ABILITY TO UNDERTAKE A COLLABORATIVE COMPREHENSIVE ASSESSMENT

The focus of this section is on working with patients who are presenting with an acute mental health crisis. Clinical judgment will be needed about the scope of a specific assessment but is likely that it should focus on the presenting crisis and reasons for admission. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Assessments need to be comprehensive, identifying biological, psychological, and societal factors that may be contributing to the patient's presenting strengths and difficulties – usually referred to as a 'biopsychosocial' assessment. The aim is to develop an understanding of the whole person, placing them in the context of their community.

Knowledge of assessment

An ability to draw on knowledge that a patient should be assessed by a team member promptly following admission
An ability to draw on knowledge that the assessment process aims to create a formulation that guides the care plan, and improves the quality of life of the patient and their family and carers
An ability to draw on knowledge that assessment should prioritise engaging the patient and their family and carers in a meaningful dialogue about their current presenting difficulties
An ability to draw on knowledge that talking about risk does not increase the likelihood of harmful behaviour being carried out and that it is helpful to maintain an upfront and direct approach to the assessment
An ability to draw on knowledge that by building hope and identifying specific ways forward in collaborative assessment can be a powerful intervention in its own right
An ability to draw on knowledge that because it is difficult to predict future risk behaviours, even a comprehensive risk assessment may have limited predictive value
An ability to draw on knowledge that assessment should not be limited to one source of information and that a comprehensive assessment will draw upon multiple sources of information (for example, a clinical assessment, clinical notes and reports, information from the patient's family and carers, staff, other clinical teams), but prioritise the patient's perspective

Engagement

An ability to conduct an assessment in a flexible, compassionate, and collaborative manner that aims to:	
	actively engage the patient and their family and carers in the assessment process
	help the patient identify the factors generating and maintaining crisis
	identify treatments/interventions that will help manage the crisis
	balances problem-focused questions with eliciting areas of strength and resilience
An ability to help the patient and their family and carers manage the potential distress associated with discussing difficult topics by ensuring that they understand the rationale for the questions, and discussing how they might like to manage distress during and after the assessment	
An ability to draw on knowledge that the process of assessment needs to be responsive to any interpersonal issues that threaten the integrity of the assessment, for example where there is evidence that the patient and their family and carers:	

have negative expectations based on prior adverse and/or traumatising experiences with the mental health system, including experiences resulting from the current admission
perceives the assessor as an authority figure who is judging them or keep them detained
expects the assessor to misunderstand them or let them down
An ability to identify and engage other relevant people and agencies in the patient's network in the assessment process
An ability to ensure that the assessment process is coordinated with the wider team to minimise repetition, overlap and patient burden

An ability to undertake a multidimensional biopsychosocial assessment

An ability to assess key triggers or reasons for the admission, for example:
stopping medication
drug and alcohol use
social isolation
bereavement or breakdown in relationships
experience of trauma or abuse
social difficulties such as housing instability or financial problems
An ability to assess the presenting mental health symptoms (for example, experiences of psychosis) and their characteristics
An ability to assess behaviours that may cause harm (for example, self-harming behaviours, restrictive eating), their characteristics (for example, severity, frequency, intent to die, the function of the behaviour) and the motivations behind them
An ability to assess coping strategies that the patient has used to manage their difficulties
An ability to assess key cognitions which relate to their presenting difficulties (including their content, duration, frequency and intensity of thinking, and intent)
An ability to assess any cognitive difficulties which may be transient (i.e., due to the crisis) or more permanent (such as issues with memory and concentration)
An ability to assess emotional difficulties (for example, hopelessness, fear, anxiety)
An ability to assess related physiology and comorbid physical health difficulties (for example, chronic pain)
An ability to assess impacts of difficulties on current functioning and quality of life
An ability to assess any current forensic needs
An ability to help the patient identify protective factors such as:
attitudes, beliefs, and values (for example, hopefulness, reasons for living, a wish to live)
a sense that it may be possible to manage their difficulties
interpersonal networks and social support
other relevant strengths and resources

An ability to assess the patients cultural and social content

An ability to ask about any potential stressors in the patient's physical or social environmen example, overcrowding, poor housing, neighbourhood harassment, problems with gangs)
An ability to draw on knowledge of the patient's and family/ carers cultural, racial, and religi background when carrying out an assessment of their behaviours, beliefs, and the potentia impact of this perspective on their views of problems
An ability to understand cultural influences on gender roles and gender identity, relationshi and family values

An ability to assess a patient's history

An ability to assess the patient's history to help inform their current care, including:
mental health history, including admission history

developmental history (for example, developmental delay, social skills)
trauma history (for example, experiences of abuse and neglect)
medical history (for example, contact with specialist services, head injury, prescribed medication)
family history (for example, family mental health diagnoses, family relationships and dynamics, current family stress)
social history (for example, education, work, housing)
forensic history (for example, previous convictions or index offence)

An ability to assess cognitive function

An ability to assess cognitive functioning, and to:
assess level of consciousness
assess the patient's orientation to time, place, and person
carry out basic memory tests
estimate the patient's intellectual level, based on their level of vocabulary and comprehension in the interview, and their educational achievements
conduct or refer for formal cognitive assessment if there are indications of a learning disability

An ability to assess risk

An ability to conduct a risk assessment that explores and understands the specific functions of risk behaviours for the patient and offers personalised risk management and intervention opportunities
An ability to identify and utilise historical information in a way that mitigates the impact of repeated assessments (for example, by summarising what is already known), while recognising that information may change and need updating

An ability to assess potential factors relating to current risk behaviours that are threatening the patient's or others safety, including:
severity, method, and potential reasons/motivations for this behaviour
links between risk behaviours (for example, self-harm and suicide)
presenting mental health difficulties which relate to the risk behaviour
psychological factors (for example, commanding voices and hopelessness)
psychosocial factors (for example, a recent bereavement and relationship breakdown)
the specific characteristics of the risk behaviours, such as the frequency, duration, context, and function of the behaviour
protective factors such as their family, supportive social network, attitudes, and beliefs (for example, hopefulness and reasons for living)
cognitions relating to the risk behaviour (for example, suicidal ideation) including their content, duration, frequency, and intensity
experience of bereavement by suicide in their social network, including fellow patients on the ward

An ability to work with people to identify behaviours (both current and in the past) that relate to the risk behaviour (for example, saying goodbye to others)
An ability to discuss with people the specific characteristics of a risk behaviour (for example, the function of the behaviour, level of intent) and use this to estimate the likelihood of future behaviours

An ability to assess interpersonal factors associated with risk behaviours

An ability to identify a sense of social isolation, for example, the perceived absence of caring, meaningful connections to others, recent losses through death or relationship breakdown, conflict with peers or bullying
An ability to identify a sense of being a burden on others, for example, expressing the view that others would be better off if they were gone or that they are a burden
An ability to assess 'markers' that indicate the development of a capability to carry out the risk behaviour, for example, current markers, such as:

fearlessness about undertaking the behaviour
prolonged preoccupation with the behaviour
if the behaviour has taken place, the intent behind the behaviour
current and past experiences of the behaviour
frequent exposure to or participation in violence (including conflict and military service)
exposure to childhood physical and/or sexual violence participation in painful and provocative activities (for example, jumping from high places, engaging in physical fights)
patterns of risk behaviour associated with substance use
evidence of clear plans (for example, a written suicide note, having affairs in order, taking out life insurance)