

Integrated Psychological Assessment INSTRUCTIONS

Name:	Date of Admission:
AVATAR #:	Date of Last Transfer (as applicable):
DOB/Age:	Date of Continuous Admission:
Gender:	Legal Status:
Race:	Unit/Attending Physician:

PURPOSE FOR EVALUATION:

The Integrated Psychological Assessment is to be completed on all individuals admitted to XXX before the first Individualized Recovery Plan (IRP-15 days). Typically, it should be completed and shared with the Recovery Planning Team (RPT) members by the 13th day of admission or members of the Interdisciplinary Treatment Team (IDT)'.

This is **not** the template for Focused Psychological Assessments. Focused Psychological Assessments are those that are requested by the RPT or deemed essential by the RPT Psychologist to answer specific questions about the individual. Examples of such assessments include behavioral assessments, neuropsychological personality tests, other assessments that may assist differential diagnosis, assessments related to specific psychiatric disorders and psychological distress, and outcome measures.

SOURCES OF INFORMATION:

1. Interview with <the individual> (<Month Day, Year;> <xxxx> minutes).
2. Intellectual screening using the <xxxxx> (<Month Day, Year;> <xxxx> minutes).
3. Review of records (specify, if applicable).
4. Other sources (specify, if applicable [e.g., interview with family members, friends, or staff])

BACKGROUND INFORMATION:

Include the following information as applicable: place of birth and most recent location in the community; childhood relationships with parents or other adults (early maladjustment is a risk factor and secure attachment is a protective factor); history of childhood physical or sexual abuse or neglect; childhood conduct problems (e.g., running away, aggression, etc.); living arrangements and quality of shelter/safety of the neighborhood; history of homelessness; feasibility of future living plans; sources of social support (existence, location, frequency of contact, and marital history), including quality of relationship with spouse, family and friends vs. social isolate; some criminal associates; few anti-criminal associates; sexual identity issues (if pertinent); cultural issues; and leisure/recreation activities (structured activities are a protective factor).

Overall self-reported health status, history of head injury with loss of consciousness (frequency, age, length of time, medical treatment received), medical hospitalizations, chronic medical conditions, and physical medications; sensory deficits; outpatient and inpatient mental health history (diagnoses, focus, general dates, past and present medication adherence, responsiveness, escape); self-injury (method, dates, reason); suicide attempts (method, dates, reason); emotionally traumatic events (experienced or witnessed); substance use (current or past history of alcohol or drug problem,

negative consequences of substance use [e.g., legal, marital/family, school/work, medical]); arrest history (listing with dates or ages, incarceration, violations of probation, and escape).

Education (highest grade completed, special or regular classes, repeated grades and reason, and behavioral problems and punishments), work history (type of work, history of termination, quitting without other employment, longest employment, frequency of unemployment, reliance on public assistance [stable employment is a protective factor]), financial management (steady income, budgeting skills, payee/guardian), and life goals.

REVIEW OF PREVIOUS PSYCHOLOGICAL ASSESSMENTS AND OTHER PERTINENT MEDICAL RECORDS:

Include a review of all previous psychological assessments, forensic reports, Individualized Recovery Plans, and other salient medical records. Each document reviewed should be listed in the "Sources of Information" section with author name and date. Consider:

1. reason for transfer from other hospital (if applicable),
2. whether or not cognitive / academic assessments have been completed within the past year for individuals 22 years and younger,
3. whether or not previous behavioral interventions, behavioral guidelines, and / or positive behavior support plans have been utilized and their outcomes (including determinations and actions taken by the Positive Behavioral Support [PBS] team, as applicable),
4. types of therapeutic and rehabilitation services which the individual has found to be helpful or have been recommended,
5. other documentation which will inform the development of the case formulation and other components of the IRP or Individualized Support Plan (ISP),
6. diagnostic confusion as evidenced by multiple diagnoses over time, use of NOS or rule out specifiers, numerous medication changes, and so on,
7. medical issues causing or exacerbating mental health symptoms,
8. identified psycholegal deficits in defendants adjudicated as Incompetent to Stand Trial, and
9. identified risk factors for instant offense(s) in individuals acquitted as Not Guilty by Reason of Insanity.

MENTAL STATUS EXAMINATION:

Include appearance, hygiene and grooming, motor activity, speech (productivity, tone, articulation), cooperation level, mood, affect, appetite, sleep (type[s] of insomnia), current suicidal or homicidal ideation, intrusive thoughts, hypervigilance and startle reaction (if noteworthy), hallucinations (describe), delusions (describe), thought processes, thought content, orientation (name, date, location, situation, length of time in hospital/jail), attention/concentration, recent memory, remote memory, insight, motivation for treatment, and potential destabilizers.

DIAGNOSTIC IMPRESSIONS:

List specific DSM-IV-TR diagnostic criteria to support the diagnostic impression (including a discussion of differential considerations and / or rule-out criteria). Include all five axes with DSM-IV-TR codes. Describe the specific symptoms of the individual that support the diagnoses.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: GAF (current):

STRENGTHS/PROTECTIVE FACTORS:

Discuss findings from the ***Strengths-Based Conversation***, a 40-item protocol that clinicians may use as the basis for holding a conversation with the individual (see Appendix 1 of the IRP manual). The aim of this conversation is to facilitate the mutual exploration of the individual's general strengths and highlight specific strengths that the individual wishes to enhance or use in recovering from mental illness. The ***Strengths-Based Conversation*** is not used as a tool for a structured interview. In addition, an individual's strengths may emerge from discussions of his or her Life Goals, but remember that an individual's Life Goals should be discussed prior to, but not during a Recovery Planning Team Conference (RPTC). At the RPTC, the team will need to discuss goals, objectives and interventions as they relate to the individual's Life Goals.

ASSESSMENT WITH THE SHORT-TERM ASSESSMENT OF RISK AND TREATABILITY (START):

Short-Term Assessment of Risk and Treatability (START) is completed in consultation with other Recovery Planning Team Members (coordinated by the psychology staff) prior to final scoring (improves reliability and validity of results) with discussion of rationale for scoring of each item. Ratings are completed based on functioning over the past two to three months with comparison to the average, well-adjusted person on the street (not changes in the individual's baseline functioning).

1. **Social Skills:** (what is scope of skills, how facile is the individual in using skills, which skill sets would benefit from improvement, which are assets that can be utilized now)
2. **Relationships:** (history of abusive relationships, social isolation, procriminal relationships; length/stability of relationships; any positive interpersonal relationships & community ties, past positive therapeutic alliances; note whether or not individual has a therapeutic alliance with at least one professional)
3. **Occupational:** (values education &/or employment; has sought out/obtained employment; has employment skills/good work habits – specify strength and weakness)
4. **Recreational:** (what activities does person like or has participated in the past; has used leisure time constructively; possible interests)
5. **Self-Care:** (can/does carry out personal hygiene and dress; eating, fluid intake and sleeping is okay; health understanding; boundaries/personal space)
6. **Mental State:** (organization, quantity, and stability of thought, content of thought – reality based, obsessive, delusions; attention/concentration, memory)
7. **Emotional State:** (mood –range and stability; affect – appropriateness; hopefulness)
8. **Substance Use:** (history of substance use – specific substances; impact of substance use on relationships, legal involvement, and so on.)
9. **Impulse Control:** (history of impulsive behaviors; is there tension build-up before impulsive acts; gratification/relief/anxiety reduction afterward; ability to consider consequences before acting; ability to be deliberate)
10. **External Triggers:** (discuss factors that may precipitate inpatient aggression; consider this from the individual's perspective, what is the individual's ability to recognize, avoid or cope with triggers)
11. **Social Support:** (availability and acceptance of social support from family, friends and professionals; note whether or not individual has positive peer support)
12. **Material Resources:** (financial means, ability to manage finances, housing options and stability)
13. **Attitudes:** (what and how individual thinks – beliefs about criminality, attribution of responsibility, empathy, tolerance, respect for authority)

14. Medication Adherence: (understanding of medication purpose and side effects, acceptance/resistance to psychotropic and non-psychotropic medication – specify individual’s concerns; indicate N/A if not applicable)
15. Rule Adherence: (obeys rules, attempts to understand rationale for rules, cooperation with routine medical procedures)
16. Conduct: (aggression, intimidation, threats, destruction of property, sexual impropriety, arson, escapes; ability to adjust behavior to context)
17. Insight: (awareness of strengths and limitations; acknowledgement of disorder and need for intervention; ability to manage personal risk factors)
18. Plans: (socially acceptable, focused, realistic, short and long-term)
19. Coping: (ability to solve problems –independently and with help, ability to cope with stress including losses and transitions, resiliency, adaptability)
20. Treatability: (interest in participation, belief in ability to change, responsiveness to prior treatment)
21. Case Specific Item: (if indicated) (consider including medical and health factors, examples may include unlawful and unsafe use of a motor vehicle or engaging in unprotected sex when known to be HIV positive, individuals at risk of self-neglect for failure to take medications for serious disorders [e.g., diabetes] or tendencies to walk in extreme cold without adequate protection/extreme heat while wearing a winter coat, individuals requesting to remain at a particular level of security or demonstrating anxiety or aggression when it is proposed that he/she might be transferred to a lower level of security, drug withdrawal, drug interaction, expressed intent to harm, etc.)
22. Case Specific Item: (if indicated)

Critical Risk Factors/Vulnerabilities:

When present, describe particularly prominent individual risks/“red flags that have been identified in the START items—either at present or historically—that need specific and close attention in individualized recovery planning and supervision. Consider the factors that are most highly correlated with the individual’s specific risk behavior (e.g., incident precipitating hospital admission occurred when noncompliant with medication or when intoxicated). Critical and Key factors can co-exist on individual START items.

Key Strengths/Protective Factors:

When present, describe particularly prominent individual strengths that have been identified in the START items—either at present or historically—that could be used in treatment and risk management planning (e.g., history of strong family relationships that could be nurtured, a history of stable work, etc.). Consider motivating forces for the individual and/or factors that offer some protection against the specific risk behavior. Critical and Key factors can co-exist on individual START items.

Signature Risk Signs:

Include any subtle signs or symptoms, “quirks,” or idiosyncrasies that reliably predict relapse and elevated risk of violence in self or others. Specifically describe individual-specific characteristics (e.g., behaviors, symptoms, changes in appearance, ideation) that represent unique signs that the individual is at increased risk for engaging in risk behavior (e.g., an individual who invariably puts on a red coat or paces the hall only immediately before fighting).

Strength/Risk Formulation Resulting from the START Findings:

Include circumstances that may alter risk, identification of potential targets, and likely time frame with probability of occurrence (categorized as “low,” “moderate,” or “high” [high = many relevant risk

factors present—Imminent or serious threat, requires frequent, intensive, or highly restrictive supervision, monitoring, management, or intervention; low = few relevant risk factors present—requires minimal or no supervision, monitoring, management, or supervision; and moderate = neither high nor low risk but still above average] for the domains of violence, self-harm, suicide, unauthorized leave, substance abuse, self-neglect, victimization, and other/case specific [e.g., sexual acting out]). Note any T.H.R.E.A.T. (Threat of Harm that is Real, Enactable, Acute, and Targeted). Describe what factors will increase the likelihood of personal success or decrease the likelihood of an adverse outcome.

COGNITIVE FUNCTIONING:

A preliminary estimate of cognitive level of functioning may be determined by but not limited to the following:

1. chart review (educational history, previous assessments, substance abuse history, head trauma),
2. clinical interview,
3. interviews with staff members,
4. intellectual screening or full intellectual testing completed prior to the individual's 15-day Recovery Planning Team meeting unless there is documented results from valid testing within the last five years,
5. adaptive ratings (if indicated), and
6. cognitive screening tests (viz., Montreal Cognitive Assessment or other instruments [RBANS, Luria-Nebraska Screener, etc.]) completed prior to the individual's 15-day Recovery Planning Team Conference meeting.

SUBSTANCE ABUSE STAGE OF CHANGE (IF APPLICABLE):

Use the University of Rhode Island Change Assessment rating scale.

SUMMARY AND IMPLICATIONS FOR INDIVIDUALIZED RECOVERY PLAN:

<Individual name> is a xx-year-old, race/ethnic culture, man/woman who was admitted to xxxxxx Hospital on <month day, year> as <legal status>. Include a very brief description of any noteworthy background information (e.g., pending charges/event precipitating hospitalization, educational level, etc.) and past mental health records. Provide a brief summary of noteworthy findings from the mental status exam, diagnostic impressions, risks (what factors/predict-explain what acts the individual might be at what level of risk in what time period) and strengths (what factors will increase the likelihood of personal success or decrease the likelihood of an adverse outcome) formulations, cognitive functioning, and substance abuse stage of change (if applicable). If individual threatens harm that is real, enactable, and targeted, immediately take necessary precautions to avert risk behavior.

A. Recommended Therapeutic Modalities and Rehabilitation services

Specifically address the level of psychological functioning (e.g., cognitive status, psychiatric symptoms, interpersonal style, developmental level, behavioral challenges, suicide risk, and violence risk) to support the therapeutic and rehabilitation service planning process and provide recommendations of how to ameliorate identified risks/vulnerabilities and capitalize upon/foster strengths/protective factors. The "Key" and "Critical" items on the START are especially important

considerations in the construction of rehabilitation plans. Document how the individual meets commitment criteria/barriers to discharge to the community. For defendants adjudicated as incompetent to stand trial, discuss the underlying cause of psycholegal deficits, and describe how deficits in competency functioning will be addressed. Identify PSR Mall groups that may be beneficial. If appropriate, recommend individual psychotherapy and explain clinical justification. Note priorities of treatment as well as issues deferred (with explanation).

B. Intellectual Assessment

Individuals in forensic or adult mental health services and scoring 75 or below on intellectual screening tests shall have full intellectual testing with adaptive ratings within 30 days of admission (i.e., second 15-day review), unless deferred because of clinical contraindication (e.g., ongoing acute, severe psychosis). Individuals admitted to Developmental Disabilities Services shall have full intellectual testing with adaptive ratings completed within 30 days of admission unless there is documentation of valid intellectual assessment within the last five years.

C. Academic Assessment

An academic assessment is required for individuals under 23 years of age for whom previous academic assessment (within one year) is not available. This assessment should be completed within 60 days of admission.

D. Personality Assessment

If personality assessment is indicated, provide a brief rationale.

E. Neuropsychological Assessment

If neuropsychological assessment is indicated, provide a brief rationale.

F. Malingering Assessment/Competency Observation Status/Observation for Inconsistent Symptomatology (if indicated)

If malingering is suspected, provide a brief rationale. For defendants who are incompetent to stand trial and suspected of feigning incompetence, it may be helpful to alert staff members to document behavior in a “parallel assessment” of competency (e.g., a defendant who contends to the Recovery Planning Team that he is paranoid, afraid of others, and confused but readily plays complex card games with peers on the evening shift; displays confused and severely reduced speech productivity around professionals but has long, animated conversations on the phone; claims memory deficits but readily learns unit rules or is able to describe his/her medications). Note type of malingering or feigning suspected and what instruments may be useful to provide evidence (e.g., SIRS, Inventory of Legal Knowledge, a forced-choice symptom validity test for crime-related amnesia).

G. Behavioral Assessment

A behavioral assessment is indicated if the individual has demonstrated maladaptive behavior(s) that are severe and / or persistent, that interfere with the individual’s ability to meet objectives, that present a barrier to placement or discharge, or that negatively affect quality of life; the maladaptive behaviors have not responded positively to the efforts of the Recovery Planning Team (e.g., modifying mall group enrollment, individual therapy, reallocation of points [in incentive system]). If behavioral interventions are indicated, a structural and functional assessment is to be completed. If a behavioral assessment is indicated, provide a brief rationale.

H. Additional Specific Risk Assessment

Long-term violence (e.g., HCR-20), sexual violence (e.g., SVR-20), suicide (S-RAMM), stalking (e.g., SAM), psychopathy (e.g., PCL-R [2nd]), criminogenic (LSI-R, IORNS, etc.), protective factors (SAPROF), and so on.

I. Other Issues

Signature & Degree of Psychologist

Date

Time

Print Name