Unit 2.1

Child and Youth Mental Health Assessment

Additional Learning Materials

Additional Learning Materials

Adapted from: CYMHS Inpatient Training Program – Introduction to Mental State Assessment and Interviewing the Child and Adolescent developed by Matthew Cartwright, Senior Project Officer, CYMHS

Introduction

Interviewing and assessment of children, adolescents and their families can be an overwhelming task for the new practitioner. Integrating theory and practice will enhance personal skills and confidence. Assessing diverse and complex clients provides staff with opportunities to develop assessment and diagnostic skills. Obtaining a client and family history unfolds with time, nurturance and patience. The skilled practitioner learns quickly not to make assumptions in the early stages of assessment.

Clients and families may sense a lack of empathy that stifles the therapeutic alliance. All clinicians are constantly learning, join them, and talk about your experiences. Clinical supervision, case conferencing, and treatment planning are useful forums to develop assessment skill and knowledge. Remember that practice will improve your confidence.

What are your strengths in interviewing and conducting mental health assessments?

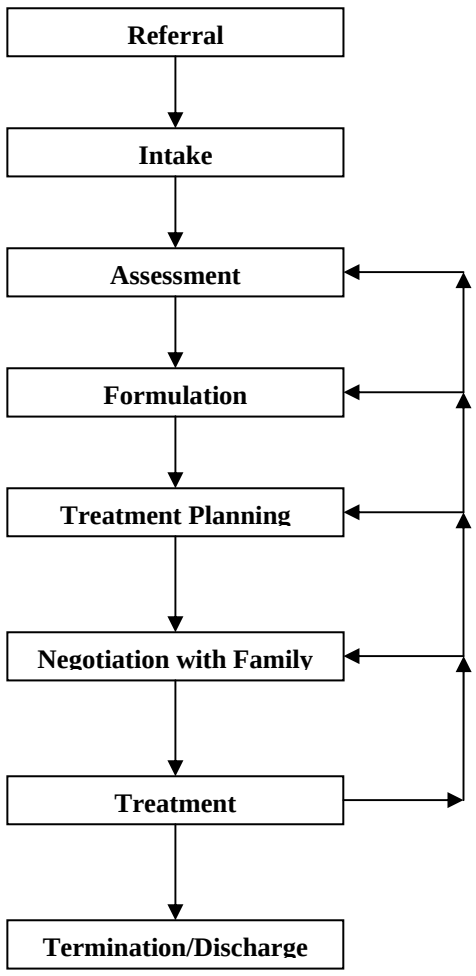
What knowledge and skills do you need to develop to conduct better assessments of children and adolescents? (For example **- f**amily history, developmental history, mental status examination, use of drawings, health history, behaviour assessment, sociocultural assessment, use of play, sense of self, self harm and risk.

Make a plan how you are going to strengthen your skills. Make sure that you set realistic time frames to achieve this.
GOAL:

Suggest to the team that you observe a number of interviews if you are unsure or need more assistance.

The Clinical Process In Child And Adolescent Mental Health Settings

The diagram below outlines the clinical process from receiving the referral, to the client being discharged from the service. The intake and assessment stages focus on acquiring information from a range of sources and gaining an understanding of presenting problem and reason for referral. The formulation stage is the process of synthesizing all the data gathered into a concise summary clarifying the presenting problem and related pre-disposing, precipitating, perpetuating and protective factors (to be explained in more detail in Unit 2.2). Based on the diagnosis and formulation, goals and options for treatment are identified in consultation with the child and family. Once agreed, the process of treatment implementation can occur. The reverberating circuit depicted by the arrows in the diagram below, highlights the fact that these stages are not discreet from one another and that information is continuously being gathered, and incorporated into one's assessment, formulation and treatment plan. It is important to remember that one is constantly making hypotheses from the information provided and testing such hypotheses through lines of questioning



Follow Up

Does this model differ for your work environment? How?

Purpose of Conducting an Assessment

What are the purposes of conducting an assessment?

Prior to conducting an assessment, it is important to understand the purpose of the assessment. Foremost, the aim of the assessment process is to gain a clear understanding of the child's presentation and the reason for the referral. The assessment is also used to establish rapport, gather information, determine whether psychopathology is present, establish a provisional diagnosis, generate a formulation, determine whether treatment is needed, and to develop an appropriate treatment plan. In order to achieve these aims, the child should not be assessed in isolation, yet considered with respect to their environment. Obtaining a full and accurate assessment of the child or adolescent requires the clinician to gather information from an array of sources, including the child, family, school, and other agencies involved with the child.

Where do I gather information from?

During the assessment process information can be gathered from a variety of sources including:

- Obtaining documentation and collateral information concerning the child (eg hospital records, developmental assessments, psychological tests, school reports)
- Parent interviews
- Child/Adolescent Interview
- Teacher interview
- Administering questionnaires e.g. outcome measures
- Medical examination of the child
- Specialist assessments and consultations
- Referral to other professionals for assessment information and input

Information to Gather in an Assessment

Reason for Referral

- Reason for attendance at this point in time

History of Current Problems

- Onset, duration, significant recent events, level of distress and symptoms functional impairment

History of Past Psychiatric Problems

- Prior treatment including admissions or other agency interventions

Medical History

- Any significant medical history including allergies, chronic illness or acute injury

Current Medication

- Any medication the client is currently taking, the dose and when it was last taken

Family History/Relationships/Genogram

- Significant family history and relationships relevant to the presentation. Illness in relative, family membership and atmosphere, parental history, parental occupational status, parental education/income/foster family

Personal and Social History

- Developmental history including negotiation of major milestones and events of infancy, childhood and adolescence; education/occupation/income; school performance and school based issues; peer interaction/relationships; sexual/marital; abode; recreation interests, social supports

Cultural and Linguistic Factors

- Cultural norms, cultural factors affecting presenting problem or treatment, cultural influences, languages spoken, migration, acculturation

Drug and Alcohol History

- Type of substances used, means of access, age and circumstances of first use, route of administration, amount used, pattern of use, frequency of use, advantages /disadvantages of use, level of concern, motivation to address, relationship to mental health problems and interference with current functioning, impact on relationships and roles (To be further explained in Unit 2.3)

Forensic History

- Involvement in or at risk of involvement in the justice system. Note examples of delinquent behaviour and failure to comply with rules.

Strengths, Resources & Needs

- Support system; coping skills; friendships/social relationships; general health; safety issues; emotional; spiritual and cultural needs

Mental State Examination (To be further explained in Unit 2.2)

Risk of harm to Self/Others (To be further explained in Unit 2.4)

- Assess and summarise degree of risk to self or others

Formulation (to be further explained in Unit 2.2)

Diagnosis

Prognosis

- Assessment of what the outlook for this patient/client is likely to be with or without treatment. It is based on knowledge of specific disorder, available treatment, and client characteristics.

Treatment Goals (to be further explained in Unit 2.2)

The Parent Interview

Parents play a fundamental role in the assessment process of children and adolescents, and enable the clinician to gain detailed information about the child and to understand the child's behaviour within their environment. It is important to gain parental consent, cooperation and involvement during the assessment and treatment stages. If the referral has come from a source other than the parent or legal guardian, it is necessary, both clinically and legally, to obtain consent from the parents in most cases.

In what circumstances, may consent not be required from the parents?

The aim of the parent interview to gather information, develop rapport and an alliance and establish a shared understanding of the presentation and goals for treatment. Thus, one should aim to use interview techniques that will elicit quality information, whilst maintaining an empathic and non-judgemental approach.

It is advisable that the clinician develop a tentative agenda for the interview in advance. The type of information that can be obtained from the parents or guardians may include:

Presenting problem

- Reason for presentation at this time
- Description of the problem and symptoms
- Nature, frequency and intensity of the problems
- Degree of distress and impact on functioning
- Impact of symptoms on parents and family
- Views on the causes of these problems
- Onset (timing and association with precipitating factors)
- Previous successful and unsuccessful solutions

Child's Personal History

- Developmental History (across lifespan)
    - Circumstances around birth/pregnancy/infancy
    - Physical Development
      e.g. Fine and gross motor, eating behaviour, sleep patterns, pubertal maturation, physical growth
    - Cognitive functioning
      e.g. verbal skills, attention, organisational skills, intellect, school functioning/progress, cognitive strengths/weaknesses

- Social
  e.g. Peer relations, participation in peer activities, social skills
- Emotional Development and Temperament
  e.g. Personality, mood and affect regulation, style of attachment, anxieties, depression, frustration tolerance

Family History

- How child relates to family members
- How child fits into family unit
- Child's compliance with family rules
- Family life events
- Parenting skills, style and parental expectations
- Parents limit setting and discipline
- Psychiatric status of parents
- Parental relationship

4. Medical history

- Medical illnesses, disability, or health concerns and their treatment, including medically prescribed, over the counter and alternative therapies

5. Drug and Alcohol Use

6. Any significant events or traumatic circumstances

- Separations, losses, illnesses, accidents, abuse and deaths

7. Child's strengths, talents, hobbies and positive qualities

8. Risk Assessment

NOTE Parents/carers may present to such interviews with many concerns, including:

- Is my child normal? Am I normal? Am I to blame?
- Am I silly to worry?
- Can you help us? Can you help my child?
- Does my child need treatment? Do I need treatment?
- What is wrong? What is the diagnosis?
- What are your recommendations? How can the family help?
- What will treatment cost, and how long will it take?

These concerns may impede the interview. Allaying anxiety of the parents is a primary goal of the interviewer.

Parents are most often interviewed first when the client is a child. Adolescents may be given the option of being assessed first or with their parents in the initial interview. It can also be useful to see the parents individually to gain each of their perspectives, and to see the whole family together which can provide information about family interactions. As a young person's problems are effectively connected to, and impact on the whole family, engaging families in the therapy process is crucial. Families can provide resources essential for healthy development and can assist in the therapy process and contribute to treatment success.

QUESTION

Why is important to assess the parents family of origin, their family relationships, discipline patterns and important family life events?

What is a family genogram? If you are unfamiliar with the use of a genogram, consult an experienced clinician or research this area.

ACTIVITY

Role-play the initial 10 minutes of your first assessment session with a parent. Within this role-play, you may discuss your role, qualifications, purpose of assessment, expected time-frame, the clinical process, their rights and responsibilities, and limits to confidentiality.

Child and Adolescent Interview

The clinical interview with a child or adolescent provides an opportunity to gain a clear understanding of the young person's view of the problem and to assess their mental state. The clinical interview is aimed at acquiring similar information to that obtained in the parent interview; however, the focus is on the child's perspective.

Important behaviours to observe and assess in the interview are the child's motivation, responses to separation from parent/carer, imaginative play, response to direction, limit setting, impulse control, attention and concentration, level of agitation or irritability and problem solving ability. The non-structured interview and general observation of the child will provide you with useful information.

Interview Techniques with Children and Adolescence

Prior to commencing the assessment, it is preferable that the parents have spoken to the child about the purpose of the interview and what to expect. In the initial assessment, it is suggested that the child be given some time to explore their surroundings. It is useful to clarify with the child why they think they are seeing you and then to provide an explanation for the interview. It is suggested that the interview begin with neutral questions about the child's home, family, friends, pets, and interests (Dulcan, M.K., & Wiener, J.M., 2006). It is also important to inquire throughout the assessment about school, family, peers, functioning and psychological symptoms and difficulties.

There are several different interview techniques that can be utilised when assessing a child. Different techniques and approaches will prove useful in establishing rapport and engaging young people. The technique chosen depends on a number of factors including the child's age, gender, presenting problems, developmental, cognitive and linguistic ability, as well as the interviewer's personal style and the clinical setting. Direct questioning is more often used with adolescents. Play and projective techniques are more commonly used with younger children. Given this however, the clinician needs to be prepared to be flexible and adapt their approach as required. There are generally three classifications of techniques – direct questioning, interactive play techniques and projective techniques.

1. Direct Questioning

Direct questioning involves asking the young person for specific information related to the presenting problem or their history. It requires the clinician to tailor their questions to the cognitive and linguistic ability of the child, and it is important that the clinician uses tact when asking potentially uncomfortable questions. Direct questioning can be completed in a structured, semi-structured and non-structured fashion.

Semi-structured and structured interviews are available to guide clinicians in making specific inquiries about symptoms and provide a comprehensive and systematic way of eliciting information. Such interviews ensure that extensive information is gathered about a broad array of diagnoses and symptoms. Given this however, semi-structured and structured interviews are rigid and limit one's use of clinical judgement. They do not capture of complexity of some cases and do not take into consideration the child's environment and the developmental influences.

2. Interactive Play Techniques

Play interviews are most effective with children, mixing activity with conversation. Play is useful for easing the child's anxiety, observing the child's mental state, and can be used to make inferences and gain information about the child's internal world. Using play techniques the examiner can gain insights into the psychological conflicts experienced by the child. Children enact their underlying anxieties and conflicts in play. Conflicts may be secondary to developmental delays, internalised conflicts, or difficulties with the child rearing environment (Cepeda, 2000).

Given that children have limited verbal capacity in comparison to adolescents and adults it is appropriate during the interview that you attempt to engage the child into something they find safe, eg: play, drawing, use of puppets, dolls house, movement toys, age appropriate games etc.

Direct observation of the child in play and interpersonal interaction is important. This data will support or discount what has been reported or highlight a more detailed description of the emotion and behaviour.

3. Projective Techniques

A range of projective techniques exist that can assist in gaining information from the child about their problems. The use of drawings in the initial interview and subsequent assessments with young children are useful, and give a good indication of a child's level of intelligence, developmental skills (eg fine motor and visual perceptual skills), creative and artistic talents and may indicate whether neuropsychological deficits are present. They also serve as concrete evidence that may be presented to the parents that do not believe that anything is wrong with their child. Commonly clinicians will invite a child to draw a picture by either making a specific request (e.g. a person, family, house, animal) or leaving the child to decide what to draw. The clinician then asks the child to talk about and describe the picture. Similar to this, Winnicott's(1970) "squiggle" drawing game requires the clinician to draw a squiggle and the child uses their imagination to complete the drawing and tell a story about the picture.

Cepeda, (2000, p71) suggests using a sequence of diagnostic drawings.

1. Free drawing
2. Draw a person
3. Draw a person from the opposite sex of the previous drawing
4. Draw the family doing something together (Kinetic family drawing)

Another technique is where the clinician asks the child projective questions such as "If I had a magic wand, what three wishes would you make?", "What animal would like to be?", "Who would you take to a deserted island?" Furthermore, projective techniques can be used in story telling. A child can be shown a picture and asked to tell a story from the picture. Alternatively, the clinician and child may take turns in writing a sentence in a story.

Children may be cautious and mistrusting when they present for assessment. It is likely that children will act differently in the clinical setting, thus, it is important to have several sessions to gain a clearer understanding of the client. Also, home visits often provide a richer understanding of what is happening.

ACTIVITY

Read books and articles on play and projective techniques. Provide a summary to your supervisor/team leader of some other techniques that may be useful in engaging and interviewing children and adolescence

QUESTIONS

What factors contribute to making the assessment process less threatening for a child less than 10 years?

What factors contribute to making the assessment process less threatening for an adolescent?

The adolescent is surly and mildly oppositional about the interview. They are concerned how the information will be used and what ill be written in the chart.

Consider and list the strategies or statements you could make to reduce the negativism and gain cooperation.

In the interview the adolescent tells you about their hopes and dreams. One of them includes a strong desire to leave home. What developmental, social and emotional issues might the patient be experiencing?

The patient asks you to keep a secret about personal information they tell you in the interview. How will you respond to this? How can this situation be managed?

During the assessment, the adolescent states "I'm depressed all the time". What questions will you ask to elicit the nature of their depressed mood?

A child draws a picture for you of their family but leaves one parent out even though they live at home. How could you respond to this situation?

What thoughts come to mind about the missing parent and the relationship with the child and other family members?

School Interview

Different informants may have varying views on the presenting problems due to their access to such information, the type and amount of interaction, the context and how they perceive what their see. This highlights the need to gain information from multiple sources.

Children's teachers or school staff can be a particularly useful source of information. An interview with the child's teacher or school staff may provide information related to:

- Academic performance
- Non-academic performance (e.g. sports, drama)
- Relationships with teachers
- Relationship with peers
- Child's behaviour in and out of the classroom
- Teacher's perception of the child and the problem
- Teacher's involvement with the child
- Resources available at the school
- Schools expectations
- Teacher-parent relationship

Medical Examination

It is sometimes useful, for clients to be refereed for additional testing and a medical consultation. This may include (but is not limited to) to a:

- Physical examination
- Organic screen
- Neurological evaluation (includes neuroimaging, Electroencephalography (EEG) and Electrocardiography (ECG))
- Metabolic, endocrinological or genetic testing
- Vision or hearing tests

Such tests may assist with identifying or excluding different causes for the presentation.

Also, if a client has not had a recent physical examination, or if any of the following symptoms are present, a full physical examination is recommended.

- Recurrent headaches, especially if associated with vomiting
- Loss of previously acquired skills (language, motor development, social development, school functioning, sphincter control)
- Impairment of social development
- Stunted or uneven biopsychosocial development (particularly in regard to language, intelligence, motor skills, social skills, school achievement)
- Behaviour disorder in association with physical anomalies
- A history of seizures
- Explosive rage attacks
- Vagueness, lapses of attention, trance-like states
- Abnormal movements, muscle weakness, sensory loss, poor coordination
- Loss or increase of appetite or weight

Where would you obtain further collateral to make this assessment more complete?

Special Assessments and Consultations

The following are the special investigations and consultations most likely to be requested for children and adolescents.

- Psychiatric consultation
- Neurologic consultation
- Paediatric consultation
- Speech, language and hearing assessment
- Occupational therapy assessment – developmental, motor, visual perceptual, sensory
- Psychological testing (psychometric tests and projective evaluations including tests of intelligence, achievement, personality)
- Neuropsychological assessment
- School performance
- Vocational aptitude

Familiarise yourself with these assessment processes and when they may be required. This will assist you build on your current knowledge, and alleviate concerns for clients and families if they ask questions.

Considerations

How much time should be allocated for conducting an assessment?

An assessment can take between 1 to 3 sessions; however, this largely depends on the situation and the client. The following information serves as a guide. When families are distressed they need the sessions to be broken up. If the situation is a crisis, allow up to 2½ hours for a family interview and interview with the identified patient. If the case is non-urgent, a possible allocation of time is as follows: interview with parents (2 hours);

interview with child/adolescent (1 to 2 one-hour interviews); interviews with family, for negotiation of diagnosis and treatment plan (1 hour).

Another consideration is the practical arrangements relating to who is seen and the order in which interviews are conducted varies with the case and clinical setting. For example, if the whole family arrive in a crisis arising from one member, they should be seen as a family. The identified patient can then be interviewed alone, at a later time. If there is no urgency, the parents can be interviewed first and the child seen at a later appointment. Try to interview *both* parents at the first interview. If the whole family arrive, it may be more convenient to interview the identified patient first, then the whole family. Avoid situations in which you interview the parents while the child or adolescent waits anxiously outside.

The advantages of interviewing the parents first at a separate interview are that you will have a full history before you see the identified patient. The parents will have the opportunity to look you over before they entrust their child to you, and the parents can prepare the child or adolescent to be interviewed by you.

The disadvantages are that it takes more time, and adolescents may be upset if they become aware that their parents have discussed their problems with a stranger. On the other hand, if you interview the identified patient first and he or she is relatively uncooperative, you may not know the basis for the resistance until you see the parents, and the parents may be antagonised by your apparent unwillingness to hear their side of the story. If you conduct the entire evaluation by family interviewing, you will obtain rich information about family interaction but much less about early development, past physical and mental health, and other data required for a comprehensive biopsychosocial diagnostic formulation. Some of this information may be collected at the Intake telephone interview with the parents.

What other factors may impact on your decision to see the young person or the parent first, or to see them together?

It is important to be aware of precautions you can take to safeguard yourself and the child or adolescent during assessment.

List some considerations you would have in place to protect yourself from any untoward allegations of misconduct.

Situations to avoid during and prior to assessment and interview.

- Avoid conducting assessments in secretive places or rooms, bedrooms, bathrooms, in the dark lit areas, places unfamiliar to patients or in open places where people can hear all the discussion. Use rooms designated for the purpose.
- Note: a bedroom is not the ideal place to conduct assessments. If this has to be done then the person in charge should be informed. It is advisable to have the door or curtains open and document the reasons why.
- Avoid any discussion about other patients or yourself personally.
- Avoid touching the patient or becoming too close.
- Avoid sitting on the patient's bed to discuss their progress.
- Avoid making the patient feel trapped in the room.
- Avoid impromptu style assessments and try to schedule appointments outside times that the young person is engaged in pro-social activities like sport or work.

Strategies to consider during and prior to assessment and interview.

- Plan to conduct assessment in designated interview rooms
- Inform other staff whom you are seeing and estimate the time you are expecting to finish, if there are any risk issues.
- Inform the client of the purpose of the assessment and the estimated time frame and negotiate an appropriate appointment time.
- Give them time to prepare themselves.
- Offer them to have a parent there if appropriate.
- In the initial interview, highlight to the client the voluntary nature of the assessment, explain what the assessment involves, how long it may take, explain the clinical process, and also clarify the limits of confidentiality.
- Make sure there is a reasonable space between you and the patient.
- Ensure the environment is well lit, good temperature and reasonably quiet.
- Reduce distractions and noise.
- Offer them the seat they wish to take. Children may wish to sit on the floor.
- Plan to do assessments outside of group activities or school where able.
- Be cautious of the patient who is aggressive or paranoid. You may wish to take the seat closest to the door. Ensure a duress alarm is available in these situations.
- If the client is potentially aggressive make sure you have two people or have a staff member check on you. Remember working as a team means looking out for each other to reduce risk.

- Don't be afraid to question a staff member's decision if the concern is regarding safety or a situation that could be misinterpreted.
- Any situation where a patient may feel uncomfortable in the environment may hinder the trust and constitute boundary violations.
- Have food or water on offer, especially for adolescents.
- Have toys, paper and pencils available or encourage comfort objects for younger children.
- Document the assessment promptly after the interview.
- If the patient becomes sexually inappropriate or threatening in any way, terminate the interview and discuss with the team promptly, document the facts.

You will add to the list as you come across more situations in your work. This will teach you the skills relevant to better assessment considerations. Children and adolescents are great teachers.

Are there any areas of assessing a child and family that you are unsure of? Do you have questions that still need answering? Write them down and consult an experienced team member for clarification.

Summary

The aim of the assessment process is to establish trust and a therapeutic alliance, whilst gaining an understanding of the child within multiple systems. The initial assessment plays a pivotal role in the clinical process and involves the acquisition of detailed information from a range of sources, to develop a clear picture of the presenting problems and the factors leading to their presentation.

Such information can be gained through obtaining collateral information, history taking, parent interviews, child/adolescent interviews, teachers/school interviews, physical examinations, special investigations or consultations. Through all of these avenues information is obtained on the presenting problem, history of current problems and past problems, medical illnesses or disability and their treatment/medication, family history, personal history, developmental history, home, school, peer, and recreational adjustment, drug and alcohol history, strengths, resources and needs.

This information is then used to provide feedback, develop a formulation and guide further treatment and management.

A framework for planning the agenda for assessment interviews

Figure 4.2. A framework for planning the agenda for assessment interviews. (Copied from pages 108-109 from The Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach (2nd Ed.) (2006), Carr, A.)

THE REFERRAL
- The referrer
- The customer
- The child and the reason for referral
- The legally responsible guardians
- The primary caregivers
- The child's main teacher
- The social control agents
- Other involved professionals

TYPES OF MEETINGS USED FOR ASSESSMENT
- Child-centred assessment
- Parental interview
- Nuclear family interview
- School interview
- Extended family interview \
- Interview with other involved professionals
- Professional network meeting
- Team meeting
- Case conference

THE HISTORY OF PRESENTING PROBLEMS AND MAINTAINING FACTORS
- Main problems as identified by referrer, child's parents and other significant network members
- History of their development
- Previous successful and unsuccessful solutions
- Network members views on causes of problems and possible solutions
- Denial of the problem
- Lack of commitment to resolving the problem
- Inadvertent reinforcement
- Insecure attachment
- Coercive parent-child processes
- Over-involved parent-child processes
- Disengaged parent-child relationship
- Inconsistent discipline
- Confused communication
- Triangulation
- Chaotic family organization
- Father absence
- Marital discord

CHILD DEVELOPMENTAL HISTORY

The first five years
- Particular strengths shown in first five years
- Pregnancy and birth problems
- Physical health and any early childhood illnesses
- Feeding and eating patterns and problems
- Sleeping pattern, age when first slept through night and sleep problems
- Physical growth and any problems with height or weight being below 3rd percentile
- Sensory and motor development and any delays in motor development
- Bowel and bladder control, age when toilet training was complete and any soiling or wetting problems
- Temperament and attachment and any attachment problems Language development and any language delays
- Cognitive development and any problems with sustaining attention and solving puzzles and games
- Social development and adjustment to pre-school and any attachment problems or peer problems
- Emotional regulation and problems with persistent crying
- Anger control and problems with tantrums

Middle childhood 6-12 years
- Particular strengths shown in middle childhood
- Physical health and illnesses during middle childhood
- Academic performance and cognitive development and any attainment problems
- Internalization of rules and moral development during middle childhood and any conduct problems
- Emotional regulation, anxiety and depression in middle childhood
- Making and maintaining friendships and peer problems during middle childhood

Adolescence 12-18 years
- Physical health and illnesses during adolescence
- Academic performance and cognitive development in adolescence and any problems with schoolwork
- Rule-following in adolescence and any conduct problems at home, school or in the community
- Adjustment within the peer group in adolescence and any problems with making and maintaining friendships or membership of deviant peer group
- Emotional regulation, anxiety and depression in adolescence
- Eating pattern in adolescence and any indication of anorexia or bulimia

- Experimentation with or abuse of drugs and alcohol
- Psychotic features in adolescence

FAMILY DEVELOPMENTAL HISTORY AND GENOGRAM

- Current household membership
- Extended family membership
- Other network members
- Identifying information such as names, ages, occupations and locations of important family and network members
- Major illnesses and psychosocial problems including hospitalizations, physical and psychological problems and criminality
- Major protective factors and strengths of family members
- The major transitions that the family has made through the family lifecycle
- Current stage of the lifecycle
- Supportive relationships for the child and caregivers within the network
- Stressful relationships for the child and caregivers within the network
- Family factions and patterns particularly multi-generational patterns

PARENT-CHILD RELATIONSHIPS

- Parents' style for meeting child's need for safety particularly with infants and toddlers and problems with neglect
- Parents' style for meeting child's needs for physical care, food, shelter, clothing and problems with neglect
- Parents' style for meeting the child's needs for emotional care, warmth, acceptance and love throughout childhood and adolescence (and problems with abuse or neglect)
- Parents' style for meeting the child's needs for control, clear limits and discipline particularly in middle childhood and adolescence (and problems with being too punitive and abusive or over-indulgent)
- Parents' style for meeting the child's needs for intellectual stimulation particularly in infancy and early childhood (and problems with neglect)
- Parents' style for meeting the child's needs for age-appropriate autonomy and responsibility particularly in adolescence (and problems with being too demanding or too lax and over-protective)

PARENT-PARENT RELATIONSHIPS

- People involved in parenting the child including biological parents, step-parents, foster parents, other family members
- Quality of marital relationship and degree of sharing of childcare if child lives with married or co-habiting parents
- Support network available to single parents
- Quality of co-operative parenting relationship if parents are separated and child lives with one parent but visits the other regularly

LIVING CONDITIONS AND FINANCIAL RESOURCES

- Location in community and proximity to schools, shops, extended family, etc. or problem with isolation
- Ratio of number of people to number of rooms and problems with crowding
- Quality of living quarters and problems with safety or hygiene Parental financial resources and need or entitlement to benefits

INVOLVEMENT WITH OTHER PROFESSIONALS AND AGENCIES

- List of other involved agencies
- Duration of involvement
- Reasons for involvement

SCHOOL CONTACT

- Current and past academic performance (including standardized test scores if available)
- Current and past performance at sports, drama and other non-academic pursuits
- Current and past relationships with teachers
- Current and past relationships with peers
- Teacher's role in the network
- Teacher's beliefs about the problem and solution
- Teacher's prediction about how the case will work out
- Availability of remedial tuition
- Degree of parent-teacher co-operation
- Amount of child-teacher contact
- Expectations for good conduct
- Expectations for academic attainment
- Pupil involvement in school affairs
- Use of praise-based motivation

OBSERVATIONS OF CHILD AND CHILD'S VIEWPOINT

- Child's account of problem, coping strategies and defences
- Child's account of parents and teacher's views of problem
- Child's genogram and lifeline

- Child's perception of relationships with parents and teachers
- Child's cognitive and academic strengths and weaknesses
- Child's self-esteem, locus of control. self-efficacy and atrrtbutional style
- Child's capacity to make and maintain friendships and social problem-solving skills
- Child's account of situations requiring protective action (abuse or suicidal intent)
- The child's wishes for the future
- Child's account of situations requiring major changes in living arrangements (parental custody or foster care)
- Child's capacity to engage in individual, group, or family therapy and to respond to behavioural programmes

FORMULATION

- Pre-disposing factors
- Precipitating factors
- Maintaining factors
- Protective factors

POSSIBLE INTERVENTION OPTIONS

Take no immediate action
Reassess periodically
Refer to another professional within the team for consultation
Refer to another professional or residential facility outside the team
Offer focal intervention to the child, parents, family or school
Offer multi-systemic intervention alone or with other professionals or residential facility to the child, parents, family or school

Unit 2.1

Child and Youth Mental Health Assessment

Record of Learning

Record of Learning

The following activities are suggestions for assessing your learning from this unit. They may be used as a self assessment tool or be reviewed with your team leader or supervisor.

1. Watch DVD 2 (Contextual Assessment), DVD 3 (Narrative Assessment) and DVD 4 (Play/projective Assessment) and complete the associated exercises.
2. Study the Self Directed Training Materials (Unit 2.1) and complete the Reflection Questions .
3. Review the answers and discuss issues that may arise with your supervisor or team leader.
4. Video-tape three client sessions in which you demonstrate your ability to conduct an assessment and utilise different information gathering techniques. View these taped sessions in consultation with your supervisor/team leader.
5. Over a period of 6 weeks, present 3 completed written assessments to your supervisor/team leader in a succinct and concise manner. Discuss the information in the assessment, what further information is required, the relevance of the information, collateral information etc.
6. Complete the ICD-10 QHEPS Education Package
   http://qheps.health.qld.gov.au/mhinfo/documents/icd_package.pdf
7. Complete QH and UQ Professional Development Program
   http://qheps.health.qld.gov.au/Hssb/mhu/mhp_train/Modules.htm
8. Complete the following Record of Learning on the following page.

Record of Learning

Unit 2.1: Child and Youth Mental Health Assessment

Name of Clinician: _____

Record of Learning	Date Achieved	Signed
Has an understanding, and knowledge of, different assessment techniques that can be used to gather information and engage young people		
Demonstrated ability to utilise different strategies and assessment techniques/styles to elicit information and engage a client in the assessment process		
Has an understanding of the components and information acquired in a mental health assessment		
Applies the relevant elements of the mental health assessment process to the clinical situation to acquire appropriate information from suitable sources		
Demonstrates an understanding of the factors that enhance and impact on interviewing children and adolescence, and how these may impact on clinical practice		

Additional Supervisor/ Team Leader feedback and comments:

Signature _____

Congratulations and well done for completing this unit of learning. We hope it has been useful and interesting.

Please now complete and return the evaluation/ feedback forms. There is a form for you as the clinician and one for your supervisor to complete. Both of these forms are found in the section 'Evaluation/ Feedback Forms at end of this package.

Thank you