences:
     Social:

   • Mother’s feelings about pregnancy:

   • Was pregnancy full term or premature? Full Term □    Premature □ And if premature, how many months was pregnancy?

9. Health of birth mother and birth father?

10. If not living with birth parents, health of current caretakers?

11. List any previous hospitalizations or outpatient treatment of child for MEDICAL (physical health) problems.

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12. PROBLEM BEHAVIOR AT HOME AND IN NEIGHBORHOOD:

Do the parent(s) or caretaker(s) report that their MAJOR CONCERNS about this child relate to EXTERNALIZING BEHAVIORS (such as hyperactivity, aggression, disruptive behavior, oppositional behaviors, refusal to follow rules and directions, resistance to authority, juvenile delinquency, substance abuse, etc.)? □YES □NO

If YES, describe specific behaviors here. Include HOW LONG these behaviors have been occurring.

Do the parent(s) or caretaker(s) report that their MAJOR CONCERNS about this child relate to INTERNALIZING BEHAVIORS (depression, anxiety, withdrawn behaviors, isolation, crying, sad affect, feelings of inadequacy, anger and frustration, sleep and eating disturbance, and other clinical indicators of depression or anxiety)? □YES □NO (Be specific. Also include HOW LONG these behaviors have been occurring.)
12. continued . . .

13. Do the parents or caretakers report behaviors and symptoms that are bizarre or suggest that a psychotic process is going on?  □ YES  □ NO  If YES, please describe here, including how long these behaviors have been occurring. (Be specific.)

14. Behavioral Health Treatment.  Has child had any formal treatment (other than meds) for his or her behavioral health problems?  □ YES  □ NO  If YES, where and when?  List any previous inpatient or residential or outpatient treatment for behavioral health problem, in TABLE BELOW, and describe the behaviors, under ‘Reason for BH Treatment’.  NOTE:  MEDICATIONS are described in 16 below.

15. In caretaker’s opinion, was child/family helped by these past treatments which you have listed below?  □ YES  □ NO  Describe, including things that were most helpful vs. those that were least helpful, here:

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16. Identify current and past medications prescribed by a physician for medical and psychiatric problems.

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<th>MEDICATION FOR WHAT?</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
<th>PAST OR PRESENT?</th>
<th>WHEN STARTED AND STOPPED?</th>
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NOTE:  If individual has taken psychotropic medications to control symptoms, which medications have been the most effective?  Least effective?

Any negative side-effects with any of these meds?  (Identify and describe side-effects here.)
PART A5. EDUCATIONAL AND VOCATIONAL HISTORY

1. Is consumer currently in school – or if summertime, is consumer planning to return to school next term?
   □ Y □ N

   Current grade level, or grade entering in the Fall (if this is summertime)?

   What is the highest grade or degree consumer has completed?

   Current or most recent school?

   School attending next term?

2. Is this child currently receiving any D or F (failing or at risk of) grades? □ YES, which grades are D or F?

   Has there been any significant change in grades over the past year? □ YES □ NO   If YES, what change?

3. Has child now or has s/he ever been in a ‘special class’ for emotional or learning difficulties?
   □ YES □ NO   if YES, when?

   And was/is it for emotional (SED) or for learning problems?

   What grades did/does child usually earn IN HIS/HER SPECIAL CLASSROOM SETTING (if has been in such a class)?

4. Ever suspended from any school? □ YES □ NO   if YES, details of when, where, for what type of behavior?

5. Ever placed in In-School Suspension or In-School Disciplinary Classes or Study Hall? □ YES □ NO   if YES, when, how often, and for what type of behavior?

6. Ever been in an Alternative / Behavior School or equivalent?
   □ YES □ NO   If YES, when, how many times, for what duration, and for what specific behaviors?

7. Ever expelled from any school? □ YES □ NO   If YES, details of when, where, for what behavior?

8. If NO to Questions 4, 5, 6, and 7, has the child been asked to leave the classroom due to a behavior problem? □ YES □ NO   If yes, why?

9. Does child have a history of truancy, and if so, extent of the problem (how often truant)? □ YES □ NO   If YES, describe.

10. Any evidence of school phobia or anxiety?
    □ YES □ NO   If yes, what evidence?

11. According to School Representatives, what is the MAIN CONCERN of the school system or counselors or teachers about this child’s behavior and functioning?

12. If expelled or dropped out of school, does consumer have any plans to return to school for completion of a GED or graduation? □ YES □ NO   Describe:

13. How does consumer rate himself as a student or employee, on a scale of 1 to 10, with 10 being excellent?

14. How does caretaker/parent rate child as a student or employee, on a scale of 1 to 10, with 10 being excellent?

15. Does the school counselor or School System know that the consumer is applying for treatment? □ YES □ NO   Are you now obtaining a consent for release of information to and from the ISD? □ YES □ NO   If NO, why not?

16. If adolescent: Is child currently employed? □ Y □ N   Describe job history, including number of hours per week, history of holding job(s):

17. Ever fired from any job? □ YES □ NO   If YES, why?
PART A6. CHILD’S LEGAL HISTORY AND OTHER FAMILY ISSUES (INCLUDING FINANCIAL OR OTHER LEGAL PROBLEMS)

1. Has consumer ever been arrested? ☐YES ☐NO If YES, complete the table at (5) below.

2. Is consumer currently on probation or parole, and for what? ☐YES ☐NO [Refer to number(s) assigned to item(s) in the table below that relate to probation or parole]

3. County of probation: [Provision Ends:
   Does the probation or parole officer know consumer is in treatment? ☐YES ☐NO If not, why not?

4. Probation or Parole Officer:
   Phone Number:

List of ALL charges or adjudications (specify which status, in OUTCOME)

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END OF SECTION ‘A’

Note: If Section A has been completed by someone other than the individual who completes Section B, please summarize any critical issues of which the Section B completer should be aware, and sign and date below.

Name (print): ______________________________ Date: _____________

Signature and credentials: ______________________________________
SECTION B.

The assessing clinician is expected to thoroughly review all of the historical information and presenting issues documented in Section A (which may have been collected by another, unlicensed individual), and then integrates this information with his/her clinical findings and observations, to arrive at a DIFFERENTIAL DIAGNOSIS and summary conclusions.

CLINICAL INTERVIEW
Including the Mental Status Exam

I. IDENTIFICATION / AGE / PRESENTING DESCRIPTION

II. CHIEF PRESENTING COMPLAINT PER PREVIOUS ‘SECTION A’ MATERIAL

III. PSYCHIATRIC HISTORY PER CLINICAL INTERVIEW

1. Psychotropic Medicine -
2. Outpatient Treatment -
3. Hospitalization / Residential -
4. Past Diagnoses -
5. Substance Abuse -
6. Tobacco -
7. Caffeine -
8. Known allergies especially medications and food –

IV. MENTAL STATUS

☐ Appearance:
☐ Dress hygiene grooming:
☐ Orientation: person, place, time and situation:
☐ Mood:
☐ Affect:
☐ Insight:
☐ Judgment:
☐ Intelligence:
☐ Attention:
☐ Concentration:
☐ Memory:
☐ Speech:
☐ Thought Process:

1. Is there evidence that this youth is socially withdrawn and/or isolated and/or a target of bullying, whether upon interview or by history? ☐ YES ☐ NO If YES, which?
2. Depressed or anxious, whether upon interview or by history? ☐ YES ☐ NO If YES, which?
3. Exhibiting psychotic features or those of bipolar disorder, whether upon interview or by history? ☐ YES ☐ NO If YES, what?

LGBT ISSUES? Assessment of Special LGBT Issues [LGBT = lesbian, gay, bisexual, or transgender.] Note: ‘Transgender’ is NOT a sexual orientation; it refers to persons whose gender identity and/or expression is inconsistent with cultural norms for their biological sex.

Based upon careful, preliminary clinical assessment:
☐ There DO NOT appear to be LGBT sexuality issues. OR ☐ This youth identifies with an L, B, G, or T orientation. If so, which?
☐ This youth is questioning or exploring the nature of his/her sexual orientation or gender identity. ☐ He/she feels that he/she is being ostracized, bullied, excluded, harassed, or discriminated against because of LGB or T issues. ☐ He/she is at risk of (or considering) suicide or self-harm. NOTE: If any LGBT issues apply, IN THE CLINICAL SUMMARY please provide details and assessment of protections which are needed to ensure emotional and cultural safety for the youth.

V. POTENTIAL FOR SUICIDE OR DANGER TO OTHERS

1. Is there information, from any source, that the consumer may be contemplating suicide? ☐ YES ☐ NO If YES, complete and attach an ‘Assessment of Acute Risk’. If no Risk Assessment form is available, describe the nature of the suicide risk and the need for immediate intervention, IN THE CLINICAL SUMMARY.
2. Is there information, from any source, that the consumer may be contemplating homicide or serious bodily harm to another person? ☐ YES ☐ NO If YES, complete and attach an ‘Assessment of Acute Risk’. If no Risk Assessment form is available, describe the nature of the risk of harm to others and the need for immediate intervention, IN THE CLINICAL SUMMARY.
VI. SUBSTANCE ABUSE SCREENING

1. Does consumer admit to use of alcohol or drugs or other illicitly used substances?
   ☐ YES ☐ NO

2. Is consumer reported to have emotional or social/behavioral problems which are (or appear to be) associated with chemical abuse or dependency?
   ☐ YES ☐ NO If YES, please explain:

3. Has consumer ever had or does s/he now have a communicable disease which may be associated with drug use or substance use behaviors (i.e., herpes, hepatitis, tuberculosis, gonorrhea, syphilis)?
   ☐ YES ☐ NO If yes, place X beneath past or present, and enter disease information
   [Communicable Disease]
   ☐ ☐ ☐

4. Is consumer currently complaining of or experiencing any physical health problems which might conceivably be associated with drug or alcohol use (for example, headaches, stomach aches, high blood pressure, dental, AIDS, blood disorder, loss of appetite, joint pain?)
   ☐ YES ☐ NO If YES, describe:

5. Has consumer ever experienced any of the following problems with drinking/using? Check which:
   ☐ Tremors ☐ Blackouts ☐ Flashbacks
   ☐ Hangovers ☐ Seizures ☐ Hallucinations ☐ DT’s
   ☐ Nervousness ☐ Other
   Details of such physiological events:

6. Are there any indications WHATSOEVER, from ANY SOURCE, OR from your own clinical judgment, that this consumer may has or may have substance abuse or dependency issues?
   ☐ YES ☐ NO
   If YES, please be specific in the space above about the predominant indicators, and from what source, and then proceed on to the following page subsection 7, completing the Drug Usage grid and the additional questions.

If NO, proceed on to Section VII, Abuse and Neglect.

But if YES . . .
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8. Has there been any change in tolerance (i.e., the amount it takes to achieve a certain effect from alcohol or drug)? If YES, please explain:

9. Does consumer think there is any difference between what his/her ethnic or family group taught about drinking and using, and what the rest of society or the peer group teaches?
   □ YES   □ NO
   If YES, please explain:

10. Has consumer participated in any support groups before? (Check)
    □ AA    □ NA    □ CA    □ AlAnon
    □ NarAnon □ Other
    How many times attended, or how long?

11. Was anything "missing" from his/her support group experience? □ YES   □ NO
    If YES, please explain:

12. What effect has consumer's drinking / using had on his/her social relationships or activities?

13. Does s/he/she have friends who are recovering or do not drink/use? □ YES   □ NO

14. Is there any information that consumer's parents, grandparents, siblings, other relatives, or spouse or significant other have/had psychological or emotional or CD-related problems? □ YES   □ NO If YES, what?

15. Does consumer feel that alcohol/drug use has caused problems in how he/she behaves sexually?
   □ YES   □ NO

If YES, please explain:

16. Does the total of gathered information related to substance use indicate that an addiction or substance use DIAGNOSIS is appropriate?
   □ YES   □ NO
   If YES, specify WHICH DIAGNOSIS(ES), here:
VII. ABUSE OR NEGLECT RELATED ISSUES

1. Based upon all available information and clinical interview, has consumer been (or does it appear that consumer has been) abused or harassed in any of the following ways?

- [ ] Physically
- [ ] Emotionally / Mentally
- [ ] Sexually
- [ ] Bullied or Harassed

Specifics:

2. Ever abused or bullied or harassed others?

- [ ] YES
- [ ] NO

If yes, how?

3. Ever abused animals?  

- [ ] YES
- [ ] NO

If yes, details:

VIII. SPECIAL ISSUES

1. Is youth sexually active?  

- [ ] YES
- [ ] NO

If YES, how many partners thus far?

If YES, uses protection?  

- [ ] YES
- [ ] NO

2. If YES, does he/she believe that his/her parents or caretakers know that he/she uses protection?

- [ ] YES
- [ ] NO

If YES, do they approve or assist him/her in obtaining protection?

3. If sexually active: If not limited to a monogamous “adult” relationship, does consumer feel that his/her sexual contacts are the result of

- [ ] impulse, or
- [ ] curiosity, or
- [ ] desire to please others, or
- [ ] “addictive” habitual pattern

4. If female, is there any possibility that the individual is pregnant?  

- [ ] YES
- [ ] NO

If YES, basis, or date baby is due?

5. Family: Strengths and weaknesses

6. Child: Strengths and weaknesses

7. Clinician: Strengths and weaknesses

IX. DIAGNOSTIC IMPRESSION [NOTE: Please use the DSM format currently in place in your practice or program]

Axis I

1. PRIMARY:

2. SECONDARY:

3. TERTIARY:

Axis II:

Axis III:

Axis IV:

- A. Problems with primary support group
- B. Problems related to the social environment
- C. Educational problems
- D. Occupational problems
- E. Housing problems
- F. Economic problems
- G. Problems with access to health care services
- H. Problems related to interaction with the legal system/crime
- I. Other psychosocial and environmental issues

Axis V: CURRENT GAF:

Estimated Highest Past Year:

Estimated Lowest Past Year:

X. SPECIAL SERVICE RECOMMENDATIONS?

- Does consumer meet criteria for a particular program, service category or service package?  

- [ ] Y
- [ ] N

If Yes, what?

- Is consumer MEDICALLY UNSTABLE with a Bipolar Disorder or other psychosis, so that he/she must be considered for an intensive service package or program?  

- [ ] Y
- [ ] N

Pending psychiatric assessment by physician

- Does this consumer need immediate crisis intervention in a psychiatric inpatient treatment facility?  

- [ ] YES
- [ ] NO

Pending psychiatric assessment by psychiatrist
XI. FOR LEVEL OF CARE: RECOMMENDATIONS BASED UPON THE INFORMATION GATHERED IN ALL SECTIONS ABOVE

1. Does child/adolescent exhibit behaviors characteristic of those needing a Skills Training and Development approach to treatment, as described in the Texas Resilience and Recovery (TRR) Utilization Management guidelines?

☐ Y ☐ N Check which:

- Physical Aggression
- Verbal Aggression
- Physical Violence
- Drug Usage
- Social Skills
- Poor Parental Mgt.
- Med Non-Compliant
- Destructive Communic’n
- Escalating Communic’n.
- Loss of Control
- Intimidation/threats
- Academic Dysfunction
- Truancy
- Frequent Suspensions
- Expulsion
- Juvenile Justice Offenses

FOR SKILLS TRAINING

- Socially Isolated
- Bullying
- Oppositional
- Defiant
- Resists Structure
- Disruptive
- Acting Out
- Truancy
- Suspensions
- Expelled
- Impulsive
- Poor Concentra’n
- Disruptive
- Hyperactive
- Short Attention Span

COMMENTS Re PRIORITIES, and is this the PRIMARY mode of treatment?:

2. Does child/adolescent exhibit behaviors characteristic of those primarily needing a Counseling approach to treatment, as described in the Texas Resilience and Recovery (TRR) Utilization Management guidelines?

☐ Y ☐ N Check which:

- Anxiety
- Depression
- Excessive Crying
- Withdrawn
- Nightmares
- Emotional Lability
- Fearful, Phobic
- Anger Control
- Sexual Promiscuity
- Eating Disorder
- Post-Traumatic
- Maladjustment

FOR COUNSELING
(May also add Skills Training as needed)

- LGBT Issues
- Runaway
- Social Isolate
- Bullied
- Self-Mutilation
- Eating Disorder
- Danger to Self
- Danger to Others
- Other (what?)

3. Is consumer MEDICALLY UNSTABLE (i.e., NOT YET STABILIZED ON MEDICATION) with a Bipolar Disorder or other psychosis, such that he/she MUST be placed in package 2.4? A response of YES to this question assumes that the child is not yet able to benefit from active treatment in another package. ☐ Y ☐ N ☐ Pending psychiatric assessment by psychiatrist

4. Does consumer meet criteria for a particular specialized program, including specially funded program(s)?

☐ Y ☐ N if YES, what, and why?

5. According to CURRENTLY DEFINED Level of Care criteria as determined by the required TRR ratings or combinations of ratings, please indicate the Service Package for which consumer qualifies (do so in the next section):

COMMENTS Re priorities, and is this the PRIMARY MODE of treatment?

NOTE: For the clearest understanding and documentation about assigning a Level of Care, please review the “SUMMARY RATINGS: RECOMMENDED ASSESSMENT GUIDELINES FOR FUNCTIONALITY AREAS” found on pages 53, 54, and 55 of this course document. These guidelines were formulated by the State of Texas, and have been reproduced here for the convenience of the course participant. You may also wish to review the entire document entitled “Texas Resilience and Recovery Utilization Management Guidelines - Child & Adolescent Services” found at this URL, which you can copy into your browser and then check ‘save’ or ‘open’:

http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979570

Proceed to next page to indicate Level of Care
Recommended Level of Care

☐ Crisis Services needed

Level of Care 1: Brief Outpatient

☐ Service Package 1.1: Brief Outpatient – Skills Training Programming

☐ Service Package 1.2: Brief Outpatient – Counseling Program

Level of Care 2: Intensive Outpatient

☐ Service Package 2.1: Intensive Outpatient With Skills Training Package

☐ Service Package 2.2: Intensive Outpatient With Counseling Package

☐ Service Package 2.3: Intensive Outpatient

☐ Service Package 2.4: Intensive Outpatient (Bipolar Disorder, Schizophrenia, and Major Depressive Disorder with Psychosis or other psychotic disorders WHO ARE NOT YET STABILIZED ON MEDICATION)

☐ Level of Care 3: Treatment Foster Care

☐ Level of Care 4: After-Care

☐ Other Special LOC _______________________

☐ Not Eligible for Services per established criteria
XII. CLINICAL SUMMARY

Please write a Brief Clinical Summary of this child’s status, based upon the information contained in Sections A and B of this assessment. For multiple diagnoses: Please explain your rationale for assigning ‘primary’ vs. ‘secondary’ to each diagnosis.

If the consumer requires both SKILLS TRAINING and COUNSELING, what is your rationale for choosing one vs. the other as the ‘primary’ disorder classification?

If the child has a Bipolar Disorder, Psychosis, or related disorder, and is NOT Medically Stable (i.e., not yet stabilized on medication) please formulate a prognosis for achieving stability and within what timeframe, based upon available data and history of treatment thus far.

Finally, please identify the CASE MANAGEMENT issues which you consider to be the most pressing at the moment, and any protections or interventions which you feel need to put into place to ensure emotional, cultural, and physical safety of the youth.

If an Assessment of Acute Risk is being completed at this time,
PLEASE CHECK HERE □ AND ATTACH TO THIS FORM

Clinical Assessment Completed By: (print): __________________ Date of Assessment ______
Signature, credentials: _____________________________ Date signed ___________
SUMMARY RATINGS
FUNCTIONALITY AREAS

This Rating Table is extracted from Texas Department of State Health Services Instructional Publications as a convenience for users of this biopsychosocial assessment. Based upon the information gathered in this assessment, you may summarize the client's supporting data here, following the assessment, if desired.

Basic Instructions: For each UA area, please CHECK ONE level of dysfunction PLUS all of the descriptors for that level which apply. Use information which is reported by family, youth, or referral resource, as well as your own impressions of clinical status.

NOTE: For Additional Comments: Please be explicit as to the DURATION of the problem, as well as any specific information that gives a better picture of what is going on here, such as "Since father's death 3 months ago, child has been playing with kitchen knives, scratching skin superficially, while talking about being a bad boy".

### AREA 3: RISK OF SELF HARM

<table>
<thead>
<tr>
<th>Level of Limitations</th>
<th>Functional Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No Notable Limitations</td>
<td>♦ No current suicidal ideation.</td>
</tr>
<tr>
<td>2. Mild Limitations</td>
<td>♦ Fleeting suicidal ideation with no plan.</td>
</tr>
<tr>
<td>3. Moderate Limitations</td>
<td>♦ Suicidal ideation or threats with no plan.</td>
</tr>
<tr>
<td>4. Serious Limitations</td>
<td>♦ Ideation with a plan but has no-harm contract with adequate safety plan.</td>
</tr>
<tr>
<td>5. Extreme Limitations</td>
<td>♦ Ideation with intent, plan and means without adequate safety plan.</td>
</tr>
</tbody>
</table>

ADDITIONAL COMMENTS:

### AREA 4: SEVERE DISRUPTIVE / AGGRESSIVE BEHAVIOR

<table>
<thead>
<tr>
<th>Level of Limitations</th>
<th>Functional Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No Notable Limitations</td>
<td>♦ Interacts appropriately with others.</td>
</tr>
<tr>
<td>2. Mild Limitations</td>
<td>♦ Frequently irritable or easily annoyed but behavior/moods are easily resolved.</td>
</tr>
<tr>
<td>3. Moderate Limitations</td>
<td>♦ General or vague threats of aggression towards others with no clear intent (e.g., I'm going to get you!).</td>
</tr>
<tr>
<td>4. Serious Limitations</td>
<td>♦ Significant verbal threats of physical harm towards others with no weapon.</td>
</tr>
<tr>
<td>5. Extreme Limitations</td>
<td>♦ Assault resulting in serious physical harm to another that necessitates medical care.</td>
</tr>
</tbody>
</table>

ADDITIONAL COMMENTS:
AREA 5: FAMILY RESOURCES
☐ BY Hx Only

[1. No Notable Limitations] ✗ Family environment is stable and caregiver feels able to meet the current needs of the child or adolescent. ✗ Caregiver reports little or no pressure or stress from lack of external resources (i.e., material or social supports).

[2. Mild Limitations (one or more of the following)] ✗ Caregiver expresses concerns regarding their ability to cope with child or adolescent’s problems. ✗ Caregiver has a slight deficit in problem solving, parenting strategies and/or communication skills but is willing to participate in treatment.

[3. Moderate Limitations (one or more of the following)] ✗ Caregiver/other family member’s physical or mental health concerns interfere to some extent with the ability to adequately meet child or adolescent’s needs. ✗ Caregiver reports pressure from unmet material or social supports. ✗ Caregiver is often dissatisfied with the relationship with the child or adolescent, but generally feels capable of handling the child or adolescent’s behavioral and emotional needs. ✗ Caregiver has moderate difficulty in problem solving, parenting strategies and or communication skills or their willingness to participate in treatment is questionable.

[4. Serious Limitations (one or more of the following)] ✗ Caregiver reports being overwhelmed by pressure or stress of their child or adolescent’s problems and has expressed significant concerns regarding their ability to deal with the child or adolescent right now. ✗ Caregiver demonstrates limited ability or willingness to participate in treatment. ✗ Caregiver expresses hostility and resentfulness toward child or adolescent. ✗ Appropriate community supports are lacking to help meet the needs of the child, adolescent, or family.

[5. Extreme Limitations (one or more of the following)] ✗ Caregiver expresses an unwillingness to participate in treatment right now and feels pessimistic about their child or adolescent’s future. ✗ Child requires extensive supervision that prevents the caregiver from being employed or fulfilling other responsibilities. ✗ Due to child’s behavior, caregiver refuses to allow the child or adolescent to return home or is considering parental relinquishment of legal custody or juvenile justice referral in order to place the child outside the home. ✗ Sexual or physical abuse or neglect or severe or frequent domestic violence present in the home.

ADDITIONAL COMMENTS:

AREA 6: HISTORY OF PSYCHIATRIC TREATMENT
☐ By Hx Only

[1. No history] of psychiatric residential treatment or hospitalizations.

[2. Psychiatric residential treatment or hospitalization has not occurred within the last 12 months.]

[3. One episode of psychiatric residential treatment placement or hospitalizations has occurred within the last 12 months.]

[4. More than one psychiatric residential treatment or hospitalization has occurred within the last 12 months but none within the last 90 days.]

[5. Discharged from psychiatric residential treatment or hospitalization within the last 90 days or had 3 or more hospitalizations within the last 180 days.]

ADDITIONAL COMMENTS:

AREA 7: CO-OCCURRING SUBSTANCE USE
☐ By Hx Only

[1. No Notable Limitations] ✗ No substance use reported.

[2. Mild Limitations (one or more of the following)] ✗ Occasional use of substances with no identifiable negative consequences. ✗ Experimented with substances but does not regularly use.

[3. Moderate Limitations (one or more of the following)] ✗ Occasional use of substances with mild to moderate negative consequences (e.g., beginning to interfere with school attendance, relationships, work performance). ✗ Regular use of substances to intoxication (i.e., 1 to 2 times per week).

[4. Serious Limitations (one or more of the following)] ✗ Evidence of an inability to control use of substances. ✗ Regular use of substances with serious negative consequences (e.g., beginning to affect health, suspended or expelled from school, fired from job). ✗ Chronic use of substances to intoxication (i.e., more than 2 times per week).
### AREA 8: JUVENILE JUSTICE INVOLVEMENT

**By Hx Only**

- **5. Extreme Limitations (one or more of the following)**: □ Has blackouts associated with substance use. □ Evidence of physical addiction to substances, including need to increase use to maintain effect (i.e., tolerance), withdrawal symptoms when not regularly using substances, or craving substances in order to feel 'normal' or to get through the day.

**ADDITIONAL COMMENTS:**

- □ 1. *No juvenile justice involvement in the last 90 days and not currently on probation or parole.*
- □ 2. *Community interventions/diversions* (including Child in Need of Supervision or CINS offenses) or informal proceedings with juvenile probation department *within past 90 days.*
- □ 3. Arrested and adjudicated for a *non-CINS misdemeanor* within the past 90 days or currently on probation or parole for a *non-CINS misdemeanor.*
- □ 4. Arrested and adjudicated for a *felony within the past 90 days or currently on probation or parole for a felony.*
- □ 5. *Rearrested within past 90 days* regardless of the nature of the offense or the outcome.

**ADDITIONAL COMMENTS:**

### AREA 9: SCHOOL BEHAVIOR

**By Hx Only**

- □ 1. *No Notable Limitations (one or more of the following):* □ No behavior problems reported. □ School behavior problems domain is not applicable for the child or adolescent (e.g., has completed school, dropped out and received GED, or too young for school and not in a structured childcare environment).
- □ 2. *Mild Limitations (one or more of the following):* □ Some problems in school/daycare as a result of minor disruptive behaviors. □ Occasionally breaks school/daycare rules.
- □ 3. *Moderate Limitations (one or more of the following):* □ Disruptive behavior has resulted in classroom behavior management interventions. □ Disruptive behavior that leads to frequent disciplinary referrals.
- □ 4. *Serious Limitations (one or more of the following):* □ Ongoing behavior that disrupts the entire class. □ Disruptive behavior results in additional behavior management interventions (e.g., one-to-one classroom supervision, in-school suspension). □ Breaks multiple school/daycare rules, regardless of consequences. □ Frequent unexcused absences or truant from school.
- □ 5. *Severe Limitations (one or more of the following):* □ Suspended, expelled or dropped out of school/daycare. □ Made serious threats or harmed teachers or other students. □ Disruptive behavior has led to placement in a self-contained classroom or to a Juvenile Justice Alternative Education placement.

**ADDITIONAL COMMENTS:**

### AREA 10: PSYCHOACTIVE MEDICATION TRX

**By Hx Only**

- □ 1. Not currently treated with psychoactive medication.
- □ 2. Currently treated with psychoactive medication and continued treatment is clinically indicated.

**Psychoactive Medication Treatment - Check one:**

- □ 1. Not currently treated with psychoactive medication.
- □ 2. Currently treated with psychoactive medication and continued treatment is clinically indicated.