**Diagnostic Evaluation for Children and Adolescents**

**Date of this Assessment**

3/19/2019

**Client Age at Time of the Assessment**

15

**Persons and Resources Utilized in the Assessment**

Social Worker and Client Report

**Presenting Problem**

Client is paranoid and delusional with episodes of auditory, tactile and visual hallucinations. He is unable to be maintained safely in a home and family setting.

**Onset of Symptoms**

Age 11

**Family and Support Network**

Client’s parents are deceased. His aunt and uncle were his legal guardians but are not actively involved in the client’s life since he went into treatment. Client identifies the staff and administrators at Hogwarts as his support system.

**Previous Attempts to Solve Problems**

The client has used the following to resolve the presenting problem(s):

* Individual therapy

**Readiness for Change**

The following have expressed an interest in making changes to solve the presenting problem:

* Client does not express a need to make changes.
* guardian or caregiver do not express a need to make changes
* No one in the system has reported a readiness to make changes.

**Risk Assessment**

The client shows the following evidence of risk of harm to self or others:

* thoughts of harm to others  \_with no plan
* psychotic or delusional
* coping with significant loss (job, relationship)

**Safety Plan**

Client agreed to tell Hogwarts administrator of unusual thoughts or experiences.

**Screenings:**  All children and adolescents require a screening for ADHD, Depression, and Substance Abuse.

The screening showed symptoms of the following disorders:

* some evidence of depressed mood

**Trauma Experience**

The client reports a history of the following traumatic experience:

* physical abuse
* physical neglect
* emotional abuse
* witnessed abuse
* community violence
* client's own aggressive behavior
* murder of family of friend
* adopted
* change in primary care giver
* death of a loved one
* multiple moves

**Health Risks**

* head injury

**Medications**

* No history of medication therapy for behavioral health needs
* There are no known allergies to Medications

**Biorhythms**

Sleep Habits are:

* within normal range

Diet is:

* \_\_\_\_\_\_unknown\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity level

* enjoys physical activities
* engages in age appropriate activities at home and in the community

**Addictive Behaviors**

Nicotine Use

* no known history of use

Alcohol Use

* recently – butter beer

Recreational Substance Use

* recently

**Sexuality**

Gender identity:

* \_ male

 Sexual orientation:

* undetermined

Puberty:

* \_ normal range onset

Sexual activity:

* inactive

Access to birth control

* no

**Education**

Grade Level:

* at age appropriate grade level

Grade performance

* above norm

Impact of behavior on education

* alternation placement

**Language and Communication**

* vision needs- wears glasses

**Vocational and Employment**

* self-care skills are appropriate for age level

**Legal**

* DCBS Custody

**Financial**

* client would benefit from resource assistance.
* client would benefit from housing assistance

**Social Relationships**

* client shows the ability to develop pro-social relationships      X\_with peers    X with adults

**Culture and Ethnicity**

* The client identifies with a minority culture

Client identifies self as a Wizard. He says he is not a Muggle (majority culture)

* White

**Recreational and Leisure Skills and Strengths**

* Client expresses a loss of interest

**Spirituality and Religion**

* Client does not see spirituality or religion as a significant resource or support

**Community and Neighborhood is identified as**

* stable

**Environmental Factors for Home Based Therapy**

* Bird(s) in the home

**Diagnosis**

F25.1 Schizoaffective Disorder depressive type with symptoms of paranoia, delusions, hallucinations, and significant shifts in emotional state.

**SED Determination Criteria**

* The client must be under 18 or under 21 if services started prior to the age of 18. The client must have a significant disorder of thought, mood, perception, orientation, memory or behavior. And is impaired in two of the five areas of functioning for a period of one year or meets the exception criteria.
  + Client is under the age of 18 or started services prior to the age of 18
  + Client has a significant disorder of thought, mood, perception, orientation, memory or behavior
  + Impaired functioning in self-care
  + Impaired functioning in interpersonal relationships
  + Impaired functioning in family life
  + And symptoms have persisted for one year or are judged to be at high risk for continuing for one year
  + And/or DCBS has removed the child from the home and has been unable to maintain in a stable setting due to emotional instability
* Does the client meet the requirements for a Severe Emotional Disability (SED)?
  + yes

**Level of Care and Intensity of Service Assessment**

The Child Adolescent Service Intensity Instrument is for ages 5 to 19.  The Early Childhood Service Intensity Instrument (ECSII) should be used for children ages 0 to 5.

CASII Scores

* I Risk of Harm: score 1 to 5
* 3 moderate risk
* II Functional Status: score 1 to 5
* 2 mild risk
* III. Co-occurrence: score 1 to 5
* 3 significant co-occurence
* IV. Recovery Environment: Environmental Stress: score 1 to
* 5 severe
* IV. Recovery Environment: Support: score 1 to 5
* 3 limited
* V. Resiliency and/or Response to Services: score 1 to 5
* 3 moderate or equivocal resiliency and/or response to services
* VI. Involvement in Services: Child or Adolescent for Service Profile Score 1 to 5
* 2 adequate
* VI. Involvement in Services: Parent and/or Primary Care taker: score 1 to 5
* 4 minimal
* Pick the highest of the two VI scores to add in the composite score
* Composite Assessment Score \_\_\_\_23\_\_\_\_\_\_\_

CASII Service Level\*

\_Level 5 (23-27) Non-secure 24 hour services without  psychiatric monitoring  Residential, group home, foster care and/or a tight knit wrap around team.

**Other Assessment Tools and Scores:** CAFAS, PHQ-9, etc.

PHQ—9 score is a 5 mild

**Do clinical recommendations differ from the assessment recommended level of care?**

* no

**Summary and Treatment Plan Recommendations**

Harry’s grades are excellent. However, his social relationships with peers are conflictual and at times aggressive. He does tend to withdraw and is a target for bullying. He is often sneaky, dishonest and defiant. His thoughts processes suggest a delusional disorder. He presents as paranoid and believes that he is being conspired against. His sense of self is distorted. He believes he has special powers and that his thoughts are invaded by the thoughts of others. He believes he can talk to snakes and reports auditory and visual hallucinations. On occasion he says his body is being invaded and his should is being sucked out of him Harry has two friends at the treatment center who evidence a shared psychotic disorder. They have adopted Harry’s delusions for themselves.

There is not known history of suicidal ideation or behavior. He is consumed with seeking revenge for the death of his parents but expresses some aversion to carrying out the threats. He has been violent toward some of the animals at his school. He has run away from the facility but voluntarily returned. Harry has a positive history of drug use. He reports having tried some type of seed that distorted his experience of his body so that he thought he could breathe underwater and fly. He also reports drinking beer.

Despite his difficulties Harry manages to meet most expected levels of functioning. He recovers quickly from periods of deterioration. Generally, his hygiene is no more disturbed than most young teens. As stated previously his grades and academic achievements are excellent. He excels in sports. These is no known disruption to his sleep cycle or eating habits. He is not sexually active and there are no known health issues.

Harry has developed a positive relationship with a few of the Hogwarts staff and they create a network that is partially able to compensate for Harry’s unmet needs, he does not have access to them during the summer break and decompensates when returned to his family. Harry cooperates with treatment and is bright enough to know that there is something wrong with him. He just doesn’t always agree with the staff’s interpretation of his difficulties.

The client’s social worker is considering placing Harry in foster care for the summer break and referring for in-home therapy with wrap around care.

Treatment recommendations include Individual psychotherapy to help Harry cope with traumatic experiences that maybe fueling his need for delusional power, revenge and his many hallucinations. Wrap around services of targeted case management should focus on resources to assist in summer placement. Home and community-based psychotherapy services could help Harry and his family reconnect. Medication therapy evaluation could determine if he would benefit from an antipsychotic and or anti-depressant medication.

**Client response to the treatment recommendations**

The client and any legal guardian is encouraged to collaborate in the development of the treatment plan.

* The client \_X\_ agreed to \_\_\_ did not agree to the treatment recommendations.
* The guardian/social worker X\_ agreed to the treatment recommendations
* The aunt and uncle were not involved in the devaluation and recommendations at this time.
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_