Reviewing templates and requesting MARS within Pyramid Healthcare. (Completed as of 7/6)

Parental Consent Forms will be uploaded into CL and remain in MAR Notebook for staff review.

PRN Consented Medications will be added to orders and MAR immediately upon admission.

Executive Director and LPN scheduled meeting for 6/14/18 to set standing schedule and times for MAR reviews (Completed).

Scheduled standing Bi-weekly meeting.

MD contacted to set up weekly meeting.

LPN scheduling trainings.

Facility Staff completing this form: Jessie Alexander, Executive Director
Name/Title Date:7/6/18

Clearview Pyramid Acquisition Company - Tapestry Pre-Admission Assessment

Session Information

Client:	*Caller, Female (1180476)
Staff:	Lettiere, Meagan (1227)
Document Date:	7/11/2018
Client Program:	(Not Set)

Tapestry Initial Contact (4)

Screening Type: ○ Adolescent ○ Adult

Are you employed? ○ Yes ○ No

Goal After Discharge:

Are your eating disorder symptoms or behaviors causing any of the following at work: ☐ Difficulty concentrating/ completing tasks ☐ Reduction in attendance ☐ Reduction in work performance ☐ FMLA or Leave of absence

Are you currently a student? ○ Yes ○ No

Goal After Discharge:

Are your eating disorder symptoms or behaviors causing the folliwing at school: ☐ A medical withdrawl or leave of absence ☐ Grades/GPA decline ☐ Reduction in clasess/ course/attendance ☐ Difficulty with concentrating/completing tasks

Is your school/ university requiring a physician's note to re-enroll/return to school? ○ Yes ○ No

Current Living Situation:

Living Situation Other:

Age when ED symptoms/behaviors started:

Evolution of ED

Description of eating disorder behaviors and symptoms from onset to now:

Current ED Symptoms

Restricting? ○ Yes ○ No

Restricting (describe based on highest intensity):

Specific Meal(s):

Specific length of time:

Caloric Intake: # of calories per day/per meal

Food Groups: ☐ Gluten ☐ Fat ☐ Vegetarian
☐ Lactose ☐ Carbohydrates/Starches ☐ Vegan
☐ Dairy ☐ Meat ☐ Other

Comments: Time/Hours/Days/Other

Binge Eating? ○ Yes
○ No

Binge-eating (describe based on highest intensity): # times per day/estimated calories per binge/describe typical binge

Purging? ○ Yes
○ No

Purging (describe based on highest intensity): ☐ Vomiting ☐ Exercise ☐ Compulsive Exercising
☐ Laxatives ☐ Diuretics

Exercising Information: Type of workout/Hours/Miles per day

Notes:

Obsession surrounding weight gain or food intake? ○ Yes
○ No

Fixated about food quality/content/"healthy": ○ Yes
○ No

Are you currently receiving treatment? ○ Yes
○ No

Treatment Receiving: ☐ Inpatient/Residential ☐ IOP ☐ Other
☐ PHP ☐ Outpatient

Is current treatment provider/facility recom-mending a higher level of care? ○ Yes
○ No

If yes, explain:

What triggered your need for treatment now?

Describe what you had yesterday for: (food names, portions, calories, etc)

Breakfast:

Lunch:

Dinner:

How many times per week do you eat out?

Who usually cooks at home?	
Does the family sit together for meals?	○ Yes ○ No
Current Height/Weight:	
BMI:	
Ideal Body Weight %:	
How much would you like to weigh?	
In the last 3 months, has your weight:	☐ Decreased ☐ Increased
By how much?	
Highest weight & when:	
Lowest weight & when:	

Tapestry Initial Contact MS

Mental Status

Speech (articulation, rate, volume, coherence):	
Thought Process (rate, content, computation):	
Associations:	
Mood:	
Judgement:	
Insight:	
Orientation x 3:	
Impaired For:	
Memory:	
Impaired For:	
Attention/Concentration:	
Thought Content:	
Psychomotor:	
Affect:	

Substance Abuse List

Medication assisted treatment:	
Frequency of attendance at self help programs:	

Tapestry Initial Contact Continued (3)

Current Body Image

How do you feel about your body when you:	Look in mirror, try on clothes, see picures of yourself? Do you avoid lookng in mirror?

Social History Information

Psychiatric dx history:	

Family Psychiatric/ Addiction History:	
Trauma/Abuse History:	
Current support system:	
Have your eating disorder behaviors affected your relationships with your friends or family?	○ Yes ○ No
If yes, describe how:	
Do you ever lie about your daily intake?	○ Yes ○ No
Do you avoid events or isolate from friends or family to avoid eating in front of people?	○ Yes ○ No
Binge Eater?	○ Yes ○ No
(Binge Eaters Only) Hide or sneak food or food wrappers to conceal your binges?	○ Yes ○ No
(Binge Eaters Only)Has your binge eating disorder created any financial hardships or excessive debt?	○ Yes ○ No
Comments:	
Describe Current Sleep Patterns:	☐ Frequent awakenings ☐ Nightmares ☐ Difficulty staying asleep ☐ Napping ☐ Difficulty falling asleep
How many hours do you sleep per night?	
Do you have a history of mood swings?	○ Yes ○ No
History of self harm?	○ Yes ○ No
Self Harm Information:	☐ Cutting ☐ Picking ☐ Other ☐ Burning ☐ Scratching
Self harm past or current?	
Suicidal ideations or attempts?	○ Yes ○ No
Suicidal ideations or attempts past or current?	
Self Harm, Suicidal Ideations/Attempts Comments:	

Medical History

Females only - date of last menstrual cycle:

Females only - Irregular periods?
- ○ Yes
- ○ No

Non Gender Specific Medical History:
- ☐ Dizziness/fainting
- ☐ Muscle cramping
- ☐ Joint/Bone issues
- ☐ Hairloss
- ☐ Fatigue
- ☐ Malnourishment
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Dental decay/issues
- ☐ Abnormal blood sugar
- ☐ Elevated cholesterol
- ☐ High blood pressure
- ☐ Bradycardia (low heart rate)
- ☐ Tachycardia (elevated heart rate)
- ☐ Heart paliptations
- ☐ Cold intolerance
- ☐ Lanugo
- ☐ Other medical issues

Other Medical Issues:

Past Surgeries:

Current Medications:

Medication Allergies:

Food Allergies:

Medical documentation to support medications, medication allergies & food allergies?
- ○ Yes
- ○ No

Dietary comments/ foods that you don't eat:

Treatment history to report?
- ○ Yes
- ○ No

Inpatient: Location/When/Outcome

PHP/IOP: Location/When/Outcome

Current Treatment

Primary Care Physician: Name/Phone #

Psychiatrist: Name/Phone #

Therapist: Name/Phone #

Specialist: Name/Phone #

Other Provider: Name/Phone #

Provisional Diagnosis

Axis 1:
Axis 2:
Axis 3:
Axis 4:
GAF:
Disposition:

If appropriate for admission, what action was taken?

- ☐ Emailed/Faxed medical form to client and asked to fax results
- ☐ Wishes to utilize insurance, instructed to fax insurance information
- ☐ Wishes to be considered for scholarship, emailed form, instructed to fax financials
- ☐ Obtained payment authorization

Date sent to Clinical Director:

Date sent to Medical Director:

Signatures

Validation Issues: Error: Requirements not met for Tapestry Initial Contact (4).

Electronic Signature: The document can not be signed until the errors above are resolved.

Signature History

Action	Date	Staff
No records found		

Session Information

Client:	Test, QSI (OCTRD1145618) 9/29/1975
Staff:	Konopka, April (1011)
Document Date:	7/11/2018
Client Program:	(Not Set)

CPAC Presenting Problem rev917

Date of Initial Screening:

Assessment Appointment: If assessment was not scheduled within 7 days, please explain

Reason: Reason for Referral/Presenting problem-Please include symptoms and areas of concern

Description: Family/Guardian description of problem (if relevant):

Treatment History v1

TREATMENT HISTORY

History of Treatment?
- ○ Yes
- ○ No

Type of Treatment:
- ☐ Ambulatory Detox
- ☐ Inpatient Rehab
- ☐ Outpatient
- ☐ Inpatient Detox
- ☐ Intensive Outpatient
- ☐ Partial Hospitalization

Please Explain (Name of Facility, Dates, Length of Treatment, Discharge Status):

Currently in Treatment?
- ○ Yes
- ○ No

If 'Yes', where?

What was helpful with your past treatment?

What was not helpful with your past treatment?

Substance Abuse Hx v1

History of Substance Abuse:
- ○ Yes

	○ No
How has your substance abuse affected your behavior or your relationships with family and others?	
Has anyone ever expressed concern over your use of substances?	○ Yes ○ No
If Yes, Explain:	
Have you ever attended meetings or support groups?	☐ AA ☐ CoDA ☐ OTHER ☐ AL-ANON ☐ NA ☐ SMART ☐ CELEBRATE RECOVERY ☐ OA ☐ SOS
What was your experience with support groups?	
Longest Period of Abstinence:	
When?	
How did you maintain your abstinence?	

Mental Health v1

Mental Health History

Do you have a history of depression, anxiety, mood swings, or psychosis?	○ Yes ○ No
If yes, please explain:	
Do you have a history of any significant changes in sleeping or eating habits?	○ Yes ○ No
If yes, plaese explain including timeline :	
Current Stage of Change :	

CPAC Trauma History rev917

Do you have a history, or current experience as a victim of any of the following?	Check all that apply: ☐ None Reported ☐ Elder Abuse ☐ Life Threatening Injury or Illness ☐ Community Violence ☐ Emotional Abuse ☐ Physical Abuse ☐ Domestic Violence/ Abuse ☐ Exploitation ☐ Physical Neglect

	☐ Sexual Abuse ☐ Witness to Domestic Violence or Abuse ☐ Witness to Violence/ Combat Experience ☐ Other
If 'Other', please specify:	
Please explain (for all items indicated above):	
Do you believe you response to current situations differently because of trauma experienced ?	○ Yes ○ No
If yes, please explain:	
Treatment Goal should be initiated for Trauma:	○ Yes ○ No

CPAC Suicide, Self-Harm and Homicide Assess rev 917

Sources of Information:	☐ Clinical Interviews ☐ Clinical Records ☐ Collaterals ☐ Columbia-Suicide Severity Rating Scale (C-SSRS) ☐ Other approach or evidence based tool
Please specify (for all indicated above):	
History of Sucidal Ideation?	○ Yes ○ No
Current Suicidal Ideation?	○ Yes ○ No
If 'Yes', provide details:	
History of Suicidal Plan?	○ Yes ○ No
Current Suicidal Plan?	○ Yes ○ No
If 'Yes', provide details:	
History of Homicidal Ideation?	○ Yes ○ No
Current Homicidal Ideation?	○ Yes ○ No
If 'Yes', provide details:	
History of suicidal	○ Yes

behaviors? ○ No

If 'Yes', provide details:

History of self-injurious behaviors (i.e. cutting, burning)? ○ Yes ○ No

If 'Yes', provide details:

History of homicidal behaviors? ○ Yes ○ No

If 'Yes', provide details:

Is there evidence of suicide risk? ○ Yes ○ No

If 'Yes', provide details:

Is there evidence of homicidal risk? ○ Yes ○ No

If 'Yes', provide details:

Does the individual have access to lethal means/weapons? ○ Yes ○ No

If 'Yes', provide details:

Describe discussion with individual/family to secure access to lethal means/weapons:

Identify and discuss impact of significant risk and protective/ mitigating factors:

Safety Management Plan:

CPAC Medical History 917

HEALTH HISTORY

Are your immunizations up to date?	☐ Yes	☐ No	☐ N/A
Have you ever had Turberculosis?	○ Yes ○ No		
If yes, when?			
Have you ever had Hepatitis?	○ Yes ○ No		
If yes, when?			
Are you currently sexually active?	○ Yes ○ No		
Do you practice safe sex?	○ Yes ◉ No		
Have you ever had an STD?	○ Yes ○ No		
If so, when?			
Have you ever been tested for HIV?	☐ Yes	☐ No	☐ Prefer Not to Answer
Are you seeing any specialists?	○ Yes ○ No		
If yes, whom and for what?			
Additional Comments/ Treatment Recommend-ations:			

MEDICAL PROBLEMS CHECKLIST

	Please indicate past/present/NA and family history for each item.		
Medical Issues:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Abnormal Bleeding:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Diabetes:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Hypertension:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Swelling:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Abcesses/Ulcers:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Cancer:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Kidney Disease:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Seizures:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Headaches:	☐ Past	☐ Mother	☐ Present

	☐ Father	☐ N/A	☐ Grandparents
Liver Disease:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Thyroid Issues:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Anemia:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Loss of Memory:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Heart Conditions:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Asthma:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Neurological Disorders:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Blood Disorders:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Sleep Issues:	☐ Past	☐ Present	☐ N/A
	☐ Mother	☐ Father	☐ Grandparents
Additional Comments/ Treatment Recommend-ations:			

NUTRITIONAL SCREEN

Have you experienced weight loss or gain if 10lbs or more in the last 6 months?	○ Yes ○ No
Have you experienced difficulty with your appetite?	○ Yes ○ No
Has your food intake decreased to less than 50% of "normal" intake in the last 3 months?	○ Yes ○ No
Are you satisfied with your eating patterns?	○ Yes ○ No
Do you ever eat in secret?	○ Yes ○ No
Does your weight affect the way you feel about yourself?	○ Yes ○ No
Have any members of your family suffered an eating disorder?	○ Yes ○ No
Do you currently suffer with or have you suffered in the past with an eating disorder?	○ Yes ○ No
Additional Comments/ Treatment Recommend-ations:	If indicated in answers above, refer to dietary consultation if appropriate

PAIN ASSESSMENT

Are you currently being treated for pain? ○ Yes
○ No

If yes, please complete the following information:

Provider Name:

Provider Phone Number:

Type of Pain:

Location of Pain:

Frequency of Pain:

Duration of Pain:

Instensity of Pain: On a scale of 1-10, 1 being the least and 10 being the greatest.

Course of Treatment:

Additional Comments:

MEDICAL HOSPITALIZATIONS

Medical Hospitalization History: ○ Yes
○ No

Name of Hosptial:

Year:

Length of Stay:

Reason for Hospitalization:

Name of Hospital:

Year:

Length of Stay:

Reason for Hospitalization:

Name of Hospital:

Year:

Length of Stay:

Reason for Hospitalization:

Additional Comments:

CPAC Medical Assessment Rev917

Medical Information

Do you have a Primary Care Physician? ○ Yes
○ No

If 'Yes', provide name and contact information:

Have you had a physical in the last year? ○ Yes ○ No

Do you have any current acute or chronic medical issues? ○ Yes ○ No

If 'Yes', please explain:

Have you had any medical hospitalizations in the last year? ○ Yes ○ No

If 'Yes', explain (when, for what, outcome):

Medication

List all Past Medications:

Did you have any adverse/side effects? ○ Yes ○ No

If 'Yes', please explain:

Are you currently prescribed medication? ○ Yes ○ No

If 'Yes', please identify reason for medication: ☐ Medical ☐ Psychotropic ☐ Other

Do you take your medication as prescribed? ○ Yes ○ No

If 'No', please explain (overuse or underuse):

Do you have any adverse/side effects? ○ Yes ○ No

If 'Yes', please explain:

Client Medications

Begin Date	End Date	Amount/Refills	Status
No Client Medications found.			

Current Client Allergies

Allergen	Type	Begin Date	End Date
No Known Allergies, including Allergens, Drugs, and Ingredients - Konopka, April (1011) on 5/21/2018 10:23			

Inactive Client Allergies

Allergen	Type	Begin Date	End Date
No Allergies found.			

CPAC Violence Assessment 917

Do you have a history of being accused of any of the following:

Check all that apply:

- ☐ None Reported
- ☐ Bullying
- ☐ Community Violence
- ☐ Cruelty to Animals
- ☐ Domestic Violence/ Abuse
- ☐ Destruction to Property
- ☐ Elder Abuse
- ☐ Emotional Abuse
- ☐ Exploitation
- ☐ Fire Setting
- ☐ Gang Activity
- ☐ Physical Abuse
- ☐ Physical Neglect
- ☐ Run Away Behavior
- ☐ Sexual Abuse
- ☐ Sexual Aggression
- ☐ Truancy
- ☐ Witness to Domestic Violence or Abuse
- ☐ Witness to Violence/ Combat Experience
- ☐ Other

If 'Other', please specify:

Please explain (for all items indicated above):

Do you have a history of being involved in violent behavior that resulted in injury?

○ Yes
○ No

If 'Yes', please explain:

CPAC Legal Involvement rev 917

Have you ever been arrested or been involved in the court system?

○ Yes
○ No

If Yes, How many times and when?

What is the status of any arrests or charges? Please explain :

Have you ever been charged with a violent crime? (i.e. rape, armed robbery, assault):

○ Yes
○ No

If Applicable, please explain:

Do you have a

○ Yes

Probation or Parole Officer? ○ No

If yes, name and contact information :

Are you Court Mandated to Treatment? : ○ Yes ○ No

History or Current involvement with Child Protective Services : ○ Yes ○ No

If yes, please explain :

Educ, Employ, Finances and Military v1

EDUCATION / ACADEMIC HISTORY

Education History:
☐ Did Not Complete High School
☐ High School
☐ GED
☐ Associate's Degree
☐ Some College
☐ Bachelor's Degree
☐ Master's Degree
☐ Advanced Graduate Work/Doctorate
☐ Technical/Trade School

Highest Grade/Level of Education Completed:

SCHOOL HISTORY:

Name of School:

Year:

Level of Performace: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Did you Graduate? ○ Yes ○ No

Name of School:

Year:

Level of Performance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Did you Graduate? ○ Yes ○ No

Name of School:

Year:

Level of Performance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Did you Graduate? ○ Yes ○ No

Additional Comments:

History of Learning Difficulties: ☐ None Reported

OR: Check all that apply:
☐ Learning Disability/Type
☐ Intellectual Disability
☐ Special School Placement
☐ Other

Please explain (for all items indicated above):

Barriers to Learning: ☐ None Reported

OR: Check all that apply:
☐ Difficulty with Reading and Writing ☐ Inabiity to Read or Write ☐ Other

If 'Other', please specify:

Special Communication Needs: ☐ None Reported

OR: Check all that apply:
☐ TDD/TTY Device ☐ Sign Language Interpreter ☐ Other
☐ Assisted Listening Device(s) ☐ Language Interpreter Services

If 'Other', please specify:

If 'Language Interpreter Services Needed', specify spoken language:

How has your education been impacted by your eating disorder or mental health,?

EMPLOYMENT HISTORY

Employment Status: ☐ Full Time ☐ Disabled ☐ Self-Employed
☐ Part Time ☐ Laid Off ☐ Unemployed

If employed, name of Current Employer:

If not currently employed, are you interested in finding employment? ○ Yes ○ No

Please Explain:

Job History, including current:

What skills, abilities, and interests do you have in regards to employment?

What affect has your eating disorder or mental health concerns had on your employment?

FINANCES

Source of financial support:

In general, how would you describe your financial situation? ☐ Very Poor ☐ Fair ☐ Excellent
☐ Poor ☐ Good

What do you typically do with your money? ☐ Save ☐ Budget Towards Basic Needs ☐ Other

MILITARY

Military Experience? ○ Yes ○ No

Combat Experience? ○ Yes ○ No

Branch: ☐ Air Force ☐ Coast Guard ☐ Navy ☐ Army ☐ Marines ☐ Other

Currently Active? ○ Yes ○ No

Type of Discharge: ☐ Bad Conduct ☐ General under Honorable ☐ Other ☐ Dishonorable ☐ Honorable

Are you eligible for military benefits? ○ Yes ○ No

What affect did eating disorder or mental health concerns have on your military experience?

Family History v1

FAMILY INFORMATION

HOUSEHOLD MEMBERS Please indicate below all members of your household:

Household Member Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Household Member Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Household Member Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Household Member Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Household Member Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Household Member Name:
Relationship:
Age:
Relationship Staus: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

*

Where was the client raised?
Whom was the client raised by?

SIGNIFICANT OTHERS Please indicate below any significant others not listed above as a household member:

Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Name:
Relationship:
Age:
Relationship Status: ☐ Excellent ☐ Fair ☐ Poor ☐ Good

Name and phone number of emergency contact:

*

FAMILY CONCERNS Please indicate any family concerns below:

Alcohol Abuse: ○ Yes ○ No
If yes, select all that apply: ☐ Parent ☐ Child ☐ Other ☐ Sibling
Substance Abuse: ○ Yes ○ No
If yes, select all that apply: ☐ Parent ☐ Child ☐ Other ☐ Sibling
Mental Health Problems: ○ Yes ○ No

If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
Health Problems:	○ Yes		
	○ No		
If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
Disability:	○ Yes		
	○ No		
If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
Legal Issues:	○ Yes		
	○ No		
If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
Financial Concerns:	○ Yes		
	○ No		
If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
Deceased Family Member:	○ Yes		
	○ No		
If yes, select all that apply:	☐ Parent	☐ Child	☐ Other
	☐ Sibling		
How has your Eating Disorder or Mental Health affected your relationships :			

CPAC Family, Relationships, Social Supports,Spirituality 917

FAMILY AND RELATIONSHIPS

Do you have children?	○ Yes		
	○ No		
If 'Yes', how many? (include names and ages):			
Do you currently have custody of your children?	○ Yes		
	○ No		
If 'No', why and who has custody?			
Do you have a visitation schedule?	○ Yes		
	○ No		
Current childcare arrangements:			
Current Relationship Status:			
How do you define your	☐ Heterosexual	☐ Other	☐ Bisexual

sexual orientation?	☐ Homosexual
Are there aspects of your orientation you would like to include or address in treatment?	○ Yes ○ No
If 'Yes', please explain (include current level of disclosure):	
Have you ever experienced discrimination due to your orientation?	○ Yes ○ No
If 'Yes', please explain:	
Current Living Situation?	
Do you feel safe in your environment?	○ Yes ○ No
Additional Comments:	
Is your current living situation positive for your recovery?	○ Yes ○ No

SOCIAL SUPPORTS/ISSUES

Peer Support Relationships:	
Meaningful Activities:	
Community Supports/ Self-Help Groups:	
Do you have adequate transportation for treatment and social/ recreational activites?	○ Yes ○ No
Additional Comment if No:	
Is there any way in which your culture may impact your treatment?	
Additional Comments:	

SPIRITUALITY

Do you consider yourself spiritual or religious?	○ Yes ○ No
Do you have specific preferences or practices that are important to you?	

Are you part of a spiritual or religious body or community?	○ Yes ○ No
If 'Yes', please explain:	
Additional Comments:	

CPAC Gambling Screen 917

Have you or do you gamble?	○ Yes ○ No
If 'Yes', please explain (type, frequency):	
Have the size and frequency of your bets increased beyond what you can afford or intended?	○ Yes ○ No
Do you frequently gamble to make up losses?	○ Yes ○ No
Has gambling ever caused issues with your family, relationships, employment, or finances?	○ Yes ○ No
Have you ever felt the need to bet more and more?	○ Yes ○ No
Have you ever felt the need to lie to those important to you about your gambling?	○ Yes ○ No
Do you believe you have a gambling problem?	○ Yes ○ No
Client screen is postiive for gambling problem:	○ Yes ○ No

CPAC Mental Status Examination (MSE)917

	Provide answers below covering the following areas: Appearance and Behavior; Mood and Affect; Speech; Thought Process; Thought Content; Suicidal/Homicidal ideation; Cognition (if impaired, do Folstein Mini-Mental Status Exam), Insight and Judgment,
Or Select, if applicable:	☐ Refer to Mental Status Addendum

General Observations

Appearance:	☐ WNL ☐ Appears older than age ☐ Appears younger than age ☐ Disheveled ☐ Unkempt
Comment/Other (Appearance):	

*

Build/Stature:
- ☐ WNL
- ☐ Short
- ☐ Thin
- ☐ Overweight
- ☐ Tall

Comment/Other (Build/ Stature):

*

Posture:
- ☐ WNL
- ☐ Rigid
- ☐ Slumped
- ☐ Atypical
- ☐ Slouching
- ☐ Tense

Comment/Other (Posture):

*

Eye Contact:
- ☐ Average
- ☐ Intense
- ☐ Intermittent
- ☐ Avoidant

Comment/Other (Eye Contact):

*

Activity:
- ☐ WNL
- ☐ Agitated
- ☐ Slowed
- ☐ Accelerated
- ☐ Impulsive
- ☐ Stereotyped/Peculiar

Comment/Other (Activity):

*

Attitude Toward Examiner:
- ☐ Cooperative
- ☐ Defensive
- ☐ Ingratiating
- ☐ Anxious
- ☐ Demanding
- ☐ Manipulative
- ☐ Avoidant
- ☐ Evasive
- ☐ Mistrustful
- ☐ Confused
- ☐ Hostile
- ☐ Seductive

Comment/Other (Attitude Toward Examiner):

*

Attitude Toward Parent/ Guardian:
- ☐ N/A
- ☐ Ignores parents
- ☐ Lack of spontaneity
- ☐ Demanding
- ☐ Immature
- ☐ Positive interaction
- ☐ Disrespectful

Comment/Other (Attitude Toward Parent/ Guardian):

*

Separation (for Children/Adolescent):
- ☐ N/A
- ☐ Clingy to parent/ guardian, but separates
- ☐ Unremarkable/age appropriate
- ☐ Cannot separate
- ☐ Disinhibited/does not care

Comment/Other (Separation for Children/ Adolescent):

*

Mood:
- ☐ Euthymic
- ☐ Anxious
- ☐ Depressed
- ☐ Angry
- ☐ Elated
- ☐ Euphoric
- ☐ Irritable
- ☐ Silly

Comment/Other (Mood):

*

Affect:
- ☐ Full
- ☐ Constricted
- ☐ Flat
- ☐ Inappropriate
- ☐ Labile

Comment/Other (Affect):

*

Speech:
- ☐ Clear
- ☐ Echolalic
- ☐ Loud
- ☐ Overproductive
- ☐ Pressured
- ☐ Rapid
- ☐ Slow
- ☐ Slurred
- ☐ Soft
- ☐ Underproductive

Comment/Other (Speech):

*

Thought Process:
- ☐ Logical
- ☐ Blocked
- ☐ Circumstantial
- ☐ Concrete
- ☐ Flight of Ideas
- ☐ Incoherent
- ☐ Loose
- ☐ Poverty of Content
- ☐ Racing
- ☐ Slowed Thinking
- ☐ Tangential

Comment/Other (Thought Process):

*

Perception:
- ☐ WNL
- ☐ Depersonalization
- ☐ Derealization
- ☐ Illusions
- ☐ Reexperiencing

Hallucinations:
- ☐ N/A
- ☐ Auditory
- ☐ Command
- ☐ Gustory
- ☐ Olfactory
- ☐ Tactile
- ☐ Visual

Comment/Other (Perception / Hallucinations):

*

Thought Content:
- ☐ WNL
- ☐ Depressive
- ☐ Grandiose
- ☐ Obsessional
- ☐ Paranoid
- ☐ Phobic
- ☐ Preoccupations/Rumin-ations
- ☐ Self-Deprecatory
- ☐ Sexually Preoccupied

Comment/Other (Thought Content):

Delusions:

	☐ None reported	☐ Persecution	☐ Thought Broadcasting
	☐ Control	☐ Reference	☐ Thought Insertion
	☐ Erotic	☐ Religious	☐ Thought Withdrawal
	☐ Grandeur	☐ Somatic	
Comment/Other (Delusions):			

*

Risk Assessment:	☐ None Reported or Observed		
	OR:		

Danger To:

Self:	☐ Ideation	☐ Plan	☐ N/A
	☐ Intent	☐ Attempt	
Comments:			

*

And/Or Others:	☐ Ideation	☐ Plan	☐ N/A
	☐ Intent	☐ Attempt	
Cognition:	☐ WNL		
OR Check all impairments that apply:	☐ Ability to Abstract	☐ Calculation Ability	☐ Concentration
	☐ Attention		

*

Intelligence Estimate:	☐ Above Average	☐ Borderline	☐ MR
	☐ Average		

*

Insight:	☐ WNL	☐ Moderate	☐ None
	☐ Minimal		

*

Judgement:	☐ WNL	☐ Moderate	☐ None
	☐ Minimal		
Impaired ability to make reasonable decisions:	☐ Not Impaired	☐ Moderate	☐ Severe
	☐ Mild		

*

Comments:	
Elaboration on mental status findings:	

DSM-5 Cross-Cutting Symptom Measure - Adult

0=None; 1=Slight - Less than a day or two; 2=Mild - Several days; 3= Moderate - More than half the days; 4=Severe - Nearly every day

1. (I) Little interest or pleasure in doing things?	O 0	O 1	O 2	O 3	O 4
2. (I) Feeling down, depressed or hopeless?	O 0	O 1	O 2	O 3	O 4
3. (II) Feeling more irritated, grouchy or angry than usual?	O 0	O 1	O 2	O 3	O 4
4. (III) Sleeping less than usual, but still have a lot of energy?	O 0	O 1	O 2	O 3	O 4
5. (III) Starting lots more projects than usual or doing more risky things than usual?	O 0	O 1	O 2	O 3	O 4
6. (IV) Feeling nervous, anxious, frightened, worried or on edge?	O 0	O 1	O 2	O 3	O 4
7. (IV) Feeling panic or being frightened?	O 0	O 1	O 2	O 3	O 4
8. (IV) Avoiding situations that make you anxious?	O 0	O 1	O 2	O 3	O 4
9. (V) Unexplained aches and pains:	O 0	O 1	O 2	O 3	O 4
10. (V) Feeling that your illnesses are not being taken seriously enough?	O 0	O 1	O 2	O 3	O 4
11. (VI) Thoughts of actually hurting yourself?	O 0	O 1	O 2	O 3	O 4
12. (VII) Hearing things other people couldn't hear, such as voices even when no one was around?	O 0	O 1	O 2	O 3	O 4
13. (VII) Feeling that someone could hear your thoughts or that you could hear what another person was thinking?	O 0	O 1	O 2	O 3	O 4
14. (VIII) Problems with sleep that affected your sleep quality overall?	O 0	O 1	O 2	O 3	O 4
15. (IX) Problems with memory or with location:	O 0	O 1	O 2	O 3	O 4
16. (X) Unpleasant thoughts, urges, or images that repeatedly enter your mind?	O 0	O 1	O 2	O 3	O 4
17. (X) Feeling driven to perform certain behaviors or mental acts over and over again?	O 0	O 1	O 2	O 3	O 4
18. (XI) Feeling detached or distant	O 0	O 1	O 2	O 3	O 4

from yourself, your body, your physical surroundings or your memories?					
19. (XII) Not knowing who you really are or what you want out of life?	○ 0	○ 1	○ 2	○ 3	○ 4
20. (XII) Not feeling close with other people or enjoying your relationships with them?	○ 0	○ 1	○ 2	○ 3	○ 4
21. (XIII) Drinking at least 4 drinks of any kind of alcohol in a single day?	○ 0	○ 1	○ 2	○ 3	○ 4
22. (XIII) Smoking any cigarettes, a cigar, or pipe or using snuff or chewing tobacco?	○ 0	○ 1	○ 2	○ 3	○ 4
23. (XIII) Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	○ 0	○ 1	○ 2	○ 3	○ 4

Depression Subscore:	
Depression Highest Individual Question Score:	
Anger Subscore:	
Anger Highest Individual Question Score:	
Mania Subscore:	
Mania Highest Individual Question Score:	
Anxiety Subscore:	
Anxiety Highest Individual Question Score:	
Somatic Symptoms Subscore:	
Somatic Symptoms Highest Individual Question Score:	

Suicidal Ideation Subscore:

Suicidal Ideation Highest Individual Question Score:

Psychosis Subscore:

Psychosis Highest Individual Question Score:

Sleep Problems Subscore:

Sleep Problems Highest Individual Question Score:

Memory Subscore:

Memory Highest Individual Question Score:

Repetitive Thoughts and Behaviors Subscore:

Repetitive Thoughts and Behaviors Highest Individual Question Score:

Dissociation Subscore:

Dissociation Highest Individual Question Score:

Personality Functioning Subscore:

Personality Functioning Highest Individual Question Score:

Substance Use Subscore:

Substance Use Highest Individual Question Score:

TOTAL:

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Threshold to guide further inquiry based on the Highest Individual Question Score	Domain
2-4	I. Depression
2-4	II. Anger
2-4	III. Mania
2-4	IV. Anxiety
2-4	V. Somatic Symptoms
1-4	VI. Suicidal Ideation
1-4	VII. Psychosis
2-4	VIII. Sleep Problems
2-4	IX. Memory
2-4	X. Repetitive Thoughts and Behaviors
2-4	XI. Dissociation

2-4	XII. Personality Functioning
1-4	XIII. Substance Use

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge:	O Not at all	O Several days	O Over half the days	O Nearly every day
2. Not being able to stop or control worrying:	O Not at all	O Several days	O Over half the days	O Nearly every day
3. Worrying too much about different things:	O Not at all	O Several days	O Over half the days	O Nearly every day
4. Trouble relaxing:	O Not at all	O Several days	O Over half the days	O Nearly every day
5. Being so restless that it's hard to sit still:	O Not at all	O Several days	O Over half the days	O Nearly every day
6. Becoming easily annoyed or irritable:	O Not at all	O Several days	O Over half the days	O Nearly every day
7. Feeling afraid as if something awful might happen:	O Not at all	O Several days	O Over half the days	O Nearly every day

TOTAL:

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? :

Behavior And Symptom Identification Scale (Adult Version)

During the PAST WEEK, how much difficulty did you have...

1. Managing your day-to-day life?	O No difficulty	O A little difficulty	O Moderate difficulty	O Quite a bit of difficulty	O Extreme difficulty
2. Coping with problems in your life?	O No difficulty	O A little difficulty	O Moderate difficulty	O Quite a bit of difficulty	O Extreme difficulty
3. Concentrating?	O No difficulty	O A little difficulty	O Moderate difficulty	O Quite a bit of difficulty	O Extreme difficulty

During the PAST WEEK, how much of the time did you...

4. Get along with people in your family?	O None of the time	O A little of the time	O Half of the time	O Most of the time	O All of the time
5. Get along with people outside your family?	O None of the time	O A little of the time	O Half of the time	O Most of the time	O All of the time
6. Get along well in social situations?	O None of the time	O A little of the time	O Half of the time	O Most of the time	O All of the time

7. Feel close to another

person?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time
8. Feel like you had someone to turn to if you needed help?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time
9. Feel confident in yourself?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time
10. Feel sad or depressed?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time
11. Think about ending your life?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time
12. Feel nervous?	○ None of the time	○ A little of the time	○ Half of the time	○ Most of the time	○ All of the time

During the PAST WEEK, how often did you...

13. Have thoughts racing through your head?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
14. Think you had special powers?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
15. Hear voices or see things?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
16. Think people were watching you?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
17. Think people were against you?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
18. Have mood swings?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
19. Feel short-tempered?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
20. Think about hurting yourself?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always

During the PAST WEEK, how often...

21. Did you have an urge to drink alcohol or take street drugs?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
22. Did anyone talk to you about your drinking or drug use?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
23. Did you try to hide your drinking or drug use?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always
24. Did you have problems from your drinking or drug use?	○ Never	○ Rarely	○ Sometimes	○ Often	○ Always

Depression/Functioning:
Relationships:
Self-Harm:
Emotional Lability:
Psychosis:
Substance Abuse:

TOTAL:

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Client DSM Diagnosis as of 7/11/2018

02:34 PM

Client:	Test, QSI (OCTRD1145618) 9/29/1975
Effective Date/Time:	7/11/2018 02:34 PM
External Diagnosis:	No
Diagnosed By:	
Comments:	

Diagnosis

DSM-5	Severity/Specifier	ICD-10	Comments
No records found.			

The Diagnoses above display in priority order.

Psychosocial and Contextual Factors

ICD-10 Code - Description	Comments
No records found.	

Diagnostic Formulation

No records found.

CPAC LOC ASSESSMENT CONCLUSIONS921

Clinical Impressions and Recommendations:

Level of Care Recommendation:

Signatures

Validation Issues:

Error: Requirements not met for CPAC Presenting Problem rev917.
Error: Requirements not met for Treatment History v1.
Error: Requirements not met for Substance Abuse Hx v1.
Error: Requirements not met for CPAC Legal Involvement rev 917.
Error: Requirements not met for Educ, Employ, Finances and Military v1.
Error: Requirements not met for CPAC Family, Relationships, Social Supports, Spirituality 917.
Error: Requirements not met for CPAC Mental Status Examination (MSE)917.
Error: Requirements not met for CPAC Mental Status Examination (MSE)917.
Error: Requirements not met for CPAC Mental Status Examination (MSE)917.
Error: Requirements not met for CPAC Mental Status Examination (MSE)917.
Error: You must complete a Diagnosis or Psychosocial and Contextual Factor before this document can be signed.
Error: Requirements not met for CPAC LOC ASSESSMENT CONCLUSIONS921.

Electronic Signature: The document can not be signed until the errors above are resolved.

Signature History

Action	Date	Staff
No records found		

Safety Plan: Brief Instructions

Step 1: Recognizing Warning Signs

__ Ask *"How will you know when the safety plan should be used?"*
__ Ask, *"What do you experience when you start to think about suicide or feel extremely distressed?"*
__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the clients' own words.

Step 2: Using Internal Coping Strategies

__ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"*
__ Ask *"How likely do you think you would be able to do this step during a time of crisis?"*
__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"
__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct clients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
__ Ask *"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"*
__ Ask clients to list several people and social settings, in case the first option is unavailable.
__ Ask for safe places they can go to do be around people, e.g. coffee shop.
__ Remember, in this step, suicidal thoughts and feelings may or may not be revealed.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

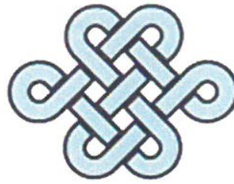
__ Instruct clients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
__ Ask *"Among your family or friends, who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*
__ Ask clients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, clients reveal they are in crisis.
__ Ask *"How likely would you be willing to contact these individuals*?"
__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct clients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
__ Ask *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers?"*
__ List names, numbers and/or locations of clinicians, local urgent care services, __ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask clients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.
__ For methods with low lethality, clinicians may ask clients or family members to remove or restrict access to these methods
__ Restricting the clients access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.



Tapestry

Premier Program by Pyramid Healthcare

Introduction

This document describes a brief clinical intervention, safety planning, that can serve as a valuable ***adjunct*** to the Care Logic tabs under Clinical Record. These tabs include the Tapestry Risk Assessment tab where you gather historical information regarding suicide ideation or self-harming behaviors, the Crisis Prevention and Intervention Plan within the Tapestry Person Center Plan tab as you are developing the treatment plan, and the Tapestry Behavioral Modification Agreement. After gathering an exhausted list of assessment information and documenting within Care Logic under tabs noted, a Safety Plan can be developed with the client. Safety planning may be used with clients who have made a suicide attempt, have suicide ideation, have psychiatric disorders that increase suicide risk, or who are otherwise determined to be at high risk for suicide. This is intended to be used by mental health clinicians, including suicide prevention coordinators, as well as other clinicians who evaluate, treat, or have contact with clients at risk for suicide in any setting.

Collaboration is often improved when the clinician and client can sit side-by-side, use a problem-solving approach, and focus on developing the safety plan. **Given that collaboration and the therapeutic alliance is paramount for developing safety plans and engaging clients in treatment, the safety plan should be completed using a paper form with the client**. This Information from the safety plan may then be scanned into the electronic medical record. This is in addition to documenting in the specific tabs noted in Care Logic.

In general, safety plans should consist of *brief instructions using the clients' own words* and should be *easy-to-read for the client. They have access to this this easy-to-read plan throughout the course of their treatment.*

A safety plan is a prioritized written list of coping strategies and sources of support that clients can use before, during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of

potential coping strategies as well as a list of individuals or agencies that clients can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides clients with something that is easy for them to access in the midst of a crisis. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, clients can determine and employ those strategies that are most effective.

The purpose of this document is to provide a detailed description of how clinicians and clients may collaboratively develop and use safety plans as an intervention strategy to lower the risk of suicidal behavior. This approach is consistent with Recovery Models, which views clients as collaborators in their treatment and fosters empowerment, hope, and individual potential.

Developing a Safety Plan

Safety plans should typically be developed following a comprehensive suicide risk assessment in Care Logic. During this risk assessment, the clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis (this may be a suicide attempt or increased/chronic suicide ideation). During this part of the intervention, clients have the opportunity to "tell their story" about the crisis. This description may include the activating events as well as the client's reactions to these events. This discussion helps to facilitate the identification of the warning signs to be included on the safety plan as well as the identification of specific activities that may have been used to alleviate the crisis.

The basic components of the safety plan include (1) recognizing warning signs that are proximal to an impending suicidal crisis; (2) identifying and employing internal coping strategies without needing to contact another person; (3) utilizing contacts with people as a means of distraction from suicidal thoughts and urges. This includes going to healthy social settings, such as a coffee shop or place of religion or socializing with family members or others who may offer support *without discussing suicidal thoughts*; (4) contacting family members or friends who may help to resolve a crisis and with whom suicidality can be discussed; (5) contacting mental health professionals or agencies; and (6) reducing the potential for use of lethal means. Clients are instructed first to recognize when they are in crisis (Step 1) and then to follow Steps 2 through 5 as outlined in the plan. If following the instructions outlined in Step 2 fails to decrease the level of suicide risk, then the next step is followed, and so forth.

Step 1: Recognizing Warning Signs

Rationale: The first step in developing the safety plan involves the recognition of the signs that immediately precede a suicidal crisis. These warning signs can include personal situations, thoughts, images, thinking styles, mood, or behavior. One of the most effective ways of averting a suicidal crisis is to address the problem before it emerges fully.

Instructions: In order to do this, clients should be helped to identify and, just as importantly, to pay attention to their warning signs. In helping clients to identify these signs, the clinician may ask: "*How will you know when the safety plan should be used?*" Alternatively, clients may be asked to identify what they experience when they start to think about suicide or encounter extreme distress. The specific warning signs will vary from client to client and may include one or more of the following domains: thoughts, images, thinking processes, mood, or behavior. These warning signs are then listed on the safety plan *using the client's own words.*

Examples: *Thoughts:* "I am a failure." "I don't make a difference." "I am worthless." "I can't cope with my problems." "I can't take it anymore." "Things aren't going to get better."

Images: "Flashbacks."

***Thinking Processes*:** "Having racing thoughts."

Mood: "Feeling irritable." "Feeling down." "Worrying a lot."

Behavior: "Spending a lot time by myself." "Avoiding other people." "Not doing activities that I usually do." or "Using drugs." "Participating in disordered eating patterns"

Step 2: Using Internal Coping Strategies

Rationale: After clients have identified the signs that are associated with a suicidal crisis, they are asked to list some activities that they could employ without needing to contact other people. Such activities function as a way to help clients take their minds off their problems and prevent suicide ideation from escalating. Given that the most effective activities will vary from person to person, the client should be an active participant in generating these strategies. The specific strategies may or may not include skills that were learned during therapy. As a therapeutic intervention, it is useful to have clients try to cope on their own with their suicidal feelings, even if it is just for a brief time.

Instructions: There are several steps for identifying internal coping strategies including (a) the identification of coping strategies, (b) the likelihood of using such strategies, and (c) the identification of barriers and problem solving.

Identification of coping strategies: Clients may be asked, "*What can you do on your own if you become suicidal again, to help yourself not to act on your thoughts or urges? What activities could you do to help take your mind off your problems even if it is for a brief period of time?*" The coping strategies should include specific behaviors that the client could do without contacting another person.

Assess the likelihood of using such strategies: After some internal coping strategies have been generated, the clinician should obtain specific feedback. For example, the clinician might ask, "*How likely do you think you would be able to do this step during a time of crisis?*"

Identification of barriers and problem solving: If clients express doubt about their ability to implement a specific step on the safety plan, then the clinician may ask, "*What might prevent you from thinking of these activities or doing these activities even after you think of them?*" The clinician may use a collaborative, problem solving approach to ensure that potential roadblocks to using these strategies are addressed and/or that alternative coping strategies are identified. If clients still remain unconvinced that they can apply the particular strategy during a crisis, other strategies should be developed. The clinician should help clients to identify a few of these strategies that they would use in order of priority; the strategies that are the easiest to do or most likely to be effective may be listed at top of the list.

Examples: Internal coping strategies may involve engaging in a wide variety of specific behaviors such as going for a walk, praying, listening to inspirational music, going online, taking a shower, playing with a pet, exercising, engaging in a hobby, reading, or doing chores.

Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support

Rationale: When the internal coping strategies are ineffective and do not reduce suicidal ideation, clients should identify key social settings and people in their natural social environment who may help take them outside themselves and distract them from their suicidal thoughts and urges. This may be either individuals, such as friends or family members, or may be healthy social settings in which socialization occurs naturally. Examples of the latter include coffee shops or places of religion. These settings depend, to a certain extent, on local customs but clients should be encouraged to exclude environments in which alcohol or other

substances may be present. Also, excluding environments and groups of people that trigger disordered eating patterns. In this step, when contacting others, clients should be advised to identify social settings or individuals who are good "distractors" from their own thoughts and worries. This step is not for reaching out to others for specific help with the suicidal crisis. Socializing with friends or family members without explicitly informing them of their suicidal state may assist in distracting clients from their problems including distracting them from their suicidal thoughts. A suicidal crisis may also be alleviated if clients feel more connected with other people.

Instructions: Clients are instructed, specifically, to reach out to these individuals or to go to these social settings if engaging in the internal coping strategies in the second step does not resolve the crisis. It is important to ask clients to list several people and/or settings, in case the first choice is unavailable. Thus, the list is prioritized, and phone numbers and/or locations may be included. It is important to remember that both individuals and safe places where they have the opportunity to be around others, such as coffee shops, may be included. It may be helpful to ask, *"Who helps you feel good when you socialize with them?" or "Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings." or "Where can you go where you'll have the opportunity to be around people in a safe environment?"*

Examples: Identify individuals who are friends or acquaintances with whom the client has a cordial, noncontroversial relationship or, if few friendships exist, identify places where casual social contacts may occur, e.g. local coffee shop, schools.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

Rationale: If the internal coping strategies or social contacts for purposes of distraction and connection offer little benefit to alleviating the crisis, clients need to contract to inform family members or friends that they are experiencing a suicidal crisis. This step is distinguished from the previous step in that clients explicitly identify that they are in crisis and need support and help.

Instructions: The clinician may ask: "*Among your family or friends, who do you think you could contact for help during a crisis?*" or "*Who is supportive of you and who do you feel that you can talk with when you're under stress?*" Given the complexity of deciding if client should or should not disclose to others that they are thinking about suicide, the clinician and client should work collaboratively to formulate an optimal plan. Thus, clients may choose to enlist individuals who may help to distract themselves as indicated in Step 3 as well as individuals who will assist in managing a suicidal crisis as indicated in Step 4. For both of these steps, clients

should be asked about the likelihood that they would contact these individuals and to identify potential obstacles and problem solve ways to overcome them. Someone close to the client with whom the safety plan can be shared should be identified. **Examples:** Spouse/partner, sibling, parent, close friend, clergy.

Step 5: Contacting Professionals and Agencies

Rationale: The fifth step consists of professionals or other clinicians who could assist clients in a time of crisis and the corresponding telephone numbers and/or locations. Clients are instructed to contact a professional or agency if the previous strategies (i.e., coping strategies, contacting friends or family members) are not effective for resolving the crisis.

Instructions: As with the other steps of the safety plan, the list of professionals or agencies may be prioritized. If clients are actively engaged in mental health treatment, the safety plan may include the name and phone number of this provider. However, the safety plan should also include other professionals who may be reached especially during non-business hours. The safety plan emphasizes that appropriate professional help is accessible in a crisis and, when necessary, indicates how these services may be obtained. As mentioned previously, clients may be reluctant to contact professionals and disclose their suicidality for fear of being hospitalized or rescued using a method that is not acceptable to them. The clinician should discuss the clients' expectations when they contact professionals and agencies for assistance and discuss any roadblocks or challenges in doing so. As with the previous steps, the clinician should discuss any concerns or other obstacles that may hinder the client from contacting a professional or agency. Only those professionals whom the client is willing to contact during a time of crisis should be included on the safety plan. Questions here might be, "*Who are the mental health professionals that we should identify to be on your safety plan?*" and *"Are there other health care providers?"*

Examples: Primary mental health clinician, other mental health clinician, 24-hour local urgent care services facility or emergency department.

In some settings or circumstances when access to urgent mental health or medical care is limited (or not appropriate), then the clinician and client may decide to include calling 911 on the safety plan.

Step 6: Reducing the Potential for Use of Lethal Means

Rationale: The risk for suicide is amplified when clients report a specific plan to kill themselves that involves a readily available lethal method. Even if no specific plan is identified by the client, a key component in

a safety plan involves eliminating or limiting access to any potential lethal means in the client's environment. This may include safely storing medication, implementing gun safety procedures, addictive substances, or restricting access to knives or other lethal means.

Instructions: Depending on the lethality of the method, implementing the decision to remove or restrict the method will vary. The clinician should ask clients which means they would consider using during a suicidal crisis and *collaboratively identify ways to secure or limit access to these means*. For methods with lower lethality (such as drugs or medication with a low level of toxicity), the clinician may ask clients or guardians to remove or restrict their access to these methods themselves before they are in crisis. The clinician should also be aware that restricting access to a lethal method does not guarantee a client's safety because they may decide to use another method. If clients report any other methods or specific *"What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?"* and *"How can we go about developing a plan to limit your access to these means?"*

Implementation of the Safety Plan

Assess for likelihood that the plan will be used and problem solve if there are obstacles: After the safety plan has been completed, the clinician should assess the clients' reactions to it and the likelihood they will use the safety plan in general. The clinician may ask: *"How likely is it that you will use the safety plan when you notice the warning signs that we have discussed?"* If clients report or the clinician determines that they are reluctant or ambivalent to use it, then the clinician should collaborate with them to identify and problem solve potential obstacles and difficulties to using the safety plan. The clinician may ask: *"What might get in the way or serve as a barrier to you using the safety plan?"* For specific barriers that are identified, the clinician may say: *"Let's discuss some ways to deal with this problem(s) so that you will be able to use the safety plan when it would be the most helpful for you."* For example, some clients may feel that they may have trouble reaching out to others for help. The clinician should help clients identify what is likely to stand in the way of asking for help and ways to minimize this obstacle. They may also refuse to use their safety plan because they find the name of the strategy, "Safety Plan," to be offensive. In this instance, the clinician would work with the client to find an alternative name such as "Plan B" or "Action Plan" that they may find has a more neutral connotation. Once clients indicate that they are willing to use the safety plan during a crisis, then the original

document is given to them to take with them and a copy is scanned and kept in the medical record. The clinician also discusses where the client will keep the safety plan and how it will be retrieved during a crisis.

Evaluate if the proposed safety plan format is appropriate to the clients' capacity and circumstances: In some circumstances, the clinician may determine that the format of the safety plan is not appropriate for a particular client. For example, if the client has cognitive impairment that makes it impossible to follow the plan as put forth in this document, or for any other reason the client is unable to follow a plan on his or her own, the clinician should adapt the approach to the client's needs. The implementation of the safety plan should always be made using good clinical judgment that involves an assessment of the appropriateness for any given safety plan methodology. Thus, the format of the safety plan may be adapted depending upon the personal needs of the client. For example, the Safety Plan form that is provided includes 3 items to be listed under each subheading. In practice, more than 3 items may be listed. **However, regardless of the format that is chosen, the most important feature of the safety plan is that it is readily accessible and easy to use. That is, lengthy and complex safety plans are less likely to be used by clients during a crisis.**

Review plan periodically: The Safety Plan should be periodically reviewed and discussed and possibly revised by the clinician and client after each time it is used during the course of treatment. The plan is <u>not</u> a static document. It should be revised as clients circumstances and needs change over time.

The safety plan is one component of comprehensive care of the suicidal individual: Brief crisis interventions, such as safety planning, may be especially useful when the opportunity or circumstance for acute care is limited. While safety planning is a useful intervention with clients at risk for suicide, it is important to consider safety planning as one component of comprehensive care for clients who are suicidal. Other important components include risk assessment, appropriate psychopharmacologic treatment, psychotherapy and hospitalization if needed.

Safety planning for self-harming behaviors: Safety planning protocols have been developed for managing suicidal crises in outpatient or inpatient mental health settings as part of ongoing and long-term psychotherapy treatment. In that context, safety plans are used as part of ongoing mental health treatment in outpatient and inpatient settings and are revised during subsequent visits as new coping skills are learned or as the social network is expanded.

If a client is not able to create a safety plan and contract for safety by participating in creating a safety plan, then the clinician and the treatment team assess the appropriateness of the level of care for the client and the referral to inpatient hospitalization. The clinician will need to sign and have client sign documents is an important part of contracting for safety.

Creating a safety plan for any self-harming behaviors: A safety plan should be done with a client when a client presents with any self-harming behavior. Self-harming is also termed self-mutilation, self-injury or self-abuse. The behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of oneself. Some examples are cutting, trichotillomania, scratching, picking scabs or interfering with wound healing. Each safety plan is individualized and can be individualized for the client in residential settings.

Please use attached safety plan in addition to charting within Care Logic (tabs noted throughout this document) until Tapestry can get easy-to-read document uploaded and created in Care Logic. There is a tab that is titled Tapestry Comprehensive Crisis Plan but it isn't an easy-to-read document or tool that clients can access in an emergency or suicidal crisis. This will be addressed so that there is an easy-to-read printable form to be done with the client with an electronic signature.

Tapestry SAFETY PLAN:

Step 1: Warning signs:

1. ________________________________
2. ________________________________
3. ________________________________

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. ________________________________
2. ________________________________
3. ________________________________

Step 3: People and social settings that provide distraction:

1. Name________________________ Phone______________
2. Name________________________ Phone______________
3. Place________________ 4. Place ________________

Step 4: People whom I can ask for help:

1. Name________________________ Phone______________
2. Name________________________ Phone______________
3. Name________________________ Phone______________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name____________________ Phone______________
   Clinician Pager or Emergency Contact #________________
2. Clinician Name____________________ Phone______________
   Clinician Pager or Emergency Contact #________________
3. Local Urgent Care Services ________________________
   Urgent Care Services Address________________________
   Urgent Care Services Phone ________________________

Step 6: Making the environment safe:

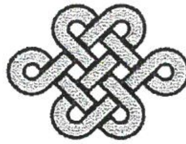
1. ________________________________
2. ________________________________

Signature of Client ________________________________ Date: ________

Signature of parent, guardian or personal representative ________________ Date: ________

Signature of Therapist ________________________________ Date: ________

Patient Name: ______________________ DOB: __________ Exam Date: ____________



Tapestry

Premier Program by Pyramid Healthcare

Please fax completed form to: (828) 654-0920
Phone: (828) 884-2475

Vitals

Sitting BP: __________ HR: __________
Standing BP: __________ HR: __________
Height: __________ Wt: __________
Last Menstrual Cycle: __________

ED Diagnosis

- ☐ Anorexia Nervosa - Restricting/ Binge/Purge
- ☐ Bulimia
- ☐ Binge Eating Disorder
- ☐ Other Specified Feeding/Eating D/O
- ☐ Other: __________

Mental Health History/Hospitalizations

____
____
____
____

Past/ Current Medical Conditions

____
____
____
____

Surgeries/Hospitalizations

____
____
____

Communicable Diseases

Active TB Yes No
Other: __________

Allergies

Food: __________
Drug:__________
Other Dietary Restrictions:

____

Current Eating Disorder Behaviors

(List Frequency/ Amount)

Bingeing: __________
Purging: __________
Type: Vomiting Laxative
Exercise: __________
Calorie Restriction: __________
Other: __________

Risk Assessment

Suicidal Ideation	Yes	No
Suicide Attempt	Yes	No
Self Harm	Yes	No
Violent Behavior	Yes	No

Labs – ALL ARE REQUIRED

***Results must be within 14 days PRIOR to admission date**

- ☐ CBC
- ☐ CMP
- ☐ EKG
- ☐ Phosphorus
- ☐ Magnesium
- ☐ HCG
- ☐ Urinalysis
- ☐ Hepatitis A, B, C screening
- ☐ TSH, free T3, free T4
- ☐ Pre-Albumin
- ☐ Vitamin D and Vitamin B12
- ☐ Urine Drug Screening
- ☐ PPD
- ☐ Documentation of any other pertinent history
- ☐ Growth Chart *(for pediatric clients only)*

Current Medications: (Name/Dose/Freq) Or attach list

____
____
____
_

Patient Name: ______________________________ DOB: __________ Exam Date: _______________

Physical Exam

HEENT	☐ WNL	Other:
Dental	☐ WNL	Other:
Thyroid	☐ WNL	Other:
Chest/ Lungs	☐ WNL	Other:
Breast	☐ WNL	Other:
Heart	☐ WNL	Other:
Abdomen	☐ WNL	Other:
Pelvic	☐ WNL	Other:
Hair/Skin/Nails	☐ WNL	Other:
Musculoskeletal	☐ WNL	Other:
Neurological	☐ WNL	Other:
Extremities/Edema	☐ WNL	Other:

REQUIREMENTS FOR ADMISSION TO A RESIDENTIAL FACILITY

Is the patient ambulatory? Yes / No Details:
Can the patient manage her/his own medications? Yes / No Details:
Are there any limitations on physical activities? Yes / No Details:
Is the patient free from communicable diseases? Yes / No Details:

Are there additional assessments needed? Yes / No Details:
Are there any medical/psychiatric/medication instructions? Yes / No Details:

I hereby certify that ________________________________ is medically stable and meets all requirements for admission to a residential facility.

Physician Name: ____

Physician Signature: ______________________________________ Date: __________

Office Address: ____

Office Number: ____________________________

Referral Contact: ______________________ Phone: ______________________

Patient Name: ______________________________ DOB: __________ Exam Date: ______________

RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ____________________________________Date of Birth:____________________

I authorize the use or disclosure of the above named individual's health information as described below. The information is to be disclosed by/ exchanged with:

Tapestry *11 N. Country Club Rd* *Brevard, NC 28712* Phone: *828-884-2475* Fax: *828-884-2187*	***AND***	NAME OF FACILITY: ADDRESS: CITY/STATE: PHONE #: FAX #:

The purpose or need for this disclosure is: (MARK ALL THAT APPLY)

- ✓ Tapestry Medical Form
- ✓ Labs results for last 3 months
- ✓ EKG results from last three months
- ✓ Growth Chart, if applicable
- ✓ Progress notes that relate to eating disorder/ mental health issues
- ✓ Current Medication List
- ✓ Last History and Physical
- ✓ Immunization Record
- ☐ Other: ____________________

I understand that this authorization will expire 365 days from the date it is signed unless I have specified a different expiration date or expiration event as follows: ______________________

I understand that I may cancel this authorization at any time by notifying in writing the Tapestry, 11 N Country Club Road, Brevard, NC 28712, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws. I understand that Tapestry will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided for the sole purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

____________________________________ ____________________

Patient Signature Date

____________________________________ ____________________

Parent or Legal Guardian Signature Date

____________________________________ ____________________

Witness Name and Signature Date

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What is an incident anyway? When does it need to be reported? AND HOW?

<u>3 levels of incidents</u>

<u>Level 1- this is anything out of the ordinary that occurs. It needs to be reported internally on our RIR forms located on the N-Drive under, "Incident Reports"</u>

Examples:

- Medication errors that do not threaten the client's health or safety (as determined by MD, NP or pharmacist).

Wrong dosage- if a client take's the wrong dose of medicine or WE fill a pillbox with the wrong dose

Wrong administrative technique- ex. client attempts to give self-injection

Wrong consumer or wrong medication

Loss or spillage of medication- pills are dropped ***and lost*** *or liquid medication is spilled*

- Any client injury that requires first aid only
- Disclosure from a disabled adult about abuse that occurred **PRIOR** to October Road services (for example; disclosure of neglect at FCH one month before starting services)
- Suicidal behavior-any suicidal threat that indicates **NEW or DIFFERENT** behaviors
- Inappropriate sexual behavior that is **NOT** a potentially serious threat to health and safety of self or others (client disrobes while staff is present or makes significantly inappropriate sexual comments)
- Aggressive or destructive acts that do not involve a report to law enforcement- i.e. clt throws a chair, breaks a window, pushes someone, self-injures
- Fire- any fire that poses no threat to health or safety of others
- Breach of client's confidentiality
- Motor vehicle accidents that do not result in injury
- Loss or damage of company property
- Any staff injury
- Contraband on premises (drugs, weapons, etc.)
- Fighting
- Any Law enforcement assistance (safety check etc.)
- Communicable diseases where the threat of transmission is low. I.e. client has TB and is being treated by a medical professional
- Infection control- client has open wounds and first aid is provided –personal protective equipment is used.
- Needle stick (of staff).
- Biohazardous accident- blood is spilled and cleaned without exposure, chemical spill in community that affects ORI operation

<u>Level 2- must be reported internally on RIR and externally on IRIS (state required reporting system) within 48 hours of our learning of the incident</u>

- Client death due to terminal illness or other natural causes

- Client injury that requires treatment by MD, RN or LPN (treatment does not include first aid, diagnostic tests- blood work, MRI, EKG etc.)
- **ANY** allegation of abuse, neglect or exploitation of our client by anyone (caretaker, friend, relative, staff, stranger) INCLUDING domestic abuse- for example If we call DSS because FCH staff or family member pushed a client, withheld medication, etc...
- Any medication error that threatens the client's health or safety
- Any suicide attempt that does not result in death or permanent physical or psychological injury
- Sexual behavior that involves a threat to self or others or a report to law enforcement or DSS
- Aggressive or destructive acts or illegal behavior that involves a report to law enforcement or is a potentially serious threat to self or others i.e. client huffing on property and police are called, client chases staff after throwing trash can and police are called
- Any missing person's report filed with police
- Any permanent withdrawal of our services due to client misconduct
- Any fire that threatens health or safety of consumers
- Communicable disease- threat of transmission high i.e. client has communicable disease and it is decided by leadership that it must be reported to health department.
- Needle stick (of client)
- Biohazard- blood is spilled and client is exposed, client exposure to chemical

Level 3- must be reported internally on RIR and externally on IRIS (state required reporting system) within 48 hours of our learning of the incident and verbally to Vaya immediately - call Ayofemi Powell 828-586-5501 ext. 1104

- Client death due to suicide, violence/homicide, accident, unknown cause (includes client's that have been discharged in the last 90 days if we learn of their death)
- Any client injury that results in permanent physical or psychological damage/impairment
- Any allegation of abuse, neglect, exploitation that results in permanent physical or psychological impairment
- Any sexual abuse of a client of ours that is deemed incompetent
- A medication error likely to result in permanent physical or psychological impairment
- Any suicide attempt that results in permanent physical or psychological impairment
- Any sexual behavior that results in death, permanent impairment **OR** is perceived to be of significant danger or concern to the community ex. client rapes or sexually assaults someone
- Any Amber or Silver Alert for one of our clients
- Any fire that results in permanent physical or psychological impairment or is perceived to be significant danger to community

9/18/17

EXECUTIVE INCIDENT REVIEW

CLIENT NAME: **INCIDENT TYPE:**

ATTENDANCE:

DATE OF INCIDENT:

WHAT SERVICE LINE WAS IMPACTED:

INCIDENT SUMMARY:

[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

MEETING SUMMARY:

[Grab your reader's attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

FINDINGS & PLAN:

Topic	Proposed Action	Responsible Party	Action Due Date	Progress

CHANGES MADE AS A RESULT OF THIS INCIDENT (FINAL):

CLINICALLY INTEGRATED TREATMENT FOR EATING DISORDERS AND TRAUMA

Tapestry Treatment Centers

Overview of the Presentation

- Overview of Eating Disorders (Anorexia, Bulimia, and Binge Eating)
- Warning Signs and Medical Consequences of Eating Disorders
- Overview of Trauma
- Warning Signs and Risk Factors of Trauma
- The Relationship Between Trauma and Eating Disorders
- Family Dynamics and Treatment
- Theoretical Orientations
- Interventions

Jessie Alexander.2018

Eating Disorders

- An eating disorder is a complex illness that develops over time from a combination of physiological, psychological, interpersonal, cultural, and spiritual factors resulting in a disturbance of thoughts and behaviors about food, weight, and body image issues.
- It is progressive in nature, impacts males and females, and can have life threatening consequences.

Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
  - Significantly low body weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.
- Intense fear of gaining weight; persistent behavior often interferes with weight gain.
- Body image disturbance; often highly influences self evaluation; denial of severity of illness.
- Two Types:
  - Restricting and Binge Eating/ Purging Type

Warning Signs of AN

- Fear of weight gain
- Excessive weight loss
- Denial of hunger and refusal to eat
- Excuses to avoid meals
- Preoccupation with food
- Distorted self image
- Excessive or compulsive over exercising
- Depression and/or isolation
- Amenorrhea/ delayed menstruation

Jessie Alexander.2018

Personality Characteristics Associated with AN

- Extreme compliance and need to feel in control
- Poor self confidence and self worth
- Avoidant of conflict
- Ineffective coping skills
- Often shy or fearful of social situations
- Indecisive
- Extremely sensitive to external stimuli
- Seeks others approval
- Avoids taking risks
- Views life and situations in all or nothing terms/ dichotomous thinking
- Low frustration tolerance

Jessie Alexander.2018

Medical Consequences of AN

- Amenorrhea
- Dehydration
- Abdominal pain/ constipation
- Lethargy and fatigue
- Intolerance to cold temperatures
- Emaciation
- Development of lanugo (fine, downy body hair for warmth)
- Osteoporosis/ weak bones (from decreased estrogen and other hormones)

Bulimia Nervosa

- Recurring binge episodes:
- Eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
- A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent use of inappropriate behaviors to prevent weight gain (vomiting, laxatives, exercise, diet pills)
- Both binging and purging occur, on average, at least once per week for 3 months
- Self evaluation unduly influenced by weight/ shape
- Does not meet criteria for anorexia

Warning Signs of BN

- Preoccupation with food and calories
- Secret eating/ hoarding food
- Feeling of being out of control
- Bathroom trips immediately after eating
- Eating of enormous meals without weight gain
- Binge eating, then purging by vomiting, laxatives, diuretics, fasting or diet pills
- Dental problems from acid on the teeth

Personality Characteristics Associated with BN

- Difficulty controlling impulses and anger
- Presence of impulsive symptoms
- Mood instability, cognitive instability (unstable thought patterns), unstable behavior and self image
- Frequent sense of guilt and shame connected to behaviors, particularly impulsive behaviors
- Low self esteem chronic feelings of unworthiness

Medical Consequences of BN

- Extreme dehydration
- Electrolyte imbalance
- Dental issues/ tooth erosion
- Swollen parotid glands

Jessie Alexander.2018

Binge Eating Disorder

- Recurring episodes of eating large amounts of food, more than most people would eat in similar circumstances in a short period of time.
- Feelings of loss of control during binge episodes, as well as marked distress.
- Binge eating associated with 3 or more of the following:
  - Eating much more rapidly than normal
  - Eating until uncomfortably full
  - Eating large amount of food without feelings of physical hunger
  - Eating alone due to embarrassment about amount of food
  - Feeling disgusted with oneself, depressed, very guilty afterward
- Binge episodes occur, on average, at least once a week for 3 months.

Jessie Alexander.2018

Warning Signs of BED

- Disgust and shame with self after overeating
- Hoarding food (especially high calories/ junk food)
- Coping with emotional and cognitive dysregulation (stress, unhappiness, disappointment) by eating
- Eating large amounts of food without being hungry
- Consuming food to the point of being uncomfortable or even in pain
- Attributes ones successes and failures to weight
- Avoiding social situations, especially those involving food

Personality Characteristics Associated with BED

- Increased self hate as weight increases
- Intense feelings of guilt and shame
- Preoccupation with thoughts of food and weight
- Chronic feelings of deprivation underlying intense cravings
- Feelings of worthlessness
- Emphasis on being a people pleaser
- Distorted body image

Medical Consequences of BED

- Obesity
- Diabetes
- High blood pressure
- High cholesterol
- Kidney disease/ kidney failure
- Gall bladder disease
- Arthritis

Jessie Alexander.2018

Eating Disorder Stabilization

- Academy for Eating Disorders Recommendations for Inpatient Treatment:
  - Evaluation of medical stability (evaluation by physician, laboratory testing, EKG, medical history.
  - Mental health screening- co- occurring disorders (personality disorders, substance abuse, suicidal ideation, violence risk).
  - Nutritional screening for eating disorder behaviors and nutritional status.
  - Special needs (language barriers, disabilities, etc).
  - Assessment of impact of illness on patient and family.

Jessie Alexander.2018

Eating Disorder Stabilization

- Core Components of Treatment:

1. Medical, Nursing
2. Nutritional
3. Psychological
4. Psychiatric
5. Milieu therapy (daily milieu management and support).

Jessie Alexander.2018

Trauma and Eating Disorders

- You are working with traumatized patients, whether you recognize it or not.
- Late 1980's- research began to emerge about the link between trauma and eating disorders.
- Literature review by Fallon and Wonderlich (1997):
  - Binge-purge behaviors of bulimic individuals represent efforts to regulate extreme affective states related to earlier abuse.
  - Restrictive behaviors serve to attain body shape that will help regulate interpersonal factors associated with the abuse.
  - Comorbidity with EDS clients with history of trauma:
    - Mood disorders, anxiety disorders, conduct disorders, personality disorders, dissociative disorders, etc.

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Trauma and Eating Disorders

- Literature Review Continued:
- 80-98% of inpatients have significant trauma exposure.
  - Data suggests that other forms of trauma, apart from sexual abuse, may be linked to eating disorders.
    - Childhood physical abuse, psychological abuse, various forms of victimization in adulthood.
  - High Risk for Eating Disorder due to Trauma:
    - Victims of sexual abuse, particularly individuals who suffered at a younger age.
    - Victims or observers of domestic violence.
    - Those who suffer from PTSD.
- Traumatized individuals often engage in eating disorder behaviors to manage feelings and experiences related to PTSD (NEDA, 2012).
  - 30% of individuals with an eating disorder have been sexually abused.
  - Connection between eating disorder, self harm, and body shame.
  - Body shame triggers self destructive habits aimed at destroying the body of which victim is so ashamed.
    - Starvation, purging, binge eating, etc.
    - ***Eating disorder is the coping skill.***

Jessie Alexander.2018

Trauma and Eating Disorders

- According to NEDA (2012) (www.nationaleatingdisorders.org):
  - Treatment of eating disorder for individuals with trauma should also incorporate treatment for trauma.
    - Treatment aimed at healing individual, helping individual engage in meaningful relationships/ intimacy with self and others.
    - Need for promoting resolution of trauma AND attachment trauma.
    - Restructuring of attachment style.

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Trauma, Eating Disorders, and Substance Abuse

- There is an absolute need for clinical integration.
- We want to move away from the parallel treatment model, particularly for these clients.
- Most individuals entering into treatment rarely meet criteria for one diagnosis.
- Experiential Avoidance, chemical dissociation.
  - However, many treatment providers consciously and unconsciously attempt to treat only one part of the individual, which often leads to relapse and ineffective treatment experiences.
    - "There was strong resistance by paraprofessional staff (often addicted persons in sustained remission) and drug counselors who tend to label primary psychiatric symptoms as "drug seeking behavior" rather than recognizing primary psychiatric symptoms of PTSD, mania or major depressive disorder." (Worley et al, 2003)
    - Need for extensive education.

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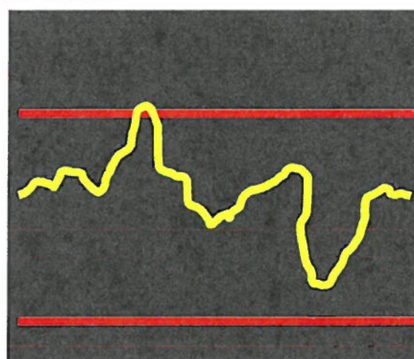
Window of Tolerance

arousal



Family Dynamics

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Family Dynamics

- Attachment Issues, Eating Disorder, and Trauma:
  - Attachment System:
    - Biologically based
    - Ensures physical safety and coping with emotional distress.
    - Results in disruptions and impairment in identity development/ sense of self, relational functioning/ intimacy, and regulation of affect, impulses, and boundaries.
  - Dysfunctional Attachment System:
    - Absence/ fear of the primary attachment figure; inability/ unwillingness of attachment figure to protect client from trauma.
    - Dysregulation of adrenal cortical system; high levels of stress hormone.
      - Basis of learned helplessness.
      - Feelings of disconnection, depersonalization, loneliness, overwhelmed, out of control, unsafe, abandoned, and empty
        - **Compulsive over/ under eating.**

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Family Dynamics

- Common dynamics:
  - Failure to develop autonomy from parents (parental intrusiveness and control).
  - Perfectionism (no questioning of diverging from parental values; emphasis on external presentation, image).
  - Dependency ("good girl"= development of a compliant false sense of self).
    - Patient is overly focused on pleasing others (otherization).
  - Control (child's feelings must be congruent with family values).
  - Inability to express emotions/ vulnerability.
  - Avoidance (family pattern of moving on without resolution).
  - Patient is overly focused on pleasing others.
    - Often the result of over critical/ narcissistic/ emotionally fragile parenting style.
- Knowing and not knowing (Fallon and Wonderlich, 1997):
  - Dynamics associated with non protecting bystander, family secrets.
  - Important to not re-create this dynamic in therapy.

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Family Dynamics and Trauma

- Relational Dynamics:
  - Attachment Cry- Crisis = communication.
  - Safety and control through caretaking.
  - Ambivalence- need to use others (binge) and not need anyone (restrict); want help, but nothing works.
  - No separate sense of self- enmeshed with others, overprotective.
  - Eating Disorder helps regulate ambivalence and duality associated with attachment issues.
- Trauma Reenactment:
  - Affective flashbacks; Trauma reenactment is either literal or figurative recreations of the emotional dynamic associated with the trauma.
  - "Acting in" compulsions (cutting, eating disorder) and "acting out" compulsions (abusive/ alcoholic partners, hypersexuality).
  - Distraction from unresolved issues, illusion of connectedness, power, and control.
  - Physiological response to trauma reenactment- endorphin release.
    - Paradoxical- soothing and destructive .

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Acceptance and Commitment Therapy

Clinical Integration

"The more I know about how we are designed to function- what neurophysiology, infant research, affect theory, cognitive psychology, semantics, information theory, evolutionary biology, and other pertinent disciplines can tell me about human development- the better I am prepared to be empathic with a patient's communication at a particular time in his or her treatment."

- Michael Basch, 1995

Acceptance and Commitment Therapy

- Experiential Avoidance:
  - The process wherein an individual is unwilling to contact certain private experiences and actively works to escape such experiences.
    - Eating disorders, within the ACT model, are versions of experiential avoidance.
  - Misapplied control- trying to control external experience from the place of "non wholeness" with the implication that the trauma survivor is fundamentally broken.
    - Trying to control the experience results in incorporating the trauma into the individual's identity. It makes the trauma bigger, more powerful.
    - Attempting to control and avoid the trauma only amplifies the experience.
  - Fusion: "Melting with Language"
    - Holding thoughts and interpretations of experience to be literally true.
      - Sexually traumatized- thoughts of ruin and worthlessness considered to be true. The problem lies within the concept that the experience ruined her, and, in order to heal, she must undo the experience.

ACT

- ACT: In place of…
  - literal meaning- there are multiple meanings
  - Fusion- there is defusion
    - seeing it for what it is, content of the mind
  - Reason- movement towards living in ways that promotes personal values
  - emotional and experiential control- emotional and experiential acceptance.
- Mindfulness:
  - 1. acceptance of experience
  - 2. defusion from the literal meaning of a thought
  - 3. continuous contact with the present moment
  - 4. transcendent sense of self.
- Observation without effort to make something more, better, or different.

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Jessie Alexander.2018

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- I would like to credit Christine Engstrom, RD, LD and Kathy Steele for their help with this presentation.

Jessie Alexander.2018

Chad Husted
Vice President of Southeastern Operations
Pyramid Healthcare
119 Tunnel Road, Suite D
Asheville, NC, 28807
770-639-9657
chusted@pyramidhc.com
7-16-18

DHSR - Mental Health
JUL 18 2018
Lic. & Cert. Section

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey completed June 14, 2018
Tapestry Adolescent Residential Program, 5030 Hendersonville Road, Fletcher, NC 28732
MHL # 045-133

Dear North Carolina Mental Health Licensure and Certification Section:

Tapestry Treatment Centers of North Carolina was purchased by Pyramid Healthcare on July 1st 2017. The intended aim of Pyramid Healthcare with the acquisition of Tapestry was to add exceptional primary eating disorder residential treatment services to the array of behavioral health services already offered in the Pyramid Healthcare system of care. Tina Nowak, the founder and Executive Director of Tapestry offered Pyramid Healthcare the opportunity to add leadership to the executive team with extensive operational and clinical experience in the realm of eating disorder treatment.

The notification of a client complaint received from the State of North Carolina in June of 2018 prompted an internal investigation by Pyramid Healthcare. The internal investigation found many of the same deficiencies that the State has identified in the complaint survey performed on June 14th 2018. Tina Nowak, the former Executive Director of Tapestry, was relieved of her duties on July 1st 2018. The operational and clinical deficiencies identified in the internal investigation were not acceptable to any degree. Jessie Alexander, an experienced leader in the eating disorder treatment field, assumed the Executive Director role on July 1st 2018. Tapestry is undergoing a complete overhaul from an operational and clinical perspective. Staff supervision, clinical trainings and the general direction of the program has significantly shifted since receival of the Complaint notification. The new direction, we believe, will be articulated further in the attached plan of correction. Tapestry will represent clinical excellence in the region and the State survey and complaint has been transparently addressed and corrected across the entire program.

Sincerely,

Chad Husted
Vice President of Southeastern Operations
Pyramid Healthcare

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

Josie Ruganda
Executive Director
7/15/18

July 6, 2018

Tina Nowak, Executive Director
Appalachian Outpatient Services, LLC
5030 Hendersonville Road
Fletcher, North Carolina 28732

RE: Suspension of Admissions
Tapestry Adolescent Residential Program 5030 Hendersonville Rd., Fletcher, NC 28732
MHL # 045-133
E-mail Address: tnowak@tapestrync.com

Dear Ms. Nowak:

Based on the findings of this agency during a survey completed June 14, 2018, we find that Appalachian Outpatient Services, LLC has operated Tapestry Adolescent Residential Program in violation of North Carolina General Statute (N.C.G.S. § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities and Substance Abuse Services. After a review of the findings, this office is taking the following action:

Suspension of Admissions –The documented violations indicate that conditions in the facility are found to be detrimental to the health and safety of the clients. Therefore, pursuant to North Carolina General Statute § 122C-23, the Division of Health Service Regulation, Department of Health and Human Services, is hereby ordering you to suspend all admissions to the facility effective immediately. The Suspension of Admissions is to continue until conditions are documented to meet approved inspection status. The facts upon which the suspensions of admissions are based are set out in the attached Statement of Deficiencies which is incorporated by reference as though fully set out herein.

The rule citations include:

- 10A NCAC 27G .1301 Scope (V179)
- 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111), 10A NCAC 27G .0202 Personnel Requirements (V108), 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27E .0107 Training on alternatives to Restrictive Interventions (V536), 10A NCAC 27G .0603 Incident Response Requirements (V366), 10A NCAC 27G .0604 Incident Reporting Requirements (V367), and 10A NCAC 27G .0209 Medication Requirements (V118).

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within twenty (20) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

Office of Administrative Hearings
6714 Mail Service Center
Raleigh, NC 27699-6714

North Carolina General Statute § 150B-23 provides that you must also serve a copy of the petition on all other parties, which includes the Department of Health and Human Services. The Department's representative for such actions is Ms. Lisa G. Corbett, General Counsel. This person may receive service of process by mail at the following address:

Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the twenty (20) day period, you lose your right to appeal. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR at 336-861-7342. Please note that the use of informal procedures does not extend the 20 days allowed to file for a contested case hearing as explained above.

Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Robin Sulfridge, Western Branch Manager at 336-861-7342.

Sincerely,

Stephanie Gilliam

Stephanie Gilliam, Chief
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
ncdma.dhsrnotice@lists.ncmail.net, Provider Enrollment DMA
Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
Jerrie McFalls, Director, Henderson County DSS
Cindy Koempel, MH Program Manager, DSOHF
Pam Pridgen, Administrative Assistant
File

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA CERTIFIED MAIL

Jose Alexander
7/15/18
Executive Director

July 6, 2018

Tina Nowak, Executive Director
Appalachian Outpatient Services, LLC
5030 Hendersonville Road
Fletcher, North Carolina 28732

RE: Type A1 Administrative Penalty
Tapestry Adolescent Residential Program, 5030 Hendersonville Rd., Fletcher, NC 28732
MHL # 045-133
E-mail Address: tnowak@tapestrync.com

Dear Ms. Nowak:

Based on the findings of this agency from a survey completed on June 14, 2018, we find that Appalachian Outpatient Services, LLC has operated Tapestry Adolescent Residential Program in violation of North Carolina General Statute (N.C.G.S.) § 122C, Article 2, the licensing rules for Mental Health, Developmental Disabilities, and Substance Abuse Services. After a review of the findings, this agency is taking the following action:

Administrative Penalty – Pursuant to N.C.G.S. § 122C-24.1, the Division of Health Service Regulation, Department of Health and Human Services (DHHS), is hereby assessing a Type A1 administrative penalty of $6,000.00 against Appalachian Outpatient Services, LLC for violation of 10A NCAC 27G .1301 Scope (V179). Payment of the penalty is to be made to the Division of Health Service Regulation, and mailed to the Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, North Carolina 27699-2718. If the penalty is not paid within sixty (60) days of this notification, a 10% penalty plus accrued interest will be added to the initial penalty amount as per N.C.G.S. § 147-86.23. In addition, the Department has the right to initiate judicial actions to recover the amount of the administrative penalty. The facts upon which the administrative penalty is based and the statutes and rules which were violated are set out in the attached Statement of Deficiencies which are incorporated by reference as though fully set out herein.

Appeal Notice – You have the right to contest the above action by filing a petition for a contested case hearing with the Office of Administrative Hearings within thirty (30) days of mailing of this letter. *Please write the facility's Mental Health License (MHL) number at the top of your petition.* For complete instructions on the filing of petitions, please contact the Office of Administrative Hearings at (919) 431-3000. The mailing address for the Office of Administrative Hearings is as follows:

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Raleigh, NC 27699-6714

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Ms. Lisa G. Corbett, General Counsel
Department of Health and Human Services
Office of Legal Affairs
Adams Building
2001 Mail Service Center
Raleigh, NC 27699-2001

If you do not file a petition within the thirty (30) day period, you lose your right to appeal and the action explained in this letter will become effective as described above. *Please note that each appealable action has a separate, distinct appeal process and the proper procedures must be completed for each appealable action*

In addition to your right to file a petition for a contested case hearing, N.C.G.S. § 150B-22 encourages the settlement of disputes through informal procedures. The Division of Health Service Regulation is available at the provider's request for discussion or consultation that might resolve this matter. To arrange for an informal meeting, you must contact DHSR 336-861-7342. Please note that the use of informal procedures does not extend the 30 days allowed to file for a contested case hearing as explained above.

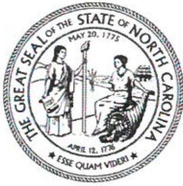
Should you have any questions regarding any aspect of this letter, please do not hesitate to contact us at the Department of Health and Human Services, Division of Health Service Regulation, Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718 or call Robin Sulfridge, Western Branch Manager at 336-861-7342.

Sincerely,

Stephanie Gilliam

Stephanie Gilliam, Chief
Mental Health Licensure & Certification Section

Cc: DHSRreports@dhhs.nc.gov, DMH/DD/SAS
ncdma.dhsrnotice@lists.ncmail.net, Provider Enrollment DMA (For Article 3 only)
Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
Cindy Koempel, MH Program Manager, DSOHF
Jerrie McFalls, Director, Henderson County DSS
Pam Pridgen, Administrative Assistant File



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 5, 2018

Jesse Alexander 7/15/18 Executive Director

Tina Nowak, Executive Director
Appalachian Outpatient Services, LLC
5030 Hendersonville Road
Fletcher, NC 28732

Re: Complaint Survey completed June 14, 2018
Tapestry Adolescent Residential Program, 5030 Hendersonville Road, Fletcher, NC 28732
MHL # 045-133
E-mail Address: tnowak@tapestrync.com, jgrabowski@tapestrync.com
(Intake #NC00139457)

Dear Ms. Nowak:

Thank you for the cooperation and courtesy extended during the complaint survey completed June 14, 2018. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation(s) are cited for 10A NCAC 27G .1301 Scope (V179) with crosses of 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V111), 10A NCAC 27G .0202 Personnel Requirements (V108), 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27E .0107 Training on Alternatives to Restrictive Interventions (V536), 10A NCAC 27G .0603 Incident Response Requirements (V366), 10A NCAC 27G .0604 Incident Reporting Requirements (V367), and10A NCAC 27G .0209 Medication Requirements (V118) .

Time Frames for Compliance

- Type A1 violations and all cross referenced citations must be ***corrected*** within 23 days from the exit date of the survey, which is July 7, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1/A2 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Appalachian Outpatient Services, LLC for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.

- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

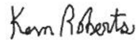
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Robin Sulfridge at 336-861-7342.

Sincerely,



Kem Roberts
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
File