

The Diagnostic Assessment Report has components that correspond to the following areas.

Client's current life situation

The components under client's current life situation include:

- 1) **Age.** Age is meant to be actual stated age, but can also include developmental age, especially as it pertains to children and adults with cognitive disabilities.
- 2) **Current living situation, including household memberships and housing status.** Describe who is in the house, what type of living situation (i.e. stability, multiple moves, potential eviction).
- 3) **Basic needs status, including economic status.** Basic needs status, including economic status. Describe the client/family fiscal situation including whether the client receives economic assistance, and whether basic needs like housing, food, and clothing are being met.
- 4) **Education level and employment status.** Level of education or placement in school, current employment status, and/or engagement with the workforce.
- 5) **Significant personal relationships, including the client's evaluation of relationship quality.** Describe who is important in the client's life and how they relate to each other.
- 6) **Strengths and resources, including the extent and quality of social networks.** What does the client do well? What is going well in his or her life? Who does the client consider supportive?
- 7) **Belief systems.** Describe religious affiliation or spiritual belief system.
- 8) **Contextual non-personal factors contributing to the client's presenting concerns.** Describe the other factors that the client has no control over that help create the client's current issues i.e. divorce in the family, a recent death, natural disaster, economic downturn.

- 9) **General physical health and relationship to client's culture.** Describe the client's physical health symptoms/diagnosis and use of traditional rather than Western medical practices to treat illness.
- 10) **Current medication.** Listing of current medications—herbal, prescription or over the counter.

Reasons for the assessment

There are also required components that fall under reasons for the assessment.

1. **Description of symptoms including reason for referral.** Report all the symptoms the client is having, not just those that match the end diagnosis.
2. **Client's perception of his or her condition.** How the client sees his/her situation in comparison with others around him/her.
3. **History of mental health treatment including review of records.** This includes: information from other providers, historical diagnoses, and past symptoms. The review of historical records should be documented.
4. **Developmental incidents.** Developmental milestones, accidents, and issues that impeded meeting milestones, etc. This is not limited to children's stages of development.
5. **Maltreatment or abuse.** Discuss if there has ever been child protection involvement, a documented abuse history or client self-report.
6. **History of alcohol and/or drug use/abuse.** Discuss self-report of use and reports by others, if available.
7. **Health history and family health history.** All history should be mentioned that impacts client's genetic predisposition to potential physical and mental health issues.

8. **Cultural influences.** Discuss cultural issues in the client's life and how they impact current functioning.

Mental status exam

The mental status exam (MSE) is a structured way of observing and describing a client's current state of mind. It typically includes the domains of:

- Appearance
- Attitude
- Behavior
- Mood and affect
- Insight and judgment
- Speech
- Thought process
- Thought content
- Perception
- Cognition

Assessment of client needs based on baseline measurements, symptoms, behaviors, skills, abilities, resources, vulnerabilities, safety needs.

Assessment of client needs is based on the following six areas. We will explore these on the next screens.

Baseline measures

Comparing or compiling information of an individual's mental health symptoms and their impact on functioning are the key to not only measuring the outcomes of treatments on a broad scale, but crucial to the clinician's full understanding of patient's individual needs.

Symptoms of behaviors

Behavior is an action or reaction to the environment or to internal thoughts and emotions. Behavioral symptoms are persistent or repetitive behaviors that are unusual, disruptive, inappropriate, or cause problems.

Skills and abilities

What unique aptitudes and talents do the individual have that may influence the recovery and reliance for an individual? These may include skills such as reading or writing or problem solving or decision-making skills. Or they may include skills such as being able to manage time or money.

Resources

Where does the individual receive support or aid and are there resources that they are able to readily draw upon if needed? These can include personal resources or professional resources.

Vulnerabilities

These include areas where the individual is susceptible to physical or emotional injury or attack. These may include an individual's susceptibility to manipulation, persuasion, temptation, etc.

Safety needs

Safety needs can include vulnerabilities, suicidal thoughts/actions, and self injurious behavior (SIB).

Screenings used to determine substance abuse, and other standardized screening instruments.

Screenings used to determine substance abuse, and other standardized screening instruments. At this time substance use/abuse screenings are

the only required screening. The tools required can be found on the Integrated Dual Disorders Treatment (IDDT) website. More information about substance screening tools will be covered in chapter 10.

Assessment methods

There are additional assessments currently required for DA's completed for a child. Please note that these need to be put into the MN-ITS system.

These include:

- CASII/ECSII
- SDQ

Clinical summary

The following is a list of component items under the clinical summary:

- Recommendations
- Prioritization of needed mental health, ancillary, or other services
- Client and family participation in assessment
- Referrals to services required by statute or rule
- Service preferences
- Cause, prognosis, likely consequences of symptoms
- How Dx criteria is met: symptom, duration and functional impairment
- Strengths, cultural influences, life situations, relationships, health concerns and how Dx interacts/impacts with the client's life

- Explain R/O, other provisional Dx, and why alternative Dx that were considered were ruled out

Diagnosis

Diagnosis on all Five Axis:

Axis I: Clinical disorders, including major mental disorders, learning and substance use disorders.

Axis II: Personality and intellectual disabilities.

Axis III: Acute medical conditions and physical disorders.

Axis IV: Psychosocial and environmental factors contributing to the disorder.

Axis V: GAF (Global Assessment of Functioning) or Children's Global Assessment Scale.