ASSESSMENT & CLINICAL UNDERSTANDING

CORE ELEMENT:
ASSESSMENT & CLINICAL UNDERSTANDING

Assessment is the process of gathering a sufficiency of information about the needs and strengths of a youth and family, evaluating the relevance of that information, and developing a comprehensive narrative of the youth and family in the context of their environment, experiences, culture, and present situation. **Clinical understanding** results in an interpretive summary and diagnostic formulation that can be understood and supported by family members, professional helpers, and natural supports. Both assessment and clinical understanding change over time as new information emerges and the family situation evolves.

CONTRIBUTION TO THE OUTCOME: A successful intervention relies on a thorough, accurate discovery of the history, strengths, and needs of the youth, their family, and the larger community. Youth and family voices in the assessment process help ensure that the prioritization of needs is driven by the family. Arriving at understanding requires knowledge of both past experience and current functioning as well as clinically astute evaluation to determine the relevance of the information gathered. Strengths that are clearly articulated and incorporated into the assessment serve as a basis for building positive change. A quality assessment draws a picture of the family situation as a whole, describes specific clinical concerns, and evolves as the practitioner's understanding deepens. Revising the assessment over time shows a willingness to learn from experience and feedback.

REMINDER: Review all Elements. See especially: Practicing Cultural Relevance, Engagement, Risk Assessment and Safety Planning, Engaging Natural Supports and Community Resources, and Collaborative Intervention Planning. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
First meetings and initial assessment		
• Fully informs family of the assessment process and purpose. • Elicits each individual family member's impression of core concerns, including risk and safety, in their own words. • Uses family member language in subsequent descriptions of needs and strengths. • Attends to pace and timing of information-gathering when families feel overwhelmed. • Within 24 hours, clinician completes a brief initial assessment with family input regarding needs and strengths, youth/family vision for their future, what helps, what gets in the way, and next steps to guide first stages of IHT intervention prior to comprehensive assessment.	• Discusses with some but not all key family members. • Uses only clinical language without family-friendly language. • Late or incomplete initial assessment. • Leaves out family concerns, strengths, or expressed vision for future. • Slanted toward provider view of what family "should" work on.	• No youth voice and no attempt to initiate contact or discussion. • Ignores family's concerns in favor of provider bias. • No initial assessment. • Relies solely on another provider's assessment. • Ignores or weeds out important concerns due to lack of expertise of IHT team.
Exploring needs, vision, history of help, and strengths		
• In gathering further information for comprehensive assessment, explores family members' perspectives on identified needs — what causes them, what keeps them going, what stressors make them worse. • Invites family members to describe times in the past when needs were less acute and what was different. • Invites discussion of why choose IHT at this time (why now?).	• Explores needs but not family perspective on context. • Discusses with only a subset of family members or discusses only as a group. • No follow-up to clarify how family thinks about needs; too superficial. • Too narrow a scope for what might cause problems or distress. • Looks at only limited range of possible stressors. • Looks only at general or external stressors but not intergenerational issues.	• Lacks curiosity about family. • Biased toward provider view of what causes problems; does not balance with family view. • Exaggerates or minimizes challenges that family is experiencing. • Assumes knowledge of stressors. • Discusses stressors without acknowledging coping strategies.
• Invites family members to envision and describe a time in the future when their family is able to manage these challenges more effectively. • Discusses this future-oriented vision as a way to	• Talks about discharge from IHT without linking to family vision. • Alters vision to make it more "realistic" or "achievable."	• No discussion of future or discharge. • Expresses pessimism, hopelessness about change. • Generates vision without family endorsement.

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know when IHT will end.	• Elicits vision from some but not all. • IHT generates vision and gets family endorsement.	
• Explores family member perceptions of what types of support have helped manage the needs in the past or at present when the needs are less acute. • Discusses with family members their history of professional help (types, sequence), what they have perceived as most effective, what their understanding of IHT is, and how they hope it may be delivered. • Inquires specifically about history with psychiatric medications and their impact.	• Asks only about therapeutic support (treatment) not informal supports. • Explores only what didn't work, not what did. • Overwhelms family with suggestions for support rather than eliciting their perceptions. • Discusses with family but unable to validate/manage family emotions (hopelessness, anger) about past experiences. • Partial or superficial discussion.	• Does not address past supports. • Dismisses supports that family found helpful but IHT does not see why. • Limits options for supports to what is known by IHT. • Does not consider past experience with systems and services. • Assumes services that are offered will be sufficient. • Dismisses family concerns or experiences. • Neglects medication history.
• Invites each family member to identify and describe skills, abilities, knowledge, interests, and other strengths of the youth, individual family members, and family as a whole.	• Superficial or incomplete exploration. • Inquires about strengths narrowly (talents, accomplishments) and misses likes, motivations, "things that give joy." • Identifies strengths and talents without considering their use in intervention.	• Focuses only on needs, not strengths. • Assumes strengths without discussion. • Asks only caregivers, not youth.
Filling in the contextual understanding with the family		
• Explores and gathers understanding of all of the following, including youth and family member perspectives and histories: - Structure and routines in the home - Limit-setting and discipline practices - Caregiver needs (mental health, life skills, basic needs) - Past history of trauma, losses, and other adverse experiences - History of substance use/abuse - Protective and risk factors in the community environment, and their impact - Full family configuration (custodial parents, marital status, foster parents) - Practical barriers (work schedule, child care, physical health) - Intangible barriers (distrust of mental health concepts, fear of violence in neighborhood, stigma)	• Asks questions at overwhelming pace for family. • Discusses with subset of family, not all. • Asks without persevering to understand. • Asks too vaguely rather than explicitly addressing possible adverse experiences; avoids difficult topics. • Fails to scale the degree of adverse experiences, or sees each as black and white with no gray areas. • Narrows the definition of community environment. • Limits possibilities for "family" to nuclear family or those who are easy to reach. • Limits idea of barriers to practical items only. • Identifies barriers without offering possible ways to mitigate or adjust intervention.	• Uses judgmental language; asks questions in "inquisition" style. • Uses only referral information or external reports. • Considers only current situation (no exploration of past). • Judges substance use without discussing. • Focuses on community risk; neglects community protective factors; neglects community impact. • Decides without consulting family which members to include or exclude. • Fails to establish who has legal custody of youth. • No consideration of absent family members. • No discussion of barriers. • Considers it "not the job" of IHT to problem-solve with family about barriers.

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Observation		
• Takes time to get to know the youth, observing and continuously assessing: interactions with others, impulse control, communication and cognitive abilities, sensory processing, social/emotional development, health and wellness, risk behaviors, and overall mental status. • Observes changes in youth's behavior and capacities with different caregivers and other adults. • Observes (over time) youth's strengths and how they use these strengths.	• Observes youth but only in context of family. • Assesses some but not all relevant aspects of development. • Interacts with youth only with caregivers present. • Misses opportunities to assess different capacities in different relationships.	• Accepts caregiver perspective without interacting with or observing youth. • Neglects to consider developmental age and capacities as relevant to intervention. • Looks only for deficits, not strengths.
Young adult concerns		
• Explores young adult ability to meet developmental expectations in essential areas of education, employment, housing, financial literacy, physical and mental health care, healthy social relationships, community connections, personal safety, substance use, and overall health and wellness.	• Explores some but not all aspects of young adult development and preparation for independence.	• Makes assumptions about readiness for independence. • Ignores developmental stages of transition to adulthood.
Filling in the contextual understanding with other stakeholders		
• Obtains (with consent) relevant information via live conversations whenever possible and written documents, as follows: - Assessments (including CANS) and other clinical information from current and recent treatment providers - Medical history of youth with documentation of any physical health concerns, current wellness status - School records (IEP, evaluations, report cards) and information about attendance, behavior, academic progress, and any known risk factors - State agency documents and information relevant to current risk, family history, needs and strengths • Identifies primary school support ("champion," mentor, person with most understanding) for	• Makes initial attempts but does not follow up. • Tries to do all contacts without sharing tasks with TT&S. • Postpones work of prioritizing and triaging family's immediate needs while gathering information. • Gathers some information but not thoroughly. • Accepts family's denial of consent without explaining purpose of obtaining records. • Obtains information from school without incorporating into broader assessment and recommendations. • Identifies strengths related to school but does not include in possible interventions. • Does not identify person(s) for future contact. • Has conversations without obtaining written records. • Considers only Department of Children and	• Does not consider importance of collateral conversations and documents. • Uses past clinical information or diagnosis without citing source. • No attempt at medical history. • Asks only about problems at school. • Does not recognize importance of school domain for youth. • Gets information without communicating with family about the information. • Obtains information without written consent. • No persistence in contacting collaterals.

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this youth. • Educates family, as needed, on importance of integrating behavioral and physical health. • Demonstrates persistence when response is slow.	Families, not other state agencies. • Obtains documents without reading or incorporating information into assessment.	
Contemplating the written comprehensive assessment		
• Clinician* regularly uses critical thinking and clinical judgment during the initial assessment and ongoing process of understanding the youth and family. • Clinician assesses the validity and relevance of information gathered and suspends conclusions until information is gathered from multiple sources, including CANS and other providers. • Clinician evaluates need for specialized assessments (e.g. fire-setting, neuro-psychological testing) or outside consultation. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*	• Uses diagnosis (and other information) that came with the youth without further exploration. • Recommends specialized evaluations without explaining and assisting with access. • Aligns with one party in assessment rather than balancing all information through strong clinical filter. • Ignores differences in CANS ratings by other providers without considering rationale. • Attempts to pack all information into assessment without prioritizing the most relevant.	• Uses initial referral information without further exploration. • Gets stuck in Us/Them stance. • Jumps to conclusions without well-rounded information.
• Within 14 days, based on what is known to date, clinician compiles information into a written comprehensive assessment, inclusive of the CANS, which communicates a well-rounded understanding of youth and family. • Addresses both needs and strengths. • Addresses risk and safety. • Assesses youth's mental status. • Includes both family and professional input. • Writes in clear, respectful language that family members and others can understand. • Acknowledges areas for further exploration.	• Uses too much clinical jargon ("psycho-babble"). • Focuses on needs without exploring strengths. • Omits family's own words in descriptions. • Writes insufficient narrative. • Focuses on youth to exclusion of whole family. • Does not discuss how diagnosis impacts family functioning. • Completes CANS (or updates) in isolation, without family input. • Neglects to incorporate new information into assessment.	• No assessment. • Writes assessment as point in time without revisions or updates. • Writes assessment in ways that sound judgmental and could not be shared with family. • No initial CANS, or no updates. • Does CANS only, and considers it to be the comprehensive assessment.
• Clinician provides a clear interpretive summary and diagnostic formulation that synthesizes available evidence, explains rationale for diagnosis, gives specific information to support rationale, and addresses differences from other diagnoses (if any).	• Does some of these steps, but not all, or does all the steps but without sufficient clarity, explanation, or depth. • Summarizes information without synthesizing and interpreting.	• Presents the assessment as "final" to family without prior review by supervisor. • Unfamiliar with changes in DSM-V.

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• Clinician makes recommendations for treatment with corresponding support for proposed level of care. • Clinician reviews assessment with supervisor for consultation with TT&S as needed.	• Assumes TT&S is knowledgeable about diagnosis.	
• Clinician engages in two-way conversation about the assessment with family in family-friendly language, shares both strengths and needs, discusses any areas of disagreement, revises as needed, and ensures consensus with family members about completed assessment. • Clinician discusses specific diagnosis with family, explains basis for diagnosis, and offers further information as needed. • Clinician documents discussion; obtains signatures.	• Focuses on needs or strengths with family, but not both. • Shares assessment but does not share recommendations. • Shares assessment but without inviting family input or possibility of revisions. • Presents diagnosis as definitive.	• Does not share assessment with family. • Discourages family input into "expert" document. • Uses language that family does not understand. • No discussion of diagnosis with family.
Ongoing evolution of assessment		
• Clinician reviews and updates the assessment (including CANS) at least every 90 days. • Discusses at each meeting with family members any changes which may affect understanding. • Clinician continues to incorporate new information, amending assessment as needed. • Clinician considers diagnostic accuracy in light of new information. • Clinician reviews all changes to the assessment with family, explains reasoning, and discusses any impact that changes may have on diagnosis, treatment options, or expected end of treatment.	• Updates sections that were previously addressed, but does not explore areas where information was incomplete. • Updates rating changes on CANS without narrative explanation. • Reassesses diagnosis without family input. • Updates family but does not elicit input from family members. • Rushes through discussions without fully exploring. • Discusses intermittently or with only some of the key family members.	• Neglects updates or fails to share changes with family. • Excludes family members who speak another language. • No updates.