Mental Health Toolkit for Primary Care

Presenting Issue:

A participating PCP recently reached out to WI CPCP with a consultation request concerning the diagnosis of ADHD. The PCP acknowledged that ADHD is a diagnosis of exclusion, requiring the elimination of other conditions that might mimic its symptoms. Given their busy schedule and long wait times for neuropsychological testing and counseling referrals, the PCP sought advice on how to efficiently navigate this diagnostic process.

Consultant's Response:

1. **Utilize Rating Scales:** To clarify current symptoms and rule out other conditions that may be contributing to the patient's presentation, consider employing rating scales. These scales can help pinpoint specific issues that need attention. Here are some preferred options:
    - **PHQ-9:** For assessing depression.
    - **SCARED (or SCARED Parent for young children)** with **SCARED Scoring Aid (PDF)**: For evaluating anxiety.
    - **Child Mania Rating Scale (CMRS)** with a **scoring guide:** Useful when there are significant mood swings or concerns about clinical depression. This scale is especially valuable if there's a family history of bipolar disorder or if you're contemplating antidepressant medication (as some antidepressants can induce manic symptoms).
2. **Screen for Adverse Childhood Experiences (ACEs):** If not already done, it is highly recommended to screen for ACEs. A higher number of ACEs can make the ADHD diagnosis less reliable and increase the likelihood of attachment issues and disruptive behaviors resulting from traumatic exposure, including PTSD. Included are the preferred screening tools:
    - **ACE Checklist:** To assess possible trauma exposure.
    - **Pediatric ACES and Related Life Events Screener (PEARLS) Tool: Teen (Self-Report)**
    - **PTSD Symptom Scale (CPSS):** Consider using this if the ACE score is not zero.
3. **Additional Rating Scales:** To ensure comprehensive evaluation, here are some other rating scales that might prove useful:
    - **Child Yale-Brown Obsessive-Compulsive Scale (CY-BOCS):** Useful for assessing obsessive-compulsive disorder when untriggered explosive behavior is observed.
    - **CRAFFT:** For assessing the use of recreational substances.
    - **EAT-26:** For identifying potential eating disorders.
    - **Columbia Suicide Severity Scale (C-SSRS)**
    - **The Prodromal (Psychosis) Questionnaire—Brief (PQ-B):** This can be somewhat helpful in tracking psychotic symptoms in clinical practice, though it's primarily a research tool. It has been studied in patients aged 12-35 years ago and more recently in adolescents, showing reasonable validity.

Teaching Points:

1. **Role of Rating Scales:** It's important to note that rating scales should not be used in isolation to establish a diagnosis or clinical treatment plan. However, they are valuable tools to complement the clinician's assessment and follow-up interviews:
    - Rating scales can help clarify symptoms to target during treatment.
    - They offer a wealth of information in a short amount of time.
    - Not utilizing them can be likened to "treating high blood pressure without using a blood pressure cuff to measure if a patient's blood pressure is improving."
2. **Patient-Centered Approach:** While it's true that some patients with psychiatric disorders may have difficulty cooperating with rating scale assessments, lack insight into their symptoms, or exaggerate/mask their condition, it's essential to maintain a patient-centered approach. Patients are often best positioned to assess their own well-being.
3. For further information, refer to Using rating scales in a clinical setting: A guide for psychiatrists.