Assessment of mental health in preschool children

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Impact of mental illness in children

- Provision of mental health services to young children
  - Decreases burden on community
  - No other illnesses damage so many children so seriously
    - (Grimes, Kapunan, & Mullin; 2006)
  - Can reduce the risk for negative outcomes across an individual’s lifespan
Mental health in preschoolers

- Children aged three to five years of age
- Clinically significant psychiatric symptoms and disorders can be present in preschool aged children (Egger, 2009).
- Prevalence
  - Estimated to be 14% in clinical range
- The process of clinical assessment is the key factor in successfully identifying those individuals most at need for mental health services
Diagnostic classification

- Challenges include:
  - Difficulty of formulating stable and valid diagnosis
  - Requirement for specialised knowledge
  - ‘Labelling’ young children with mental illnesses
  - Diagnostic classification systems

- Advantages include:
  - Structure for organising findings and observations
  - Communicate clearly across disciplines
  - Consistent framework for treatment and measuring outcomes
  - Access to resources
Specific challenges of assessing mental health in preschoolers

- Complex nature of development
- Difficulty of directly assessing children
- Likelihood of co-morbidity
- Impact of family and environment
- Recognition of need/low service usage
Recommended approach to assessment of preschoolers

- Assessment as a multidimensional process
- Use valid and reliable methods within a multidimensional framework
- General agreement that ecological or context based models of assessment are most appropriate
  - e.g. Egger, 2009; Egger & Angold, 2006)
# Clinical utility

<table>
<thead>
<tr>
<th>Component</th>
<th>Aspects</th>
<th>Issues that might be considered</th>
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</thead>
<tbody>
<tr>
<td>Appropriate</td>
<td>Effective</td>
<td>Formal evidence; impact on existing treatment process; disruptions to current work or care importance for clinical decision-making.</td>
</tr>
<tr>
<td></td>
<td>Relevant</td>
<td></td>
</tr>
<tr>
<td>Accessible</td>
<td>Resource Implications Procurement</td>
<td>Costs and cost-effectiveness; availability, supply &amp; quality; navigating financial processes.</td>
</tr>
<tr>
<td>Practicable</td>
<td>Functional</td>
<td>Are the materials, methods, instructions complete and working? Are the suitable for the context? Adequacy of current levels &amp; potential future needs; need to renegotiate professional or work-practice boundaries; everyday constraints on training.</td>
</tr>
<tr>
<td></td>
<td>Suitable</td>
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<td></td>
<td>Training or knowledge</td>
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<tr>
<td>Acceptable</td>
<td>To clinician</td>
<td>Ethical, legal, social or psychological concerns that may affect practice, treatment process, or acceptance; preferences about service delivery.</td>
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<tr>
<td></td>
<td>To clients (including families/carers)</td>
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<td>To society</td>
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Table 1. Summary of the dimensions of clinical utility – adapted from Smart, 2006
References


References, continued


