Jessica Warren

Noticing

MSE

The client I interviewed has depression and suicidal ideations. Even with this diagnosis, which commonly comes with communication barriers, Adam was cooperative and answered all questions. Adam appeared to be relaxed and was willing to talk with me. He was sent to OSF in Urbana because the facilities in Iowa were no longer helping him, according to Adam.

Additional Assessment

The Suicide Risk Screening tool is the additional assessment I did with Adam. His assessment came back with no risk of self-harm, however there are some concerns due to Adam stating he thinks about suicide passively but has no intent and no plan. I did this assessment because of his suicidal ideations. Adam was cooperative and answered all questions.

Interpreting

MSE

What stood out to me about Adam is that he kept to himself the entire time I was there for the clinical experience unless someone went to him to engage in conversation. Adam is from a different state and is away from those he knows so my concern is that placing him somewhere outside of his routine could trigger depression and cause more harm than good for him. He is established with a psychiatrist that knows him and may have been able to help him better than a completely new doctor.

Additional Assessment

The Suicide Risk Screening tool is the additional assessment I did with Adam. His assessment came back normal, with no risk of self-harm however there are some concerns due to Adam stating he thinks about suicide passively but has no intent and no plan

Responding

MSE

I realize there are some staffing challenges on that unit at OSF, but clients like Adam would benefit from some 1:1 time. Adam had stated that he doesn't feel comfortable in groups and group therapy would not benefit him. Communication techniques used were Active Listening, Verbal Communication, Nonverbal Communication, compassion, and trust.

Additional Assessment

The Suicide Risk Screening tool is the additional assessment I did with Adam. His assessment came back with no risk of self-harm however there are some concerns due to Adam stating he thinks about suicide passively but has no intent and no plan. A mood assessment could have been completed as well.

Reflecting

MSE

I was very open and willing to talk with all the clients on the unit. I need to keep reminding myself that they are on that unit for mental health reasons and keep my guard up more. I approached the clients on the unit like I do the little old lady and older men I care for. Since I have such an open and welcoming attitude, it made those comfortable around me, and they were talking openly to me even though this was my first time around them. I was able to have an open dialog with one of the patients that doesn't really open up to people especially if she doesn't like your vibe. I thought that was a very rewarding experience. I look at this clinical experience in a positive light, and as of right now, I am very comfortable interacting with the clients.

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Mental Status Exam

Client Name	Alex	Date	9/8/2023

OBSERVATIONS

Appearance	☑ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Other
Speech	☐ Normal	☐ Tangential	☐ Pressured	☑ Impoverished	☐ Other
Eye Contact	☑ Normal	☐ Intense	☐ Avoidant	☐ Other	
Motor Activity	☑ Normal	☐ Restless	☐ Tics	☐ Slowed	☐ Other
Affect	☑ Full	☐ Constricted	☐ Flat	☐ Labile	☐ Other

Comments: Only responded to questions or if was prompted to talk.

MOOD

☐ Euthymic ☐ Anxious ☐ Angry ☐ Depressed ☐ Euphoric ☐ Irritable ☑ Other

Comments: "OK"

COGNITION

Orientation Impairment	☐ None	☐ Place	☐ Object	☑ Person	☐ Time
Memory Impairment	☐ None	☑ Short-Term	☑ Long-Term	☐ Other	
Attention	☑ Normal	☐ Distracted	☐ Other		

Comments:

PERCEPTION

Hallucinations	☑ None	☐ Auditory	☐ Visual	☐ Other
Other	☑ None	☐ Derealization	☐ Depersonalization	

Comments:

THOUGHTS

Suicidality	☑ None	☐ Ideation	☐ Plan	☐ Intent	☐ Self-Harm
Homicidality	☑ None	☐ Aggressive	☐ Intent	☐ Plan	
Delusions	☑ None	☐ Grandiose	☐ Paranoid	☐ Religious	☐ Other

Comments:

BEHAVIOR

☑ Cooperative ☐ Guarded ☐ Hyperactive ☐ Agitated ☐ Paranoid
☐ Stereotyped ☐ Aggressive ☐ Bizarre ☐ Withdrawn ☐ Other

Comments:

INSIGHT	☐ Good	☐ Fair	☑ Poor	Comments:
JUDGMENT	☐ Good	☑ Fair	☐ Poor	Comments:

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient: Alex

1. **In the past few weeks, have you wished you were dead?** ○ Yes ✓ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ○ Yes ✓ No
3. **In the past week, have you been having thoughts about killing yourself?** ○ Yes ✓ No
4. **Have you ever tried to kill yourself?** ○ Yes ✓ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers Yes to any of the above, ask the following acuity question:

5. **Are you having thoughts of killing yourself right now?** ○ Yes ✓ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = acute positive screen (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.** Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☑ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed.** Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741