QA KNOWLEDGE ASSESSMENT SURVEY # 4 Answer Rationales

Question 1. What is the purpose of the Assessment?

- **A.** To get a complete picture of the client in order to understand the interrelationship between the client's symptoms/behaviors and the client as a whole person in order to provide the most effective clinical interventions
- **B.** To determine how quickly someone needs to be seen for an appointment
- **C.** To enable the clinician to diagnose and effectively treat the client
- **D.** To establish Medical Necessity
- **E.** A, C and D

Question 1 Answer: E

Rationales for Question 1 Answer Options**:**

Option A:
The Los Angeles County Organizational Provider's Manual or Org Manual emphasizes in its Assessment section that "*An Assessment is important in beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a whole person.*"

Option B:
Determining how quickly someone needs to be seen for an appointment is the purpose of Triage and not primarily the purpose of the Assessment. (Org Manual – Updated 7/12/21, pg. 16).

> ***Note:*** *The Assessment does provide information on how quickly someone needs to be seen, so if you chose this option give yourself credit.*

Option C:
The primary clinical purpose of the assessment is to identify/diagnose what the problems are in order to provide effective treatment.

Option D:
Medical necessity can only be determined through an assessment completed by a practitioner within scope to diagnose. (Org Manual – Updated 7/12/21, pg. 16).

> ***Note:*** *Triage can determine level of functional impairment, but not diagnosis, and therefore cannot establish medical necessity.*

Option F:
Options A, C and D are all accurate statements in regard to the purpose of the Assessment

Question 2. In order to get a complete picture of the individual described in the Assessment Information Sample, what areas/information could have been better developed or would have been helpful to have?

- **A.** Current relationship/circumstances with partner and children
- **B.** Circumstances of the DCFS involvement
- **C.** Family of Origin/Childhood history
- **D.** Impairments resulting from the diagnosis

E. Potential risks (history of aggression, passive suicidal ideation)
F. All of the Above

Question 2 Answer: F

Rationales for Question 2 Answer Options:

Option A:
The information in the sample regarding the client's relationship with girlfriend and children is minimal, mentioning that he resides with the girlfriend, son and stepdaughter. Also per the Assessment Information client reports history of DCFS case due to domestic violence, but denies physical and sexual abuse or other safety issues in the home. It would be helpful if more details were included regarding what precipitated DCFS becoming involved and the current status, as well as more regarding what client's relationships with girlfriend and children are like.

Option B:
Per the Assessment Information client reports history of DCFS case due to domestic violence, but denies physical and sexual abuse or other safety issues in the home. It would be helpful if more details were included regarding what precipitated DCFS becoming involved and the current status.

Option C:
Per the Assessment Information client reported growing up as the middle child with 2 biological siblings and 3 half siblings in the Lancaster area. He also stated that his parents used to argue a lot, but that there was no abuse. It might be helpful if more details were included regarding circumstances of having half siblings and what his parents "arguing a lot" looked like. If indicated, document if family of origin members are currently involved in client's life and if they are a resource or source of strength for client.

Option D:
Per the Assessment Information client reports impairments in home and social life functioning, but does not elaborate or clearly describe specifically how client is impaired at home and in his social functioning. Mentions that client reported no work related problems. Exploration of client's reports of getting irritated and raising his voice, trouble sleeping daily, trouble concentrating daily, and no interest in usual activities daily was not reflected in the Assessment Information.

Option E:
Per the Assessment Information client reported that he has days in which he wishes he was dead but has not thought about actually killing himself and a history of DCFS involvement due to domestic violence. It would have been helpful for these issues to have been explored more in the Assessment Information to have a clearer sense of the level of risk.

Option F:
More detail and elaboration in all the above areas would have helped to provide a more complete picture of the client as a whole and his current situation

Question 3. The following is TRUE regarding the documentation of the client's family situation in the documentation sample.

- **A.** The description of the client's current family situation is sufficient in that it describes who the client lives with, and mentioned that there are no problems presently
- **B.** A complete picture of this client's situation should include more clear documentation/description around client's reported history of DCFS involvement due to domestic violence
- **C.** In order to be compliant with privacy rights of the client, it is important to avoid documenting overly detailed information, for example, specific circumstances around domestic violence.
- **D.** Given that treatment is focused on the client's current situation, detailed information about the client's own childhood environment and dynamics is not necessary or important

Question 3 Answer: B

Rationales for Question 3 Answer Options:

Option A:
No, not true. The information in the sample regarding the client's current family situation is minimal, briefly mentioning that he resides with his girlfriend, son and stepdaughter. The lack of detail makes it difficult to get a clear picture of client's current family situation.

Option B:
Yes, true. The Assessment Information briefly mentions history of DCFS involvement due to domestic violence, but denies physical and sexual abuse or other safety issues in the home. Including more detail regarding what precipitated DCFS becoming involved and the current status would assist with identifying any related risks that need to be addressed in treatment.

Option C:
No, not true. Including significant details in the assessment (and elsewhere in the clinical record) is not a violation of privacy rights. Including key information such as the specific circumstances of reported domestic violence helps to convey a full picture of the client in order to ensure that all treatment needs and risks are identified and addressed.

Option D:
No, not true. Details regarding the client's childhood environment and dynamics can be part of the information gathered by the clinician to inform the diagnosis and to provide a clear and full picture of the client.

Question 4. The following is TRUE regarding the documentation of a client's history of symptoms

- A. It is acceptable to provide general, non-specific information about the history of symptoms since this is a general overview
- B. It is important to provide as much concrete, specific information as possible about the history and development of the client's symptoms in order to provide a clear picture of the relevant factors impacting the client's current functioning

C. In order to protect the client's privacy, very detailed information about the contexts and circumstances of the development of symptoms should be avoided
D. A non-specific and general overview of the history of symptoms is acceptable given that the focus of treatment is on the client's current presenting symptoms, behaviors, and impairments

Question 4 Answer: B

Rationales for Question 4 Answer Options:

Option A:
No, not true. Information regarding the client's history of symptoms in context with current symptoms and other key information assists the clinician in developing their diagnostic formulation. On the whole, gathering and documenting thorough assessment information helps to create a fuller, more accurate picture of the client so that treatment can be tailored to address their needs.

Option B:
Yes, true. Providing as much concrete, specific information as possible about the history and development of the client's symptoms helps to provide a clear picture of the relevant factors impacting the client's current functioning.

Note: Including quotes can be helpful in supporting the specificity of information.

Option C:
No, not true. Excluding significant details from the assessment regarding the context and circumstances of the development of symptoms is not a valid means of protecting the client's privacy rights. Including detailed information around the client's symptom and treatment history helps to convey a full picture of the client in order to help ensure accurate diagnosis and identify appropriate treatment options.

Option D:
No, not true. A client's current presenting symptoms, behaviors, and impairments are best understood in the context of the client's history of symptoms and treatment. Details regarding the client's history of symptoms and treatment are part of the information gathered by the clinician to inform the diagnostic formulation and recommendations for treatment.

Question 5. The following is TRUE regarding the Treatment Plan

A. The Objective is based on information that is articulated in the Clinical Formulation
B. TCM interventions must relate to a "TCM Objective"; therefore the TCM intervention as formulated cannot be listed under the stated Objective
C. The TCM intervention is relevant, assuming that Domestic Violence is a presenting problem for the client
D. The rationale that the decrease in family altercations is linked/reflects a reduction in depression makes sense and is clear

Question 5 Answer: C

Rationales for Question 5 Answer Options:

Option A:

No, not true. The Objective in the Treatment Plan portion of this survey's documentation sample, **"***Client will improve depression as evidenced by decrease in family altercations and increase in reported improved mood"* focuses on improving depression/mood. Although, the clinical formulation and other sections of the assessment information do list client's depressive symptoms, the occurrence of family altercations is not mentioned or described. Based on the Assessment information provided the connection between a decrease in family altercations and a reduction in Depression for this client is not clear.

Option B:

No, not true. We often hear practitioners refer to an objective as the "TCM Objective" or the "MHS Objective" or the "Medication Objective," which is misleading. Types of Service such as TCM, MHS or MSS are actually associated with interventions, which are the actions or ways in which the practitioner will be assisting the client in reaching their treatment objective(s). Treatment plan objectives are based on the symptoms, behaviors and impairments identified in the assessment and about what the client is going to do or the sought after change in the client as related to their mental health diagnosis. Interventions address the treatment plan objectives and are about what the practitioner is going to do, specifically the services they will provide (e.g. TCM, MSS, MHS) to assist the client in reaching their objectives. A TCM intervention can be the sole intervention addressing an objective or one of multiple interventions addressing the same objective.

Option C:

Yes, true. "*TCM 1-2x/week to link client to domestic violence programs for perpetrators*" from the treatment plan portion of the documentation sample is a relevant proposed intervention if Domestic Violence is indeed a presenting problem for the client.

Please note however, that the brief mention of a "*history of DCFS case due to domestic violence*" in the Assessment Information Sample is not explored, and elsewhere it mentions that "*physical and sexual abuse or other safety issues in the home*" were denied. It's important to keep in mind that clear and thorough documentation in the Assessment are helpful in ensuring that treatment is appropriately tailored to address the client's situation and needs.

Option D:

No, not true. The objective in the treatment plan portion of the documentation sample is, "*Client will improve depression as evidenced by decrease in family altercations and increase in reported improved mood*". Based on the Assessment Information provided the connection between a decrease in family altercations and a reduction in Depression for this client is not clear. There is mention in the Presenting Problem section of the Assessment Information that client reports "I get irritated and raise my voice;" however, there's no additional detail regarding how often that occurs or what it looks like and there is no mention or details related to any "family altercations".