Adult Mental Health Clinical Assessment & Treatment Planning Exercise

Clinician Training Case Study

Instructions

Read the following clinical scenario. Using your clinical judgment, complete the assessment below.

Please complete the following:

1. Identify **at least two (2) mental health diagnoses** using **ICD-10-CM**.
2. Include the **ICD-10-CM code** for each diagnosis.
3. Provide a **clinical rationale** supporting each diagnosis.
4. Develop a **person-centered treatment plan** that includes:
    - Presenting Problem
    - Client Strengths
    - Long-Term Goal
    - Three (3) Short-Term Goals
    - Three (3) Interventions for each Short-Term Goal
    - Anticipated Date of Discharge

Clinical Scenario

Client Information

Client Name: Angela M. (Fictional)

Age: 39

Gender: Female

Marital Status: Separated

Employment: Certified Nursing Assistant (currently working part-time)

Family Composition

Angela lives with her three children:

- Daughter – Age 16
- Son – Age 12
- Daughter – Age 6

The children's father has limited involvement and inconsistent financial support.

Presenting Concerns

Angela was referred by her primary care provider after reporting worsening depression and anxiety.

She reports:

- Feeling "hopeless most days"
- Crying several times each week
- Loss of motivation
- Difficulty getting out of bed
- Decreased energy
- Difficulty concentrating
- Poor appetite
- Sleeping only 3–4 hours per night
- Frequent panic attacks (approximately twice weekly)
- Excessive worrying about finances and parenting
- Irritability with her children
- Feelings of guilt related to being "a bad mother"
- Social withdrawal
- Loss of interest in church and family gatherings

Angela reports these symptoms have gradually worsened over the past 18 months following her separation and the death of her grandmother, who had been her primary source of emotional support.

Trauma History

Angela reports:

- Childhood emotional neglect

- Emotional abuse during marriage
- No history of physical abuse
- No psychiatric hospitalization

Substance Use

- Drinks alcohol socially (1–2 drinks monthly)
- Denies illicit drug use
- No history of substance use disorder

Medical History

- Hypertension
- Type II Diabetes
- Chronic migraines

Mental Status Examination

Appearance: Appropriate

Behavior: Cooperative

Mood: Depressed and anxious

Affect: Tearful and constricted

Speech: Normal rate and tone

Thought Process: Logical

Thought Content:

- No hallucinations
- No delusions

Orientation:
Alert and oriented ×4

Memory: Intact

Insight: Good

Judgment: Good

Risk Assessment:
Denies suicidal plan or intent but reports occasional passive thoughts such as:

"Sometimes I think everyone would be better off without me."

She identifies her children as her strongest reason for living.

Functional Impairments

Symptoms interfere with:

- Parenting
- Employment
- Sleep
- Household responsibilities
- Social relationships
- Self-care

Client Strengths

- Strong commitment to her children
- Stable housing
- Motivated for treatment
- Employed
- Insightful
- Good communication skills
- Strong faith
- No substance abuse
- Previous positive counseling experience
- Willing to participate in therapy

Clinician Response Form

Part I – Diagnostic Formulation

Primary Diagnosis

Diagnosis:

ICD-10-CM Code:

Clinical Rationale:

Secondary Diagnosis

Diagnosis:

ICD-10-CM Code:

Clinical Rationale:

Additional Diagnosis (Optional)

Diagnosis:

ICD-10-CM Code:

Clinical Rationale:

Part II – Person-Centered Treatment Plan

Client's Stated Goal

"What is most important to me is..."

Presenting Problem

Client Strengths

Long-Term Goal

Short-Term Goal #1

Interventions

1.
2.
3.

Short-Term Goal #2

Interventions

1.
2.
3.

Short-Term Goal #3

Interventions

1.
2.
3.

Anticipated Date of Discharge

Discharge Criteria