Chapter 4
Behavioral Health Screening and Assessment

4.1 An Orientation to Behavioral Health Assessment

Screening and assessment are an important set of competencies that drive effective and efficient integrated behavioral health practice (SAMHSA 2020). In this chapter, I will review a behavioral health assessment approach that is holistic, person centered, strength based, and recovery oriented. First, assessments must consider the whole person. Holistic behavioral health assessments gather and synthesize the individual and social information necessary to develop a useful, person-centered and multidimensional treatment plan (Adams and Grieder 2014). One way to accomplish this is to utilize the person-in-environment perspective (PIE) that is rooted in the ecological systems theoretical model discussed in Chap. 2 (Bronfenbrenner 1979; Germain and Gitterman 1980, 2008). The PIE approach to assessment focuses on the bio-psycho-social aspects of health and functioning and views the individual as part of their broader environmental system or ecosystem. Providers using a PIE approach focus on the “fit” between a person’s strengths, capacities, and resources and their social environment (Germain and Gitterman 1980, 2008). It is a comprehensive assessment method that goes beyond individual pathology to address various domains that impact functioning (Karls and O’Keefe 2008). An assessment process rooted in the PIE approach begins by engaging clients though rapport-building and development of a therapeutic alliance. It then blends screening and assessment of both individual and social determinants of health (SDOH) along with commonly comorbid clinical conditions to provide a comprehensive and person-centered assessment of the bio-psycho-social factors influencing a client's physical and behavioral health. This assessment can then be used to develop a multidimensional case conceptualization that then informs the treatment planning process. Figure 4.1 outlines each of the phases of the assessment and treatment planning process.

Behavioral health assessment has four interrelated processes. First, at the individual level it is important to screen each client for common behavioral health
symptoms and issues that impact behavioral health such as social determinants of health (SDOH), depression, anxiety, perceived stress, traumatic stress, violence, substance use, and suicidal behavior. Providers should also screen and assess for health issues and conditions that are commonly comorbid with behavioral health disorders such as diabetes, hypertension, inflammatory conditions, cerebrovascular, and cardiovascular diseases, as well as health risk behaviors such as obesity, sedentary lifestyle, and the use of tobacco, alcohol, and other substances. Health and behavioral health are closely connected and exert a strong impact on each other and overall health, making both areas an important focus of assessment and treatment (Karls and O’Keefe 2008).

Using the PIE framework, providers also assess and address relevant aspects of a person’s social environment. As mentioned in Chap. 2, health is impacted by social determinants. Social determinants of health include factors such as housing quality, income, employment, social support, environmental conditions, transportation, safety, and the ability to meet basic needs such as food, rent, utilities, and medical expenses. Assessing for strengths and problems in each of these domains is an important part of any comprehensive assessment. Treatment planning that is based on a holistic assessment means addressing SDOH by helping client’s access resources such as better housing, employment, financial resources, child care, transportation, food, and social support among other resources (Adams and Grieder 2014).

Second, effective behavioral health assessment requires an approach to communication with clients that is person centered. Person-centered approaches focus on the importance of client and provider relationships built on communication, trust, partnership, empathy, and support. Through these relationships, providers find common ground with clients and are committed to: (1) meeting client preferences and needs; (2) measuring client satisfaction with care; (3) improving quality of care and
outcomes; and (4) reducing costs and making care more efficient (Stewart et al. 2000). A person-centered approach also requires providers to practice from a lens of cultural competency and equity. This includes recognizing that clients who are Black, Indigenous, and People of Color (BIPOC) endure racism and discrimination that have an impact on health. This also means recognizing that clients who are members of the LGBTQ community have experienced discrimination that has similarly impacted their health. Ensuring that individual and agency practices are sensitive, competent, inclusive, equitable, open, and affirming is central to the person-centered approach.

Third, assessment approaches using a strength-based perspective explore how clients can use their skills, talents, capacities, and resources to deal with current problems and achieve their goals (Gottlieb 2014; Rapp and Goscha 2012). Strength-based approaches to assessment are inherently holistic and collaborative, making them compatible with person-centered approaches. The strengths perspective to assessment is an alternative to the diagnostic method of focusing solely on pathologies. This perspective can be blended with traditional diagnostic approaches to more fully capture a person’s strengths, capacities, and vulnerabilities. The strengths perspective is perfectly compatible with the PIE and person-centered assessment approaches because it is holistic, collaborative, and provides a way to assess both problem areas and a person’s talents, resources, coping skills, and future goals (Saleebey 1996).

And lastly, assessment should utilize a recovery orientation. The personal mental health recovery model, as outlined in Chap. 3, is a perspective that views recovery as a process or journey from a state of despair, isolation, and illness to a state of well-being. Recovery from this perspective moves beyond clinical outcomes such as symptom remission or reduction in hospitalization days, to include elements of subjective and psychological well-being such as: (1) a sense of happiness and satisfaction with life, (2) insight into one’s illness, (3) a sense of belonging and connection through nurturing social relationships, (4) self-determination and empowerment as one learns coping skills and takes control of their lives, (5) the development of a sense of meaning and purpose as one takes up functional roles and activities, and (6) the positive sense of self-efficacy and mastery that develops from these sources of well-being (Dell et al. In Press; De Ruyscher et al. 2017; Leamy et al. 2011; Mancini et al. 2005; Mancini 2006, 2007; McCarthy-Jones et al. 2013; McKenzie-Smith et al. 2019).

Assessment practices oriented toward recovery share many similarities with person-centered care and are defined by several components. First, providers conduct assessments using a warm, engaging approach that is respectful, nonjudgmental, empathic, and welcoming (Davidson et al. 2009; Tondora et al. 2014). Providers take their time, ask questions in a sensitive manner, show concern, provide culturally affirming, fluent and competent care, and seek to engage clients in service. Second, providers are concerned about more than symptoms. They ask people about who is important to them; what activities give them meaning and joy; what interests, strengths, and talents they possess; and what troubles or concerns them about their lives in terms of health, relationships, safety, and access to resources. Lastly,
providers consider a client’s stage of change regarding a particular issue (Prochaska et al. 1992). Once problems have been initially identified and defined, it is important for service providers to offer clients a range of options to address the problem. Clients will be in various stages of change. Some may not be interested in addressing the problem at all or may not even recognize that a problem exists. Some clients will recognize the problem, but be ambivalent about how, or if, to address the problem. Some clients may be ready to take action. Given this range of perspectives, service providers should offer treatment options that can fit any one of these stages.

In the following sections, I will review the four areas of screening and assessment that can provide a comprehensive, detailed, and accurate portrait of a client’s current situation and set the stage for the treatment planning process. These four areas are: (1) engaging clients and building rapport; (2) assessing for strengths and resources; (3) screening and assessment for common behavioral health symptoms, problems, and concerns; and (4) screening and assessment for social determinants of health (SDOH). Following this description, a review of important areas of documentation will be provided. A case study of Mr. Clarence Smith will be offered at the conclusion of this chapter.

4.2 Setting the Stage: Engaging Clients and Building Rapport

Assessment occurs at the beginning of the treatment partnership and continues throughout the relationship. During the early stages of assessment, it is important to take the time to create a welcoming, engaging, and empathic atmosphere. This is the time to engage clients in treatment and build trust and a solid rapport with them. Building rapport and trust with clients makes them feel safe and comfortable. This can lead to more honest and open conversations around experiencing discrimination, violence, and trauma as well as health-related behaviors surrounding drinking, suicidality, drug use, and sex that can be seen as intrusive and difficult to answer. Building good rapport and a strong therapeutic alliance during the initial visits and consultation is important in identifying and effectively treating behavioral health issues in clients because doing so can increase the motivation of clients to follow through with treatment recommendations leading to better treatment outcomes and higher satisfaction with services (Parker et al. 2020). Engaging clients in treatment and building rapport require providers and organizations to routinely engage in several practices that increase a sense of safety, respect, welcoming, warmth, empathy, hope, and optimism. I will review these areas next.

Creating WISE Service Environments That Are Welcoming, Inclusive, Safe, and Equitable

The people that walk through our doors have often experienced tragedy, oppression, poverty, despair, neglect, and abuse. They may be in pain. They may feel afraid. And they may be lonely. Despite these experiences, they have survived and they have
decided to come see us for help. This is an honor and a responsibility. This may be your only chance to help them. Don’t let clients walk away from you or your agency thinking that they made a mistake coming to see you. When clients knock on our door, we want them to feel welcomed and safe. We want them to feel like it was a good idea to come to see us.

Make your setting a welcoming place to be. Ask yourself, what are the first things a client experiences when they call or arrive at my agency? Is it a pleasant place to be? Are they acknowledged and treated with respect and courtesy? Was it easy to make an appointment? Making the clinical environment safe, comfortable, and welcoming can be the first step in building rapport with clients. For instance, having plants, artwork, and pleasant wall colorings, flooring, and comfortable furniture can be an important way to create a safe and comfortable environment. Ensuring that staff treat all clients equally and respectfully and implementing visible messaging about safety, confidentiality, cultural competence, and respect are important. It is also important to ensure that organizations are adequately staffed with providers and administrative personnel who are supportive, pleasant, trauma informed, patient, warm, and inviting on the phone when scheduling appointments or answering questions, upon arrival in the waiting area, in the exam room or therapy office, and all the way through discharge. This can increase clients’ sense of safety and create a safer overall work environment for everybody. If you want to engage clients—then send the message: “We see you and we’re glad you’re here.”

Procedurally, it is important that providers have adequate time to conduct thorough assessments, listen to clients, and answer all of their questions and review information on treatment options.

Being inclusive and equitable means that staff composition is reflective of the diversity of the client populations they serve. It means minimally that all staff are adequately trained to recognize and address their own implicit and explicit biases so they can provide services that are affirming and inclusive of all identities and avoid racist, sexist, heterosexist, and trans-discriminatory practices that are invalidating, hurtful, and (re)traumatizing. Ideally, staff are trained in recognizing and dismantling structures, policies, and practices that are racist and discriminatory throughout the agency including holding each other accountable. For instance, they affirm the gender identities and sexual orientations of all clients in their messaging, forms, records, and practices. They share their pronouns and invite clients to share theirs as well. Their forms are in various languages and language interpretation services are available on site. Providers understand how implicit bias can influence clinical practice and how the experience of racism and discrimination over the course of a lifetime can lead to poor health. Providers are skilled and comfortable in having conversations with clients that explore their racial and cultural experiences and perspectives including their experiences of racism and discrimination in ways that are validating, constructive, and affirming and that lead to interventions that are culturally tailored and effective.

Inclusivity and equity also mean that all clients can easily access resources and services regardless of their personal circumstances. Equitable providers design their service environments with the needs of their most vulnerable, stressed, and
disadvantaged clients first. It means that services are easily accessible and that the childcare, work or treatment schedules, transportation, and the ability of clients to get to services are acknowledged and addressed through responsive policies and procedures. Agency structures and procedures are also in place that regularly holds providers and leadership accountable to consistently provide services that are inclusive and equitable.

Organizations must be safe and trauma informed. Being trauma informed means that providers can sensitively and competently screen and assess for trauma and provide clients with support, education, and access to trauma services upon request. It means that practices and procedures are designed so they do not retraumatize clients. Intake and exam procedures are also conducted in ways that ensure safety and privacy. These are important ways to enhance rapport and engagement in treatment. Another important way to create safe environments that are welcoming, inclusive, safe, and equitable is the utilization of community health workers and/or peer providers or navigators. These individuals provide outreach and engagement services to clients by giving support, teaching coping skills, and helping them navigate the treatment environment. These individuals often share the same lived experiences as those of clients and can use those experiences to provide genuine and authentic support, hope, and guidance (Mancini 2018, 2019).

**Showing Warmth, Respect, Patience, and Empathy**

The ability of clinicians to convey a sense of warmth, respect, patience, and empathy to clients can lead to improved outcomes (Dowrick 2015; van Os et al. 2005; Jani et al. 2012). Supportive professionals have been found to be a key element of recovery for persons with serious mental health disorders (Mancini et al. 2005), and a strong therapeutic relationship is often viewed as an intervention in its own right (Dowrick 2015). Clinicians who build trust and rapport are able to convey a sense of warmth, affirmation, understanding, and support. This begins by engaging in active listening. Active listening involves a set of communication skills that convey to the client that they are respected, cared for, and heard. It also signals to clients that what they are experiencing is important and real. Hearing a client’s words and their underlying concern while focusing directly on the client is an important initial step. This requires providers to face clients, give them their full attention, and avoid being distracted by computer screens, charts, and interruptions. This also involves allotting the necessary time to provide a competent consultation and avoid being rushed.

Clinicians can engage in active listening by doing the following: (1) make and maintain direct eye contact (if culturally appropriate); (2) sit facing the clients with an open stance; (3) ask open-ended questions designed to gather as much information from the client about their symptoms as possible; (4) listen intently to the client and patiently wait for the client to finish their story or encourage them to go on; and (5) be comfortable with silences and pauses and wait for the client to complete their thoughts. Clients with behavioral health concerns (e.g., depression, anxiety, trauma, and substance use) can often have difficulty concentrating, and can experience fatigue and shame. Reflecting back to the patient what you have heard them say is
also a way to help the client know that they are understood and can encourage them to expand on their experiences. Writing down treatment instructions and reviewing them with clients can also improve treatment participation and follow-up.

**Offering Hope and Optimism**

After listening to clients, it is important to summarize what they say in order to assess accuracy. This practice can also be used to recognize strengths, share concerns, validate experiences, educate about alternatives, and provide the message that while what they are experiencing has implications of their health, they are not alone, and that help is available. Summarizing what has been said can help the provider and client develop a shared understanding of the problem. Thanking the client for sharing their concerns and complimenting them on the courage it took to come forward and ask for help are also important. In short, listen to people. Validate their experiences. Normalize what they are experiencing so they don’t feel alone without minimizing the impact or seriousness of their distress. And drive home the message that while their behavioral health symptoms have health consequences, what they are experiencing is treatable, and their problems are solvable. Doing so can increase the chances a client continues in treatment, follows treatment protocols, and reports satisfaction with their treatment experience. It may also improve the sense of trust and respect necessary to encourage honest communication necessary for an accurate assessment (Dowrick 2015; van Os et al. 2005; Jani et al. 2012).

**4.3 Assessing for Strengths and Resources**

While developing a comprehensive and multidimensional understanding of client problems and concerns is the central feature of any assessment protocol, an understanding of client strengths is just as important. In a strength-based assessment approach, behavioral health providers create discursive space that explores how a person has coped with their issues and what special abilities, skills, and resources a person possesses. This type of assessment also identifies a person’s hopes and dreams for the immediate and more distant future (Rapp and Goscha 2012). Understanding a client’s strengths, hopes, and dreams can inform the treatment-planning process as it highlights the internal and external resources that can be redeployed to assist the person in coping with their problems. Strength-based assessment also helps continue to build rapport, increase motivation, and enhance self-efficacy in clients (Adams and Grieder 2014).

The strengths perspective values self-determination and views clients as experts in their own lives. Behavioral health providers invite clients to reflect upon their strengths and capacities in multiple domains and help them identify and (re)deploy those strengths to set goals and address behavioral and social problems. The approach also identifies areas in the client’s life that need to be reinforced and strengthened. Problems are positioned as barriers to goals that can be overcome. As part of the assessment, the behavioral health provider takes on an approach that is
conversational, engaging, encouraging, and affirming. Strength-based assessment is designed to help people acknowledge and utilize their abilities and resources to solve problems and to connect with natural resources and supports whenever possible (Rapp and Goscha 2012). Rapp and Goscha (2012) identify at least three main domain areas important for strength-based assessment that exist at the personal, interpersonal, and environmental levels: (1) personal skills and attributes; (2) interpersonal strengths and connections; and (3) environmental strengths and resources. When assessing personal, social, and environmental domains, it is important to first identify the things in the client’s life that are going right, that can help them achieve their goals, what they have used in the past that they can use now, and what the client wants to accomplish in the future within these domains (2012).

**Personal Skills, Character Traits, and Attributes**
Clients are doing the best they can and are often doing better than they (or we) think. Why not identify and highlight those positive qualities and skills? The field of positive psychology has identified several broad character strengths and virtues that are constellations of persistent thoughts, perspectives, worldviews, behaviors, feelings, and tendencies that help define each person (Peterson and Seligman 2004). Peterson and Seligman (2004) have identified 24 character strengths and virtues that include integrity, love, kindness, gratitude, optimism, humor, bravery, self-control, leadership, forgiveness, teamwork, humility, curiosity, perseverance, and creativity to name several. Character strengths can be assessed and measured through the values in action (VIA) inventory of strengths (VIA-IS) (Peterson and Seligman 2004). It is important for clients (and providers) to know their character strengths so they can embrace and rely on them when needed. For instance, do clients have a good sense of humor? Are they humble, kind, generous, curious, brave, honest, or determined? Are they survivors? Are they protectors of their family? Knowing and embracing their positive traits help boost a client’s sense of self-efficacy and guide them to rely on the parts of their selves that can be sources of strength and resilience.

It is also important to identify the skills and talents of an individual. What do they love to do and what do they know how to do well? What unique talents do they possess? What skills do they have that are important for achieving their goals? The beginning of the assessment process involves the identification of the strengths that people have used in the past to solve problems and the characteristics and attributes they currently have that they can use to work toward their goals. Identifying client skills and attributes can achieve three practice goals: (1) it frames the client more holistically and in positive terms rather than being problem focused; (2) it can help build rapport and treatment engagement; (3) it highlights areas that the client may have forgotten about and lead to increased motivation; and (4) it identifies resources that can be used to design and work toward identified goals (Rapp and Goscha 2012).

**Interpersonal Strengths and Resources**
A second domain of strength assessment focuses on interpersonal relationships and social support in the client’s life such as helpful and supportive family, friends, coworkers, neighbors, and faith or community group members. These interpersonal resources can include people the person has relied on in the past, currently rely on,
and could rely on in the future (Rapp and Goscha, 2012). It is important to assess if clients have people in their lives that can provide emotional and psychological support. Do they have someone they can confide in such as an intimate partner, child, parent, or close friend? Is there someone they can call upon to go for a walk, talk on the phone, have a cup of coffee, or go to the movies? In addition, it is important to explore if the person has people they can rely on to provide instrumental support such as transportation, childcare, or help with household chores. These organic forms of naturally occurring supports are far more reliable, holistic, efficient, and sustainable than support provided by professional sources (Rapp and Goscha 2012). Exploration of interpersonal relationships is also a form of culturally informed practice that validates worldviews that are more focused on interdependence rather than individualism. Clients from various cultural backgrounds place their interpersonal relationships at the center of their lives. When these relationships are stressed or fractured, it can lead to significant distress. Focusing explicitly on interpersonal health can help providers and clients collaboratively identify areas in the client’s social network that are sources of strengths and areas that may require targeted interventions (Díaz et al. 2017).

Environmental Strengths and Resources

A third practice is to identify the positive assets and resources in each client’s environment that have been and/or can be used to solve problems. This includes access to economic and basic resources such as income, transportation, safe housing, food, employment, education, and access to opportunities for recreation and meaningful activities. These resources can also include community or faith groups, schools, libraries, coffee shops or other businesses, or other neighborhood or community organizations that can provide access to needed resources. These resources can be highlighted to provide a more balanced picture of a client’s ecology, which can often times be viewed as unnecessarily bleak or hopeless by the client. They can also be reorganized and redeployed to help solve client problems. Again, naturally available resources within the client’s community or household are often more sustainable and efficient than professionally provided services (Rapp and Goscha 2012).

An assessment that only provides descriptions of barriers and problems lacks important information about how best to generate solutions that are organic to the person’s lived reality. The strengths assessment can be a separate section of the assessment process, or it can be integrated throughout the process and act as an orienting perspective. For instance, assessment of personal strengths could be integrated into the assessment of behavioral health experiences, and assessment of interpersonal and environmental strengths could be a part of the assessment of social determinants of health discussed below. However documented, assessing for strengths helps the client (1) identify naturally occurring personal, social, and environmental resources they can rely on to help solve problems and (2) create a realistic sense of hope and optimism that can help motivate the person to work toward solutions to problems and build a sense of personal self-efficacy (Rapp and Goscha 2012).
4.4 Screening Areas for Common Behavioral Health Issues

Screening is an ongoing, formal process that begins when the client first presents for services and is used to identify the presence of symptoms, experiences, or problems that indicate the need for further assessment. Screening results are not a substitute for a full assessment and should not be used to make diagnoses. A positive screen does not confirm the presence of a disorder, but only indicates that symptoms of the disorder are present and that a full assessment is warranted. Assessment is a more detailed process to determine if a client meets the diagnostic criteria of a behavioral health disorder (e.g., major depressive disorder, post-traumatic stress disorder (PTSD), anxiety disorders, cognitive impairment, and substance use disorder) as identified by the American Psychiatric Association’s fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA 2013). It can also be used to confirm the presence of other issues that negatively impact behavioral health that requires exploration (e.g., interpersonal violence, poverty, discrimination, harmful drinking or other drug use, loneliness, suicidality, or housing instability). Screening results should be used to begin a conversation with the client about what the results mean for their health and to guide the assessment process. Figure 4.2 outlines the most common areas for behavioral health screening. Providers should universally screen for several common behavioral health problem areas in every new client as part of the intake process using brief, reliable, and valid instruments. Screening for psychiatric distress, trauma, stress, suicidal thinking, problem drinking, and drug use can be done in a remarkably efficient, sensitive, and reliable way with minimal questions.

4.4.1 Screening for Depression and Anxious Distress

Depressive and anxiety symptoms are prevalent, commonly comorbid with each other as well as other physical and behavioral health issues, and can lead to increased morbidity and early mortality. The two main symptoms of depression include a persistent pattern of low mood and lack of interest in all or almost all activities of daily living. This lack of interest and pleasure is sometimes called anhedonia. Depression also includes fatigue, disturbances in sleep, appetite, psychomotor activity, concentration, and persistent thoughts of worthlessness, guilt, and death. One of the most common screens for depression used in primary care and outpatient behavioral health settings is the Patient Health Questionnaire (PHQ-9) (Kroenke et al. 2001). The PHQ-9 is a publically available scale that screens for the presence of all nine depressive symptoms identified by the DSM-5. Five symptoms are required for a diagnosis with at least one being low mood or anhedonia (APA 2013). The PHQ-2 screens for the two main symptoms required for depression (e.g., low mood and anhedonia), and is also a reliable and valid screen for depression (Kroenke et al. 2003).
Anxiety is pathological worry or fear across a range of issues that is either excessive or experienced in the absence of perceived threats. This fear results in significant distress and avoidance behavior that can impair functioning. Symptoms include panic, nervousness, social anxiety, excessive worry, fear of a range of situations or objects (e.g., phobias), and obsessions and compulsions (APA 2013). One of the most common screens for anxiety is the Generalized Anxiety Disorder Scale (GAD-7) (Spitzer et al. 2006). The GAD-7 screens for seven prominent anxiety symptoms which include restlessness, excessive worrying, uncontrollable worrying, inability to relax, being on edge, fear, and irritability.

A scale that combines depression and anxiety screening in four questions is the Patient Health Questionnaire 4 (PHQ-4) (Kroenke et al. 2009). Two questions focus on the two main depressive symptoms and the other two focuses on anxiety symptoms (nervousness and uncontrollable worry). Using the PHQ-4, providers ask clients how often over the last two weeks they have been bothered by the following problems: (1) feeling nervous, anxious, or on edge; (2) not being able to stop or control worrying; (3) experiencing little interest or pleasure in doing things; and (4) feeling down, depressed, or hopeless. The scale has four anchors (Not at all (0); Several days (1); More than half the days (2); and Nearly every day (3)). Scores for depression and anxiety can range from 0 to 6 point for each disorder. A score of 3 or greater indicates a positive screen for the presence of symptoms for that disorder (Löwe et al. 2010). These screens will be discussed further in Chap. 8.
4.4.2 Screening for Substance Use

Substance use including alcohol misuse can be quickly screened using a variety of scales including the CAGE-AID (Cut down, Annoyed, Guilty, Eye-opener-Adapted to Include other Drugs) (Mayfield et al. 1974; Brown and Rounds 1995). Providers using this screen ask clients if: (1) they have ever felt they should cut down on their drinking or other drug use; (2) others have ever been annoyed with their drinking or drug use; (3) they had ever felt guilty by their drinking or drug use; (4) they have ever had to use drugs or alcohol in the morning as an eye-opener or to control withdrawal effects. A “yes” response to any two questions indicates a positive screen (Brown and Rounds 1995).

Other common screens include The Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1989). This is a 10-item screen that is very popular in medical settings. The AUDIT screens for frequency and quantity of drinking as well as problem drinking, hazardous use, and alcohol use disorders (Babor et al. 1989, 2001). The Michigan Alcohol Screening Test (MAST) is a commonly used, reliable, and valid 28-item (yes/no) screen for alcohol use disorders (Selzer 1971). The screen assesses for lack of control over drinking behavior and whether the person has experienced a range of negative consequences related to drinking. There is a 24-item short-form geriatric version (SMAST-G) that is one of the first and most common screens for alcohol use disorders and problematic drinking behavior in older adults (Selzer 1971). A score of five or more positive responses indicates the presence of problem drinking (Blow et al. 1998). The 10-item Drug Abuse Screening Test (DAST-10) is a brief instrument that assesses for problematic and hazardous drug use and has been shown to have good reliability and validity (Skinner 1982; Gavin et al. 1989).

Prescreening questions can include asking clients if they drink or use drugs, how frequently they have drank or used drugs in the past two weeks, and how many drinks they have had in the past two weeks. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has set average daily and weekly drinking limits for men at no more than two drinks per day or 14 drinks per week. For persons who identify as female and persons over the age of 65, the daily limits are one drink per day and seven drinks per week. Hazardous drinking limits include five or more drinks within one day for men, and four or more drinks per day for women or persons over 65 years of age. Unfortunately, there are currently no specific guidelines for Trans Gender Non-Conforming (TGNC) persons. Persons who exceed the above drinking limits are at a higher risk of developing an alcohol use disorder and experiencing other health problems.

Providers can also ask two additional questions: (1) how many times in the past year have you had five or more drinks (four or more if client is over 65 years old or identifies as female)? An answer of more than one indicates the potential presence of hazardous drinking and (2) how many times have you used an illegal substance or misused a prescription medication in the past year? An answer greater than one indicates the potential presence of a substance use problem requiring further
4.4  Screening Areas for Common Behavioral Health Issues

assessment (Smith et al. 2010). Screening instruments for substance use will be further covered in Chap. 10.

4.4.3  Adverse Childhood Events (ACEs) and Trauma

As reviewed in Chap. 2 and, later in Chap. 7, experiencing adverse childhood events and/or traumatic events can have a substantial, dose–response impact on a wide range of health and behavioral health domains including increased use of healthcare resources, comorbid medical conditions, depression, and substance use. Screening for ACEs and trauma can provide valuable information for providers that can inform treatment planning. Asking the question “Have you ever experienced or witnessed a situation where you thought your life was in danger?” can lead to important conversations about trauma and stress. Using an ACE questionnaire as routine part of intake can give providers an ACE score that can help them determine whether a more complete assessment for trauma is necessary and can give guidance on a proper course of treatment.

Two screens that provide important information regarding ACEs and trauma are the Revised Adverse Childhood Events Questionnaire (Finkelhor et al. 2013, 2015) and the Primary Care-Post Traumatic Stress Disorder Screen for DSM-5 (PC-PTSD-5) (Prins et al. 2003, 2015, 2016). Both are easy to administer and have been found to be useful and appropriate in primary care settings, outpatient and inpatient behavioral healthcare settings, emergency departments, and in integrated care settings. The Revised ACE questionnaire screens for most of the original ten ACEs as well as questions regarding peer bullying, peer rejection, and community violence exposure. The PC-PTSD-5 is a five-item scale that screens for probable PTSD symptoms in response to an identified traumatic event including intrusive thoughts or images (e.g., nightmares), dissociation (e.g., numbing), hyperarousal (e.g., being on guard), avoidance of reminders of the event, and experiencing guilt or self-blame regarding the event. A “yes” to any three questions suggest possible PTSD and warrants further assessment.

A valuable screen that combines items from the above instruments is the Patient Stress Questionnaire. This is a 26-item screen used in behavioral health and primary care settings that integrates items from the PHQ-9 (depression), GAD-7 (anxiety), PC-PTSD-5 (trauma), and AUDIT (alcohol use) to form a brief screen for the most common disorders listed above (SAMHSA 2020).

4.4.4  Perceived Stress

Like trauma, high perceived stress related to poverty, discrimination, violence, caregiving, occupation, and other stressors can lead to increased risks for depression, anxiety, and adverse health behaviors (e.g., smoking, drinking, poor diet, and
sedentary lifestyle), resulting in higher rates of morbidity and premature mortality (Algren et al. 2018; Geronimus et al. 2006; Krueger and Chang 2008; Mancini and Farina 2019; Ng and Jeffery 2003). Given these clinical implications, identifying clients with high levels of perceived stress is an important component of any health assessment. Perceived stress can be effectively screened using the Perceived Stress Scale-4 (PSS-4) (Cohen et al. 1983). This four-item scale measures qualities of stress that include how overwhelming, negative, and persistent clients perceive their stress to be, and how much control the person thinks they have over their stress. Higher scores indicate more stress. This is a simple tool that can be used to quickly assess the stress burden of clients and indicate whether there is a need for intervention.

Perceived stress can also be assessed by simply asking people how stressed they feel. A reliable and valid single-item stress scale includes the question: “Stress refers to a situation where a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her mind is troubled all the time. Do you feel that kind of stress these days?” The anchors are Not at all (1); Only a little (2); To some extent (3); Rather much (4); and Very much (5). A score of 3 and above indicates intermediate to high stress levels (Elo et al. 2003).

Clients who score highly on stress can receive interventions designed to reduce stress that can include: (1) social support interventions (e.g., case management) designed to address and alleviate the burdens of poverty such as poor housing, income constraints, access to transportation and childcare, and other resources; (2) psychoeducation and stress reduction techniques such as mindfulness-based stress reduction (MBSR) interventions, which have been found effective in reducing stress (Janssen et al. 2018; Kabat-Zinn 1990); and/or (3) helping clients advocate for their rights if they are experiencing discrimination or other forms of unfair treatment at work, school, or other life domains that are causing stress.

### 4.4.5 Interpersonal Violence

Interpersonal violence is common and takes an enormous toll on the lives and health of millions of people (CDC 2020a, b). Two forms if interpersonal violence are intimate partner violence and community violence. Intimate partner violence (IPV) is defined as physical, sexual, or psychological violence, threats, intimidation, stalking, and other actions with the intent to control an intimate partner (Decker et al. 2018; CDC 2020a, b). Community violence is violence that is committed by strangers or acquaintances. This form of violence usually takes place outside of the home and can include fights, robberies, assaults, and homicides. Assessing for community violence involves asking clients if they have ever experienced physical violence in their community such as a violent attack, assault, being shot, stabbed, robbed, or beaten up. Assessment questions can also include asking about how safe a person feels in their community or neighborhood.
Screening for intimate partner violence can utilize a brief screening instrument that has been highly valid in a variety of settings. The HITS screening tool (Sherin et al. 1998; Rabin et al. 2009) is a four-item scale that asks clients if their partner has ever: physically Hurt you, Insulted or talked down to you, Threatened you with harm, or Screamed or cursed at you. The scale uses the anchors (never, rarely, sometimes, fairly often, and frequently). Another question to ask people is simply whether or not they are afraid of their partner. When screening for IPV, providers should do so alone with the client in a confidential and private location and fully inform clients of the limits of confidentiality if they disclose whether they have experienced violence. Mandatory reporting laws vary by state in relation to IPV. Providers should know the laws of their respective geographic location and relay those constraints to the client before screening for IPV or other forms of violence. Professional language interpreters independent from the client’s family or friends should be available to translate items on the scale or interview. Results should be discussed privately with the client in a calm and neutral tone. Providers should provide education and information about IPV regardless of disclosure. If a client screens positive for IPV, providers are encouraged to show concern, inform clients about the health implications, and ask clients if they would like to receive further assessment or other services. Services should be readily available and co-located at the setting. If services are not co-located on site, the provider should have formal referral relationships with outside community providers such as behavioral health providers, legal services, crisis teams, victim advocacy groups, and shelters so as to facilitate timely and effective referrals and following up (i.e., warm referrals) (Decker et al. 2018).

The information in the above screening areas can be used to guide the assessment process that will inform the development of the case conceptualization and subsequent person-centered care plan (Adams and Grieder 2014). In the next section, information regarding the psychiatric examination and social determinants of health will be reviewed. In each of these domains, it is important to identify past history and current difficulties for each area as well as the strengths, skills, and resources needed to address problems experienced in any domain area.

### 4.5 Behavioral Health Assessment Areas

**Presenting Problems**

Problem formulation guides and orients the assessment and treatment process. Problem formulation is a conceptualization of the presenting problems brought forth by the client. Problems are stated in clear, measurable, and solvable terms. Adequately exploring, describing, and defining the problem are vital steps toward proper assessment and treatment. What problems have brought the client to your agency? If part of a routine clinical exam or checkup—what pressing concerns or problems does the client have? What problems have they experienced in the past? The problems reviewed can include mental health symptoms (e.g., depression, anxiety, psychotic symptoms, and ADHD); substance use issues (e.g., problem drinking,
substance misuses, and substance use disorders); experiencing stress, adverse events, interpersonal violence, or other traumas; suicidal behavior; social isolation; functional impairments; medical conditions; or social factors such as poverty, homelessness, or family-relational issues.

During this conversation, it can be helpful to clarify the problem from the client’s point of view. Problem definition is not simply what the client says is the problem. While it is important to listen to the client and take their views into consideration, what the client perceives is the problem is not always accurate, complete, or stated in a way that is solvable. For instance, a client who is depressed and has negative core beliefs about themselves as helpless and unlovable often underestimate their ability to solve problems, take on too much responsibility for perceived problems, and overestimate the severity and future negative consequences of problems. This can lead to pessimism, hopelessness, and paralysis. In these situations, providers may need to help clients reframe problems so that they more accurately reflect the client’s situation, their role and responsibilities in the problems, and the achievable solutions that can be undertaken by the client. This process can lead to relief, motivation, and action on the part of the client. This process relies on building trust and actively listening, reflecting, and exploring problems with clients during assessment.

Medical History
As reviewed in Chap. 2, behavioral health disorders are commonly comorbid with many chronic illnesses and that this relationship is often bidirectional. A medical history and evaluation can provide important information for behavioral health providers. For instance, several diseases such as diabetes, thyroid disease, delirium, Parkinson’s disease, Huntington’s disease, multiple sclerosis, asthma, arthritis, chronic pain, irritable bowel syndrome, cardiovascular and cerebrovascular disease, obesity, HIV/AIDS, hepatitis, lupus, fibromyalgia, and other diseases are either comorbid with behavioral health issues or have symptoms that mimic behavioral health symptoms such as depressed or labile mood, anxiety, hallucinations, attention problems, cognitive disorganization and deficits, and difficulty concentrating (APA 2013; Scott et al. 2016). While medical conditions can produce symptoms that mimic behavioral health disorders, it is also possible that behavioral health and medical conditions exist as separate comorbidities. As a result, it is paramount for behavioral health providers to know the degree to which behavioral health symptoms are a part of a medical condition and how medical and behavioral health symptoms impact each other. Other important medical information that behavioral health providers need to know are what medication the client is taking or has taken in the past, whether they have had any recent surgeries or procedures conducted in the past, and whether they are pregnant or nursing. Medical information can be collected as part of the routine physical examination, from medical records, or via an intake form or other self-report format.

Family History
Behavioral health issues often run in families, and conducting a careful review of family history for various behavioral health conditions can provide important information about the client system. Tools such as genograms and eco-maps can help
providers understand past and current family structure, contexts, and dynamics that can inform assessment. A genogram (McGoldrick et al. 2020) provides a generational diagram of family structures that identify relationships within the client system that are supportive, stressful, or toxic. This diagram can outline who the client can rely on in their family, who relies on them, and relationships in the family that are negative and stressful due to mental illness, substance use, or violence. A genogram can also provide important information about positive or negative patterns that exist across generations. An eco-map (Hartman 1978) is rooted in the ecological framework and positions the client in the center of an expanding web of relationships with other systems such as household, immediate and extended family, friends, schools, neighborhood, community groups, work, service organizations and systems (e.g., criminal justice systems, health, or behavioral health systems), and faith communities. The eco-map identifies the quality of the relationships between the client and these other systems such as whether they are nurturing, helpful, stressful, or toxic (1978).

**Functional Assessment**

Functional assessment refers to the level to which a client can live independently and successfully complete daily activities and routines. Functional assessments are particularly important for persons with intellectual, developmental or physical disabilities, traumatic brain injury, dementia-related or cognitive impairments, and severe forms of mental illness who may need support living independently in the community (APA 2013). Some areas of a functional assessment include:

- Ability to effectively communicate and socialize with others and develop safe, positive relationships with others
- Safety or the ability to stay safe and avoid danger
- Occupational skills and abilities
- Physical mobility and ability to get around, such as walking or using assistive devices
- Sensory abilities such as seeing and hearing or the ability to use adaptive tools such as walking stick, braille, sign language, or assistive technologies
- Ability to complete activities of daily living (e.g., eating, using the toilet, bathing, and dressing) and instrumental activities of daily living (e.g., household chores, cooking, cleaning, laundry, and grocery shopping)
- Ability to budget, pay bills, and handle money
- Transportation—ability to drive a car or use of public transportation
- Literacy ability

Several scales can be used to assess functioning. A common scale that is part of the DSM-5 is the World Health Organization’s Disability Assessment Scale (WHODAS 2.0) (APA 2013). The WHODAS 2.0 is a brief but comprehensive assessment scale that measures several functional domains including cognition, mobility, self-care, getting along with others, life activities, and community participation (Ustun et al. 2010).
Behavioral Health Symptoms

A behavioral health assessment includes an evaluation of a range of internalizing (e.g., depression and anxiety), externalizing (e.g., substance use, aggression, ADHD, mania, and disruptive disorders), and psychotic (e.g., hallucinations, delusions, and disorganized thinking) mental health symptoms that can assist in identification of behavioral health disorders and guide treatment planning and intervention selection. I will review specific information on diagnostic symptoms for depression, anxiety, PTSD, and substance use disorders in separate chapters in this book. Here, I will review some common behavioral health symptom areas that indicate the presence of a behavioral health disorder and how to assess for them. Table 4.1 outlines the most common behavioral health symptom domains and their relationship to behavioral health disorders. These symptom areas form the basis of the mental health status exam (MSE) discussed next.

The provider is best served by utilizing the screening information obtained in the early treatment meeting or intake process and the client’s medical history to guide their assessment. This information can then be used to inform the mental status exam (MSE), which is a psychiatric exam that explores a range of symptoms areas and domains with the client. Providers should gather information regarding past and current use of psychiatric medications, psychiatric diagnoses, and psychiatric hospitalization or treatment history. The MSE relies on self-report of historical and current information from the client as well as observation of verbal and nonverbal behavior of the client by the service provider. Information from collateral contacts such as family or caregivers can also inform the MSE. Service providers should consider all observation within the context of their client giving consideration to culture, race, age, gender identity, ability, sexual orientation, religious preferences, and socioeconomic factors that may influence what the service provider is observing in their clients. The mental status exam can help service providers determine if mood, anxiety, psychotic, substance use, or other disorders such as delirium are present (Snyderman and Rovner 2009; Vergare et al. 2006). The following sections outline the specific components of the mental status exam that are displayed in Table 4.1.

Appearance  The provider can initiate the MSE by observing the client’s appearance upon arrival to the visit. Appearance can include grooming, dress, personal hygiene, and general demeanor such as eye contact, distinguishing features such as scars and tattoos, and attention to detail. A person with a disheveled or unkempt appearance, dirty clothing, poor hygiene, or inappropriate dress may indicate poverty, stress, or illness such as depression, addiction, or psychosis.

General Behavior  General behavior includes the person’s level of openness, politeness, calmness, and cooperation. Persons who are excessively guarded, nervous, suspicious, withdrawn, irritable, or resistant could be experiencing a range of issues such as depression, anxiety, substance use, psychosis, or mania. Persons experiencing intimate partner violence or abuse may also exhibit guarded or nervous behavior, especially if the abuser is present or nearby. The person may also be
| Symptom area   | Depression                              | Anxiety                        | Mania                                       | Psychosis                          | Delirium or intoxication |
|---------------|----------------------------------------|--------------------------------|---------------------------------------------|-------------------------------------|--------------------------|
| Appearance    | Disheveled                             | Disheveled Poor grooming      | Disheveled Poor grooming Poor hygiene, Inappropriate or provocative dress | Disheveled Poor grooming Poor hygiene | Disheveled Poor grooming Poor hygiene |
| General behavior | Irritable Withdrawn                   | Fearful                        | Inappropriate Grandiose Irritable Aggressive Euphoric Interrupting Restless | Suspicious Distracted Irritable Guarded Resistant Withdrawn Fearful Aggressive | Disoriented Somnolent Hyperalert Disorganized Fluctuating alterations in consciousness Poor attention |
| Speech        | Slow Low Soft Sad Monotone             | Staccato                       | Fast Loud Aggressive Angry Irritable Euphoric | Angry Paranoid Incoherent Disorganized Illogical Monotone Mutism | Slurred Incoherent Disorganized Shifting/labile tone |
| Motor         | Bradykinesia                           | Agitated Restless Hand wringing Pacing Fidgety | Akathisia Inability to sit still Psychomotor agitation or restlessness Hyperactive | Parkinsonism (Rx) Akathisia (Rx) Catatonia Bradykinesia (Rx) Negativism Psychomotor agitation | Psychomotor agitation Bradykinesia Negativism Somnolence Lack of coordination |
| Affect        | Sad Irritable Dysphoric Tearful Dysregulated | Fearful Irritable Nervous On edge | Euphoric Irritable Energized Dysregulation | Nervous/on edge irritable Fearful Dysregulated | Fluctuating between calm, euthymic, and irritated or dysphoric |
| Cognitions    | Poor concentration Poor memory         | Poor concentration Distracted | Distracted, Overly alert | Distracted Disorganized Poor memory Impulsive Lack of focus Impaired executive functioning Poor planning | Fluctuating consciousness ranging from alert to clouded, lethargic to somnolent and comatose |

(continued)
having a bad day or may not like being asked personal questions. It is normative for clients to be a guarded or nervous in psychiatric interviews. Be sure to position the client’s behavior within the context of the situation and other signs and symptoms.

**Speech**  A client’s speech can indicate a range of problems. Important factors to pay attention to speech include how much the person is talking (quantity), how fast they are talking (rate), how loud they are talking (volume), the tone of speech (e.g., angry or euphoric), and coherence of speech. For instance, persons speaking rapidly, loudly, and exhibiting grandiose flight of ideas may be experiencing a manic episode, ADHD, anxiety, or stimulant intoxication. Persons speaking very slowly, softly, and with an irritable or sad tone may be depressed. People speaking in ways that are illogical or incoherent may be experiencing disorganized thinking, which is commonly seen in clients experiencing delirium, psychosis, substance use, or cerebrovascular accident. Speech that is monotone or with a blunted effect may indicate psychosis or the side effects of psychiatric medication. Slurred speech

| Symptom area       | Depression | Anxiety | Mania | Psychosis | Delirium or intoxication |
|--------------------|------------|---------|-------|-----------|--------------------------|
| Thought Content    | Suicidal   | Obsessive| Grandiose| Paranoid or bizarre delusions| Fluctuating |
|                    | Self-blame | Fearful | Delusions | delusions | Disorganized |
|                    | Guilt      | Avoidant| Flight of ideas | Flight of ideas | Labile |
|                    | Worthlessness | Preoccupied with feared stimuli | Racing thoughts | Incoherent | Incoherent |
|                    |            | Overestimate risks | Incoherent Disorganized | Illogical Incoherent | |
| Hallucinations     | Auditory or visual hallucinations may be present during active mood syndrome | Not usually present | Auditory or visual hallucinations may be present during active mood syndrome | Evidence of internal stimuli in the form of auditory (e.g., voices) or visual hallucinations | |
| Insight Judgment   | Insight and judgment can be impaired Impulsiveness a risk factor for suicide | Insight usually intact | Poor insight and judgment High impulsivity. High degree of risk behaviors and dangerousness when mania is present | Poor insight and judgment High impulsivity High degree of risk behaviors especially when using substances High victimization risk | Poor insight and judgment High impulsivity High degree of risk behaviors especially when using substances High risk for victimization |

Based on Snyderman and Rovner (2009) and Vergare et al. (2006)
could indicate the effects of overmedication, cerebrovascular accident stroke and transient ischemic attack (TIA’s), or substance use, or it could also indicate a number of health disorders such as Bell’s palsy, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), or poorly fitting dentures or thought disorders.

**Motor Movements** This includes body movements, posture, and facial expressions. Some nervousness would be expected in an interview—but generally a person is expected to appear calm, relaxed, and animated. Signs of ill health would include overt restlessness (akathisia) or psychomotor agitation (e.g., the inability to sit still and excessive motor activity). These could indicate anxiety, ADHD, mania, psychosis, or addiction/withdrawal. These could also be side effects of neuroleptic/antipsychotic medication, which can also include tics, tremors, and involuntary fine motor movements (e.g., Tardive Dyskinesia or parkinsonism). Psychomotor retardation (bradykinesia), such as slowness of movement and physical/emotional reactions, can indicate depression, side effects of psychiatric medication (overmedication), or the negative symptoms of schizophrenia.

**Affect/Mood** It is important to screen for the presence of mood and anxiety disorders in patients, and this is usually done through patient self-report (Vergare et al. 2006). Ask people directly, “How would you describe your mood?”, “Have you felt depressed, blue, sad, or discouraged lately?”, “Have you felt angry or irritable lately?”, “Have you felt euphoric, energized, and like you’re out of control lately? (e.g., mania),” or “Have you felt nervous or on edge lately?” Any of these symptoms might indicate the presence of mood, anxiety, or a bipolar spectrum condition.

**Thought Process and Content** Thought processes include how clients express themselves in the visit, organize and communicate their ideas, and answer questions. Are statements logical and goal directed? Is the person able to answer questions appropriately? Do their answers make sense? For instance, clients who exhibit a flight of ideas or who express thoughts that are disorganized, incoherent, disconnected, obsessional, or delusional could indicate a number of conditions such as anxiety, depression, schizophrenia, substance use, or obsessive compulsive disorder. This can also be assessed via self-report or standardized instruments. Some questions to ask include: (1) Do you have intrusive thoughts or images that you can’t control or shake that cause you anxiety? (2) Do you have an excessive fear of something? (3) Do you find yourself worrying about a lot of different things? (4) Do you think people are out to get you? (5) Do you think you have any special powers that other people don’t have? (6) Do you feel guilty about things that happened a long time ago? (7) Do you think you’re a bad person? The DSM-5 has a number of dimensional scales that can thoroughly assess for the above symptoms and point the provider in the direction of a potential diagnosis (APA 2013).

**Suicidal/Homicidal Ideation** Screening for suicidality and homicidality is important and should be a part of any intake and assessment process in integrated behavioral health settings. A detailed suicide assessment procedure is reviewed in Chap.
Basic questions to screen for suicidality include: Have you ever thought about hurting or killing yourself? If so, how often do you have these thoughts? How would you do it? Have you ever tried to kill yourself? Do you ever feel that life is not worth living? Questions to ask about homicidality include: Have you ever thought about killing or hurting other people to get even with them? If so, when was the last time you had those thoughts?

While there is little evidence supporting specific suicide screening instruments, a brief four-item screening instrument for suicide that can be used in a variety of settings is the Ask Suicide-Screening Questions questionnaire (ASQ) (Horowitz et al. 2012). In a 2012 study, a “yes” response to one or more of the four questions identified 97% of youth at risk for suicide (Horowitz et al. 2012). The screening questions include: In the past few weeks have you: (1) Wished you were dead? (2) Felt that you or your family would be better off dead? (3) Been having thoughts about killing yourself? (4) Have ever tried to kill yourself? (If yes, how?). A “yes” to any of the four questions requires the interviewer to ask a fifth question: Are you having thoughts of killing yourself right now? (If yes, please describe)

A positive screen for suicide is if the client answers “yes” to any of the first four questions. If they answer “yes” to the fifth question, the client is in imminent risk for suicide, requiring an emergency evaluation or risk assessment. Appropriate medical personnel or first responders should be notified. The client should not be left alone for any period of time. The client should not be out of sight of a professional and should be in a secure and safe environment until the full evaluation is complete. When a client answers “yes” to any of the first four questions, and “no” to question five, this is considered a nonacute positive screen requiring a suicide safety assessment to determine if a full mental health evaluation is needed. The client should not leave until evaluated for safety and a safety plan (see Chap. 8) is developed. Proper personnel responsible for client care should be alerted.

**Hallucinations** Hallucinations are perceptual experiences, sometimes referred to as internal stimuli, that occur in the mind of the client and are not perceptible to others. Common examples include hearing voices or other sounds that others do not hear, or seeing objects, images, distortions, or people that others do not see. In other words, people hear and see things that others do not. Hallucinations are common symptoms in persons with schizophrenia, bipolar spectrum disorders, major depression, delirium, dementia, intoxication, or withdrawal. In fact, most of us will experience a hallucination at some point in our lives. Exploratory questions to ask include: Do you see or hear things that upset you that others cannot? The provider should observe if the client is responding to any internal stimuli or auditory or visual hallucinations such as tracking eye movements, facial expression, body language, attention, or verbal responses.

**Consciousness and Cognition** Consciousness can be considered alert, clouded, somnolent, lethargic, and comatose. Cognition can include attention, concentration, and memory. Any disturbance or fluctuation of consciousness may indicate a delirium, which is a medical condition that must be immediately addressed (APA 2013).
Delirium is often misdiagnosed in older adults as dementia or cognitive impairment. This can be a lethal mistake. Delirium is often the result of a significant medical condition or event such as an infection (e.g., urinary tract infection and staph infection), stroke, drug overdose, intoxication, head trauma, nutritional deficit, or dehydration. Delirium is a confusional state that can share some symptoms and etiologies with dementia and depression. Delirium has several primary and secondary diagnostic features impacting a person’s attention, memory, arousal, and awareness. Symptoms can be hyper- and hypoactive in nature. The primary diagnostic features for delirium are: (1) an acute disturbance in cognition (e.g., memory, language, orientation, and perception), awareness, and the ability to focus, sustain, and shift attention; (2) clinically significant symptoms develop rapidly (e.g., within hours), fluctuate over the course of a day, and result in a marked difference in baseline functioning; (3) disturbance is not part of a pre-existing neurocognitive condition and there is evidence (e.g., lab tests, examination, and medical history) symptoms are caused by a medical condition or substance (withdrawal, side effect, and intoxication); (4) fluctuating changes in psychomotor activity, mood and behavior that can include restlessness, agitation, euphoria, nervousness, aggressive behavior, paranoia, social withdrawal, confusion, disorganized speech, slurred words and incoherence, subdued motor activity, and limited arousal and attention (APA 2013).

These symptoms can often be misdiagnosed as fatigue, dementia, stroke, and psychiatric disorders including bipolar and schizophrenia spectrum disorders, and depressed or anxious mood. A particular challenge is the fact that hyper- and hypsymptoms can fluctuate and cycle widely over the course of a delirium. This fluctuation and rapid onset are key indicators that a delirium may be present (Mandebvu and Kalman 2015; Kalish et al. 2014; APA 2013). Assessing for delirium can include using the Confusion Assessment Method (CAM), a brief screening instrument for delirium that assesses for the main diagnostic symptoms of depression including rapid onset, fluctuating course, and confusion and attention issues (Inouye et al. 1990; Wei et al. 2008).

Assessing for attention and concentration can also be done by asking a person to spell the word “W.O.R.L.D.” backward and forward. You can ask them to do so with their name if they have trouble reading or spelling. You can also ask people to subtract serial 7’s from a hundred (e.g. 100, 93, 86, 79…). Questions measuring cognition in an MSE must take into account a person’s education and cultural background. Memory can also be assessed using a number of instruments including the Mini-Mental State Exam (MMSE) (Folstein et al. 1975) or the Mini-Cognitive Assessment Instrument (MINI-COG), which asks people to repeat and remember three words (e.g., dog, car, and tree). They are then asked to draw the hands on a clock that specifies a particular time (e.g., 3:35). Once this is complete, they are asked to recall and recite the three words they were given. The Mini-Cog is brief, sensitive, and easy to administer regardless of education level to detect cognitive impairment (Borson et al. 2003).

**Insight and Judgment** Insight is a person’s awareness of illness, how it impacts their life and those around them, and their need for treatment. Persons with
schizophrenia, bipolar disorder, and dementia may often lack insight into their illness and this (in schizophrenia) predicts poor treatment response (Lysaker and Buck 2007). Judgment is the level to which a client can appreciate and recognize the consequences of their actions. Persons with bipolar and schizophrenia spectrum disorders, dementia, and some personality disorders can sometimes struggle to exhibit sound judgment due to their symptoms. A common question used to assess judgment is: What would you do if you found a stamped envelope on the sidewalk? Persons who struggle to answer the question directly (e.g., put it in the nearest mailbox) may be having trouble with judgment that could indicate several disorders such as delirium, bipolar spectrum disorder, schizophrenia spectrum disorder, or dementia, among others.

### 4.6 Social Environmental Domains of Assessment

Racial health disparities are the result of health inequities in many social determinants of health (SDOH) related to income, health insurance access, access to transportation, childcare, food and other basic resources, adequate and stable housing, interpersonal safety, and environmental conditions among others (WHO 2010; Nuruzzaman et al. 2015; CSDH, 2008; Phelan et al. 2010). These differences in SDOH result from the creation and maintenance of racist policies and systems designed to benefit white populations at the expense of BIPOC communities. Health disparities can only be resolved through the dismantling of these racist systems and policies and the creation of new policies that seek to provide equitable access to the resources important to health (Kendi 2019). Health and behavioral health providers can play an important role in this work at multiple levels. The first step in addressing the social determinants of health is to routinely assess the social needs of all patients and provide them, either directly or through coordinated referrals, with the resources needed to resolve unmet needs. Recent research in the field of family medicine suggests that many providers, particularly early career providers and those serving high need communities, are engaged in addressing SDOH at least in some form (NASEM, 2019; Nuruzzaman et al. 2015; Kovach et al. 2019). While addressing SDOH in clients is gaining ground and has shown to lead to care that is more holistic, effective, and efficient, barriers to effective implementation in clinical practice exist. These barriers include: (1) lack of provider training; (2) insufficient time in the clinical encounter; (3) lack of staffing and organizational capacity; (4) lack of community programming to address social needs outside of the clinic; and (5) lack of financial incentives and billing codes (Andermann 2018; Kovach et al. 2019). The need to change billing restrictions, provide training, enhance electronic health record prompts, and the routine deployment of community health workers and peer staff are just some areas that could enhance utilization of SDOH assessment and intervention (NASEM, 2019; Kovach et al. 2019). Figure 4.3 identifies the broad domains of the most common social determinants of health relevant for behavioral health assessment.
Several screening forms currently exist to guide efficient and effective SDOH assessment. For instance, the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE Protocol) developed by the National Association of Community Health Centers (2016) asks a range of questions that address SDOH (NACHC 2019). The first section assesses demographic and language preferences for the patient. The form then assesses: (1) how many family members live in the home; (2) housing status; (3) money and resources including education level and employment situation, insurance status, and access to health care; (4) ability to pay for basic resources including utilities, food, childcare, and medicine; (5) access to transportation; (6) social and emotional health including social networks; (7) perceived stress; and (8) optional questions regarding refugee status, incarceration history, and safety/IPV. The protocol is a total of 21 questions and can be completed in a matter of minutes (NACHC 2019).

Another screening tool is the Center for Medicare and Medicaid Services and Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities Health-Related Social Needs Screening Tool (Billioux et al. 2017). The tool screens for social needs that impact health such as homelessness, hunger, and interpersonal violence. This 26-item self-report tool is designed for healthcare providers to screen for the presence of health-related social needs in several areas. The five main areas of the screening form are: (1) housing instability; (2) need for utilities assistance; (3) access to food; (4) exposure to violence; and (5) transportation access. Several other questions were added to screen for mental health and substance use, financial stress, employment and education status, presence of family/community support, and disabilities. The tool is currently being tested at several Accountable Health Community (AHC) sites across the United States (Billioux et al. 2017). If it is not possible to implement the above tools into your practice setting, the following areas are relevant for social determinants of health and all or most should comprise a component of assessment.

**Family and Community Support**
Assess the quality of support the client has in their household and community. What important and positive relationships does the person currently have and what relationships were important in the past? What is the quality of their social support? Who is important to them and why? How do they get along with their neighbors? How would they rate the quality of their interpersonal relationships? Do they ever feel lonely or isolated?

**Housing and Daily Living**
In this section, the provider assesses the quality of the client’s home life. What is the client’s current housing situation? What do they enjoy about their home (what makes it “home”)? What living skills do they have and what would be their ideal living situation? Also, what are the problems they encounter in their living situation (e.g., safety, homelessness, and lack of access to resources)? Is the housing safe and stable? Are there any health concerns such as mold, pests, fire hazards, lead paint, inadequate heating/cooling, plumbing, or appliances for cooking? Does the client feel safe in their community?
Transportation
Access to safe, reliable, and affordable transportation is an important element in health and well-being. Having access to adequate transportation can enable the client to get to work or school, go shopping, and attend medical appointments. Assess clients’ level of access to transportation to get them where they need to go. Do they have their own vehicle? Are they in a walkable or bikeable neighborhood? Are they on the train or bus line? How does the person get around? Do they lack access to affordable and accessible transportation that limits their ability to go to work or school, attend medical appointments, or complete daily living activities such as shopping?

Employment and Education
Stable employment and income are vital to health. Assess the employment status and education level of your client. What is the client’s current work situation? What have they done in the past and what would they like to do now and in the future? How stable is their current employment? Are they looking for work or need help finding work? How satisfied are they with their job? How much stress does their job give them? What vocational skills does the person have? What do they aspire to do? What skills does the person have and what would they like to learn in the future?

Food Insecurity
Having regular access to healthy food is an important contributor to health. Does the person have access to healthy, affordable food? Has the person ever run out of food or not had money to buy food in the last 12 months? Does the person have easy

Fig. 4.3 Social determinants of health
Financial Resources and Basic Needs
Assess clients’ ability to pay their bills and their level of financial strain. What are their sources of income and how well does their income meet their needs? What goals do they have regarding income and finances (e.g., savings, vacation, saving for home)? Has the person had or come close to having their utilities turned off or do they have trouble paying for utilities such as gas, heat, hot water, water, and electric? Do they have medical insurance and are they able to pay medical bills? How much money do they have leftover at the end of the month after paying monthly bills? How much do they worry about making ends meet?

Activity/Leisure/Recreation
What do they do for fun? How would they characterize their physical activity level? For instance, on average how many days a week do they exercise and how long is each activity? What are their hobbies and pursuits? What have they enjoyed in the past that they currently do not utilize? Do they have access to parks and other recreational activities? What low-cost recreational activities does the client have access to such as museums, science center, zoo, etc.?

Spirituality/Culture
Providers often feel uncomfortable assessing spirituality due to not being clear on the goal or the definition of spirituality (Starnino et al. 2014). Assessing spirituality means assessing anything that provides meaning, joy, and purpose to the person and helps them strive to be the best version of themselves that they can be. From this perspective, spirituality can go beyond religious descriptions and include hobbies, artistic endeavors, activities, activism, and other things that help people be whole and help the person feel a part of something bigger than themselves. These aspects of spirituality can then be used to help enhance people’s recovery and well-being (Starnino et al. 2014). What gives a person a sense of accomplishment, meaning, and purpose? What activities initiate a sense of flow or engagement (see Chap. 3) or a sense of wholeness and well-being (Starnino et al. 2014)? These aspects can also be identity-forming activities such as cultural or religious traditions, rituals, foods, celebrations, beliefs, and values.

4.7 Common Components of the Behavioral Health Assessment

Assessment documentation formats vary across behavioral health settings. The following sections identify the most common and important areas that can comprise a behavioral health assessment. The information in these sections will be used to inform the case conceptualization and treatment planning process discussed in Chap. 5.
Demographic Information
Demographic information about the client includes age, sex, race, ethnic and/or cultural group, preferred gender identification (e.g., cis-gendered woman/man, trans woman/trans man, gender variant, intersex, two spirit) and preferred pronouns, sexual orientation, marital status, number of children, and roles within the household (parent, spouse, and adult caregiver). This section can also include relevant roles such as: are they a veteran or in the military, student, parent, adult caregiver, or retired?

Referral Information
How did the client come to the agency? Who or what agency referred the client to you? Is the client mandated or voluntary? Identify any other status information (e.g., inpatient and partial hospitalization) or where else the client receives services.

Presenting Problems
This section provides a description of the problem that brought the client to the agency and any relevant problems impacting treatment and behavioral health status of the client such as substance use, trauma, lack of support, life stressors, or grief. This can include other persons in the client’s family or household that are impacted by, or are impacting, the problem. If the presenting problem is recurrent, describe how the client has experienced it and dealt with it in the past. Identify related difficulties that stem from the presenting problems and any personal, interpersonal, or environmental issues are exacerbating the presenting problem.

Client Strengths
This section includes strengths at the personal, interpersonal, and environmental level. It is important that client strengths be mentioned up front rather than anecdotally at the end of the assessment. The assessment is a narration of a client’s life. It should leave the reader with an impression that, while the client has problems, they are balanced by several strengths and positive qualities. This section should outline personal strengths that include the following: (1) talents and abilities across a range of areas such as home, work, school, hobbies, recreation/sports, and other areas; (2) special abilities, attributes, and characteristics such as loving-kindness, friendship/camaraderie, courage, integrity, openness, conscientiousness, charisma, listening, gratitude, humor, grit/perseverance, and the ability to abide and survive disappointment; and (3) interests, aspirations, hopes, and dreams that drive and motivate the person to achieve. The strengths section should also identify supportive relationships and social networks in the client’s life that they can lean on such as family, friends, faith, community, and work community, and any environmental strengths that exist such as stable housing, health insurance, or adequate income.

Current Living and Social Situation (SDOH)
This section includes information about the client’s household and family situation including the number of people in the household, location, housing status (e.g., independent, residential, institutional, shelter, and homeless), and quality of housing (e.g., safe, affordable, in good repair, quality of plumbing, heat appliances,
clean, number of bedrooms, and any problems with pests). It also includes information about the level of safety and environmental barriers such as lack of access to healthy food, transportation, recreation, or support, or the presence of environmental risks such as lead, pollution, crime, and violence. Financial resources are also discussed in this section and should include information on financial resources, basic needs, current occupational and income status, and benefits. Education and employment history can also be included in this section as well as the client’s work skills, vocational training areas, or employment/education aspirations not included elsewhere.

Medical Problems
Provide a summary of the current health status of the client and any relevant health history such as current and past medical issues and ongoing or chronic medical needs, medication history and current medications and preferences, allergies, and any risk behaviors regarding alcohol use, diet/weight, smoking, drug use, sexual activity, and physical activity levels.

Behavioral Health Problems
Provide a summary of the current and historical behavioral health information. This includes psychiatric diagnosis and treatment history, current diagnoses and treatment, results of the most recent mental status exam, screening instruments, and assessments. This information also includes substance use history and current use patterns for alcohol, prescription and other drugs, caffeine, and nicotine.

Interpersonal Relationships
Summarize the quality of the most important interpersonal relationships in the client’s life including intimate partners, family, and friends. It highlights important positive social supports and relationships as well as relationships that cause stress.

Safety and Trauma
For trauma, identify any history of interpersonal trauma (e.g., IPV, sexual abuse, and community violence) as a victim or perpetrator and report any childhood adverse events. Also note whether there is any family history of past or current psychiatric symptoms or diagnoses, addictions, suicide, or criminal behavior. For safety, identify any past or current threats to safety such as intimate partner violence, community violence, abuse and neglect, and the presence of any unsecure firearms in the home.

Functional Impairments
Summarize the level of functioning in the areas of psychological, behavioral, and living skills. Note any areas of impairment in daily or behavioral functioning such as developmental delay, intellectual functioning, problem solving, head trauma, or impairment in physical, language, or sensory functioning. Identify any problems in cognitive processes such as any cognitive deficits or impairments (e.g., traumatic brain injury (TBI), memory, mental, or language processing) and negative thinking patterns that may be related to negative automatic thoughts, cognitive distortions, or
maladaptive schemas that can lead to negative emotions (e.g., depression, anger, and anxiety).

Legal Status
Note any history of or current legal difficulties (e.g., criminal charges, civil issues, and divorce/bankruptcy), incarceration, and criminal justice involvement including any criminal justice involvement of close family and friends.

4.8 Summary and Conclusion

Assessment is a process of gathering information from the client in order to inform the case conceptualization and treatment planning process. The assessment frames how problems and goals are conceptualized and delineates the range of strategies and interventions that will be selected to address identified problems and achieve goals. The assessment is the foundation of your work with the client. The process of assessment, since it is initiated at the beginning of the treatment relationship, also sets the stage for the development of a trusting therapeutic alliance. The success of any particular treatment relationship is often determined during the assessment process. Assessment consists of engaging the client and introducing them to the therapeutic process while assessing for personal, social, and environmental strengths and capacities. It also involves screening for common health and behavioral health symptoms and the quality of several social, functional, and environmental domains. This information is combined with a careful analysis of family, medical, mental health, and substance use history. Providers then use this information to more fully assess for the presence of any symptoms that suggest the presence of a behavioral health disorder. This information is then organized and documented so as to inform the case conceptualization and treatment planning processes.

Case Study 4.1: Mr. Clarence Smith
Mr. Clarence Smith1 is a 62-year-old cis-gendered Black man attending his primary care appointment with one of his daughters visiting him from out of town. She has been concerned for his physical and behavioral health for the last year. Clarence is kind, generous, hardworking, and enjoys cooking, working on old cars, fixing things around the house, and wood working. He likes to help friends and neighbors with home projects (he can do carpentry, plumbing, landscaping, and electrical) and enjoys talking about politics and world events with a close group of friends. Clarence lost his wife, Angela, of 40 years to a sudden and massive stroke approximately two years ago. They were in the kitchen making dinner one evening when Angela suddenly fell to the floor and was nonresponsive. Clarence called 911 and tried to resuscitate Angela, but the EMT said that she died almost instantly. Angela had just

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1 All names and other identifiers of this case have been changed to protect privacy and confidentiality.
retired from a large telecommunications company after 25 years of service. Clarence retired from the Postal Service two years earlier. Both had great retirement pensions and they had plans to travel, visit grandchildren, and work on the house.

Clarence didn’t show much emotion at Angela’s funeral. He has always been a stoic man. Clarence initially found comfort in his faith life and the close friends he spoke to each morning at a local coffee shop and played cards with once or twice a month. He and Angela have three grown children and four grandchildren. All live out of State, but kept in touch and visited relatively often. While he put on a strong public exterior after Angela’s death, Clarence was devastated and continues to struggle with his grief. He blames himself for not being able to save Angela. He states, “It’s my fault. I should have encouraged her to relax more. I should have done more to help her around the house. She should have retired when I did. I should have made her go to the doctor when she complained of those migraines. I should have done something! I was right there. I was an EMT in the army! I couldn’t save her. My own wife and I couldn’t save her.”

He was also ashamed of himself for missing his wife so desperately even though it was two years after her death. He could not stop thinking about her and he could not shake his despair over Angela. He admits that he speaks to her often, apologizing for not being there enough and for past arguments. He reports having trouble sleeping at night because he thinks of Angela. He reports losing interest in cooking and taking care of the house, although he still accomplishes these tasks as if on autopilot. He reports feeling empty and alone. He started to avoid his friends because he did not want to talk about Angela and felt awkward. He is now isolated from family, friends, and his faith community due to restrictions from COVID-19. He states, “I stopped playing cards and going to church regularly for the past year, but I always went to breakfast with my friends and I looked forward to seeing my grandkids. Now that’s gone too with this damn disease. I know if I get it, it might kill me. Sometimes I wonder if that wouldn’t be such a bad thing. But I love my kids and grandkids. I wish I could see them more.”

Clarence has a history of hypertension and Type 2 diabetes. He takes medication as prescribed for both conditions. Recently, Clarence has developed vision problems and an increase in painful neuropathy related to his diabetes. As a result, he has trouble walking long distances and he drives less. His house is a couple of miles away from the center of town. It is too far for him to walk. His children pay to have groceries delivered to his house once a week and have a neighbor call him and check on him each day. Clarence does not like relying on people for help and is reluctant to burden his friends or people at his church. This and the COVID-19 pandemic have resulted in Clarence spending most days staying home and watching TV. He feels tired all the time and has trouble concentrating and sleeping at night. He is often flooded with images of his wife collapsing and the confused and startled look on her face before she became unconscious, and the lifeless look on her face while he tried to revive her. He tries to avoid the kitchen as much as he can despite being an accomplished cook. As a result, the quality of his diet is declining. He reports frequent nightmares of the event and similar dreams where he is helpless to save the
people he loves. Although never a person who drank much, he has begun to have two or three beers at night to help him fall asleep.

Overall, Clarence feels useless and stuck. When asked what he would like to be different about his life he pauses a long time and then states, “I’m not going to waste your time saying I want Angela back. She isn’t coming back. I know that. I miss her. Sometimes I wish I could join her, but I’m not crazy and I don’t want to die. I just wish I could miss her and remember her without thinking about how she died every damn minute of every damn day of my life. I try to forgive myself, but I can’t. We had plans. It wasn’t supposed to be this way. I guess I would like to still honor those plans in some way. I’m not interested in travelling the world, but I would like to feel useful and see my family and friends more. I miss them and I miss my friends. This conversation has made me realize how lonely I am. How closed in I feel. Unimportant. I guess I’d like that to change if it could.”

Case Analysis
Clarence is a loving husband, father, and grandfather. He has cultivated a number of friends and is loved by many in his family. He is financially secure and has a safe and stable housing situation. He has many interests and talents. He also has access to basic resources and, while needing some help, currently has a good level of functioning. Despite these strengths, Clarence has suffered a significant loss with the death of his partner as well as other related losses of friends and purpose. He experiences a range of social stressors. He also exhibits several health and behavioral health symptoms and possesses several risk factors for increased morbidity and early mortality. Most importantly Clarence is experiencing significant grief due to the sudden, unexpected loss of his beloved wife, Angela. This would also constitute a traumatic event. Due to the circumstances of her death and his reported symptoms, Clarence also suffers from at least partial-PTSD. He witnessed Angela’s death as he tried to resuscitate her. He reports intrusive thoughts (e.g., flashbacks and nightmares) and negative emotions and cognitions (e.g., self-blame, guilt, shame, numbing, and sadness), and avoidance (e.g., kitchen).

Clarence also reports depressive symptoms including low mood, loss of interest or pleasure in daily activities, persistent thoughts of guilt and worthlessness, fatigue, and sleep disturbances. He meets criteria for at least mild-to-moderate depression. Clarence also reports loneliness and social isolation from his family, friends, and faith community. While his isolation is exacerbated by the current pandemic, he also reported isolation beginning prior to the pandemic. He cannot attend gatherings with friends, go to church services, or complete daily errands due to concerns over contracting the virus. Clarence has a history of diabetes and hypertension. The symptoms from his diabetes appear to be worsening as evidenced by increased problems with vision and neuropathy. His diet is declining. Finally, Clarence reports drinking at least two or more beers nightly to help induce sleep. While this amount does not significantly exceed standardized daily drinking limits for alcohol, drinking alcohol may have negative health consequences given his age, depression, and comorbid health conditions.
Questions
What kind of help does Clarence need?
Based on the information in this case, what are three to five goals that would guide Clarence’s treatment plan?
What interventions would be relevant given Clarence’s current situation?

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