

GUIDELINES FOR AN ASSESSMENT SUMMARY

David Dossetor, Department of Psychological Medicine, Children's Hospital at Westmead.

This document is designed to guide a clinician through the areas of information that should routinely be sought for the standard complete mental health assessment of a child or adolescent. Whether it is used to guide a clinician in writing by hand, typing or dictating for typing, this assessment summary is designed to be compliant with the aims of the Mental Health Outcomes and Assessment Training Project for Children and Adolescents and is suitable for any clinical discipline.

There must be evidence of all 10 domains having been assessed, at least to know that further information isn't needed for completion of an assessment summary.

Italicised text

If information is recorded routinely in the department documentation then only clinically pertinent information should be reported in a clinical summary.

The interview

Child & Adolescent Mental Health interviewing is based on the technique of semi-structured interviewing, whereby the interviewer uses neutral/factually based questions and pursues a line of questioning until (s)he feels the topic is covered. This provides objective evidence on emotional content. Remember to think of objective rather than subjective measures of functioning, such as the MOF¹ or CGAS², Quality of marriage³ and the McMaster Clinical Rating Scale for Problem Solving Family Assessment⁴. Recording of samples of "flow of speech" history can also be valuable.

10 Domains

1. Basic Demographics <ul style="list-style-type: none">• Patient's name• Address• Phone number• Birth date• Next of kin/carer• Immediate family <p>Cultural Demographics (of child & both parents):</p> <ul style="list-style-type: none">• Ethnic background• Country of birth• Aboriginal and/or Torres Strait Islander• Preferred language, second language, interpreter required
2. Referral <ul style="list-style-type: none">• Referred by• Assessed by• Assessment dates(s)• <i>Name of Family Practitioner</i>• Sources of information. All assessments need information from several sources to situational and observer differences. List sources of information used: eg. interview with child, parents, school counsellor's report, Clinical Questionnaires e.g. SDQ, HONOSCA, CBCL.
3. Reasons for referral and presenting problems <p>History of current problems.</p> <ul style="list-style-type: none">• Describe presenting problems in detail: onset, duration, frequency of symptoms, situational factors.• List relevant negatives (e.g. no depressive symptoms need to be listed as present or absent, namely: suicidal behaviour, behaviour problems at home or school, learning problems, delinquent acts, obsessions or compulsions; current issues of dangerousness and safety.• Detail any medical problems.• Describe any impairment in psychosocial functioning as well as the circumstances and stressors associated with the onset of problems. <p>Current dangerousness to others or self, and special legal status, as appropriate.</p> <p>Current medications: <i>effectiveness, unwanted events and who prescribed them.</i></p>
4. Developmental and past history <ul style="list-style-type: none">• History of conception, pregnancy, delivery, adoption and infancy including temperament.• Physical development/milestones.• Previous (Pre)Schools, and social development including quality and range of relationships with adults and peers.• Current School and school year.• In those with intellectual disability a developmental profile including motor/sensory development, self-help skills, communication skills, social and relationship skills.⁵• School/academic functioning, peer and teacher relationships.• Unusual or traumatic circumstances including abnormal social circumstances (particularly sustained), neglect, physical and sexual abuse.• Areas of special talent or interest.

- Factors of resilience.
- History of sexual relations, menstruation & contraception where appropriate.

Current functioning:

- General description/personality
- Social relationships quality & range
- Affect regulation
- Behaviour.

Previous history of Medical, Psychological or Psychiatric treatment and other interventions including:

- Hospitalisations
- Self-harm/suicide attempts
- Violence & forensic history
- Effects of medications

Child agencies previously and currently involved (including notifications of Risk).

Alcohol or illicit drugs: use, experimentation and peer-group culture affiliation,

5. Social and family background

- Three generation family genogram *including age and occupation/school.*
- Strengths, weaknesses, areas of concern or conflict.
- Relevant social and cultural factors.
- Current housing/financial problems.

Family history

- D/A
- Forensic/DV
- Developmental and Mental disorders including suicide
- Chronic physical illnesses.

History of each parent/carer:

- Occupation
- Significant past medical, psychiatric, D/A, forensic history, character description, social relationships and group affiliations, affect regulation of: anxiety, depression, obsessiveness, irritability and anger and behavioural control.

If issues of parent child relationship is important, then the developmental **history of each parent** is necessary: relationship with own parents & sibs, previous and current, own childhood experience, peer relationships, education, employment, previous primary relationships/marriages, history of courtship & marriage and current quality of marital relationship, including communication, sharing of interests/activities, irritability, disagreements and separations. Parenting skills including approaches to child management/discipline.

6. Assessment of Parents/Family interview

- Family's relationship style.
- Parental attitudes towards the child.
- Is there excessive criticism, control or enmeshment, harsh discipline?
- Consistency of limit setting, love and affection.
- Relationship with siblings.
- Family strengths.

May require mental state examination of other family member.

7. Individual interview with the child and Mental Status Examination
<ul style="list-style-type: none"> • General Description, Speech, Affect, Thought Content, Abnormal perceptions/hallucination, Cognitive State, Insight. • Mention main positive and negative findings, particularly regarding suicidal ideas and disclosure of abuse. • Mention reliability of phenomena elicited or suspected. <p>Cognitive abilities can be assessed using the mini-mental state or SYSTEMS assessment. www.dementiatoday.com/wp-content/uploads/2012/06/MiniMentalStateExamination.pdf⁶</p>
8. Physical Examination (?done by other identified medical officer) and Investigations
<ul style="list-style-type: none"> • E.g. blood tests, other investigations, IQ testing, etc.
9. Diagnostic formulation
<ul style="list-style-type: none"> • Summary of child's difficulties and impairment. • Provisional ICD diagnosis (include all diagnoses), 5 axes and diagnostic uncertainties. • Potential aetiological factors. • Potential exacerbating or mitigating factors. • Summary of child's and family's strengths and weaknesses.
10. Management
<ul style="list-style-type: none"> • Describe further steps to clarify diagnosis, if required. • Treatment options offered to family or child. • Patient's and family's response to these and to the explanations of the nature of child's problems. • Document consent. • Arrangements for further treatment and follow up responsibilities (be specific). <p>NB. Reports should be written in objective descriptive terms and under the assumption that it may be read by the patient or their parent in the near or distant future.</p>

References

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4. Epstein, N, Bishop, D. 1981. Problem centred systems therapy of the family. In Gurman A & Kniskern D (Eds) *Handbook of Family Therapy*. Brunner Mazel: New York.
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6. Ouvrier, RA., Hendy, R., Bornholt, L., & Black, FH. (1999). The SYSTEMS - School-Years Screening Test for the Evaluation of Mental Status. *Journal of Child Neurology*, 14, 772 - 780.