MCPAP Clinical Conversations: After the screen: A Practical Approach to Mental Health Assessment in the Pediatric Primary Care Setting

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Overview

- Case Vignette: Max
- Essential components of a diagnostic evaluation
  - Targeted HPI
  - Additional History
  - Clinical interview/MSE
  - Impression/Plan
- Questions and Discussion

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Max

- 12 year old boy presenting with inattention and disruptive behavioral problems at school, school requested ADHD eval
- Vanderbilt rating scales positive for hyperactivity and inattention
- History gathered indicates that these symptoms are new over the last year. Mother provides additional history of substantial negativity at home, irritable, preoccupation with unfairness, become withdrawn from friends and family. Note family history of depression in mother, maternal aunt, maternal grandfather. Recent loss of pet.
- Clinical interview: child discloses feeling sad and hopeless all the time, some passive suicidal thoughts, wants help

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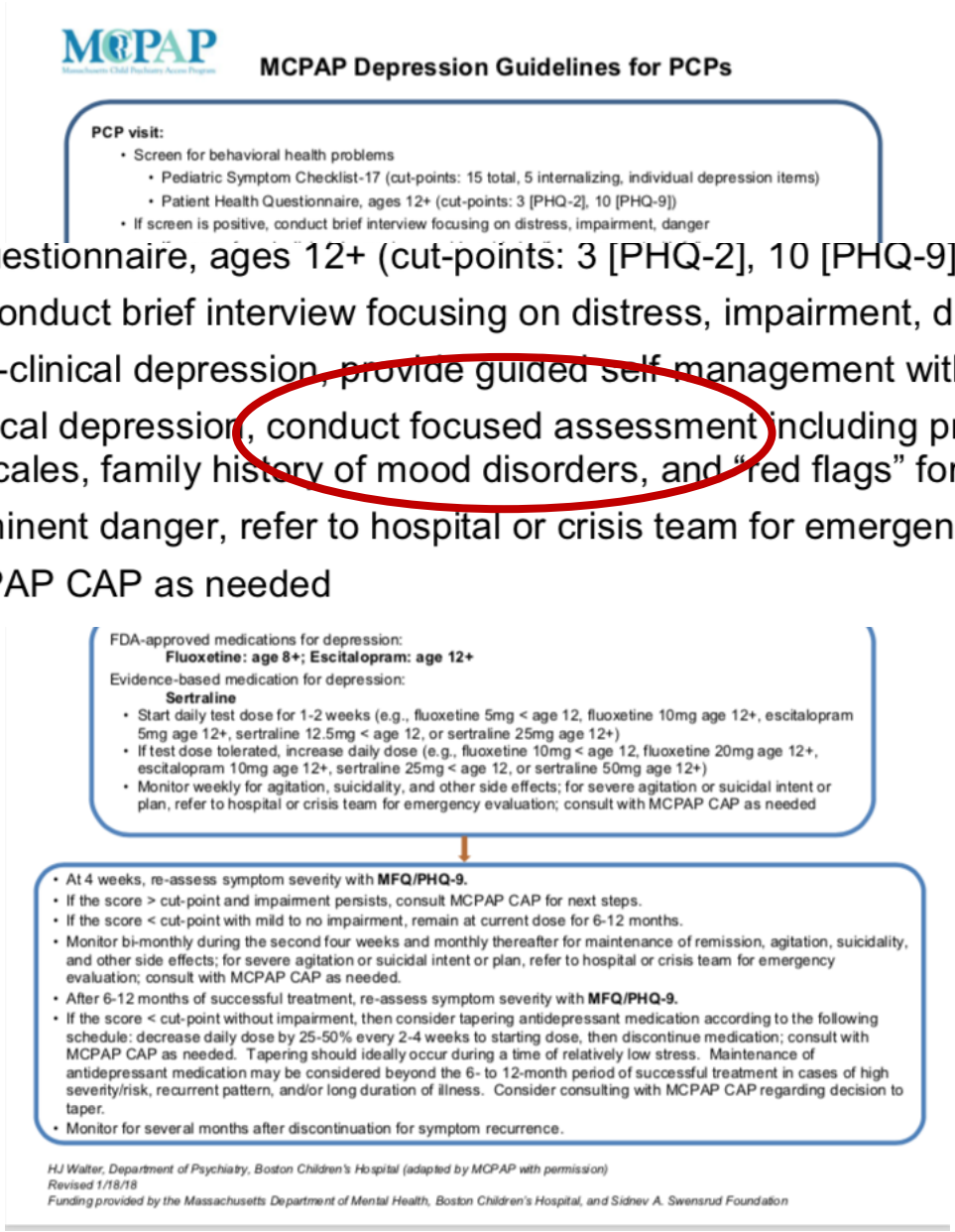

- Patient Health Questionnaire, ages 12+ (cut-points: 3 [PHQ-2], 10 [PHQ-9])
- If screen is positive, conduct brief interview focusing on distress, impairment, danger
  - If concern for sub-clinical depression, provide guided self-management with follow-up
  - If concern for clinical depression, conduct focused assessment including precipitating factors, symptom rating scales, family history of mood disorders, and "red flags" for medication use
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

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General Considerations

- Sensitivity vs. Specificity of screening assessments
- Clinical engagement and the therapeutic relationship
- Time management
- Involvement of integrated behavioral health provider
- Parent and patient involvement in the assessment
  - For children
  - For adolescents

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Focused assessment: Structuring Visit

- Dedicate 20-30 minutes of time for
  - History taking (HPI, Additional History)
  - Clinical interview (apart from parent if developmentally appropriate)
  - Consider MCPAP telephone consultation
  - Feedback/Negotiation of treatment plan options

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HPI

- Utilize positive screening questions as an initial structure
  - For core symptoms: Onset, duration, frequency, quality, severity, etc.
  - Triggers, associated stressors
  - "What does it feel like?"
  - "Tell me an example..."
- Zoom out into brief psychiatric review of symptoms (for purpose of assessing co-morbidity and differential diagnosis)

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Differential Diagnosis and Comorbidity

Initial Presentation	Other diagnoses to consider
Depression	Bipolar disorder, PTSD, Anxiety, ADHD, Adjustment disorder, Early psychosis
ADHD	Mania, PTSD, ODD, Anxiety, Early psychosis
Anxiety	Depression, ADHD, PTSD, Autism

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Additional history

- Three domains of a child's life
  - Home
  - School
  - Community
- Social History:
  - Adverse childhood experiences, Trauma
  - Substance Abuse
  - Availability of Firearms
- Medical/Developmental history (if you don't already have)
- Family psychiatric history

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Clinical Interview

- For purposes of...
  - Engagement in therapeutic relationship
  - Mental status exam
  - Gathering history of high risk behavior
  - Helping with differential diagnosis

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Clinical Interview with Child/Adolescent

- Follows the history taking portion of the visit with the parent and child
  - parent almost always does most of the talking in this previous portion
- Begin by asking child 1)if s/he agrees with what was said in the history portion 2)letting child know that you want to understand what it's like for him/her.
- Ask child to describe and explain things in the history from his/her own point of view
- Ask about strengths:
  - what things are you proud of about yourself and your family?
  - what things are going well?

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Mental Status Examination-General Considerations

- Diagnosis usually is primarily based on history
- MSE exams can support diagnosis, but absence of abnormal findings rarely rules out diagnosis
- The MSE is not really a procedure—the clinician is observing behavior, speech, and emotional expression of the child in the context of his/her interactions with the child during the visit.
- Behavior of the child in the office setting may not be representative of their behavior in their daily life because of the impact of anxiety.
- Need to explicitly assess for suicidal or homicidal ideation

Notable mental status findings

Attitude/Behavior—extremely disrespectful, levels of inappropriateness, regression, relatedness, eye contact, restlessness/hyperactivity

Speech/Communication—pressured, poverty, volume, abnormal prosody, receptive/expressive language deficit

Mood/Affect—constriction, lability, elevation, grandiosity, hopelessness

Thought process—logical or illogical association, disorganization tangentiality, blocking

Thought content—suicidality, homicidality, obsession, worries

Insight—immaturity, mania

Judgment—mostly based on history and behavior during visit

Assessing suicidal ideation

- Straightforward, frank approach
- Connect the question with a depressive or dysphoric symptom
- Separate questions about thoughts, plans, urges, behavior
- If thoughts and urges, ask if he/she has ever thought themselves on verge of acting, or whether or not he/she is planning to act
- Ask what keeps them from acting
- Acknowledge that there could be a time when suicidal feelings get worse. Discuss what it would take to keep safe in such a context and jointly come up with a safety plan.
- Note that most adolescent suicide events are impulsive and occur suddenly---hence need for emphasis on relationship and safety planning (anticipatory guidance)

Detecting Mania/Hypomania

- History
  - Overconfidence to Grandiosity
  - Recklessness
  - Hyper-sexuality
  - Hyper-religiousity
- Exam
  - Rapid, loud, pressured speech
  - Flight of ideas
  - Increased energy
  - Tangential, expansive, grandiose thinking

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Detecting Early Psychosis

- Insidious onset of...
  - Withdrawn, isolated behavior
  - Deterioration in functioning
  - Blunted emotions
  - Suspiciousness
  - Odd behavior
  - Inattentive, distracted, internally preoccupied

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Pulling it All Together: General Principles

- Primary diagnosis: In order to identify problem at the center of the presentation
  - Consider: causal relationships between symptoms
  - Consider: whether or not the course of symptoms matches known characteristics of syndrome
  - Consider: symptoms which are causing most significant distress and/or impairment
- Strengths and resiliency factors—important for treatment plan
- **Remember: Diagnosis is an iterative process☺**
- Call MCPAP for help with sorting out comorbidity and differential diagnosis

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Feedback to parent and child

- Provide impression
- Remind of strengths
- Convey hope
- Treatment plan is negotiated, not prescribed.

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Comprehensive Treatment Plan

- Key Components:
  - Psychosocial intervention: psychotherapy, program referrals, CBHI services (in home therapy, intensive care coordination, therapeutic mentors) , School Accommodations
  - Self-management: Behavioral activation, Sleep hygiene, Exercise, Nutrition, Establishing structure
  - Psychiatric Medication (if indicated)
  - Safety Plan
  - Monitoring/Follow-up plan: Use measures, track referrals

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Thank you for your attendance and attention!

Questions and Comments invited and appreciated!

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