

General Assessment

11 Mental Health Assessment Principles for Primary Care Providers:

- 1) *You do not have to complete an assessment in one visit.* Listen to the general problem, establish that the situation is safe to wait another week or so, and then schedule a second visit to finish your assessment. Mental health specialists often take more than one visit to decide on diagnoses.
- 2) *Establish what pushed the situation into your office, “Why are you here today?”* A chronic stressor (like sadness about parents separating) does not usually trigger an office visit: acute stressors do (like a major child outburst after one parent cancels their upcoming weekend plans with the child).
- 3) *Strongly consider use of a general screening instrument* during health maintenance visits, like the PSC-17, to see if mental health problems are worth investigating further.
- 4) *Seek to interview child alone*, especially if an internalizing problem like depression or anxiety is suspected, to obtain a more accurate history.
- 5) *Empathic engagement with the child is worth the effort.* Young children open up better after asking them about simple things like their name, birthday, or school. Adolescents open up better after showing genuine interest in them, such as asking about their interests, hobbies. If a patient looks like they don't want to be there, comment on this and show them you are able to connect with how they feel.
- 6) *Collateral information is invaluable.* Parents often differ from each other in their view of their child, and schools often have other information vital to your assessment. Ensure that past medical histories and treatments are available to you (i.e. see DSHS resources section)
- 7) *Once suspecting a particular disorder, give that specific rating scale to parent/child.* You could leave the room to see another patient, then return and review results. Rating scales can help confirm diagnoses, and they provide an objective measure for following treatment responses.
- 8) *Recognize that child disorders have a developmental trajectory.* For instance early oppositionality may evolve into depression or anxiety, and early depression may evolve into bipolar disorder.
- 9) *Pay close attention to what you see.* The mental status exam of a child involves watching how they position themselves, process information and interact. For instance a child complaining of body aches who appears withdrawn, speaks softly, and will not look you in the eye should be screened for depression.
- 10) *Put it all together into your best clinical judgment, then revise your diagnosis over time.* It is very difficult to get it exactly right on the first visit. Mental health specialists often revise their diagnoses over time as more information becomes available. Also with children the process of development can make it hard to be definite about a diagnosis. You are ahead of the game if you can recognize with certainty the general category of problem, such as some type of learning disability or some type of anxiety disorder. Remember Occam's Razor; a single diagnosis plus a full social/family picture may explain things better than multiple mental health diagnoses.
- 11) *Remember you can ask for help.* Contained in this care guide are numerous State and County programs, like the Partnership Access Line, that are designed to assist you and your patient. For severe behavioral problems always consider referral to an RSN contracted mental health provider to obtain a care assessment and take advantage of the state's mental health benefits.

What do you do if everything looks like a problem?

- 1) *Establish what seems to be the leading problem, and focus your attention on that.* For instance if a child is having screaming tantrums, hitting siblings, other children and care workers, then the leading problem is probably one of externalizing behavior. Though it is possible that a depression or anxiety problem exists under the surface, the problem leading to threatened expulsion from daycare should be dealt with first. In that case, review the steps of our aggression/disruptive behavior decision tree. (This would be to treat ADHD if present, inquire if there is a safety problem like abuse occurring, and focus on parenting and limit setting assistance and possibly child focused therapy.)
- 2) *Get collateral information.* Particularly if the caregiver does not know the child's full history, other information sources like school, former physicians or therapists, other relatives, and foster care case managers will likely be able to give you information that clarifies what should be done. Respect the fact that it takes time to gather this additional information, which can be done by phone calls, record requests, or by sending out questionnaires or rating scales. The DSHS resource guide describes how to obtain claims histories. Remember our first assessment principle; you don't have to figure this all out in one visit.
- 3) *Use checklists for preliminary behavior/mental health screening.* These will help you narrow down what area to investigate and can quantify the likelihood of finding different types of diagnoses. Options include:
 - a. PSC-17 (free, included in this guide)
 - b. SDQ (Strength and Difficulties Questionnaire, 25 questions, 5 subscales, good psychometrics, multiple languages available, free for individual providers to download and use, free online scoring.) You must pull up the developer's website to obtain: <http://www.sdqinfo.com/b1.html>
 - c. CBCL (Child Behavior Checklist, school age version has 113 core questions plus 2 other pages to describe child functioning, widely used, very good psychometrics, translated versions available.) Requires scoring software, requires purchase from the developer: <http://www.aseba.org/products/forms.html>
 - d. BASC-2 (Behavior Assessment Scale for Children, 2nd edition, all multiple choice, 134-160 items for parent report on school age child, commonly used, very good psychometrics, scoring software recommended, requires purchase from the developer: <http://ags.pearsonassessments.com/Group.asp?nGroupInfoID=a30000>
- 4) *Discuss the scenario with a specialist.* PAL psychiatrists would like to talk about any tricky situations with you, and are available to do this Monday through Friday from 9 to 5.
- 5) *If you suspect a specific problem, a disorder specific rating scale can help you learn how likely or severe that diagnosis might be.* Disorder specific scales like the Vanderbilt scale for ADHD will *not* make the diagnosis for you—a diagnosis must be based on your overall clinical impression. When children have severe mental health symptoms, referral to a mental health clinic is appropriate. Very high rating scale scores might similarly indicate that referral to specialty care is appropriate.
- 6) *A good therapist can help you refine your diagnosis over time.*
- 7) *If you choose to prescribe a medication when the diagnosis is still uncertain, be very clear what the target symptom is you are treating and monitor that symptom closely.* If that target symptom does not improve, then that medicine needs to be stopped. It is very important to not simply stack medicines one upon another without demonstrating a clear benefit to the child.

Where can I go to get unbiased information about child mental health treatment and medications?

(this is not an all-inclusive list)

- 1) *Peer reviewed care guidelines from a professional association:*
 - a. American Academy of Pediatrics, Clinical Practice Guidelines
 - a) <http://aappolicy.aappublications.org/>
 - b. American Academy of Child and Adolescent Psychiatry, Practice Parameters
 - a) http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters
- 2) *Peer reviewed care guidelines from a State sponsored workgroup*
 - a. Partnership Access Line(PAL) in Washington
 - a) <http://www.palforkids.org>
 - b. CMAP project in Texas
 - a) <http://www.dshs.state.tx.us/mhprograms/CMAP.shtm>
 - c. Evidence based service guide in Hawaii
 - a) <http://hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html>
- 3) *Federal agency publications*
 - a. National Institute of Mental Health
 - a) <http://www.nimh.nih.gov>
 - b. Substance Abuse & Mental Health Service Administration
 - a) <http://www.samhsa.gov/>
- 4) *Collaborative guidance from respected organizations*
 - a. www.parentsmedguide.org --from AACAP and APA
 - b. www.nami.org --from the National Alliance for the Mentally Ill
- 5) *New original research, particularly if a randomized controlled trial design is used*
 - a. Pub Med provides free Medline searches
 - a) <http://www.ncbi.nlm.nih.gov/pubmed/>
- 6) *State pharmaceutical policy reviews (which review the current evidence base)*
 - a. Independent reviews of medications performed by OHSU Center for Evidence-Based Policy (Oregon EPC), used by Washington Pharmacy and Therapeutics (P&T) committee:
 - a) <http://www.ohsu.edu/ohsuedu/research/policycenter/DERP/about/final-products.cfm>
 - b. Washington State P&T committee transcripts, processes and decisions
 - a) <http://www.rx.wa.gov>

Special Issues for Foster Care Children

Post Traumatic Stress Disorder

Children in foster care frequently have past traumatic experiences like witnessing violence or being abused themselves, which might lead them to develop a long lasting anxiety stress disorder called PTSD. *Nightmares* (that are atypical for their age), *flashbacks* (suddenly feeling like one is re-experiencing a trauma), and *hyperarousal* (hypervigilance, irritability, exaggerated startle) that are still occurring more than one month after the traumatic experience are the three hallmarks to look for when diagnosing PTSD. While checking for PTSD, it is not advisable to ask a foster child to recount to you their exact past traumatic experiences within a 10 minute office visit—the child is likely to experience this as “re-traumatizing.” Instead, simply ask the child about any current symptoms of PTSD: if they are having nightmares, if they feel very jumpy if someone walks in the room, if they ever find themselves re-experiencing difficult events from their past in a sudden way.

Primary care providers suspecting that a child has PTSD should address these things:

- 1) The child’s current and future physical and emotional safety must be assured. No one recovers from PTSD if abuse is ongoing.
- 2) The child needs to understand what the plans are for their living situation, where they will be, and for how long. Not understanding where they will live day to day is very stressful and enhances their fear of returning to an unsafe environment.
- 3) The child should be referred for counseling support with a licensed mental health professional, and the Trauma Focused Cognitive Behavioral Therapy (TF-CBT) technique is preferred where available.
- 4) Recognize that there is no “PTSD medication.” As per the anxiety treatment guideline, SSRI’s are the medications most commonly recommended when symptoms of PTSD are severe. Sometimes medications like clonidine are given at bedtime to help with nightmares that are not improving via other treatments.

Attachment Concerns

Children in foster care may have difficulties with attachment to caregivers. These difficulties may manifest in a variety of ways depending on a child’s age. Very young children may be difficult to soothe when they are upset. Slightly older children may not turn to their caregivers for comfort in the same way other children do. The degree of attachment issues may vary from very minor to relatively extreme.

On the far end of the attachment spectrum is Reactive Attachment Disorder, which is characterized by pervasively impaired social relationships. It is defined in DSM-IV TR as “markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years” and may involve either inhibited or disinhibited behavior. Assessment, according to APSAC Attachment task Force Recommendations, must look at the child’s patterns of behavior over time to avoid over-interpreting the child’s adjustment to new or stressful circumstances. By gathering information from teachers, day care providers, peers, and from prior living situations one can understand the child’s attachment pattern more accurately. Cultural issues are important, especially with cross-cultural or international placements or adoptions. Overly broad, nonspecific, or unproven checklists should not be the basis of an evaluation. Care should be taken to rule out conditions such as autism spectrum disorder, pervasive developmental disorder, childhood schizophrenia, genetic syndromes, or other conditions (for example, Conduct disorder, ADHD) before making a diagnosis of an attachment disorder.

The core elements of treatment for attachment problems include securing a nurturing and safe environment for the child, working directly with the child’s caretakers to learn appropriate parenting skills, focusing on the child and family’s coping, and maintaining the child in the least restrictive and intrusive level of care. With Reactive Attachment Disorder the need for these treatments is multiplied. No specific pharmacotherapy is recommended. Play therapy and cognitive behavioral therapy addressing the child’s symptoms of fear, anxiety, and posttraumatic stress may be of benefit. Coercive or holding therapies are not recommended as they have been associated with harming the child.