PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[4] Case Identification

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From before birth, caregivers are concerned about the healthy development of the child. Conclusions about healthy development hinge on physical and behavioural observations that gradually become more extensive as the child grows up.

Initially the observations are about appearance, size, weight, heartbeat, respiration, wakefulness and movements, perhaps supplemented by some medical tests. Later, as the child grows, observational expectations are broadened to include attentiveness to the environment and especially to reciprocity of interaction with caregivers and the display of interest and emotional responses. Observed behaviours are compared to what is generally seen in other children at the same age. Observations become systematically documented in the physical, cognitive, language and emotional domains, with statistical norms crystallised into tests and rating scales.

Caregivers, normally the child's parents, cannot be assumed to know details of these developmental norms. However, they may be aware when a child is not progressing in the way they expect, and it is up to professionals to ascertain the nature of the deviation. Children and families have the right to mental health treatment/services based upon a thorough assessment appropriate to the child's developmental stage and cultural context. As there is a wide range of problems, of various levels of seriousness, it is appropriate for the service system to have a graded series of responses to cater for the range of needs. There is no "one size fits all". There are diverse pathways depending upon the place of initial alert.

At a self-help level for parents there are various books on child development and websites with fact sheets on various paediatric topics such as those published by the Centre for Community Child Health (affiliated with Melbourne University, the Royal Children's Hospital and the Murdoch Children's Research Institute). There are community-based groups, such as Australian Breastfeeding Association and Local Government playgroups, which have members sufficiently knowledgeable about child development to encourage caregivers to seek assessment when indicated.

In Victoria, more than 95% of infants are followed up after childbirth in several consultations over a period of several months by appropriately qualified nurses from the Maternal and Child Health Branch of the Health Department. Most children are also seen by family General Practitioners for immunisation and health checks. At all of these occasions it is possible for children showing atypical developmental progress to be referred for specialist assessment.

At a later stage, children attending day care programs or kindergartens are nowadays usually screened by the Australian Developmental Index (ADI), a paediatric developmental questionnaire designed for administration to all children in the community to identify vulnerabilities or special needs requiring attention. In some cases other screening instruments may be used, such as the General Health Questionnaire (GHQ), Achenbach Child Behaviour Checklist (CBCL), the Child Depression Inventory (CDI), or others addressing psychosocial issues.

Depending upon the pattern of difficulties observed, the further investigation may be through General Practitioners and psychologists, paediatricians, specialist paediatric developmental services or child psychiatric services.

A formal mental health assessment involves interviews of child and caregivers. Interviews should cover presenting symptoms, past and current medical history, past and current social/family history, and an age-appropriate physical health and mental state assessment (cognitive intellectual abilities, reasoning, memory, thought processing, language

skills, affect and executive functioning). These psychological processes might be formalised by standardised tests as well as the clinical observations.

The goals of this assessment are:

- to determine whether functioning is sufficiently outside the normal range to be regarded as a disorder (case identification),
- to determine whether the pattern of symptomatology matches regularly occurring patterns described in the diagnostic lexicon (diagnosis),
- to state a hypothesis (case formulation) of:
    - the underlying pathophysiology of the disorder (biopsychosocial etiology),
    - what factors set the stage for the problems (predisposing factors),
    - why the disorder has occurred at this time (precipitating factors),
    - what factors maintain it as a dysfunctional pattern (perpetuating factors),
- to summarise the issues that must change to produce a desired outcome (goals for change), and
- to propose a means by which those changes could be achieved (treatment plan).

The latter two goals may be initiated by the professionals, but it is essential for success that they be collaboratively developed with clients so that they are mutually "owned" by the parties involved in any therapeutic process. The plan should address the whole psychodynamic system, not just the symptoms of an individual. For example, it may not be feasible to treat a depressive illness in a person without changes in another person's interpersonal relationships.

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