Steps from Screening to Treatment

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Learning Objectives

1. To improve knowledge of the assessment process of mental health concerns
2. To increase awareness of differential diagnoses of mental health concerns
3. To increase understanding of the Biopsychosoical factors in the assessment process

Prevalence of Child and Adolescent Mental Health

- In 2016- almost 20% of youth in the United States ages 2-8 had a diagnosed mental, behavioral or developmental disorder.
- 2018-2019- 15% of adolescents ages 12-17 had a Major Depressive Disorder
  - 37% had feelings of sadness/hopelessness
  - 20% reported they seriously considered suicide
- 2016-2020 – Depression grew by 27% in ages 3-17
- 2013-2019 – Nearly 10% of youth ages 3-17 had ADHD or Anxiety

(2022 National Healthcare Quality and Disparities Report)

The Steps

- Identification
- Evaluation
  - Evaluation structure -Interview in language client/caregiver is proficient in
  - Differential Diagnosis
    - Medical Conditions
    - Medications
    - Licit and illicit substances
    - Mental Health conditions
  - Psychiatric Comorbidities- reference screening instruments
  - Medical Comorbidities
  - Structured Interview Guides
  - Symptom Rating Scales
  - Mental Status Examination
  - Clinical Formulation
    - Bio/Psych/Social factors and the 4P's
  - Safety
  - Treatment Planning

Step - Identification

- Anxiety Disorders - No current recommendation for Universal screening
- Depression – US Preventative Services Task Force (USPSTF) recommend screening for MDD in adolescents aged 12-18.
- Screening instruments – to include collateral from: daycare, school, therapist
- Input from referral sources
- Youth or parent report
- Presenting problem – chief complaint
- Review of psychiatric symptoms
- Mental Status Examination
- Structured – systematic, APA developed, free, parent/self-rated: https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

Step - Evaluation

- Clinically significant concerns must be distinguished from a youth's everyday: sadness, irritability, worries, fears, distractibility, fidgetiness, which can be normal human experiences in specific developmental stages.
- Utilization of the most recent Diagnostic and Statistical Manual –*DSM-5-TR,*
- Follow DSM 5 TR's diagnostic criteria set requirements for duration, frequency, significant distress and functional impairment of symptoms – while also ruling out medical, substance induced and other psychiatric causes of symptoms.

(Walter et al., 2023)

Step – Evaluation- Evaluation Structure

- Diagnostic interview
  - In a language the youth/care giver are proficient in
  - With caregiver present, youth alone, all together –as developmentally appropriate
  - Interview allows for indirect and direct ways of gaining information
    - Observation of interactions between youth/caregiver
  - Input from the collateral sources (teacher, therapist, daycare etc.), record review, symptom rating scale results

  - A lot of information from a lot of sources will take some time to puzzle through, Evaluation does not have to be done in one session – can schedule follow-up appointments to determine specific diagnosis.

Step – Evaluation- Differential Diagnosis

- Goal of the History of Presenting Illness – to determine whether DSM 5 diagnostic criteria for a specific disorder is met, as well as to rule out alternative explanations for symptoms. (Walter, et. al., 2020)
- Medical Conditions that may masquerade symptoms, include, but are not limited to:

Depression	Anxiety	ADHD
Hypothyroidism, mononucleosis, anemia, autoimmune disease, chronic fatigue syndrome, migraine, epilepsy, asthma, inflammatory bowel disease, certain cancers (Walter et. al., 2023)	Hyperthyroidism, caffeinism, migraine, asthma, diabetes, chronic pain/illness, lead intoxication, hypoglycemic episodes, hypoxia, pheochromocytoma, central nervous system disorders, cardiac arrhythmias, cardiac valvular disease, systemic lupus erythematosus, allergic reactions, dysmenorrhea (Walter et. al., 2020)	Inattentive type: Severe Head Injury, encephalopathies, other neurological symptoms, Hyperactive type: Hyperthyroidism, lead exposure Fetal Alcohol Syndrome (Pliszka,et. al., 2007)

Step – Evaluation- Differential Diagnosis

- Medications include, but are not limited to:(importance of medication reconciliation)

Depression	Anxiety	ADHD
Narcotic analgesics, chemotherapy agents, cardiovascular medications, stimulants, corticosteroids, immunosuppressants, oral contraceptives. (Walter et. al., 2023)	Bronchodilators, nasal decongestants and other sympathomimetics, antihistamines, steroids, dietary supplements, stimulants, antidepressants, antipsychotics, withdrawal from benzodiazepines (Walter et. al., 2020)	Dietary supplements, antihistamines, decongestants,

Step – Evaluation- Differential Diagnosis

- Illicit and Licit Substances

Depression	Anxiety	ADHD
Nicotine, alcohol, cannabis, opiates, cocaine, other stimulants, sedatives, anabolic steroids. Exposure to lead, carbon monoxide (Walter et. al., 2023)	Marijuana, cocaine, anabolic steroids, hallucinogens, phencyclidine (PCP), withdrawal from nicotine, alcohol, caffeine, exposure to organophosphates (pesticides), ingestion of lead, arsenic (Walter et. al., 2020)	Caffeine, Meth, Exposure to lead from paint or plumbing, exposure to alcohol in utero or other toxic agents in utero.

Step – Evaluation- Differential Diagnosis

- Mental Health Conditions-that may include similar symptoms

Depression	Anxiety	ADHD
ADHD- distractibility disruptive behavior disorders- irritability, Anxiety- irritability, distractibility, insomnia, somatic complaints. Post Traumatic Stress Disorder - irritability, distractibility, insomnia Bipolar Depression- irritability, Psychotic Disorders- agitation, social withdrawal, distractibility Autism Spectrum Disorder- irritability, social withdrawal, distractibility Learning Disorders – sadness about school performance (Walter et. al., 2023)	ADHD- distractibility, restlessness Depression- distractibility, insomnia, somatic complaints Bipolar Disorder- distractibility,restlessness, irritability, insomnia Obsessive Compulsive Disorder- intrusive thoughts, avoidance, reassurance seeking Psychotic Disorders- restlessness, agitation, social withdrawal, distractibility Autism Spectrum Disorder- social withdrawal, social skills deficits, distractibility Learning Disorders- worries about school performance (Walter et. al., 2020)	Depression- distractibility, inattentive Anxiety- irritability, distractibility Post Traumatic Stress Disorder - irritability, distractibility Bipolar Depression- irritability, restlessness, Psychotic Disorders- agitation, restlessness, social withdrawal, distractibility Autism Spectrum Disorder- irritability, social withdrawal, distractibility Fetal Alcohol Syndrome

Step – Evaluation-Psychiatric Comorbidities

- Psychiatric Disorders that commonly co-occur in full diagnostic criteria
- If a youth met the full diagnostic criteria, each diagnosis gets a treatment plan
- Treatment planning follows the hierarchy of what is causing the most functional impairment

Depression	Anxiety	ADHD
Anxiety, Disruptive Behavior Disorder, ADHD, Substance Use Disorders (Walter et. al., 2023)	Depression, ADHD, Bipolar Disorder, Obsessive-Compulsive Disorder, Eating Disorders, Learning Disorders, Substance Related Disorders (Walter et. al., 2020)	Oppositional Defiant Disorder Conduct Disorder, Depressive Disorder, Anxiety (Jameson, et. al., 2016)

Step – Evaluation-Medical Comorbidities

- Youth with these disorders are more likely to present with other health disorders, including but not limited to;

Depression	Anxiety	ADHD
Physical illnesses to include neurological, gastrointestinal, autoimmune, endocrine disorders, infectious diseases, metabolic and systemic disturbances, neoplasms, and nutritional deficiencies (Walter, et. al., 2023)	Physical illnesses to include headaches, asthma, gastrointestinal disorders and allergies (Walter, et. al., 2020)	Physical illness is to include allergies/hay fever, asthma, enuresis, headaches/ migraines and serious stomach or bowel problems (Jameson, et. al., 2016)

Step – Structured Interview Guides

- Pro – enhanced diagnostic reliability over unstructured interviews
- Cons – Time, cost, burden
- Examples:
  - Anxiety
    - ADIS -Anxiety Disorders Interview Schedule – Gold standard for interview guide for anxiety.
    - Freely available structured interview guide- K-SADS PL (Present and Lifetime) (https://www.pediatricbipolar.pitt.edu/sites/default/files/KSADS_DSM_5_Supp3_AnxietyDO_Final.pdf)
  - Depression
    - Freely available structured interview guide – K-SADS PL (Present and Lifetime) https://www.pediatricbipolar.pitt.edu/sites/default/files/KSADS_DSM_5_Supp1_DepressiveDO_Final.pdf

Step – Symptom Rating Scales - Screening

- Not diagnostic alone, however, standardized symptom rating scales can be useful to organize symptoms and to quantify symptom severity at baseline and ongoing through treatment phases.
- Many free evidence-based screeners available at www.ndpmhca.org
- Broad and Narrow band, age-appropriate and scoring of screening was addressed in the Jan. 17th ECHO

Step – Mental Status Examination

Components of the Mental Status Examination

- Appearance / Behavior
- Motor Activity
- Speech
- Mood
- Affect
- Thought Process
- Thought Content
- Perceptual Disturbances
- Cognition
- Abstract Thinking
- Insight
- Judgement

Step- Mental Status Examination

Depression - example	Anxiety - example
Appearance: disheveled poor eye contact, poor engagement/uncooperativeness,, downcast facies, tearfulness, psychomotor agitation or retardation, sad mood, angry outbursts, poor frustration tolerance, distractibility, poverty of speech, perseverative or ruminative thought processes, guilt- or self-loathing- or self blame laden thought content, and poor insight and judgment (Walter et. al., 2023)	Appearance: fastidious or disheveled poor eye contact, poor engagement/uncooperativeness, shy demeanor, clinginess, tremor, fidgetiness/ restlessness, “nervous” habits, hypervigilance, poverty of or pressured speech, perseverative or ruminative thought processes, worry- or fear-laden thought content, distractibility, irritability/ agitation, and poor insight and judgment. (Walter et. al., 2020)

Evaluation – Clinical Formulation-BioPsycoSocial

- Biological, psychological and social factors and the 4P's- predispose, precipitate, perpetuate and protect, that contribute to mental health disorders.
- Biological –family history, acquired insult to developing brain, autonomic hyperactivity, sleeping/eating irregularity, chronic medical concerns
- Psychological-cognitive schemas, information processing, self-evaluations, disconnects of feelings and behavior, unconscious conflicts
- Social – stressful/traumatic life events, parenting styles, social skills deficits, peer relational issues, expectations of achievement, level of support, sociodemographic/cultural discordance

(Walter et. al., 2020)

Evaluation-Clinical Formulation – 4P's

- Predisposing - areas of vulnerability that increase risk and are primarily the items in the Biological domain
- Precipitating - The events that have a chronological association to the onset of symptoms
- Perpetuating - Issues for family, youth, community that cause the symptoms to be prolonged
- Protective - the patient's strengths, family and community supports, resilience

The BioPsychoSocial and the 4P's – when considered together support a well-developed treatment plan.

(Walter et. al., 2023)

Evaluation- Safety Planning

- Suicidal thoughts/behaviors, risk taking, impulsivity, self-harming thoughts get assessed at the initial evaluation and subsequent visits
- Assess also any adverse child events, abuse, neglect, exploitation which may need additional supports and team members
- Evaluation of safety helps to determine appropriate level of care when you have answered:
  - Is the youth at current risk of harm?
  - Is the youth/care providers able to adhere to supervision, safeguards, and follow-up care?

(Walter et. al., 2023)

Step- Treatment Planning

- Identifying range of effective treatments/interventions
- Prioritizing treatment needs –acuity, severity, distress, impairment
- Review family/youth treatment preferences for treatment– can increase engagement in treatment process

- Informed Consent:
  - Discuss diagnosis
  - Nature and purpose of treatments identified
  - Risk/benefits of treatments identified
  - Risk/benefits of not choosing treatment
  - Document informed consent when obtained

Provide written educational materials, respond to questions, include cultural treatment interventions as applicable

(Walter, et. al., 2020)

Case:

11 yo F presents with anxiety and nervousness related to school. c/o nausea and stomach aches in the morning, refusing to go to school for 4 months. She has missed 18 days of school in the last 4 months and her grades are declining. Mother shares that her classmates are bullying her about being too short.

Case:

16 yo M with depressed mood, low motivation, difficulty focussing, declining grades, poor sleep over the last 4 weeks. He has tried therapy with minimal response. He has been having passive death wishes “I wish I could just sleep and not wake up” and hopelessness over the last 1 week. His PHQ-9 is elevated.

Case:

15 yo male who presents to clinic after a 1 week psychiatric hospitalization recently for mood issues. History is positive for insomnia lasting for 4 nights, bizarre behaviors at school reported by peers, racing thoughts, delusional thoughts related to being able to “levitate” through meditation, being able to make music that would get him awards, hallucinations with voices telling him that God wants him to heal the world with his music. He seems to be in a very good mood, very talkative, difficult to interrupt, but redirectable. Mother provides h/o smoking marijuana a few times over the last year. He was started on risperidone in the hospital but could not refill it after discharge and seems to be having trouble sleeping again since he ran out.

Case:

12 yo female with a h/o ADHD stable on Methylphenidate ER over the last 2 years presents with low mood, decreased interest in activities like cheer and basketball that she previously loved, poor sleep, crying spells over the last 2 weeks. She reports feeling more anxious and worried about losing her parents or something bad happening to them. On history, she reports that they had to put down her dog recently. Patient tearful when mother talks about her dog. No prior h/o depression. No therapy in place currently.

Case:

7 yo M comes to the clinic with his parents. They are worried about him struggling in school. He is reported to be fidgety in class, won't sit still, making noises that disturb classmates, gets overexcited when in the gym and can't calm down. Mother reports that he is like an energizer bunny and starts bouncing off the walls from the minute he wakes up. He has 'big emotions' per his mother and gets frustrated easily when things are too hard. He struggles with sleep and parents report daily meltdowns when it is time to go to bed. He says he can not sleep and his mind won't shut off.

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Thank you