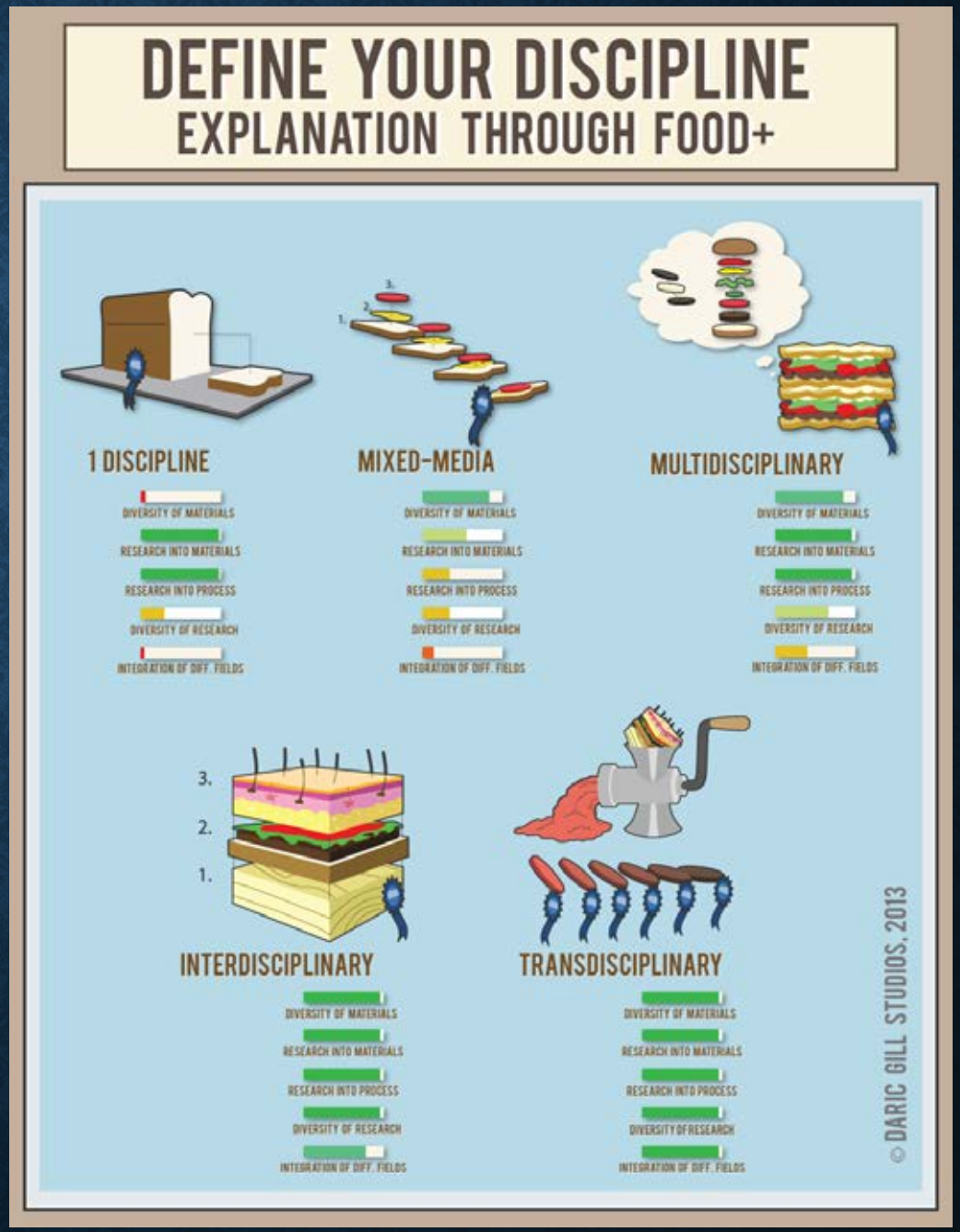
WEEK 4: CONDUCTING AN ASSESSMENT

Building a Transdisciplinary Method

TRANSDISCIPLINARY TEAMS



TRANSDISCIPLINARY TREATMENT MODEL

Table 2: Comparing Team Models

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Assessment	Separate assessments by team members	Separate assessments with consultation	Team members conduct comprehensive assessment together
Consumer participation	Consumers meet with individual team members	Consumers meet with team or team representative	Consumers are active and participating team members
Service plan development	Team members develop separate plans for disciplines	Team members share separate plans with one another	Team members and consumers develop plans together
Service plan implementation	Team members implement part of the plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible	The team is jointly responsible for implementing and monitoring the plan
Lines of communication	Informal lines	Periodic, case-specific team meetings	Regular team meetings with ongoing transfers of information, knowledge, and skills shared among team members
Guiding philosophy	Team member recognizes the importance of contributions from other disciplines	Team members are willing and able to develop, share, and be responsible for providing services that are part of the total service plan	Team members make a commitment to teach, learn, and work together across disciplinary boundaries in all aspects to implement unified service plans
Staff development	Independent within each discipline	Independent within, as well as outside of, own discipline	An integral component of working across disciplines and team building

Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT (2008)

TRADITIONAL ASSESSMENTS

- Assessments are traditionally completed within specialties with little engagement between disciplines
  - Do not look in any depth outside of the specific area being assessed
- Are often a snapshot of a person at the single time of engagement
  - Rarely include observations of person in every day environments
- Contain language specific to individual disciplines
  - Does not always translate well to other disciplines, meaning relevant information can be overlooked

ASSESSMENTS THROUGH ACT

- Each member of the team is responsible for being aware of what information is in each portion of the assessment
  - Information may be shared at staffing or treatment plan meetings to better gain a whole picture
- Services are specific to the client and may not require interaction with every member of the team
  - This is determined through the assessment process
- All team members who will be working with a client will need to be aware of all information in each portion of the assessment

THE COMPREHENSIVE ASSESSMENT

- Completed following the first 30 days of interaction
  - Gives time to get to know the whole person
  - Immediate needs are identified in first 30 days
  - Relationships are built with patient and support persons
- Individual team members are given primary responsibility for completing particular elements of the assessment
- Is a changing document as treatment progresses and new information becomes available

PRINCIPLES OF ACT ASSESSMENT

Table 4. Principles of ACT Assessment	
Start at the first meeting	The assessment process begins during visits with consumers, family members, or other supporters while consumers are being admitted to the program.
Address immediate needs first	The initial assessment focuses on basic needs, such as safety, food, clothing, shelter, medical needs.
Assess while you work	As the team begins to meet those needs, other assessments are done. Most assessments are done while the team works with the consumer on problems that were identified in the initial assessment.
Be sensitive	The assessment process begins with the most critical problems and moves next to assessing information that is not particularly sensitive or personal. Then, as trust develops, more personal information is elicited (e.g., drug use, sexual activity).
Focus on the consumer's needs	A critical part of the assessment is finding out what consumers' preferences are and what they want to accomplish.
Share what you know	Assessments are not proprietary. (For example, medical assessment may be important to mental health professionals; family assessment may be important to employment specialists.)
Look for patterns	Chronological information is collected in each area of assessment and then assembled in a timeline to show the relationship between events and experiences in consumers' lives.

COMPREHENSIVE ASSESSMENT GOAL

- The ultimate goal of the comprehensive assessment is to better understand the patient's:
  - Strengths
  - Hopes
  - Experiences
- Through their mental illness and experiences in treatment

WHAT ALL TEAM MEMBERS ARE LOOKING FOR

- Symptoms
- Effects of those symptoms on everyday activities
- Patient's strengths
- Patient's preferences
- Problems in the environment
- Resources in the environment
- Whether a particular treatment, support, or service the team is providing is serving the intended purpose

INDIVIDUAL RESPONSIBILITIES

- Team members are tasked to look at things from the perspective of their field as well as account for what may also serve other disciplines
  - E.g. if the patient mentions that they are having a poor reaction to their medication during discussions with the peer, then the peer would share that at the next team meeting so medical can follow up
- Each discipline is expected to contribute their portion of the assessment

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: PHYSICAL HEALTH

Table 5: Elements of a Comprehensive Assessment

Purpose	Who is responsible	Sources of information	Timeframe
Assessment: Physical health			
■ Identify current medical conditions. Ensure proper treatment, follow-up, support ■ Determine health risk factors ■ Determine medical history ■ Determine if there are problems communicating health concerns	Registered nurse	■ Consumer ■ Medical records	First interview within 72 hours of admission If consumer is experiencing problems concentrating or needs time to get to know staff to discuss sensitive areas, such as sexual issues, assessment may need to be completed over 2 to 3 interviews Presented at first treatment planning meeting unless immediate concerns exist, in which case nurse should consult team psychiatrist and ACT leader and present those concerns at daily meeting

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: DRUGS AND ALCOHOL

Assessment: Use of drugs and alcohol			
■ Determine if consumer currently has a substance use disorder ■ Determine if consumer has history of substance abuse treatment ■ Develop appropriate treatment interventions to be integrated into the comprehensive treatment plan ■ Establish chronology	Substance use specialist	■ Composite International Diagnostic Interview - Substance Abuse Module (CIDI-SAM) or similar standardized instrument ■ Consumer interviews or discussions conducted in home or community settings ■ Psychiatric History, Mental Status, and Diagnosis Assessment and the Health Assessment ■ Past treatment providers	Assessment begins at admission It may take several interviews to collect information since it is sensitive and requires a sufficient level of rapport and trust between consumer and mental health professional Presented at first treatment planning unless immediate concerns exist, in which case substance abuse specialist should consult ACT leader, psychiatrist, and individual treatment team and present information at daily organization staff meeting

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: SOCIAL DEVELOPMENT

Assessment: Social development and functioning			
■ Assess how illness interrupted or affected consumer's social development ■ Information gathered about: ■ childhood ■ early attachments ■ role in family of origin ■ adolescent and young adult social development ■ culture and religious beliefs ■ leisure activity and interests ■ social skills ■ involvement in legal system ■ social and interpersonal issues appropriate for supportive therapy	Mental health professional	■ Consumer interview ■ Discussions conducted in home or other community settings	Begins at admission Information may be gathered over several meetings Completed within 30 days Presented at daily meeting, to ACT leader, or at the first treatment planning meeting

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: ACTIVITIES OF DAILY LIVING

Assessment: Activities of Daily Living (ADL)			
■ Consumer's current ability to meet basic needs ■ Adequacy and safety of consumer's current living situation ■ Current financial resources ■ Effect of symptoms on consumer's ability to maintain independent living situation ■ Consumer's individual preferences ■ Level of assistance, support, and resources consumer needs to re-establish and maintain activities of daily living	Mental health professional	■ Consumer interviews ■ Discussions in home or other community settings ■ Interviewer must pay special attention to consumer's preferences and serve as consumer's advocate to ensure activities of daily living and other services meet consumer's preferences	Initial ADL plan completed at admission to identify all immediate services consumer may need (e.g., assists with nourishment, circumventing eviction) Information may be gathered over several interviews Comprehensive ADL assessment completed within 30 days Presented at daily meeting, to ACT leader, to individual treatment team, or at first treatment planning meeting

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: EDUCATION AND EMPLOYMENT

Assessment: Education and employment			
■ How consumer is currently structuring time ■ Consumer's current school or employment status ■ Consumer's past school and work history (including military service) ■ Effect of symptoms on school and employment ■ Consumer's vocational/educational interests and preferences ■ Available supports for employment (e.g., transportation) ■ Source of income ■ Education, military, and employment chronology	Employment specialist	■ Consumer interviews ■ School records ■ Past employers	Assessment may be completed over several meetings, leading to ongoing employment counseling relationship between consumer and vocational specialist Presented at daily meetings, to ACT leader, team members working with consumer, or at the first treatment planning meeting

ELEMENTS OF A COMPREHENSIVE ASSESSMENT: FAMILY AND RELATIONSHIPS

Assessment: Family and relationships			
■ Allows team to define with consumer the contact or relationship ACT will have with family or other supporters ■ Obtain information from consumer's family or other supporters about consumer's mental illness ■ Determine family's or other supporters' level of understanding about mental illness ■ Learn family's or other supporters' expectations of ACT services	Mental health professional	■ Consumer ■ Family members or other supporters	Begun during the initial meeting with consumer and family or other supporters participating in admissions process Completed within 30 days of admission Presented at the first treatment planning meeting unless immediate concerns exist, in which case mental health professional should consult team psychiatrist and ACT leader and present information at daily meetings

ASSESSMENT REVIEW

- The team leader will compile all information presented into the comprehensive assessment
- The completed comprehensive assessment will be reviewed by the contributors and discuss it as part of initial treatment plan meeting
- Any new relevant information uncovered during treatment is added to the assessment

PSYCHIATRIC/SOCIAL FUNCTIONING HISTORY TIMELINE

- Is a detailed overview of the significant events throughout a patient's life that should be completed in conjunction with the assessment
- Includes:

Significant life events	Patient's experience with mental illness	Treatment history

- Requires the patient's explicit permission

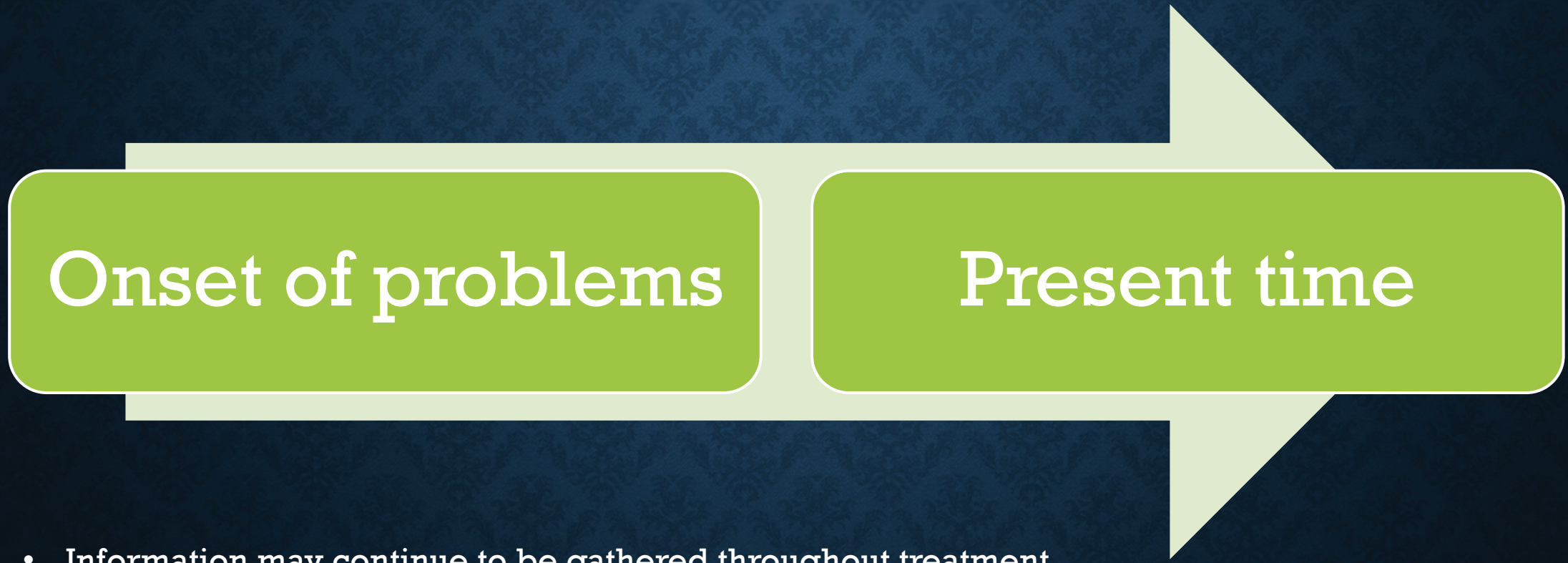
PURPOSE OF A PSYCHIATRIC/SOCIAL FUNCTIONING TIMELINE

- If done well a timeline can provide a picture to how various events relate and if there are things missing or conflicting
- Allows to see the relationship between:
  - Various treatments and the patient's symptoms and functioning
  - Events that precede an increase in symptoms, and
  - When treatments that have initially been effective begin to break down
- Useful when developing a treatment plan

COLLECTING INFORMATION

- Sources may include:
  - Past inpatient and outpatient records for psychiatric and substance abuse treatment
  - School records or transcripts
  - Medical treatment records
  - Arrest records
  - Interviews with the patient
  - Interviews with family members or other supports
  - Interviews with employers
  - Interviews with past treatment providers
- Many of these sources may require written permission from the patient to obtain

TIMELINE



- Information may continue to be gathered throughout treatment

TIMELINE STEPS: STEP 1

- Review information gathered about the patient to determine the earliest date of onset of problems with mental illness
  - This marks the beginning date for the timeline

TIMELINE STEPS: STEP 2/3

- Identify the amount of time you will be covering
- By date, compile events, facts, and other information that you find important

TIMELINE STEPS: STEP 4

- Once all information is gathered ask:
  - Is any information missing about a particular period?
  - Does any of the information conflict?
  - Have any treatments worked well in the past?
  - Do any situations or events appear to have contributed to the deterioration in the patient's condition in the past?

TIMELINE EXAMPLE

Psychiatric/Social Functioning History Timeline

Client name_____ Page _____

Timeline date	Admission or discharge date	Institution or provider	Presenting problem or legal status	Diagnosis, symptoms, significant events (suicide attempts, threats, violent acts, self-neglect)	Medication	Services rendered	Reasons for discharge	Living situation, dates, address or type, reason for leaving, Activities of Daily Living (ADL) (Personal hygiene, household activities, housecleaning, cooking, grocery shopping, laundry, and financial source and money management)	Employment or education (Dates held, employer position, type reason for leaving, other educational activities)	Other (Alcohol or drug use treatment, family relationships medical other: specify)