A Guide to Psychiatric Services in Schools

Understanding Roles, Treatment, and Collaboration

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Contents

Series Editors’ Foreword.............................. xi
Preface........................................... xiii

Chapter 1  Introduction to Psychiatry in Schools....... 1
Clinical Case: Erin ................................... 1
Importance of Psychiatry in Schools ............ 10
Child and Adolescent Psychiatrists’
    Contributions to the Educational Team. ... 10
Clinical Case: Kayla............................... 12

Chapter 2  Psychiatric Evaluation and Formulation.... 19
Psychiatrist: Background Information ........ 19
Psychiatric Evaluation: Reasons ............... 20
Psychiatric Standardization: DSM-IV-TR ...... 21
Psychiatric Evaluation .......................... 23
Psychiatric Evaluation Report ................... 28
Psychiatric Evaluation: Summary .............. 36

Chapter 3  Psychiatric Roles ............................ 37
The Psychiatrist as a Consultant ............... 37
Psychiatric Consultation: Potential Roles ...... 38
American Academy of Child and Adolescent
    Psychiatry Recommendations ............... 39
Psychiatric Evaluations for a School System ... 42
Direct Service to Identified Students .......... 48
Psychiatric Roles: Summary .................... 55

Chapter 4  Psychopharmacology ........................ 57
General Principles of Psychopharmacology .... 57
Neuroanatomy ...................................... 58
Neurotransmitters ............................... 59
Principles Related to Mechanisms of Action ... 60
Legal and Ethical Issues of Medication ......... 62
Antidepressants ................................. 62

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Contents

Mood Stabilizers ........................................ 64
Antipsychotics ........................................... 65
Stimulants ................................................ 66
Alternative Classes of Medication .................. 68
Preparing to Take Medication ....................... 69
Psychotropic Medications in the School Setting ........................................ 70
Psychopharmacology: Summary ..................... 72

Chapter 5
Disruptive Behavior Disorders ......................... 73
Disruptive Behavior Disorders: Introduction ....... 73
Attention-Deficit/Hyperactivity Disorder ........... 74
Oppositional Defiant Disorder ....................... 85
Conduct Disorder ......................................... 89

Chapter 6
Mood Disorders ........................................... 95
Depressive Disorders .................................... 95
Bipolar Disorder ......................................... 106
Mood Disorders: Educational Implications ........ 115
Mood Disorders: Summary ............................ 115

Chapter 7
Anxiety Disorders ......................................... 117
Anxiety Disorders: Introduction ....................... 117
Generalized Anxiety Disorder ....................... 118
Separation Anxiety Disorder ......................... 119
Social Phobia ............................................. 120
Specific Phobia .......................................... 121
Panic Disorder ............................................ 122
Anxiety Disorders ........................................ 122
Post-Traumatic Stress Disorder ..................... 128
Obsessive-Compulsive Disorder .................... 132
Anxiety Disorders: Educational Implications .... 137
Anxiety Disorders: Summary ......................... 138

Chapter 8
Psychotic Disorders ....................................... 139
Psychosis: Defined ........................................ 139
Schizophreniform Disorder and Schizophrenia .... 140
Major Depression With Psychotic Features ....... 150
Bipolar Disorder With Psychotic Features ......... 151
Contents

Other Psychotic Disorders .......................... 154
Psychotic Disorders: Educational
    Implications ................................ 155
Psychotic Disorders: Summary .................. 157

Chapter 9 Eating Disorders ......................... 159
    Eating Disorders: Background .............. 159
    Anorexia Nervosa .......................... 160
    Bulimia Nervosa ........................... 169
    Binge Eating Disorder ...................... 176
    Eating Disorder, Not Otherwise Specified:
        Overview ................................ 177
    Eating Disorders: Educational Implications ... 177
    Eating Disorders: Summary .................. 178

Chapter 10 Pervasive Developmental Disorders ........ 179
    Autism Spectrum Disorders: Background .... 179
    Autistic Disorder ........................... 181
    Asperger’s Disorder ......................... 189
    Pervasive Developmental Disorder, NOS .... 194
    Autism Spectrum Disorders: Educational
        Implications ............................ 198
    Autism Spectrum Disorders: Summary ....... 200

Chapter 11 Treating Target Symptoms .................. 201
    Background Information ..................... 201
    Aggressive Behavior ......................... 203
    Self-Injurious Behavior ...................... 207
    Impulsivity .................................. 209
    Insomnia .................................... 213
    Affective Instability ......................... 215
    Treating Target Instability: Educational
        Implications ............................. 219
    Treating Target Symptoms: Summary ......... 220

Chapter 12 Medicating Children ....................... 221
    Psychiatric Care ............................ 222
    Choice of Initial Medication ................ 226
    Psychiatric Care: Follow-up Visits for
        Medication ............................... 227

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Two

Psychiatric Evaluation and Formulation

PSYCHIATRIST: BACKGROUND INFORMATION

A psychiatrist is a physician who specializes in the treatment of emotional disorders. There is also an emphasis on diagnosis and prevention of these disorders. Some examples of disorders that can be treated by psychiatrists include depression, anxiety, developmental disabilities, psychosis, and substance abuse. Psychiatrists are medical physicians who have received specialized training in the field of psychiatry. The training focuses on the medical, psychological, and social components of emotional and behavioral disorders. Psychiatrists can order diagnostic tests, prescribe medication, perform psychotherapy, and help in times of stress and crisis. In addition, they may consult with primary care physicians, psychologists, social workers, child protective service systems, juvenile justice systems, and education systems.

A psychiatric evaluation is a comprehensive assessment completed by a psychiatrist. This clinician may be board certified in general psychiatry, and if the evaluation is being conducted on youth, then the clinician may be a board certified child and adolescent psychiatrist. To be board certified in this specialty, the physician must have completed medical school, 3 years of a general psychiatric residency, and 2 years of a child and adolescent residency. A portion of the residency program includes several months spent training with a medical internist and several months spent with a neurologist. A board certified physician is one who has successfully passed a national board examination that most often involves both written and oral portions. A board eligible physician is one who has successfully completed the training for the specialty but has not yet taken or passed the board examination.
As a result of this background and training, several unique characteristics are present in child and adolescent psychiatrists. The frame of reference for a psychiatrist tends to be biologically and medically based. The medical school background prepares a psychiatrist to assess both mental health and medical problems. The neurology training also allows a psychiatrist to consider structural brain abnormalities in assessment of behavioral and emotional problems. Finally, the psychiatry training provides the ability to consider strengths and weaknesses in three different domains: the biological, psychological, and social. This three-tier approach, commonly referred to as the biopsychosocial model, allows for a comprehensive view of the student’s functioning.

PSYCHIATRIC EVALUATION: REASONS

A parent or pediatrician can recommend psychiatric evaluations. In this situation, an evaluation is requested primarily to answer specific questions. This may include an assessment for use of a psychotropic medication. It may include an assessment for more intense mental health interventions such as hospitalization. There may be particular questions about a response to a therapeutic intervention such as therapy. In this type of evaluation, it is most common to see the individual and family members only.

A psychiatric evaluation should provide helpful information to the family. It can provide information about diagnosis and contributors to the diagnosis. It can also help to define the youth’s strengths and how these can be used to improve deficiencies. It can determine if the symptoms present are developmentally appropriate or a sign of pathology. Finally, it is an opportunity to have any medical contributors assessed.

A school district can also request psychiatric evaluations. This evaluation tends to be more complex. The expectation is that the evaluation, along with providing diagnoses, provides recommendations to help the student be more successful educationally. Often, more questions are asked, and there is often more information readily available by a large number of sources. A school may request an evaluation for several reasons. However, typically it is requested if a student’s emotional difficulty is interfering with his or her educational progress. At times, an evaluation is requested simply to provide diagnostic information. Understanding the emotional reasons that are contributing to the presenting problems may be helpful. In
addition, a school district might request a psychiatric evaluation to ensure that all possible educational interventions are being provided. Finally, identifying a student with an emotional disturbance can lead to additional educational supports.

Children and youth agencies or juvenile probation agencies can also request psychiatric evaluations. In this type of evaluation, more complex questions are asked. Some of these questions may include an assessment of the student’s safety in the community or the impact of past experiences on current functioning, or they may determine if more intensive mental health services are needed.

Regardless of who is requesting the psychiatric evaluation, the primary purpose of the diagnostic assessment is to determine whether psychopathology is present. If it is determined that the symptoms are a sign of pathology, then it becomes important to establish a differential diagnosis. A differential diagnosis is a listing in order of importance of all of the potential causes for the problems. From the differential diagnosis, treatment recommendations can be generated.

There may be situations in which the focus of the evaluation, besides conducting a comprehensive evaluation, is appropriately narrowed. Some examples of this include a consultation for a medical physician on an individual who has been hospitalized in a pediatric unit or an emergency evaluation to determine the dangerousness to self or others. In this type of assessment, there is often a more rapid assessment to answer the one immediate question. This answer will guide further treatment and assessment extents.

**PSYCHIATRIC STANDARDIZATION: DSM-IV-TR**

The American Psychiatric Association developed the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM-I) in 1952. It was created to provide standardization of diagnoses. This system has evolved and changed until the creation of the current psychiatric standard, the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR), which was accepted in 2000.

This reference provides a mechanism for mental health clinicians to provide consistent and clear diagnoses. In this system a mental disorder “is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability” (American Psychiatric Association,
It is also specified that this pattern must be more than a culturally sanctioned response to an event. The approach that is used is a “categorical classification that divides mental disorders into types based on criteria sets with defining features” (p. xxxi).

The *DSM-IV-TR* lists the diagnostic criteria for all currently recognized mental disorders. The criteria include a specific cluster of symptoms that must be present. For some diagnoses there are many criteria listed, and it is specified what number of these criteria must be present to reach the clinical diagnostic threshold. For example, there are nine recognized criteria for major depression, but an individual needs to have only five current symptoms to meet the diagnostic threshold for the disorder. It is also specified how long these symptoms must be present. At times the age of onset is specified. For example, an individual with attention-deficit/hyperactivity disorder must demonstrate symptoms before age 7. Some disorders specify that the symptoms must be present in several settings. It is always required that the symptoms cause functional impairment. This is a critical component that helps to differentiate psychopathology from normal. Once criteria are met for a given diagnosis, there may be further specification required. For example, if criteria are met for major depression, the severity of the disorder—mild, moderate, severe, or profound—is required. Each clinical diagnosis and specifier is given a unique identifying code.

The organizational plan for the diagnosis includes a multi-axial system for diagnostic clarity. Axis I is reserved for “mental disorders and conditions that are a focus of clinical attention” (*DSM-IV-TR*, p. 28). There may be more than one Axis I diagnosis identified, and if this is the case, they should be recorded in order of importance. Axis II is for recording personality disorders and mental retardation. Axis III is where general medical conditions are listed, particularly those that are affecting the mental health of the individual. Axis IV is where psychosocial and environmental problems are recorded. Again, if multiple stressors are present, they should be listed. Typically, these are grouped together into the following categories: problems with primary support group, problems related to the social environment, education problems, occupational problems, housing problems, economic problems, problems with access to health care services, and problems related to interactions with the legal system. Finally, Axis V is for the clinician to report his or her judgment of the
individual’s overall level of functioning. This is done using a scale called the Global Assessment of Functioning (GAF) scale. This is a scale from 1 to 100 that is divided into 10 ranges of functioning. More severe impairment is in the lower range, which describes a more severe problem. For example, numbers ranging from 91 to 100 reflect superior functioning, whereas numbers from 41 to 50 are for serious symptoms such as suicidal ideation or serious impairment in functioning, and 1 to 10 are for those individuals who are in persistent danger of severely hurting self or others.

**PSYCHIATRIC EVALUATION**

**Features**

The American Academy of Child and Adolescent Psychiatry (AACAP) is an organization that can be a helpful resource to child and adolescent psychiatrists and families. This organization devised a set of guidelines that, although not mandatory to follow, can be used by physicians to ensure that a thorough evaluation is completed. The suggestions in the following section are loosely based on these guidelines.

One unique feature of a psychiatric evaluation is its focus on developmental information. Development occurs on a continuum, and there are several different “developmental lines.” Some examples of developmental lines include motor development, speech and language development, social development, educational development, and identity development. The psychiatric evaluation should consider where the youth is on these different lines. This context helps to further identify individual strengths and weaknesses. Therefore, it is important for the psychiatrist to understand normal and abnormal development (see accompanying CD: 2.1).

Along with development, a psychiatric assessment must also consider the student in the context of family and educational settings. A child’s functioning is dependent on the interactions with others around him or her. A child does not operate independently, and a full understanding can be achieved only when there has been a consideration of the different settings in which the child functions. Therefore, these features must be understood to help clarify strengths and needs.

A final critical feature of the assessment is the mental status examination. This section is a “snapshot” description of the child at the time of evaluation. However, it must be considered...
that factors can influence this presentation of the child on that given day. For example, if a child is physically ill on the day of the assessment, the evaluation may not fully reflect the child’s presentation on a day he or she feels well. Nervousness about meeting a new person may also skew the presentation. In addition, pressure to perform and do well may change this view in an unrealistically positive way.

**Sources of Information**

A complete psychiatric evaluation includes information from as many sources as possible. At minimum, the parent and child are required informants. However, information should also be sought from the school, a medical physician, or prior treatment providers. In addition, if the child is involved with other public systems, such as child welfare or juvenile probation, information should be sought from these agencies as well.

It is important that there be the opportunity to see the child and the parents separately. This allows the opportunity for the clinician to ask more direct questions and allows each participant to answer more honestly. However, it is often equally useful to spend a portion of the time with the parents and child together. This allows the clinician the opportunity to see the interactions between the family members.

**Parent Interview**

The parent interview is critical to a full understanding of the child, and it is often framed with the intention of discovering several objectives. The first goal of the parent interview is to understand the reason for the referral. This includes understanding the child’s current difficulties and the impact these difficulties are having on both the child and the family. The second goal is to obtain relevant developmental history to have the appropriate framework in which to place these difficulties. The third objective is to gain understanding of the family’s level of functioning and the cultural context in which the family operates. Finally, obtaining information about physical or mental illnesses within the family can contribute to an understanding about biological influences on the problem.

The history should focus not only on obtaining information about the child’s struggles, but also on strengths, interests, and talents. This approach helps to foster the self-esteem of the child and bolster the self-construct of the family. In addition, it allows the opportunity to make use of these positives to modify the more challenging behaviors. Strengths should be
identified throughout the assessment, but initiating the parent interview with this information often puts the family at ease.

When obtaining information to understand the reason for the referral, it is necessary to inquire about frequency, intensity, duration, and circumstances in which problematic behaviors occur. The attitudes of the parents, child, and others toward the problem are also a helpful line on which to inquire. Often, each parent may have a different perspective of the impact of the problem, and understanding the differing views is helpful. This should include a direct account of several specific instances of the problematic behavior. Once there seems to be a thorough understanding of the behavioral problem, it is important to understand the parental view of the child’s perceived distress, the degree to which the behaviors interfere with social and academic activities, and the impact on the child’s ongoing development. Finally, it is important to understand the impact this behavior has on others (Cox & Rutter, 1985).

Certain behaviors are developmentally normal, whereas other behaviors become abnormal if they persist beyond a certain age. This is the reason child and adolescent psychiatrists attempt to gain as much information about the child’s development as possible. For example, a fear of bugs is developmentally appropriate in a preschool child but can be abnormal in a teenager. It is important to understand motor development, social development, and the development of self-regulation.

As described above, it is important to also understand the ways in which the family system functions. Considering the family’s flexibility and conflict resolution skills are often important as they can place the family’s ability to manage problematic behavior in different ways. Equally important is the cultural context in which the family operates. Some cultures are more reluctant to share personal and family information with strangers. Some cultures readily embrace the idea of mental illness and therefore are able to be more forthcoming about problems. Extended family members’ cultural context and view of information can drive the way a nuclear family functions.

**Youth Interview**

The clinical interview of the youth allows for the opportunity for the clinician to directly explore the individual’s own perception of the presenting problem and the assessment of his or her overall developmental and mental status. This direct contact allows the clinician to learn information that may
not be available from other sources. For example, the child’s perception of his or her personal suffering can be provided only by the child. In addition, thoughts and feelings such as anxiety, suicide, and obsessions can be given only in a direct child interview. It is also important to assess the child’s level of emotional awareness.

There are two main objectives that should be considered during this portion of the assessment: obtaining personal history and conducting a mental status examination. When taking the personal history, the clinician should inquire into the child’s life and level of functioning both in the past and in the present. The mental status examination is an assessment and description of the child’s appearance and functioning as seen during the evaluation. These two objectives are often addressed simultaneously during the individual assessment.

Unlike an interview with an adult, the interview of a child or adolescent often requires creativity and flexibility to obtain information. The interview must match the child’s developmental, cognitive, and language abilities. In addition, the approach and tone of the interview may need to be adjusted regarding the difficulty or intensity of the topic being discussed. Finally the degree of rapport that has been established may guide the speed of the interview.

Particularly with younger children, using interactive play can provide more useful information than asking questions. Children may be limited in their ability to give an explicit verbal account of their feelings or social interactions (Glasbourg & Aboud, 1982). This information may be readily revealed as the child plays with puppets or small figures in an imaginative way. The trained interviewer is able to facilitate such play for diagnostic and rapport-building purpose, without distorting the child’s views.

In addition, there are several informal projective techniques that can be used to complement the use of unstructured imaginative play. One of the common projective techniques is to ask the child to draw a picture. Projective questions can be asked including asking a child which three wishes she would like to have granted or what she would take with her if she were on a deserted island. Play and projective techniques and questions can often add an element of fun to the individual interview, which places the child at ease and helps to build a positive rapport.

When beginning the interview with the youth, it is often most helpful not to begin with the presenting problem. The initial time should be spent establishing rapport. It next becomes
important to obtain information that assesses the areas of functioning. It is helpful to understand the child’s interests, strengths, weaknesses, and feelings in the major areas of the child’s life. These include both the external world of family, peers, and school and the inner world, including self-concept. When attempting to understand the symptoms of distress, the clinician should inquire into mood states such as depression and anxiety. There should be some discussion to ascertain if the individual is suffering from low self-esteem or suicidal ideation thoughts. When assessing anxiety the clinician should investigate the existence of unusual fears, obsessions, or compulsions. All youth should be asked about hallucinations and delusions to rule out psychotic symptoms. Finally, there should be questions about eating patterns, delinquent behavior, substance abuse, and a history of traumatic experiences.

Other Informants
As described above, there may be other individuals, along with the student and parents, who have critical information about the child’s strengths, challenges, and developmental functioning. Depending on the scope of the evaluation, these individuals should be given the opportunity to provide this information. In some families the student may have frequent contact with extended family members such as grandparents, aunts, or uncles. The family may choose to have these individuals provide direct information or written information.

School personnel often have astute observations of the child’s functioning in the educational system. In addition, depending on the age of the child, school personnel may have accurate social information that further supports the evaluation. If school personnel are unable to participate directly in the interview, a teacher may provide a written summary or complete a checklist of observations. A probation officer may be able to provide information more honestly about past illegal behaviors. In addition, probation officers may have had the opportunity to see the student in the context of different social environments. This information further provides diagnostic information. A pediatrician may supply medical records. It is particularly important to review laboratory results if available or review prescribed psychotropic medications.

Formulation
Following the clinical interview, the psychiatrist begins to make an opinion. This medical opinion is called the psychiatric
formulation or psychiatric assessment. In this section the clinician reviews the relevant data and organizes them in a way to highlight the child’s difficulties and biological, social, and psychological contributors to this problem. The consequences of the problem to the youth and family are also relevant. It is also important to understand the factors that may cause the problem to be maintained and what factors might relieve it. Definitive answers to these questions may not be apparent at the conclusion of the initial assessment. In this situation it is appropriate to consider a differential diagnosis of several possible causes. The subsequent steps that are needed to clarify the diagnosis and treatment options should be included in this scenario.

The formulation takes into account the different biological, psychological, and social domains that may be contributing to the identified problems. The interaction between these domains often becomes critical in both the diagnosis of pathology and the subsequent recommendations for treatment.

**PSYCHIATRIC EVALUATION REPORT**

**Background**

The written report of the psychiatric evaluation should provide relevant information regarding the student’s thoughts, feelings, and behaviors. Individual and familial strengths should be highlighted. When a psychiatric evaluation is conducted for a school system, there should also be emphasis on which domain is causing interference with a student’s ability to make educational progress. There should be diagnoses provided that conform to the *DSM-IV-TR*. Finally, there should be recommendations provided to help promote success in areas that have been a struggle. Although the definitive structure of the report varies depending on the clinician, there is generally consistency in the overall format. The expected content of the report is described below.

**Identifying Data**

The start of the evaluation should identify the reasons for the evaluation and specific questions or problems that will be addressed in the report. Demographic details such as address, age, constellation of family, and educational placement should be described. The individuals who provided information should be listed. Finally, any other resources, such as other
reports or the conclusion of testing, that were used in the formulation, diagnoses, or recommendations should be listed.

**History of Presenting Illness**

Following the introduction is the history of presenting illness. The purpose of this section is to clearly identify both strengths and challenges of the student. The symptoms that cause the most interference in the student’s growth and development are important to highlight. The symptoms may be behaviors. In this case the antecedent to the behavior and a clear description of the concerning behavior should be provided. Any patterns related to the behavioral decompensation or recovery should be noted as well. For example, if a 7-year-old cries and throws items when a request is made, the length of the outburst, the intensity of the behavior, and what helps to stop it should be given. In addition to overt behavioral problems, other symptoms can also interfere in a child’s functioning. Withdrawal from interactions with others can cause interference in growth and development. Having extensive internal worries or thoughts that are not consistent with reality may also be a cause for concern. This is a comprehensive section that highlights concerns. The section is meant to reflect information conveyed from a number of sources. The parent interview often provides the majority of the content for this section, but it is also appropriate for the clinician to use information provided by the student or other informants in this portion of the report.

**Past Psychiatric History**

The third section is a review and summary of past mental health interventions. It is referred to as the past psychiatric history. This section provides the framework in which to consider the concerns highlighted in the previous section. Important components of past history include any known assessments, diagnoses, and treatment. It is important that this section be as complete as possible, because success or failure of past treatments can be an important guide to current recommendations. If prior psychological or psychiatric evaluations have been completed, there should be a listing of the date of evaluation and diagnoses given. It is important to include past psychiatric hospitalizations or participation in partial hospitalization treatment programs. If medications have been tried, the name of the medication should be listed with the dosage, length of the trial, side effects, and any positive response. Specific
psychotherapeutic interventions should be reviewed, with a brief summary of outcome.

Past Medical History
Medical problems should be summarized in the next section. There should be particular attention given to illnesses that may compound psychiatric symptoms. For example, a child with asthma may also have anxiety, and each problem may worsen the other. There should also be a consideration in this section for any somatic symptoms for which a medical cause cannot be identified. Commonly, adolescents with depression or anxiety may complain repeatedly of gastric distress for which no known physiologic reason can be found, despite repeated medical procedures. There should also be questions posed to ensure that there is no history of significant head trauma, particularly one that resulted in a loss of consciousness.

Social and Developmental History
Social and developmental history is also an important component of the assessment. This section should include any problems that were experienced during pregnancy and any exposure to medications or illicit substances that might have occurred in utero. Delivery complications should be listed, as well as Apgar scores if they are known. Acquisition of developmental milestones helps to put the current symptoms in an appropriate context. This section should also include all relevant social information such as the constellation of the family, supports to the family, and stressors that may be occurring. As described above, it is important to review how the child fits with the family and how the family functions in the context of its culture. This information as it is obtained from the parent interview should be summarized.

A history of physical abuse, sexual abuse, or neglect is also important to include in this section of history. The source of information for this should be both the student and the parents. Understanding past abusive experiences is best explored with the student individually and the parents individually. Finally, there should be a brief discussion about the peer group with whom the student associates. Again this information is best obtained from both the parents and the student.

At times students who are undergoing a psychiatric evaluation have had connections with other systems. This should be included in the social and developmental history. For
example, any contact a student has had with the juvenile probation office or children and youth services is relevant. The benefit obtained from these supports should be included, as well as any hindrance that may have occurred.

Substance use is sometimes included in the social and developmental history section, or it may encompass its own section of the report. It is important to include the pattern of tobacco, alcohol, and/or prescription medication abuse and the use of illicit substances. Efforts should be made to ascertain if the pattern of use is escalating and to what degree it is consuming the student. Asking these questions in a nonjudgmental way will often allow the student to be honest. Certainly the student is the primary informant of this information, but at times the parent or school personnel suspect abuse. In this case this information should be included as well.

**Educational History**

The section regarding educational history is important especially when a psychiatric evaluation is being completed with school personnel present. It is important to note the history of school attendance, behavioral problems, academic successes and failures, and social interactions. If there has been psychoeducational testing, the results should be included. It is important to assess any past special education services and the effectiveness of these programs. A review of the current individualized education program also provides additional insight into the challenges the student faces on a regular basis. School personnel are often in a unique position to observe the student over the course of time, and this observation takes place within a natural setting.

**Family Psychiatric History**

Family psychiatric history is also an important section. This should describe any family members who have a diagnosed mental illness. If a family member has received successful treatment, the specifics of this should be included, as it may help to identify useful interventions for the identified student. In addition, there are often suspicions that a family member has a mental illness but there has not been a formal diagnosis or treatment. This information should also be included.

**Mental Status Examination**

The mental status examination is a clinical snapshot of the student at the time of presentation. This section is often equated
with a medical physician’s physical examination. In the report this section includes only information that was obtained in the clinical interview with the student. There should be a detailed description of the student, including physical attributes, appearance, and hygiene. It has been explained that this description should provide enough detail that a person reading the description should be able to identify the student in a group of individuals. Behavioral or motor abnormalities should be included. For example, some students are restless and unable to sit still. Alternatively, a student might present with psychomotor retardation where there is excessive slowness of movement and thought. Motor or vocal tics may also be observed and should be described in detail.

The characteristics of speech should be described. This includes the rate, tone, and volume of speech, as well as any disarticulations. Mood, which is the individual’s description of his or her current feelings, is reported, and at times the exact descriptive words can be put in quotations. Affect, which is the evaluator’s view of the individual’s mood, should be described. It should also be reported if the affect changes quickly (affective lability) or is inconsistent with the reported mood (incongruent with mood). The individual’s thought form reflects the flow of thoughts and can be considered one of the hallmarks of the described mental status examination. Ideally, an individual’s thought form is termed “clear and organized” when it is logical and goal directed. Alternatively, if the thought form is disorganized, there should be clarification about the way in which it is not organized. A mild type of disorganized thinking is termed “tangential.” In this pattern an individual answers the question but provides excessive detail that gradually shifts the conversation in a different direction. A similar type of disorganization is “circumstantial thought processes.” In this case the student answers the question initially but quickly provides excessive detail or changes the topic briefly before returning the topic of conversation back to the initial answer. Another pattern of more severely disorganized thinking is called “flight of ideas.” In this pattern the thoughts are loosely related but do not flow well together. For example, “Today is Monday. On Monday I drive to school. I drive a red car. That reminds me that red is my favorite color and blue is my mother’s favorite color. She likes blue because it reminds her of the beach.” Another type of disorganized thinking is called “clanging.” In this pattern the individual will provide two or three rhyming words intermixed within a sentence. The most
severe type of disorganized thinking is termed “loosening of association.” In this pattern there are no logical connections between the words. It can also be referred to as “word salad,” which is a good descriptor. It is important to clearly describe the thought form, as certain types of disorganized thinking suggest certain mental illnesses. Flight of ideas is often heard when an individual is manic, whereas clanging and loosening of associations are most common in schizophrenia.

Thought content is a description of the internal thoughts of the student. This includes a description of the student’s internal mood states such as sadness, anxiety, or anger. When reporting symptoms of depression, the clinician should describe the degree of hopelessness and guilt that are experienced and the perversity of this emotional state. When reporting symptoms of anxiety, the clinician should describe the thoughts or situations that trigger this emotion. Anxiety can also cause physical symptoms such as restlessness, racing heartbeat, headaches, abdominal distress, or shortness of breath. Obsessions that are irrational fears or compulsions that are behaviors done repetitively to reduce anxiety can also be other symptoms of this emotional state. Understanding the students’ description of anger triggers and the way in which this normal emotion is managed should be reported. Any thoughts that demonstrate poor reality testing such as the presence of hallucinations or delusions should be detailed. Assessing suicidal or homicidal ideas is important to include in this section. It is often better to begin to inquire about these symptoms in broad terms, such as asking “Have you ever wished you had not been born?” before asking more specific questions regarding suicidal intention. The final area that should be reported in the mental status examination should reference the individual’s cognition, fund of knowledge, and insight into his or her own internal thoughts and emotions.

Diagnostic Formulation
Following the above-described information should be the diagnostic assessment or formulation section. This section should provide a very brief summary of the identified problem. It should provide details of the interactions between biological, psychological, and social aspects. For example, if a student is presenting with depressive symptoms, the biological contributor may be a genetic history of depression in several family members. The psychological contributor could be the student’s process of understanding his or her own identity
and forming an appropriate view of him- or herself. The social contributors may include an overbearing and protective family and conflict with peers. Each of these contributors has an impact on the student’s presentation right now.

**Diagnosis**

The diagnosis should be recorded in the format as recommended by the *DSM*. This format includes the five-axis diagnostic system that was highlighted above (see also accompanying CD: 2.2). An example of how this section may appear for a given individual is as follows:

- **Axis I**: Major depression: single episode, moderate severity; attention-deficit/hyperactivity disorder: primarily inattentive
- **Axis II**: Deferred
- **Axis III**: History of seizure disorder; last seizure 18 months ago
- **Axis IV**: Psychosocial stressors moderate: history of physical abuse, peer conflict, lack of educational success
- **Axis V**: GAF currently 60, highest in past year 75

**Recommendations**

The final section of the written report is the recommendations. These recommendations should be clear and concise. The recommendations reflect suggestions for treatment. At a minimum there should be recommendations for the following types of services: psychotherapy, medication management, social agency supports, and community supports. Depending on the information available, educational recommendations can also be included. At times it might be determined that a higher level of mental health intervention such as inpatient hospitalization or partial hospitalization may be indicated.

The psychotherapy interventions can include individual, group, or family therapy. In addition, the type of therapy, such as psychodynamic therapy, cognitive behavioral therapy, interpersonal therapy, or supportive therapy, should be specified. If there is an identified provider, that should also be specified, and if there is a suggested frequency of visits, that should also be included. The indication for group therapy should be included if there is an appropriate group available. Finally, if family therapy is recommended, there should be a brief review of the goals of this intervention.
Psychiatric evaluation and formulation

Medication suggestions should be clearly described, including the type of medication, reason for this medication, dose, side effects, expected time course of response, and potential benefits. At times, the family may decide during the evaluation to begin medication, and if a prescription is provided, this and a notification that informed consent for medication was given should be documented.

Social service supports vary by state. If there is a concern identified about abuse or neglect, the relevant county department of human services should be notified. Some states have mental health case managers who can help connect families with appropriate mental health services. If it is believed that the family may have difficulty finding providers for the other recommendations, it can be helpful to provide a referral for this service. Juvenile probation referrals are rarely made from a psychiatric evaluation, as this service is court ordered. However, if there is active involvement from this agency, there should be coordination of care and recommendations.

Community supports rarely require the recommendation of a psychiatrist, but these may be discussed as other potential supports. This can include participation in the Big Brothers Big Sisters program, YMCA recreation programs, or church activities.

Finally, based on the severity and intensity of symptoms, it may be determined that a higher level of care is needed. Typically, inpatient care is indicated if the student is unable to ensure the clinician of his or her safety, if there is concern about the safety of others, or if psychotic symptoms are present. This level of care is particularly needed if it is determined that the family is unable to provide the level of monitoring that is needed to keep the individual safe. Alternatively, if there is a moderately high degree of symptoms but the clinician perceives that the student will be safe for some of the day, a referral to a partial hospitalization program can be made. The clinician who makes these recommendations should understand what steps to take to ensure that these higher level interventions are followed.

Psychiatric report: Conclusion

At the conclusion of the psychiatric evaluation, the findings should be shared with the relevant parties. The physician also generates a report that includes all of the above information. Some psychiatrists will automatically provide a copy of the report to the parents. Others prefer to provide the report with consent only to other clinicians.
PSYCHIATRIC EVALUATION: SUMMARY

A psychiatrist who reviews current symptoms, past intervention, and social aspects of the presenting problem completes a psychiatric evaluation. From this information based on a set of necessary symptoms, a psychiatric diagnosis can be given. The evaluation should, however, provide much more information than a simple diagnosis (see accompanying CD: 2.2). There should be relevant information reviewing biological, psychological, and social contributors. Recommendations should be the conclusion of the evaluation, and these recommendations can guide helpful intervention strategies. Ideally, when a psychiatric evaluation is conducted for a school district, it should include information to help guide the educational team and should include educational implications.