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MRCPsych Child and Adolescent Psychiatry Module

CAMHS Assessment

Developing people for health and healthcare

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CAMHS Assessment

Aims and Objectives

- The overall aim is for the trainee to gain an overview of the assessment in CAMHS

- By the end of the session trainees should:
  - Undertake assessments of children and young people; to communicate effectively with children and young people across the age range; to take a developmental history; to formulate and prepare a plan and identify appropriate interventions.
  - Describe how the emphasis of assessments in CAMHS may be different to that in Adult Mental Health.

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CAMHS Assessment

To achieve this

- Case Presentation
- Journal Club
- 555 Presentation
- Expert-Led Session
- MCQs

- Please sign the register and complete the feedback

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Expert Led Session

Assessment in CAMHS

Dr Tim Morris

Consultant Child and Adolescent Psychiatrist

East Lancashire Child & Adolescent Service

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What Is Child And Adolescent Psychiatry?

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How Do We Work?

- The service is typically delivered in a multidisciplinary style on an out-patient, day-patient or in-patient basis from hospital departments or the community
- Important members of the Professional MDT include:
  - Psychiatrists, nurses, social workers, clinical psychologists, specialized therapist with some extended teams including OT and SALT with links to other professionals' eg teachers, voluntary agencies, paediatricians, probation services.
- Clinical assessment and diagnosis is based on the clinician's integration of subjective information including direct observation and reports from parents, teachers and young people and the MDT.
- A developmental perspective must be taken.

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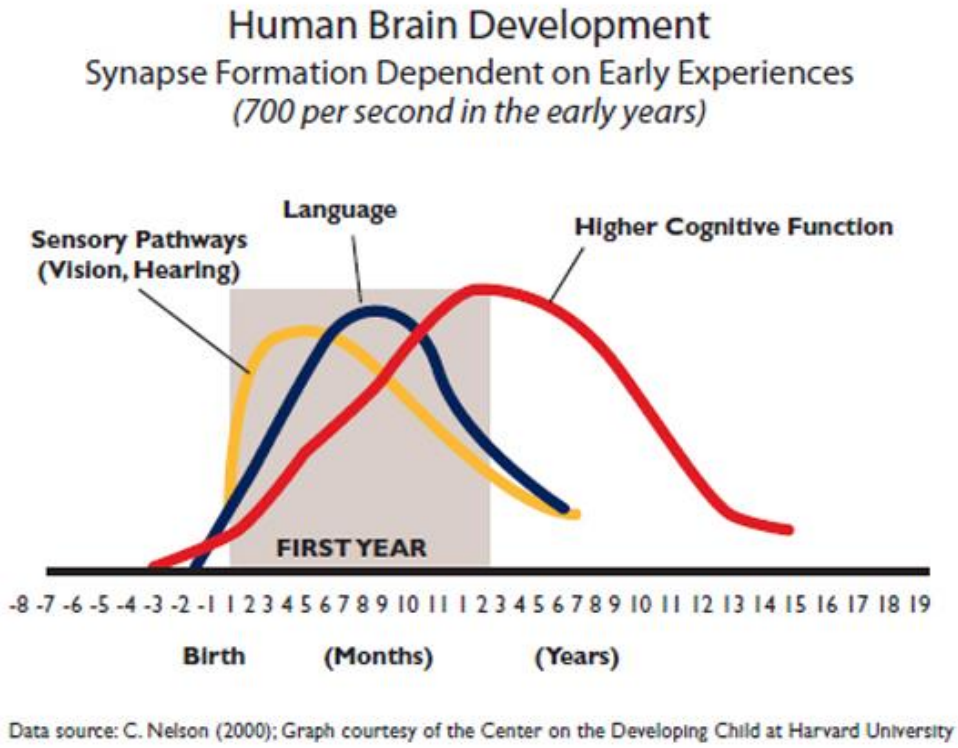
Brain Development - The Critical Years



Data source: C. Nelson (2000); Graph courtesy of the Center on the Developing Child at Harvard University

First 2 years - baby's brain grows from 25% to 80% of adult size

Development continues in childhood learning empathy, trust and community

Summary of Parallel Developments During Adolescence

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Age	12	13	14	15	16	17	18	19
Physical Development	Major pubertal change begins for boys Girls height spurt average age of menarche			Boys' maximum height spurt	Puberty completed for girls		Puberty completed for boys	
Cognitive Development	Beginning formal operations: systematic operations 'Early basic' formal operations: deductive logic						Consolidated formal operations (For a few)	
Social Cognition	Kohlberg's stage 3 continues Descriptions of others and of self begin to include exceptions, comparisons, deeper personality traits, empathy				Kohlberg's stage 4 ("law and order") for a minority			
Self/ personality development	Depression < Self-esteem >			Self esteem rises for remainder of adolescence				
	Erikson's stage of identity vs. role diffusion							
Social relationships	Cliques	Crowds		Pairs			Stable and intimate friendships continue and become more intimate	
	Parent-child conflict peaks beginning of puberty			Maximum impact of peer group				

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Types of disorder

- Classification systems - World Health Organisation (ICD 10 – ICD 11 by 2022) and DSM 5 *(also think RDoC)*
- Many disorders seen in adults present for the first time in childhood.

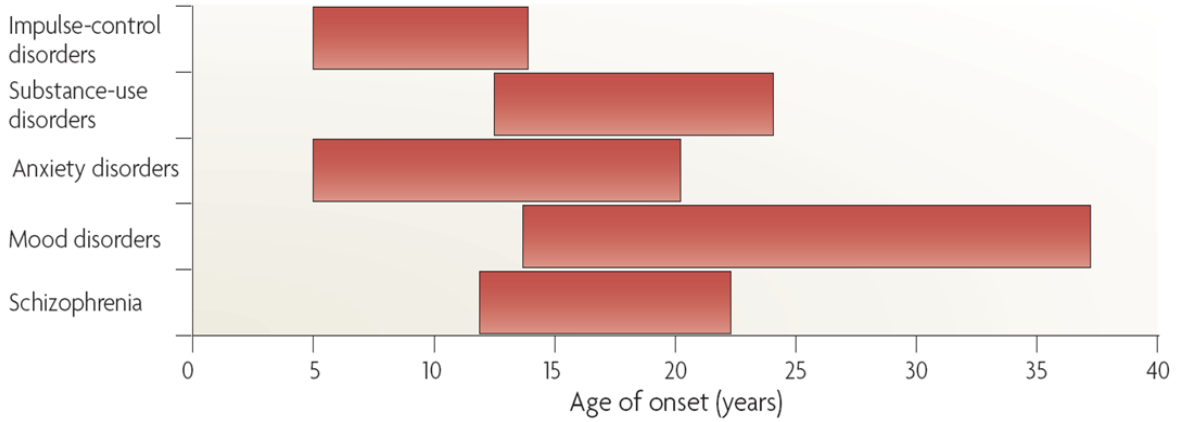

Figure 4 | **Ranges of onset age for common psychiatric disorders.** Recent data from the National

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History taking

- Foundation for a thorough assessment is to take a detailed history (as in the rest of psychiatry).
- You have transferrable skills from assessment in adult psychiatry, but the emphasis may be different.
- The history is often predominantly obtained from an informant (parent) but don't forget to ask the child and young person as well. May have a different emphasis.
- **Presenting complaint – ? from whose perspective**
  - E.g. parent may complain of disruptive behavior and young person may describe being low in mood and irritable.

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First Interview with Patient & Family

- The first interview may take up to l½ hours
- It is important to meet with both parents if possible, along with the child initially
- If assessing an adolescent, you may wish to see the adolescent before seeing the parents (but should see on own at some point)
- A younger child may not wish to separate from their parents at the first interview
- The first appointment should help the clinician have an appreciation of:
  - The presenting difficulties, their severity and impact on the family or wider society e.g. school
  - What factors may have triggered, exacerbated or maintained the presenting problems
  - The strengths of the family and child and whether they are motivated to working on the issues
  - The expectations and ideas that the family have about being seen by CAMHS (goals of coming)

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Recent behaviour /emotional state

- Being disobedient, destructive, defiant, having temper-tantrums, telling lies, fire setting, stealing, taking drugs or alcohol, smoking, cruelty to animals/young children.
- Happy or miserable, crying often worries
- Anxious, school refusal
- Suicidal thoughts or acts of self-harm
- Routines, rituals, obsessions, fussy
- Does this occur at home or outside (school) or both.
- Solitary or accompanied
- How is it dealt with?

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Health/Past Medical History

- Is he/she off school at all?
- Generally healthy?
- **ROS**
  - Asthma, headaches, stomachaches, eyesight, hearing, fainting, fits, absences
  - Childhood infections and Immunisations
  - Allergies, drugs, food
- **Eating difficulties**
  - Food refusal, faddiness, feeding problems
- **Sleeping problems**
  - settling, waking, nightmares, sleeping arrangements, when slept alone
- **PMH**
  - Illnesses, operations, hospitalisations

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Family History

- Persons in home
  - age, religion, occupation, education, current mental/ physical illness, personality, seen by psychiatrist
- Details of parents own childhood and family support network
- Family history of psychiatric disorders or other illness
- Family life and relationships
  - Parental relationships
  - how do they get on? How do they spend evenings, weekends? To what extent do they both participate in childcare, discipline etc?
  - Parent-child interaction
  - Child's participation in family activities
  - helps at home etc.
  - Rules and routines at home.
- Domestic conflict or violence/extent of childhood exposure to violence

Personal History/Developmental History

- **Pregnancy**
  - planned, complications, alcohol, smoking, drugs (previous pregnancies)
- **Delivery**
  - spontaneous/induced, place, date, labour, presentation, mode of delivery, gestation, birth weight, complications, resuscitation/SCBU
- **Mother's health during and after pregnancy - depression (PND)**
- **Neonatal period**
  - breathing, feeding, convulsions, jaundice, and infections, how long in hospital?
- **Infancy**
  - feeding, weaning, sleep pattern, placid or active, irritable, easy or difficult temperament. Any behavioral difficulties e.g. tantrums as a toddler

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Personal History

- **Milestones**

  sitting unsupported, walking unaided, first word with meaning, first 2 word phrases, and comparison with siblings, pointing
- **Bladder and bowel control**

  dry by day and night, bowel control.
- **Separations**

  apart from parents. How child reacted on separation for nursery/toddler playgroup, children's parties
- **Interactions with peers as a young child**
- **Useful to use links to specific ages e.g. 4-5 years "when they started infant school how did things go?"**

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School

- **Present & Previous Schools**
  - happy, progress, and contact with school
  - Attendance
  - Academic strengths & weaknesses.
  - Non-academic skills, independence
  - Social relationships,
  - Behaviour Support or learning support service, SENCO Educational Psychologist.

- **Relationships**
  - with other adults, with teachers, other children, opposite sex

Social history

- **Home circumstances**
  - description of the house, sleeping arrangements, community, overcrowding.
- **Other care arrangements**
  - Child minder, baby sitter
- **Finances**
  - any difficulties
- **Neighbourhood**
  - description of area, house moves, community violence, neighbour disputes

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Personality/Temperament

- Meeting new people – other adults, children, shy, clingy, how quickly does he/she adapt to change?
- **New situations**
  - new places, new tools, explore or hand back.
- **Emotional expression**
  - introvert, extrovert, generally happy/miserable
- **Affection & Relationships**
  - how does he/she show feelings, affectionate, confiding, friendships: school, at home
- **Sensitivity**
  - response to person/animal hurt, reaction if told off, did something wrong
- **Interests, hobbies**

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Interview with Child & MSE

- Determined by the child's age and developmental level
- Provide the right materials (crayons, paper, books) and a safe and private environment
- Initially, talk about neutral topics or things which the child or adolescent is interested in
- It is important that you explain to the child that the interview is confidential and the limits of that confidentiality
- With younger children you may wish to encourage the child to play with toys, draw or describe their family, friends or school
- Approach discussion of feelings later on
- With an adolescent, the interviewer may involve more direct questions and more of a verbal interchange
- By the end of the interview you should have a reasonable idea about the child's understanding of why they are being seen and some idea of their emotional state

Mental state examination

- **Appearance and behaviour:** dress, physical appearance, motor activity, co-ordination, involuntary movements
  - **Social response to interviewer:** humour, rapport, eye contact, empathy, and co-operation, shy, confident
  - **Social interaction with parents**
- **Language:** expression, comprehension, speech – spontaneous, quantity, rate, rhythm, and complexity
- **Mood:** subjective, objective, symptoms/signs of depression, suicidal feelings, anxiety, panic, anger, aggression, and irritability
- **Abnormal beliefs,** experiences, thought content, hallucinations, delusions, worries, fears, preoccupations, obsessions, fantasies or wishes
- **Cognition:** attention span/distractibility, draw a person (note grip, handedness), write name, give days of week, months of year, counting, simple arithmetic, orientation, memory, general knowledge, reading skills/level of attainment

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*Other sources of Information

- School with appropriate consent
- Undertaking school assessment with appropriate consent
- Undertaking home observations

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Assessment Tools- there are many

- Questionnaires
  - SDQ/RCADS
  - Connors/SNAP IV/ CBCL

  Psychometrics - WISC

  Observational – ADOS

  Structures interviews KIDDIE SADS/ADI/DISCO

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Risk Assessment

- **Factors**
  - Historical – what has happened in the past
  - Clinical – what disorder the child has
  - Social – deprivation/family/school/drugs
  - Demographic – gender/age
  - Developmental – stage/delay

Trauma is HIGHLY PREVALENT

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- Psychological - 11.1%
- Physical – 10.8%
- Sexual – 22%
- Witnessed domestic violence to mother – 12.5%
- Most common: substance use in household – 25.6%
- **Overall response rate to any category – 52.1%**

Clinical trauma Screening

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- “What is the scariest thing that has ever happened to you?”
  - “Has anything scary or upsetting happened since our last visit?” (add to your family/child if asking parents)
  - “Do you know of any traumatic experiences your child has gone through?”
  - “Has there ever been a time when you were (your child was) scared for your (his or her) life?”
  - “Has anyone ever touched you in ways you did not want to be touched?”
- “Does [known traumatic event] ever bother or upset you these days?”

Diagnosis

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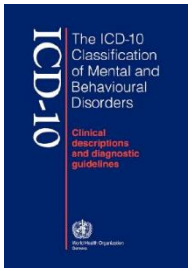

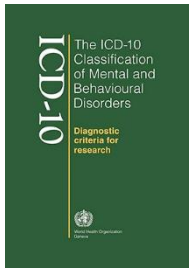

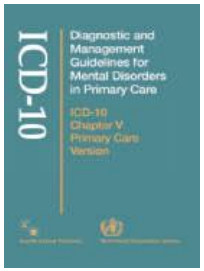

- Is it real?
- Is it useful?
- Is it flexible?
- Is it defensible or reproducible?
- Does it predict treatment?

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Formulation

- This is a brief description of the child's presenting problems. It helps to consider the factors under:
  - **BIOLOGICAL**
  - **PSYCHOLOGICAL**
  - **SOCIAL**
- PREDISPOSING / PRECIPITATING / MAINTAINING / PROTECTIVE
- The formulation is useful in helping to highlight areas for intervention and producing a management plan with a description of the likely prognosis

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Any Questions?

MCQs on the next slide

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MCQs

- Patient should routinely have a neurological examination if they present with all except:

A. History of an episode of fainting
B. History of seizures
C. Developmental delay
D. Dysmorphic features
E. Abnormal gait

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MCQs

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MCQs

- A physical risk assessment for patients with Anorexia Nervosa should include all except:

A. Assessment of BMI and weight
B. Assessment of heart rate
C. Assessment of temperature
D. Assessment of hydration status
E. Assessment of body fat percentage abnormalities

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MCQs

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MCQs

- During an assessment of a 14 year old patient with depression in primary care, which of the following would prompt you to refer to tier 2 or 3 CAMHS:

A. Mild depression in those who have not responded to interventions in tier 1 after 2-3 months
B. Active suicidal plans
C. Referral requested by the young person
D. Moderate to severe depression
E. All of the above

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MCQs

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MCQs

- Assessment of ADHD commonly include all except:

A. ADOS
B. School observations
C. History from parents/carers
D. Connors assessment
E. History from patient

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MCQs

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MCQs

- Mental state examination of a 15 year old patient should include all the following except:

A. Assessment of appearance and behaviour
B. Family history
C. Assessment of speech
D. Assessment of insight
E. Assessment of cognition

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MCQs

- Mental state examination of a 15 year old patient should include all the following except:

A. Assessment of appearance and behaviour
B. Family history
C. Assessment of speech
D. Assessment of insight
E. Assessment of cognition

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MCQs

- An assessment of a 3 year old with suspected Autistic Spectrum Disorder must include:

A. A home visit
B. A detailed mental state examination
C. Observation of the child interacting with others
D. All of the above A-C
E. None of the above A-C

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MCQs

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MCQs

- CAMHS assessments in patients with speech delay should routinely include all except:

A. Family tree
B. Family history of ASD/Aspergers
C. Developmental history
D. Details of whether the patient had the combined MMR vaccine
E. Medical history

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MCQs

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MCQs

- The presence of a disorder can be explained in terms of all except:

A. Predisposing factors
B. Precipitating factors
C. Perpetuating factors
D. Petulant factors
E. Protective factors

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MCQs

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MCQs

- In regards to initial CAMHS assessment of children under 5 with speech delay:

A. You should not see them without the presence of their parent/carer in the room
B. You should aim to get the child sat down in a chair for the majority of the assessment
C. You should observe them playing and play too if appropriate
D. You should avoid difficult topics
E. You should use more directed questioning

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Mental health in the classroom

Typical case mix of cases presenting to CAMHS

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Table 5: Potential allocation to support guided by NICE guidelines

Index difficulties as indicated on current view	Percentage in CYP IAPT dataset	Relevant NICE guideline (at time of development of algorithm 2014)
Difficulties sitting still or concentrating (ADHD)	6%	ADHD NICE guideline 72
Pervasive developmental disorder (autism)	2%	Autism spectrum NICE guideline 170
Behavioural difficulties (conduct disorder or oppositional defiant disorder)	4%	Anti-social behaviour and conduct disorders NICE guideline 158
Extremes of mood (bipolar disorder)	1%	Bipolar disorder NICE guideline 185
Depression/low mood (depression)	5%	Depression NICE guideline 28
Anxious generally (generalised anxiety disorder, GAD) and/or panics (panic disorder)	5%	GAD and/or panic disorder NICE guideline 113
Compelled to do or think things (obsessive compulsive disorder, OCD)	1%	OCD NICE guideline 31
Disturbed by traumatic event (post traumatic stress disorder)	2%	PTSD NICE guideline 26
Self-harm (self-injury or self-harm)	6%	Self-harm NICE guidelines 16 and/or 133
Anxious in social situations (social anxiety or phobia)	2%	Social anxiety disorder by NICE guideline 159
Eating difficulties (anorexia, bulimia)	2%	Eating disorders NICE Guideline 9
Delusional beliefs and hallucinations (psychosis)	1%	Psychosis NICE guidelines 155 and/or 185
Co-occurring emotional problems	10%	One or more of NICE guidelines above
Co-occurring emotional and behavioural difficulties	2%	One or more of NICE guidelines above

- 28% of CYP had mild problems or one moderate that doesn't fit NICE guidance.
- 25% of CYP had multiple or severe problems that don’t fit easily into NICE guidance.

Martin, P., Davies, R., Macdougall, A., Ritchie, B., Vostanis, P., Whale, A., & Wolpert, M. Developing a case mix classification for child and adolescent mental health services: the influence of presenting problems, complexity factors, and services on number of appointments. Considers impact of problems and complexity factors on service use

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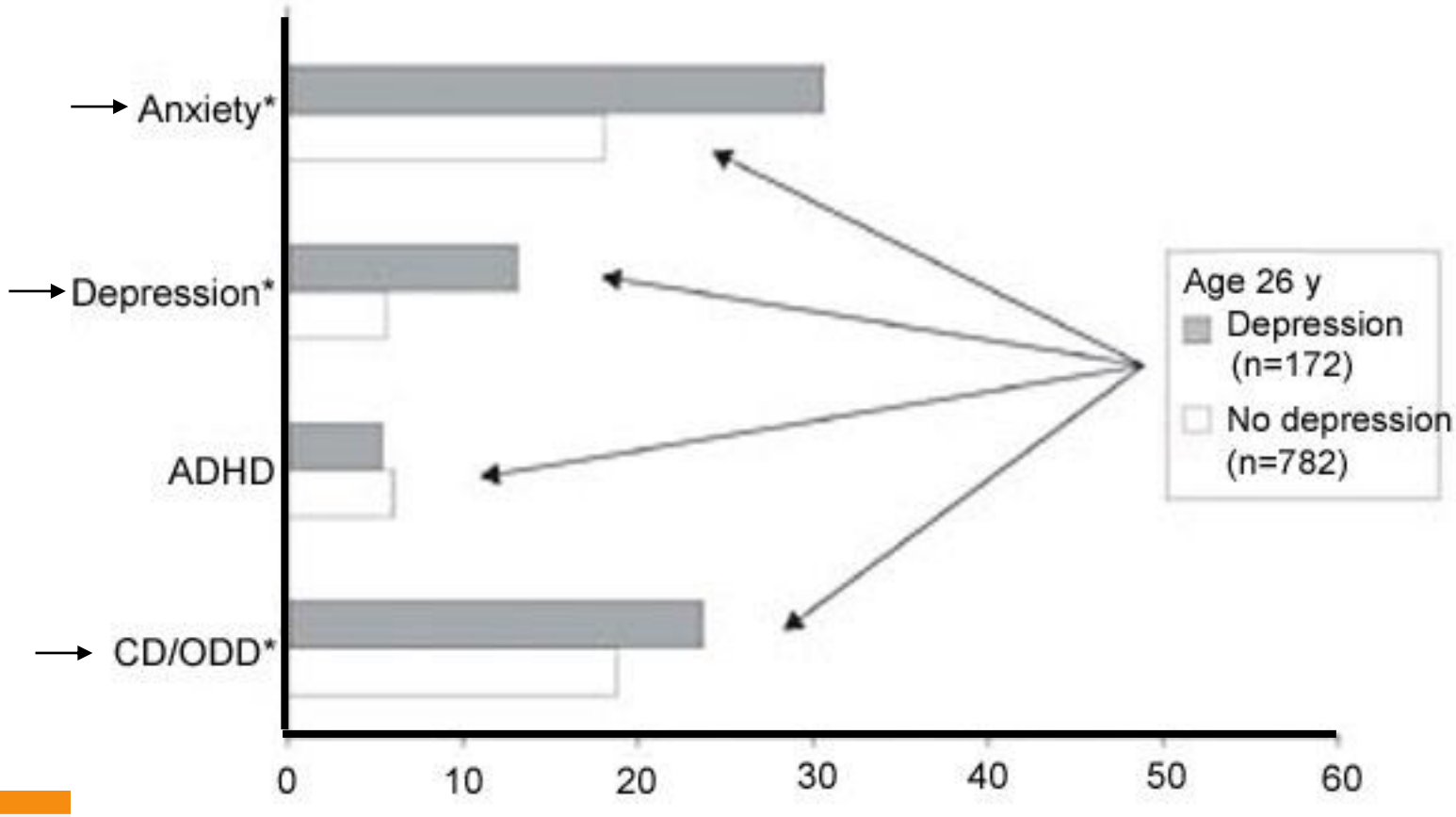
Prevalence (%) of childhood psychiatric disorders among those with and without a diagnosis of **depression** at 26 years of age



* p <.05

*Kim-Cohen, Caspi, Moffitt et al. (2003), Arch Gen Psychiat, 60, 709-717

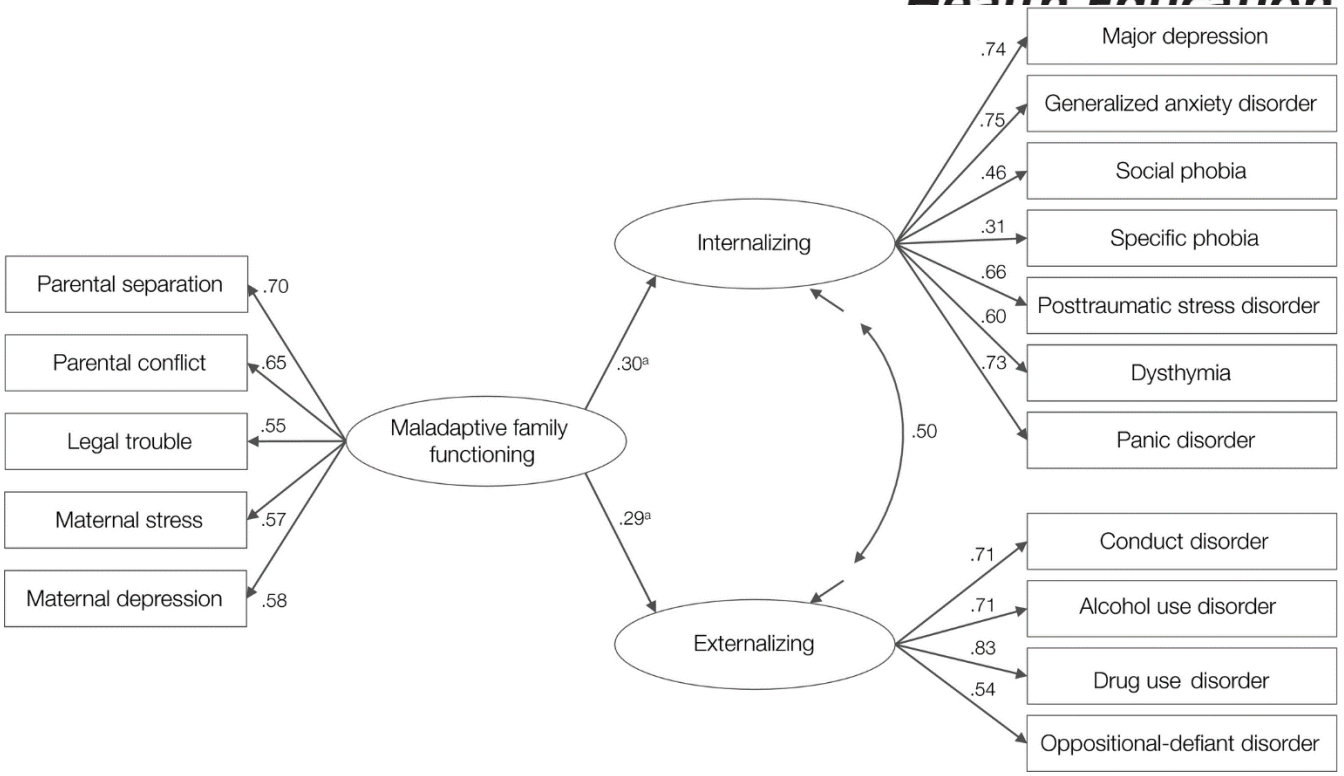
The Burden of Childhood Mental Disorder

- Between 1:10 and 1:8 children and adolescents suffer from mental disorder severe enough to result in functional impairment
- World Health Organisation Report:
  - Mental disorders will become one of the 5 most common causes of morbidity, mortality and disability among children

The Burden of Childhood Mental Disorder

- Childhood mental disorders
  - Reduce the quality of children's life
  - Diminish their productivity in later life
  - 75% of adult mental disorder anticipated by childhood disorder
  - *No other illness damage so many children so seriously*
- Stigma continues to be a significant barrier to mental health treatment for children and their families despite public education

Transdiagnostic pathways from early social stress to psychopathology: a 20-year prospective study



Transdiagnostic pathways from early social stress to psychopathology: a 20-year prospective study, Volume: 59, Issue: 8, Pages: 855-862, First published: 08 January 2018, DOI: (10.1111/jcpp.12862)

When do mental health disorders emerge?

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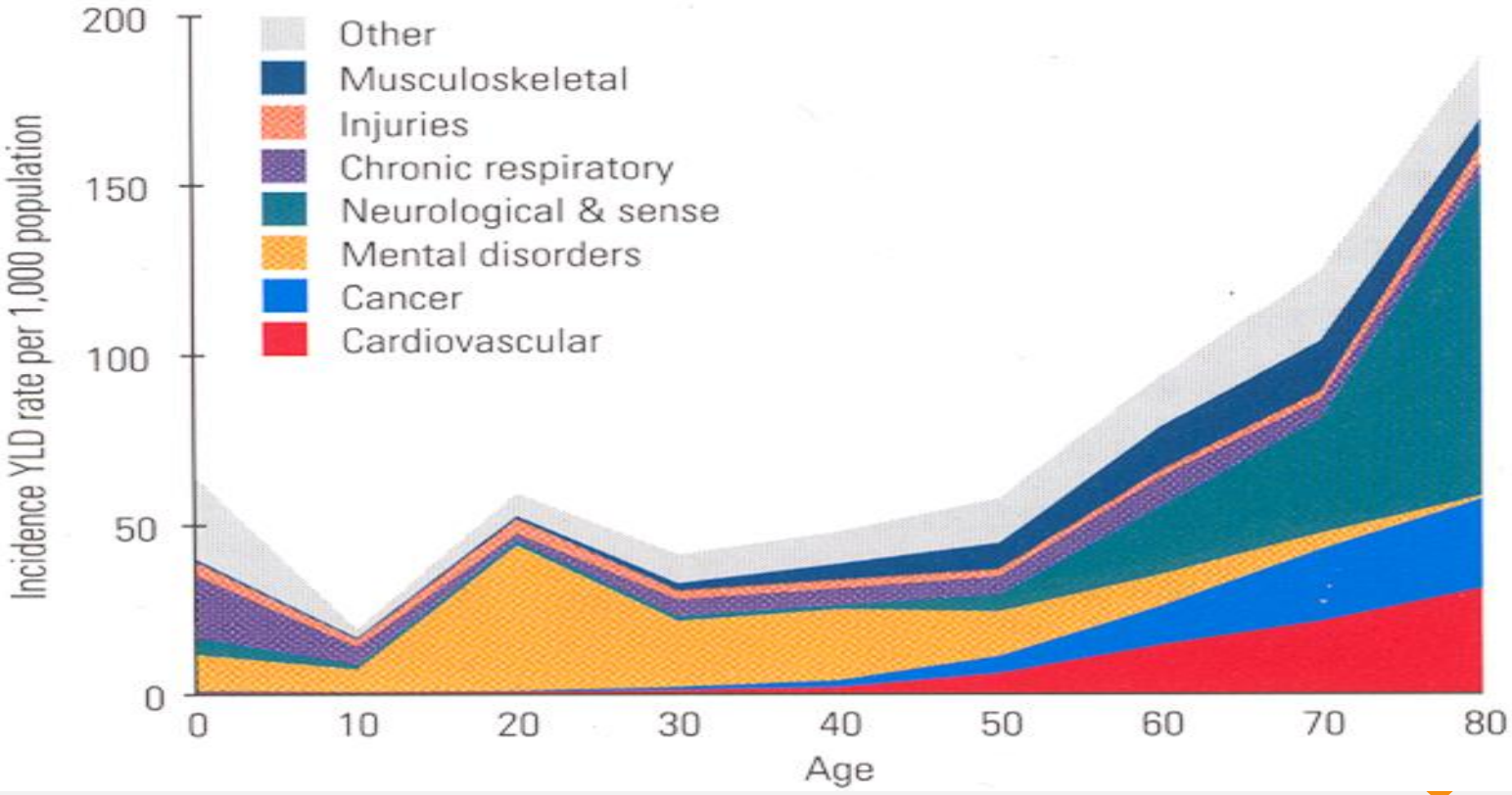

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Any Questions?

Thank you