Safety: Involves any considerations of abuse, neglect, harm to self, harm to others, substance use, medical and/or a mixture of all of them. It is important to inquire about the situation to gain more information/insight, but it DOES NOT mean that we investigate the situation when it comes to any aspects of the abuse and/or neglect (Do not take over the case, leave it to CPS or APS). DO NOT assume anything in the question or case.

Abuse and Neglect

- Child abuse and neglect: anyone from the ages of newborn to 18 years old
  - This can be physical, mental, emotional, sexual and/or all of them
  - Neglect is any aspect of their basic needs being unmet: food, shelter transportation, medical, supervision, and/or clothing etc.
  - Go to the child FIRST if they are of the age that they can communicate about their own situation.
  - When the abuse/neglect is done by a parent and/or caregiver/someone living with a child we contact CPS. If the abuse/neglect is done by someone outside of the home, then we contact the appropriate authorities.
- Adult abuse and neglect: anyone from the ages of 65 years+ OR anyone who has an intellectual/cognitive disability.
  - This can be physical, mental, emotional, sexual, financial and/or all of them
  - Neglect is any aspect of their basic needs being unmet: food, shelter, transportation, medical, connection, and/or financial etc.
  - Go to the person FIRST if they are able to communicate the specific details to you.

1) When a teacher, friend, parent, colleague, coach, pastor etc. reports the information to you about potential abuse and/or neglect then we need to speak with the person being abused and/or neglected FIRST before reporting.
   a. We need to ensure that we have enough information before proceeding, i.e., we need to have enough information to be able to relay the information, since we DO NOT want to make blank statements, or we DO NOT want to report based on hearsay.

2) When the person being abused/neglected and/or the person doing the abusing/neglecting reports the information to us, then we can REPORT it immediately. We heard it directly from the person and it would not be considered hearsay.

   *If the person is not of age to communicate (less than 3 years old, we can base it off from a decent amount of observation)

Medical

- When it appears that harm has been done to our client or a physical health concern is present during the session
  - Ex) We have someone who has a broken arm in session with you, we would have them seek medical services, rather than proceeding.

- When it appears that our client's physical health is potentially at a dangerous level during the meeting
    - Ex) Someone is in our office sweating, nodding out, and struggling to breathe. WE would suggest that they seek medical services before proceeding.

Substance Use

- Assess for someone using any drugs or consuming alcohol. This will give an idea of what their use looks like and explore the potential dangers or drawbacks of their use.
    - Are they using the substances around their children?
    - Is their use putting them, or someone else in danger?
    - Explore the impact that their use has on their functioning?
- Assess for intoxication/withdrawal within the session
    - Is their use putting them or someone else in danger?
    - Are they able to adequately benefit from services?
    - What is their motivation for change?

Keywords: Develop a safety plan, inquire more information about a situation, speak to x (person being abused or person doing the abusing), explore x (the setting someone underage is in and/or a setting we are not entirely used to.)

Feelings: The client's SUBJECTIVE point of view of their situation and what is currently going on within their life and their perspective of where they would like to go/what they want from services/to accomplish.

- The client/patient's point of view that is subject to change based on their situation or information that they receive
- The client's direct feelings, their perspective of the situation, or simply information that can be a starting point for treatment
- The social worker needs to recognize where the client is, and where THEY would like to go. "We need to start where the client is."
- Engage with the client to begin developing a therapeutic relationship/rapport with the client.
    - *BE AWARE OF WHO THE CLIENT IS!!
        - The client can be one person or multiple people!!!

Keywords: Validate, recognize, inquire, gather, elicit, feelings, perspective etc.

Assess: The clinical or OBJECTIVE information about a client's situation and what their presenting needs are. It can provide us more information on the client's situation, beyond what they have already told us.

- This information can be difficult to change since it involves direct observation and evidence for what has been and what is right now.
- May utilize screening tools, contact family members (IF we have a release), explore client's history (MH, treatment history, medications, supports, physical health etc.) and the client's previous behaviors/attempts to improve their situation
- The starting point of the social worker and client working together to develop a plan of action to address the client's identified needs/wants

Keywords: Assess, inquire, gather, delve, explore, contact etc.

Refer: Involves providing referrals to other professionals within our agency or finding professionals outside of the agency to directly influence the client's situation and to elicit change that they are looking to get out of services. Also, this can involve connecting the client to community resources, and services that can help supplement treatment. *Referrals to other professionals are based on the social worker NOT having the appropriate experience to treat the client. The social worker is exploring their limitations and finding ways to supplement them.

- Referral to a professional within our agency would involve finding someone with the appropriate knowledge and expertise within a particular area of interest to better help the client with improving their identified issue/need. The other professional will have more experience than you do.
    - Ex) A client needs substance use services and Phil does not have experience with treating clients with substance use disorders. However, Becca has experience with substance use treatment and could better treat the client. Therefore, Phil would refer the client to Becca for services.
        - We need to inform the client and make an informed referral
- Referral to a professional outside of our agency would occur when no one at our agency is about to treat or serve the client in an appropriate manner. WE need to make sure that the professional is competent, and the location is available and accessible to the client of interest.
    - Ex) Someone needs trauma treatment. Phil does not have experience with treating trauma and no one at his agency does either. Phil would need to find someone with trauma experience and make the referral to the person that can better treat the trauma.
        - We need to inform the client of the necessity of the referral and ensure the referral is made appropriately.
- Appropriate times for social workers to refer a client that they have been working with:
    - A client brings in something to treatment that the social worker cannot seek supervision around to improve.
        - The client is sexually attracted to the social worker (competence)
        - The client knows the social worker outside of the agency (Conflict of interest/Dual relationship)
        - The social worker is connected to the client in another way outside of the agency (Conflict of interest/Dual relationship)
    - The social worker knows of a community resource that could benefit the client, such as support group meetings, food banks, housing resources etc. *The client will still be in treatment with the social worker

Keywords: Refer, connect, coordinate, link, deliver etc.

Educate: Providing information about services that the social worker will provide, another professional will provide or any areas of interest to the client. The goal of this level is to ensure that the client is aware of what to expect AND so that they can provide informed consent within their treatment. The client is able to know what to expect and what is actually possible in their situation. It allows for the client to have knowledge and competency around their own services/treatment.

- To allow for the client to be able to adequately know what to expect while in treatment or to better inform them on their ability to make sound decisions for themselves.
- To become more aware of a particular topic of interest i.e., marijuana use on their medications, anger management techniques, positive strategies for anxiety etc.

Advocate: When the social worker gathers the needed information resources, and services for THE CLIENT to deliver the services to themselves.

- The person determines whether they utilize or benefit from a particular part of their treatment
- Allows for the person to have control and reinforce their work while in treatment
- "Gathering together for a cause, but it is up to the person to exercise their right."
- The client will be the main factor in their progression, regression, or stagnation.

Ex) Phil has problems with time management and would like to be able to improve it. A social worker provides him a planner that he can utilize while at home.

- It is up to Phil to fill out and utilize the schedule to improve his time management skills.

Ex) Phil is doing a study group on the acronym and walking through practice questions with social workers who are preparing to pass their ASWB exam. Phil provides them the information for the acronym and leaves it up to the participants to utilize it or not.

- The participants have the information regarding the acronym, and it is up to them whether they utilize/benefit from it.

Ex) Rebecca has been struggling with balancing studying for the social work licensure exam and handling her anxiety while answering practice questions.

- Phil provides Rebecca information on how to break down the questions, combat her anxiety and to remain focused while preparing. It is up to her, whether she uses the information or not.

Facilitate: When the social worker gathers the needed information, resources, and services for the client and another PROFESSIONAL delivers the service to/for the client.

- Someone is influencing the likelihood that someone will benefit from the services, and/or that the client's needs are being met.
- The act of someone assisting a client with getting their intended result(s) from services. The professional serves as a sense of accountability.
- "Someone helps connect you with someone to get further along in the process."

Ex) Phil gets a list of anger management techniques from his therapist to try at home, and Darline is contacting him daily to inquire about the utilization of the techniques provided.

- Someone is following up with Phil to ensure that his needs are being met or increasing the likelihood that he reaches his identified goal (to decrease his anger).

Ex) Phil is working with a client who struggles with depression and who recently lost his housing. Phil connects the client with a housing specialist, at his agency, to ensure that his client gets his needs met. The client would still work with Phil, but they are getting additional assistance.

- Phil was working with the client, and he connected with ANOTHER PROFESSIONAL to get his needs met. This level is kind of like utilizing case management services 😊

Ex) Barb has been working to pass her ASWB exam and has not been successful. Barb's friend, Jodi, recently passed her exam by watching Phil on YouTube and suggests she reaches out to him for assistance. Barb reaches out to Phil to increase the likelihood that she will pass her exam.

- Barb has been trying to pass the exam on her own, and Jodi connected her to another person to help impact her situation. The act of Phil following up and providing guidance will increase the likelihood of comprehension and passing the exam.

Intervene: When the social worker gathers the needed information, resources, and services for the client, and THEY (social worker) will provide/deliver the services for/to the client.

- Whenever the social worker does an action to elicit or promote change in a client's situation to ensure that the need/wants are being addressed
- When the social worker helps to develop or deliver plans for/with the client. They will work with the client to ensure that they are getting closer to their goals.

Ex) Phil wants to better handle his anger, so the social worker he is working with provides him a list of anger management techniques that they identified together. The social worker will follow up with Phil to ensure that the positive strategies are improving his anger.

- The social worker worked with Phil to identify positive strategies and they are following up with him to ensure that his anger is addressed.

Ex) Rebecca has been feeling more depressed since her brother moved away, and she meets with a therapist to discuss it. The therapist works with Rebecca to identify positive strategies to improve her depressive symptoms.

- Rather than providing a list or connecting her with another professional, the social worker assisted her by themselves.

Ex) Jackie has been struggling with understanding how to break down questions and stay motivated to study for her ASWB exam. She reaches out to a guy named Phil for assistance. Phil connects with her and works with her on how to break down questions and to remain motivated throughout the process.

- Phil directly interacted with Jackie, rather than just providing feedback, or having another professional assist her, he impacted her situation directly.

ANYTIME THE SOCIAL WORKER DOES AN ACTION IT IS INTERVENE

Quick Review of the acronym:

- The acronym starts with the client and moves towards the social worker
- Safety: IT is focused on the wellbeing of the CLIENT and the potential for harm to them or someone else.
- Feelings: It is all focused on the CLIENT's view and needs of their situation
- Assess: It is focused on the CLIENT's history and their situation
- Refer: It is focused on the CLIENT's needs and directing them in the best possible way to get them met.
- Educate: It is focused on increasing the CLIENT's competence and knowledge of their own situation and treatment.
- Advocate: It is focused on allowing the CLIENT to take control of their situation and to promote change. A=All by themselves
- Facilitate: It is focused on the CLIENT working through their struggles to make progress and connecting to another PROFESSIONAL to help. F=Friends because another person does it
- Intervene: It is focused on the SOCIAL WORKER working with the CLIENT to get their needs met. WE are the last resort. I= I do the action

Easy way to recall the different levels during the exam:
Savvy, Farmer, Aladin, Raises, Expensive, Apples, From, India
THE ACRONYM IS ONLY FOR APPLICATION QUESTIONS!!!!!!!!!! DO NOT APPLY THE ACRONYM TO ALL OF THE QUESTIONS!!!!!!

Medications
Antidepressant Medications
Brand name: Generic name
Zoloft: Sertraline
Cymbalta: Duloxetine
Effexor: Venlafaxine
Wellbutrin: Bupropion
Trazodone: Desyrel
Celexa: Citalopram
Lexapro: Escitalopram
Prozac: Fluoxetine
Easy ways to remember them:

- Most of the generic names have -ine (WITHOUT P or Z) at the end of the name.

Anti-Anxiety Medications
Brand name: Generic name
Xanax: Alprazolam
Klonopin: Clonazepam
Valium: Diazepam
Ativan: Lorazepam
Buspar: Buspirone
Librium: Chlordiazepoxide
Easy ways to remember them:

- Most of the generic names have -lam or -pam at the end of the name
    - Pam needs anti-anxiety medications to handle her lamb because it is out of control.

ADHD Medications
Brand name: Generic name
Adderall: Amphetamine combo
Concerta: Methylphenidate
Ritalin: Methylphenidate
Vyvanse: Lisdexamfetamine
Focalin: Dexmethylphenidate
Easy ways to remember them:

- Most of the generic names have -pheta or phen in the middle of them.
  - People phen for their pheta cheese and it is difficult for them to stay focused.

Antipsychotic (AP) Medications
Brand name: Generic name
Haldol: Haloperidol
Vraylar: Cariprazine
Risperdal: Risperidone
Thorazine: Chlorpromazine
Invega: Paliperidone
Geodon: Ziprasidone
Clozaril: Clozapine
Abilify: Aripiprazole
Seroquel: Quetiapine
Easy ways to remember them:

- Most of the generic names have -done or -ine (WITH P and Z) at the end of the name.
  - When people take their antipsychotic medications, they are done.

Mood Stabilizers (AP=Antipsychotic)
Brand name: Generic name
Lithium
Depakote: Divalproex
Lamictal: Lamotrigine
Valproic Acid: Depakene
(AP)Haldol
(AP)Risperdal
(AP)Latuda
(AP)Abilify

Psychotic Disorders
Brief Psychotic Disorder- Thought pattern disorder in which the person will experience short term gross motor deficits in reality testing, manifested by at least ONE of the following (MUST be 1, 2 and/or 3).

1) Delusions: False beliefs that are not based in reality and that the person refuses to give up, even when presented with factual information.
2) Hallucinations: Auditory (hearing), Visual (seeing), Tactile (feeling), Olfactory (smelling) things that are not actually there.

3) Disorganized Speech: Saying things that do not make sense, using made up words that have no meaning, and/or tangential speech where the person skips from topic to topic with no common theme that impairs effective communication.
4) Disorganized or Catatonic Behavior: Repetitive, senseless movements or adopting a pose which may be maintained for hours at a time. The individual may be resistant to efforts to move them into a different position or will assume the new position for hours as well.

B. Duration of an episode of the disturbance is at least 1 day, but less than 1 month, with eventual full return to premorbid level of functioning.
C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia, or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Duration: 1-30 days (Less than 30 days)

Schizophreniform- Pre-form of Schizophrenia

Criteria requirement: At least **2** of the following symptoms within at least a 1-month period, yet less than 6 months.

Symptoms 1-4 are considered positive symptoms: High energy and the mind is going quickly

1) Delusions: False beliefs that are not based in reality and that the person refuses to give up, even when presented with factual information
2) Hallucinations: Auditory (hearing), Visual (seeing), Tactile (feeling), Olfactory (smelling) things that are not actually there
3) Disorganized Speech: Saying things that do not make sense, using made up words that have no meaning, and/or tangential speech where the person skips from topic to topic with no common theme that impairs effective communication.
4) Grossly Disorganized or Catatonic behavior
   a. Repetitive senseless movements/childlike “silliness.”
   b. Repeated movements with no rhyme or reason
   c. Pacing/Walking in circles
   d. Talking to oneself
   e. Writing constantly
   f. Poor hygiene or lack of grooming/disheveled appearance
   g. Unpredictable or inappropriate agitation
   h. Adopting a pose which may be maintained for hours and may resist efforts to be moved into a different position or will assume the new position for hours
5) Negative symptoms
   a. Diminished emotional expression: reduction in the expression of emotions in the face, eye contact, intonation of speech, and movements in the hand, head, and face during communication. Flat affect.

b. Avolition: lack of motivation to complete self-initiated purposeful activities. i.e., little interest in participating in work or social situations; they withdraw from family, friends, and social activities.
c. Alogia: avoids communicating with other individuals or uses few words when communicating.
d. Anhedonia: decreased ability to experience pleasure and/or reduction in the initiation of engaging in pleasurable activities.
e. Asociality: apparent lack of interest in social interactions and may be associated with avolition but can also be due to limited opportunities for social interactions.

B. An episode of the disorder lasts at least 1 month, but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional."
C. Schizoaffective disorder and bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active phase symptoms, they have been present for a minority of the total duration.
D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
Duration: Longer than 1 month, yet less than 6 months

Schizophrenia

Criteria requirement: At least **2** of the following symptoms for 6 months or longer
Symptoms 1-4 are considered positive symptoms: High energy and the mind is going quickly

1) Delusions: False beliefs that are not based in reality and that the person refuses to give up, even when presented with factual information
2) Hallucinations: Auditory (hearing), Visual (seeing), Tactile (feeling), Olfactory (smelling) things that are not actually there
3) Disorganized Speech: Saying things that do not make sense, using made up words that have no meaning, and/or tangential speech where the person skips from topic to topic with no common theme that impairs effective communication.
4) Grossly Disorganized or Catatonic behavior
   a. Repetitive senseless movements/childlike "silliness."
   b. Repeated movements with no rhyme or reason
   c. Pacing/Walking in circles
   d. Talking to oneself
   e. Writing constantly
   f. Poor hygiene or lack of grooming/disheveled appearance
   g. Unpredictable or inappropriate agitation
   h. Adopting a pose which may be maintained for hours and may resist efforts to be moved into a different position or will assume the new position for hours

5) Negative symptoms
    a. Diminished emotional expression: reduction in the expression of emotions in the face, eye contact, intonation of speech, and movements in the hand, head, and face during communication. Flat affect.
    b. Avolition: lack of motivation to complete self-initiated purposeful activities. i.e., little interest in participating in work or social situations; they withdraw from family, friends, and social activities.
    c. Alogia: avoids communicating with other individuals or uses few words when communicating.
    d. Anhedonia: decreased ability to experience pleasure and/or reduction in the initiation of engaging in pleasurable activities.
    e. Asociality: apparent lack of interest in social interactions and may be associated with avolition but can also be due to limited opportunities for social interactions.

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care has been below the level achieved prior to the onset of symptoms.
C. Schizoaffective disorder and bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active phase symptoms, they have been present for a minority of the total duration.
D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Bipolar I Disorder- most commonly has Manic Episodes.
For a diagnosis of bipolar I disorder, someone will experience a manic episode. The manic episode may have been preceded by and may be followed by a hypomanic or major depressive episode. It DOES NOT REQUIRE an episode of depression.

B. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
C. During the period of the mood disturbance and increased energy or activity, 3 or more of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior.
    1. Inflated sense of self-esteem or grandiosity
    2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    3. More talkative than usual, or pressure to keep talking (e.g., feels pressured to have conversations with people)
    4. Flight of ideas, or subjective experience that thoughts are racing (where someone’s thoughts will run through their head, and they cannot slow them down)
    5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
    6. Increase in goal-oriented activities (either socially, at work or school or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)

7. Excessive involvement in activities with high potential for painful or negative consequences (i.e., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

D. The mood disturbance is sufficiently severe to cause marked impairment in social, or occupational functioning or to necessitate hospitalization to prevent harm to self, or others, or there are psychotic features.

E. The episode is not attributable to the physiological effects of a substance or another medical condition.

Hypomanic Episode: At least 4 days or longer

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of the mood disturbance and increased energy or activity, 3 or more of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior.

1. Inflated sense of self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual, or pressure to keep talking (e.g., feels pressured to have conversations with people)
4. Flight of ideas, or subjective experience that thoughts are racing (where someone's thoughts will run through their head, and they cannot slow them down)
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
6. Increase in goal-oriented activities (either socially, at work or school or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
7. Excessive involvement in activities with high potential for painful or negative consequences (i.e., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

Bipolar II Disorder- Hypomanic episodes and REQUIRES someone to have an episode of depression

For a diagnosis of bipolar II disorder, it is necessary for someone to have a current or past hypomanic episode *and* a current or past major depressive episode.

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of the mood disturbance and increased energy or activity, 3 or more of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior.

1. Inflated sense of self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual, or pressure to keep talking (e.g., feels pressured to have conversations with people)

4. Flight of ideas, or subjective experience that thoughts are racing (where someone's thoughts will run through their head, and they cannot slow them down)
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
6. Increase in goal-oriented activities (either socially, at work or school or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
7. Excessive involvement in activities with high potential for painful or negative consequences (i.e., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is by definition mania.
    a) Does not have a clinically significant impact on the client's life.
F. The episode is not attributable to the physiological effects of a substance or another medical condition.

DIGFAST: Distractibility, Increased goal-oriented activity, Grandiosity, Flight of idea, Activities that could be risky, Sleep disturbance, Talkativeness.

The differences between Hypomania and Mania are the duration of symptoms and the impact it has on someone's life.

- Mania: 1 week or longer or any duration that requires hospitalization (Psychosis, SI/HI) and it has a negative/clinically significant impact on someone's functioning, and it DOES NOT require someone have an episode of depression.
    - Brittany Spears, Charlie Sheen
- Hypomania: 4 days or longer, it does not require a negative/clinically significant impact on someone's functioning, and it DOES REQUIRE someone to have an episode of depression.
    - Someone who is overly productive at work, gets fixated on tasks and is often more productive with their time. Yet they find it difficult to do one thing at a time and always get involved with multiple things.

1) A social worker in an outpatient clinic has been working with a 27-year-old male for the past 5 months to better cope with his anger. Throughout treatment the man has been utilizing anger management and thought replacement techniques which have helped to improve his situation. During the intake assessment the man informed the social worker that his daughter was sexually assaulted by one of her friend's parents during a sleepover. The man reported that seeing his daughter in distress makes him angry and how he finds it difficult to control himself. During the most recent session the man reports that he has been having thoughts to hurt the person who sexually assaulted his daughter because she has been having nightmares and flashbacks again. What is the FIRST thing the social worker should do in this situation?
   A. Work with the man to identify the strategies he can utilize to cope with the thoughts he has been experiencing and provide him a list of child therapists in the area that his daughter could go to
   B. Gather information regarding the homicidal ideations that the man has been experiencing to identify whether he has plans, means and intent before proceeding
   C. Validate the man's feelings of anger that he has been experiencing and inform him of the necessity of contacting the appropriate authorities to ensure everyone remains safe
   D. Facilitate discussion around the thoughts that the man has been experiencing and inform him of the necessity of contacting the appropriate authorities to ensure everyone remains safe

2) A social worker in an outpatient clinic is completing an intake assessment with a 35-year-old male who reports finding it difficult to handle all the responsibilities in his life. The man reports that he has been working at his current job for 5 years and that he always feels like he is going to be fired. The man reports that he often feels the urge to hurt people and that when he is not at work, he will lock himself in the house to prevent himself from acting on his thoughts. The man reports that he was previously hospitalized 1 year ago, due to experiencing feelings of hopelessness. What is the MOST likely medication to improve the man's situation?
   A. Clozaril
   B. Valium
   C. Depakote
   D. Celexa

3) An emergency department social worker is completing an intake assessment with a 40-year-old female who reports feeling like nothing will ever get better. The woman reports that she has been finding it difficult to keep her thoughts straight and that there is not enough time in the day to accomplish everything she would like to. The woman reports that she has been avoiding her friends, since she feels like they are going to make fun of her or hurt her in some way. The woman reports having nightmares and constantly worrying about everything. Which medication is the doctor MOST likely going to prescribe the woman?
   A. Clozapine
   B. Clonazepam
   C. Bupropion
   D. Depakote

4) A hospital social worker is completing an intake assessment with a 32-year-old male after the police brought him in for knocking on his neighbor's doors to inform them that the world was ending. The man reports that he has been reading multiple books about life and that he had the urge to tell his neighbors about the information he found because he feels they are not smart enough to discover what he has found. The man reports that he has been awake for the past 4 days and feels like sleep would be a waste of time. The man denies experiencing any hallucinations or previous hospitalizations. What would be the MOST likely diagnosis for this man?
   A. Bipolar I Disorder
   B. Bipolar II Disorder
   C. Schizophrenia
   D. Narcissistic Personality Disorder

5) A social worker in a community mental health clinic has been working with a 21-year-old male for the past 5 months. The man reports hearing voices that tell him to hurt his parents, and that they have caused him to isolate from social situations. The man reports finding it difficult to sleep, and that he feels like someone from his dreams is going to hurt him. The man denies ever being hospitalized, and that he can keep his symptoms under control. What would be the MOST likely diagnosis for this man?
   A. Schizoid Personality Disorder
   B. Brief Psychotic Disorder
   C. Schizophreniform
   D. Schizophrenia

6) A social worker in an outpatient clinic is completing an intake assessment with a 35-year-old male upon request of Child Protective Services. According to the intake paperwork the man was ordered to treatment after he had a positive drug screen for cocaine last month. The social worker asks the man about his drug use, and he denies having any issues with drugs. The man reports he only came to this appointment to show proof of seeking out services. The man reports in order to gain visitation with his son back he needs to complete a treatment program. The social worker attempts to gain more information about the man, and he reports "I told you I do not need services, I am not crazy, and I do not need help." What should the social worker do NEXT in this situation?

   A. Validate the man's feelings of hesitance and inform him that treatment can look different for everyone to allow for him to feel less stigmatized
   B. Continue to attempt to engage the man and gather information about him to ensure a thorough assessment is completed for the courts
   C. Provide information to the man on the pros and cons of engaging in treatment to allow for him to become better informed about his situation
   D. Inform the man that he does not need to engage in treatment if he does not want to and offer to discharge him from treatment