A Resource Aid Packet on

Screening/Assessing Students: Indicators and Tools

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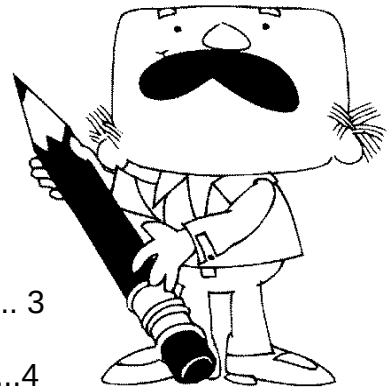
Preface

Those of you working so hard to address barriers to student learning and promote healthy development need ready access to resource materials. The Center's Clearinghouse supplements, compiles, and disseminates resources on topics fundamental to enabling students to learn. Among the various ways we package resources are our *Resource Aid Packets.*

Resource Aid Packets are designed to complement our series of Introductory Packets. These resource aids are a form of *tool kit* related to a fairly circumscribed area of practice. The packets contain materials to guide and assist with staff training and student/family interventions. They include overviews, outlines, checklists, instruments, and other resources that can be reproduced and used as information handouts and aids for training and practice.

The emphasis of screening is on early identification to prevent problems from escalating.

Efficient and accurate screening and assessment strategies are essential for matching students with the programs and interventions to address their current needs and prevent problems from getting bigger. This process calls for a range of screening tools that range from descriptions by referrers, through surveys to identify unrecognized problems, to analysis of records (such as attendance, grades, and test scores).



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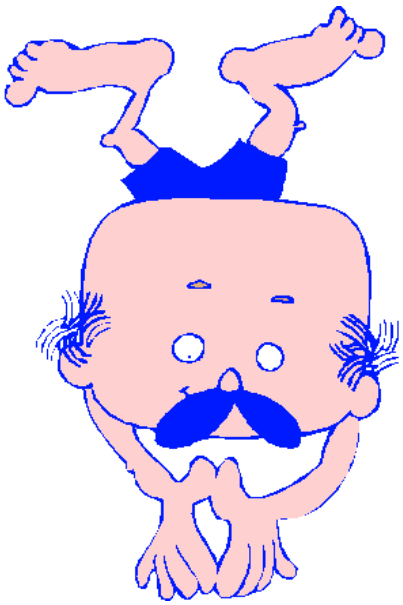


I. Screening: early identification with follow-up interventions to prevent problems from escalating

A. Screening: a note of caution

B. The debate about screening-
the pros and the cons

C. Guidelines

I. Screening

A. Screening: A Note of Caution

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to *over identify* problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see *normal variations* in student's development and behavior as problems.

Screens do not allow for definitive statements about a student's problems and need. At best, most screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

It is essential to remember that many factors found to be symptoms of problems also are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

I. Screening

B. The Debate about Screening – the pros and the cons

Should schools use behavioral screening to find `at risk' children?

Excerpted from Insight on the News. Oct. 4, 1999.

By James M. Kauffman.
http://www.findarticles.com/cf_0/m1571/37_15/56182669/print.jhtml

"...Most teachers know which students probably are headed for trouble...

Teachers do better in identifying high-risk youngsters of any age when they have a systematic way of describing kids' behavior and know just what to look for. The most accurate and reliable behavioral screening methods rely on teacher judgments guided by rating and observation instruments that have been field-tested...

Every screening device produces some errors: false positives and false negatives. A false positive means the screening identifies someone it shouldn't have; a false negative means someone who should have been identified was overlooked...

We don't want to identify more students for special services; we already serve too many. If you want to prevent problems, then you have to identify more kids – address problems earlier, which inevitably means identifying more students than we do now, when we wait for the problems to get out of hand..."

Kauffman, a former elementary-school teacher, is Charles S. Robb Professor of Education at the University of Virginia and coeditor of the journal, Behavioral Disorders.

I. Screening

C. Guidelines – an example:

The American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) provide a model and related resources that enable physicians and other health care providers to provide comprehensive clinical services for adolescents between 11 and 21 years of age. GAPS is based on a set of 24 recommendations that describe the content and delivery of the services.

The recommendations are relevant in all health care settings that deliver services to adolescents, including private medical practices, community health clinics, health maintenance organizations, school-based health centers, and medical services in correctional institutions.

This Website (http://www.ama-assn.org/ama/pub/category/1980.html) includes all 24 recommendations and information on their development; training information; and information on ordering implementation materials in the AMA Adolescent Health Resources section.

These recommendations were developed in collaboration with a GAPS Scientific Advisory Board. Funding for the development of the recommendations was provided in part by a cooperative agreement with the Centers for Disease Control and Prevention, Division of Adolescent and School Health.

http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf

Recommendations for screening

GAPS includes recommendations for the screening of biomedical, behavioral, and emotional conditions. Some GAPS recommendations lead to a definitive diagnosis (eg, cervical culture in females to diagnose gonorrhea). Other recommendations lead to a presumptive diagnosis (eg, urine test for leukocyte esterase in males to screen for gonorrhea or asking about use of alcohol or other drugs during the past six months to screen for substance use) that must be confirmed with additional assessment. Physicians can use information from the initial screening to decide whether to continue the assessment themselves or to refer the adolescent elsewhere. Health risk behaviors may, in some adolescents, be interrelated and co-occur. Adolescents who are found to engage in one health risk behavior, therefore, should be asked about involvement in others. [selected recommendations as examples]

Recommendation 13: All adolescents should be screened annually for eating disorders and obesity by determining weight and stature, and asking about body image and dieting patterns.

Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found: weight loss greater than 10% of previous weight; recurrent dieting when not overweight; use of self-induced emesis, laxatives, starvation, or diuretics to lose weight; distorted body image; or body mass index (weight/height2) below the fifth percentile. Adolescents with a body mass index (BMI) equal to or greater than the 95th percentile for age and gender are overweight and should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease.

Adolescents with a BMI between the 85th and 94th percentile are at risk for becoming overweight. A dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease should be performed on these youth if:

- their BMI has increased by two or more units during the previous 12 months;
- there is a family history of premature heart disease, obesity, hypertension, or diabetes mellitus;
- they express concern about their weight;
- they have elevated serum cholesterol levels or blood pressure.

If this assessment is negative, these adolescents should be provided general dietary and exercise counseling and should be monitored annually.

Recommendation 15: All adolescents should be asked annually about their use of alcohol and other abusable substances, and about their use of over-the-counter or prescription drugs for nonmedical purposes, including anabolic steroids.

- Adolescents who report any use of alcohol or other drugs or inappropriate use of medicines during the past year should be assessed further regarding family history; circumstances surrounding use; amount and frequency of use; attitudes and motivation about use; use of other drugs; and the adequacy of physical, psychosocial, and school functioning.

- Adolescents whose substance use endangers their health should receive counseling and mental health treatment, as appropriate.

- Adolescents who use anabolic steroids should be counseled to stop.

- The use of urine toxicology for the routine screening of adolescents is not recommended.

- Adolescents who use alcohol or other drugs should also be asked about their sexual behavior and their use of tobacco products.

Recommendation 20: All adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression or risk of suicide.

Screening for depression or suicidal risk should be performed on adolescents who exhibit cumulative risk as determined by declining school grades, chronic melancholy, family dysfunction, homosexual orientation, physical or sexual abuse, alcohol or other drug use, previous suicide attempt, and suicidal plans.

If suicidal risk is suspected, adolescents should be evaluated immediately and referred to a psychiatrist or other mental health professional, or else should be hospitalized.

Nonsuicidal adolescents with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Recommendation 21: All adolescents should be asked annually about a history of emotional, physical, and sexual abuse.

If abuse is suspected, adolescents should be assessed to determine the circumstances surrounding abuse and the presence of physical, emotional, and psychosocial consequences, including involvement in health risk behaviors.

Health providers should be aware of local laws about the reporting of abuse to appropriate state officials, in addition to ethical and legal issues regarding how to protect the confidentiality of the adolescent patient.

Adolescents who report emotional or psychosocial sequelae should be referred to a psychiatrist or other mental health professional for evaluation and treatment.

Recommendation 22: All adolescents should be asked annually about learning or school problems.

Adolescents with a history of truancy, repeated absences, or poor or declining performance should be assessed for the presence of conditions that could interfere with school success. These include learning disability, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, or alcohol or other drug use.

This assessment, and the subsequent management plan, should be coordinated with school personnel and with the adolescent's parents or caregivers.

II. Examples of screening for children & youth

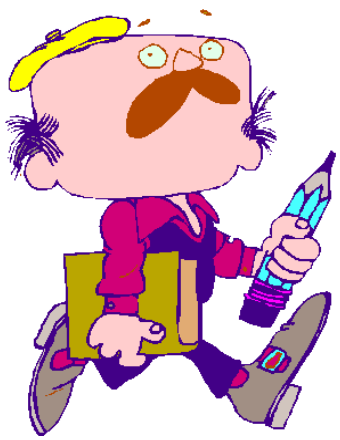
A. Screening at an early age to identify support needed to address barriers to learning and promote health development.

1. HRSA: Early & Continuous Screening

2. Bright Futures in Practice: Mental Health
http://www.brightfutures.org/mentalhealth/
   a. What can your child do
   b. Pediatric symptom checklist

3. "Stronger Efforts Needed to Ensure Children's Access to Health screening Services (2001) GAO Report on EPSDT for Congressional Requesters. http://www.gao.gov/new.items/d01749.pdf

4. Screening for Special Diagnosis



U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, Room 18-05 • Rockville, MD 20857 • Tel: 301-443-2170 • Fax: 301-443-1797 • www.mchb.hrsa.gov

Early and Continuous Screening

Goal: All children will be screened early and continuously for special health care needs.

—2010 Express 10-Year Action Plan to Achieve Community-Based Service Systems for Children and Youth with Special Health Care Needs and Their Families.

Need

It is critical to identify children in the general population who have special health care needs as early as possible so that they and their families can be given appropriate services to address those needs. Some needs may be identified in infancy or during the prenatal period, while others may emerge as a result of conditions that occur in later childhood and adolescence. In all cases, prompt identification benefits both the child and his or her family. Second, and equally important, we must ensure that children with special health care needs receive the ongoing assessments needed to identify newly emerging issues for them and to prevent secondary conditions that may interfere with their development and well-being. Screening must be ongoing to ensure that the service needs of these children continue to be appropriately met as they grow and change.

Today, some screening of children is done in their health care professionals' offices. Valuable screening is also being done in locations such as early intervention and Head Start programs, childcare centers, schools, and WIC clinics. Newborn screening is largely carried out in hospitals, and important efforts are being undertaken at the Federal and State levels to improve coordination among newborn screening programs. It is also critical that the child's medical home have strong linkages with hospital and community screening programs in order to ensure that screening results are expeditiously shared with children and families in ways that are helpful to them, and that results are incorporated into the child's ongoing comprehensive health care to ensure needed medical follow-up and referral to other community services as necessary. Over the next 10 years we need to help communities build systems so that all children with special health care needs are followed in medical homes that work effectively with community and hospital programs to coordinate screening and follow-up. Those systems must also include mechanisms for helping community and hospital screening programs link more effectively with medical homes.

Activities

As part of the national agenda for *All Aboard the 2010 Express 10-Year Action Plan to Achieve Community-Based Service Systems for Children and Youth with Special Health Care Needs and Their Families*, we have identified the following strategies for achieving that success:

- Improve access to, and availability of, screening services.
- Support data capacity for integration of screening results.
- Improve screening guidelines and standards.
- Promote awareness of the need for, and benefits of, early and continuous screening.

Get On Board

- Promote the importance of early and continuous screening as part of maintaining good health.
- Include screening concepts, tools, and procedures in education and training programs for professionals, including physicians, nurses, social workers, public health professionals, childcare providers, and schoolteachers.

Resources

- Green M., Palfrey, J.S., eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Second Edition. Arlington, VA: National Center for Education in Maternal and Child Health, 2000.
- National Newborn Screening and Genetics Resource Center: *http://genes-r-us.uthscsa.edu*
- National Center for Hearing Assessment and Management (NCHAM): *www.infanthearing.org*

This program of the Maternal and Child Health Bureau (MCHB) is administered by its Division of Services for Children with Special Health Needs (DSCSHN). For more information on this and other programs of the Maternal and Child Health Bureau contact MCHB Communications (301) 443-0205 or go to *www.mchb.hrsa.gov*.

Bright Futures: **What Can Your Child Do?**

Please indicate how well you feel your child is doing with each of the following skills:

Child's Name	**Has Difficulty With**	**Is Ok At**	**Is Good At**	**Excels At**
Running and jumping				
Playing with a ball				
Using a pen/pencil/crayon				
Putting things together and taking them apart				
Dancing				
Singing				
Appreciating Music				
Understanding what others say				
Learning from stories				
Counting				
Being interested in how things work				
Making a convincing argument				
Being sensitive to the feelings of others				
Trying hard				
expecting things to go well				
Playing make believe				
Having a sense of humor				
Getting along with people				
Managing anger				
Adjusting to changes				
Other				

Cite as: Howard BJ. 2002. What can your child do? In Jellinek M, Patel BP, Froehle MC, eds. 2001. Bright Futures in Practice: Mental health – Volume 2, Tool Kit. Alrington, VA: National center for Maternal and Child Health. - http://www.brightfutures.org/mentalhealth/pdf/professionals/ec/what.pdf

Bright Futures:Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child.	Never	Sometimes	Often
1. Complains of aches and pains.			
2. Spends more time alone.			
3. Tires easily, has little energy.			
4. Fidgety, unable to sit still.			
5. Has trouble with teacher.			
6. Less interested in school.			
7. Acts as if driven by a motor.			
8. Daydreams too much.			
9. Distracted easily.			
10. Is afraid of new situations.			
11. Feels sad, unhappy.			
12. Is irritable, angry.			
13. Feels hopeless.			
14. Has trouble concentrating.			
15. Less interested in friends.			
16. Fights with other children.			
17. Absent from school.			
18. School grades dropping.			
19. Is down on him or herself.			
20. Visits the doctor with doctor finding nothing wrong.			
21. Has trouble sleeping.			
22. Worries a lot.			
23. Wants to be with you more than before.			
24. Feels he or she is bad.			
25. Takes unnecessary risks.			
26. Gets hurt frequently.			
27. Seems to be having less fun.			

28. Acts younger than children his or her age.			
29. Does not listen to rules.			
30. Does not show feelings.			
31. Does not understand other people's feelings.			
32. Teases others.			
33. Blames others for his or her troubles.			
34. Takes things that do not belong to him or her.			
35. Refuses to share.			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help?
( )N ( )Y

Are there any services that you would like your child to receive for these problems?
( )N ( )Y

If yes, what services? _____
_____

From: Jellinek M, Patel BP, Froehle MC, eds. 2001. Bright Futures in Practice: Mental health – Volume 2, Tool Kit. Alrington, VA: National center for Maternal and Child Health.
http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

Que Puede Hacer su Niño?

Por favor indique que tan bien su niño se desempeña en esta actividades:

Nombre del Niño	**Tiene dificultad con**	**Mas o menos en**	**Bueno en**	**Excelente en**
Correr y Brincar				
Jugar con una pelota				
Usar lápiz/lapicero/crayon				
Armar cosas y desarmarlas				
Bailar				
Cantar				
Apreciar la música				
Entender lo que dicen los demás				
Aprender cuentos				
Contar				
Interesarse en como funcionan las cosas				
Hacer un argumento convincente				
Ser sensitivo hacia los sentimientos de otros				
Esforzarce/hacer el efuerzo				
Esperar que las cosas saldrán bien				
Jugar pretendiendo ser un objecto u otra cosa				
El sentido del Humor				
Relacionarce con otros				
Manejar el enojo				
Adjustarse a los cambios				
Otras				

Cite as: Howard BJ. 2001. What can your child do? In Jellinek M, Patel BP, Froehle MC, eds. 2001. Bright Futures in Practice: Mental health – Volume 2, Tool Kit. Alrington, VA: National center for Maternal and Child Health.

Pediatric Symptom Checklist (PSC)

La salud emocional y física van de la mano en los niños. Porque los padres son amenudo los primeros en notar los problemas con el comportamiento, emociones, y aprendizaje de sus niños, usted puede ayudar a su niño en obtener la mejor ayuda posible al contestar estas preguntas. Por favor indique que declaración describe lo mejor posible a su niño.

Por favor marque debajo del título que mejor describe a su niño.	**Nunca**	**Hay Veces**	**Muchas veces**
1. Se queja de dolores y malestares.			
2. Pasa más tiempo solo.			
3. Se cansa fácilmente, tienen poca energía.			
4. Nervioso, incapaz de estarse quieto.			
5. Tiene Problema con la Maestra/o			
6. Poco interés en la escuela.			
7. Actúa como si sea conducido por un motor			
8. Sueña despierto mucho.			
9. Se distrae facilmente			
10. Le da miedo las situaciones nuevas.			
11. Se siente aburrido e infeliz.			
12. Es irritable y enojoso.			
13. Se siente desesperado.			
14. Tiene dificultad en concentrarse.			
15. Desinteresado en tener amigos.			
16. Pelea con otros niños.			
17. Ausente en la escuela.			
18. Tiene calificaciones bajas.			
19. Esta siendo duro con el o ella mismsa.			
20. Visita al doctor y el doctor no encuentra nada malo.			
21. Tiene problema para domirse.			
22. Se preocupa mucho.			
23. Quiere estar contigo más que antes.			
24. Se siente como que el o ella son malos.			
25. Toma riesgos innecesarios.			
26. Lo dañan/la dañan con frequencia			

27. Parece estar teniendo menos diversion.			
28. Actua immaduro para su edad.			
29. No hace caso a las reglas.			
30. No demuestra sentimientos.			
31. No entiende los sentimietos de otros.			
32. Molesta/bromea con otros.			
33. Hecha la culpa a otros por su problemas.			
34. Toma cosas que no le pertenece.			
35. No le gusta compartir.			

Puntaje Total _____

¿Tiene su niño problemas emocionales o del comportamiento para los cuales ella o él necesite ayuda?

( )N ( )Y

¿Hay servicios que usted quisiera que su niñño recibiera para estos problemas?

( )N ( )Y

Si contesta sí, que servicios? _____
_____

From: Jellinek M, Patel BP, Froehle MC, eds. 2001. Bright Futures in Practice: Mental health – Volume 2, Tool Kit. Alrington, VA: National center for Maternal and Child Health.

Excerpts...

July 2001
United States General Accounting Office
http://www.gao.gov/new.items/d01749.pdf

Stronger Efforts Needed to Ensure Children's Access to Health Screening Services

Conclusions

More than a decade ago, the Congress passed legislative changes to help ensure that millions of low-income children under Medicaid have access to important health screening and treatment services. In the years since then, the Congress has placed even more emphasis on providing a health care safety net by expanding coverage to more and more children who do not have health insurance. This safety net, however, cannot be considered fully in place unless there are assurances that the covered health care services are actually provided. Unfortunately, reported data are unreliable and incomplete. They are inadequate for gauging Medicaid's success in providing screening, diagnostic, and treatment services to enrolled children. Particularly for children served by managed care plans—a growing segment of the population—current information does not allow a thorough assessment of progress. However, the available information indicates that many children are still not receiving health screening services. Recognizing this concern, some states are taking a more active role in identifying ways to reach the at-risk population served by Medicaid.

Screening for Special Diagnoses. ERIC Digest.

http://www.eric.ed.gov/
ERIC Identifier: ED389965
Publication Date: 1995-01-30
Author: de La Paz, Susan - Graham, Steve
Source: ERIC Clearinghouse on Counseling and Student Services Greensboro NC.

OVERVIEW

Congress enacted Public Law 94-142, the Education for All Handicapped Children Act, in November, 1975. It requires that all children with disabilities receive a free and appropriate public education. Determining who has a disability and who is eligible for special services, however, is not an exact science. It is complicated by vague definitions and varying interpretations of how to identify specific handicapping conditions (Hallahan & Kauffman, 1991). Nevertheless, recent government figures indicate that 7 percent of children and youth from birth to 21 are identified as having a disability that requires special intervention (Hunt & Marshall, 1994).

While practices differ greatly both across and within states (Adelman & Taylor, 1993), screening is an important part of the assessment process mandated by Public Law 94-142. Screening for the purpose of special diagnoses begins at birth and continues throughout the school years. In the first few years of life, most forms of screening center around developmental norms for physical, cognitive, and language abilities. Many children with severe disabilities (cerebral palsy, spinabifida, Down's syndrome, autism, severe sensory impairments, or children with multiple disabilities, for example) are identified early in life by physicians and other health professionals. However, other children, such as those with learning disabilities, attention deficit disorders, behavioral problems, and so forth, are usually not identified until they start school.

SCHOOL-BASED SCREENING

Most public schools periodically "screen" large groups of students, typically between kindergarten through third grade, to identify children who may have a disability (as yet unidentified) or may be at risk for school failure. For example, a student with an extremely low test score on a standardized achievement test administered to all first graders in a school may become the focus of further inquiry to determine the validity of the screening observation and, if warranted, to determine the causes of the child's difficulties. This may lead to a recommendation to conduct a formal evaluation to decide if the child has a specific, identifiable disability. In addition to systematically "screening" students, children with a "suspected" disability may also be identified through referrals by parents, teachers, or other school personnel. Typically, a child who is having academic or behavioral problems in the classroom may be referred for further testing to determine if a disability is present. Before testing for diagnosis begins, however, the school must obtain consent from the child's parents to do the evaluation.

While most children with a disability are identified by third grade, some are not identified until the upper elementary grades or even junior or senior high school. In some instances, a problem does not become evident until the demands of school exceed the child's skills in coping with his or her disability. In other cases, the disability may not occur until the child is older. For instance, a disability may be acquired as a result of a traumatic brain injury or as a result of other environmental factors. A disability may also not be identified until a child is older because the procedures used for screening, referral, testing, and/or identification are ineffective.

PROBLEMS AND SOLUTIONS FOR SCHOOL SCREENING

It is important to understand that there is no standard or uniform battery of tests, checklists, or procedures to follow for the identification of most students with disabilities. While there is a basic structure to the identification process, there is considerable variability in how students may come to be identified, including the types of tests used in screening and the processes by which they are referred.

Critics have argued that the procedures used to identify children and youth with special needs have resulted in over- as well as under-identification of

students with disabilities. As several studies have shown, a referred child almost always qualifies for special education (Christenson, Ysseldyke, & Algozzine, 1983). Over-identification has been particularly problematic in the area of learning disabilities (Hunt & Marshall, 1994), as approximately half of all students receiving special education services are identified as learning disabled! In contrast, students with behavioral disorders appear to be under-identified, particularly children who are compliant and nonaggressive but suffer from problems such as depression, school phobia, or social isolation (Walker et al., 1990).

To remedy problems of over- and under-identification, educators have begun to institute several changes in the screening and referral process. One approach has involved the development of better screening procedures. For example, Walker and his colleagues (1990) devised a screening process, the Systematic Screening for Behavioral Disorders, that relies on a three-step process. Teachers (1) rank-order students along specified criteria and then (2) use checklists to quantify observations about the three highest-ranked students. Then, (3) other school personnel (for example, school psychologists or counselors) observe children whose behaviors exceed the norm for the teacher's classroom. Referrals are made for further evaluation only after the three-step process is completed.

A second common practice aimed at improving the identification process involves the use of prereferral interventions (Chalfant, 1985). These interventions have been developed to reduce the number of referrals to special education and provide additional help and advice to regular education teachers. Before initiating a referral for testing for special diagnosis, teachers first attempt to deal with a child's learning or behavioral problems by making modifications in the regular classroom. If these modifications fail to address the difficulties the child is experiencing adequately and the teacher believes that special services may be warranted, then the referral process is set into motion. Currently, 34 of 50 states require or recommend some form of prereferral intervention (Sindelar, Griffin, Smith, & Watanabe, 1992).

Two of the more common prereferral intervention approaches include Teacher Assistance Teams, (TATs), and collaborative consultation. Both approaches involve professionals helping regular educators deal with students who have problems in their classroom; however, they differ in an essential way. TATs typically consist of a team of three teachers with the referring teacher as the fourth member. The TAT model provides a forum where teachers meet and brainstorm ideas for teaching or managing a student. In contrast, most collaborative consultation models employ school specialists (resource room teachers, speech-language clinicians) who work directly with the referring teacher to plan, implement, and evaluate instruction for target students in the regular classroom.

SUMMARY

Screening procedures are an important part of the assessment process to identify children and youth who have disabilities. Such procedures must be used with care, however, as they provide only a preliminary sign that a child has a disability. Additional testing is required to affirm or disprove the presence of a handicapping condition. If a disability is identified during follow-up assessment, the focus shifts to providing the student with an appropriate education.

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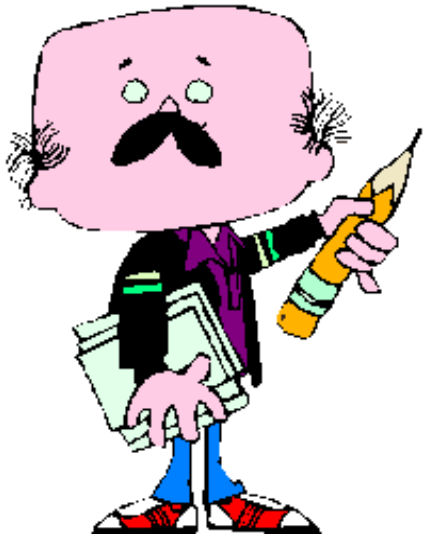
II. Examples of screening children & youth

B. Screening all children and youth to identify risks:

1. Depression/suicide/anxiety

2. Alcohol/substance abuse



Being Alert to Indicators of Psychosocial and Mental Health Problems*

No one should be overzealous in seeing normal variations in student's development and behavior as problems. At the same time, school professionals don't want to ignore indicators of significant problems. The following are meant only to sensitize responsible professionals. They should not be seen as a check list.

If a student is of significant concern, a request should be made to an appropriate person on the school staff who can do some further screening/assessment.

If they occur frequently and in a variety of situations and appear rather serious when you compare the behavior with other students the same age, the following behaviors may be symptomatic of significant problems.

Emotional appearance

(Emotions seem excessive. Displays little affect. Very rapid shifts in emotional state.)

- very unhappy, sad, teary, depressed, indicates a sense of worthlessness, hopelessness, helplessness
- very anxious, shy
- very afraid, fearful
- can't seem to control emotions
- doesn't seem to have feelings

Personal Actions

(Acts in ways that are troublesome or troubling)

- very immature
- frequent outbursts/temper tantrums, violent
- often angry
- cruel to animals
- sleep problems and/or nightmares
- wetting/soiling at school
- easily distracted
- impulsive
- steals
- lies often
- cheats often
- destroys things
- accident prone
- unusual, strange, or immature speech patterns
- often doesn't seem to hear
- hurts self, self-abusive
- easily becomes overexcited
- truancy, school avoidance
- trouble learning and performing
- eating problems
- sets fires
- ritualistic behavior
- seizures
- isolates self from others
- complains often about physical aches and pains
- unaccounted for weight loss
- substance abuse
- runs away

Interactions with others

(Doesn't seem interested in others. Can't interact appropriately or effectively with others.)

doesn't pay attention	refuses to talk
cruel and bullying	promiscuous
highly manipulative	excessively reactive and resistant to authority
alienates others	highly aggressive to others -- physically, sexually
has no friends	

Indicators of Unusual Thinking

(Has difficulty concentrating. May express very strange thoughts and ideas.)

worries a lot	preoccupied with death
doesn't stay focused on matters	seems to hear or see things, delusional
can't seem to concentrate on much	

*Additional indicators for problems (such as depression in young people) are available through a variety of resources -- see aid packet on *Resource Materials and Assistance*.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? *Y N*

Have there been suicide attempts by the student or significant others in his or her life? *Y N*

Does the student have a detailed, feasible plan? *Y N*

Has s/he made special arrangements as giving away prized possessions? *Y N*

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? *Y N*

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? *Y N*

Have there been major changes in recent behavior along with negative feelings and thoughts? *Y N*

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? *Y N*

Does the student feel alienated? *Y N*

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? *Y N*

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS
AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

a) inform about concern
b) gather additional information to assess risk
c) provide information about problem and available resources
d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

____(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:

*student's name/address/birthdate/social security number
*data indicating student is a danger to self (see Suicide Assessment -- Checklist)
*stage of parent notification
*language spoken by parent/student
*health coverage plan if there is one
*where student is to be found

____(6) For nonhigh risks, if phone contacts with parents are a problem, information gathering and sharing can be done by mail.

____(7) Follow-up with student and parents to determine what steps have been taken to minimize risk.

____(8) Document all steps taken and outcomes. Plan for aftermath intervention and support.

____(9) Report child endangerment if necessary.

Lista de comprobación Suicida*

Nombre del Estudiante:_____Fecha:_____Entrevistador:_____

(Puntos sugeridos a cubrir con los padres y el estudiante)

(1) INTENTOS PASADOS PLANES ACTUALES, Y IDEA SOBRE LA MUERTE

¿El individuo tiene pensamientos suicidas frecuentes? Y N

¿Ha habido intento de suicidio por el estudiante o familiares durante su vida? Y N

¿El estudiante tiene un plan detallado, factible? Y N

¿Ella o él ha tomado medidas especiales como dar a otros posesiones estimadas o de valor? Y N

¿El estudiante piensa del suicidio como una manera de hacer a otros sentirse mal o culpable o como una manera de conseguir una vida más feliz? Y N

(2) REACCIONES A ACONTECIMIENTOS PRECIPITADOS

¿El estudiante está experimentando señal de trastorno psicológico severo? Y N

¿Ha habido cambios mayores en el comportamiento reciente junto con sensaciones y pensamientos negativos? Y N

(Tales cambios se relacionan a menudo con la pérdida o la amenaza reciente de la pérdida de un ser querido o de la perdida de una oportunidad de estatus positivos. También pueden provenir del abuso sexual, físico, o de sustancia prohibida. Las sensaciones y los pensamientos negativos son a menudo expresiones de un sentido de la pérdida extrema, abandono, el fracaso, tristeza, desesperación, culpabilidad, y a veces cólera dirigida internamente.)

(3) AYUDA SICOSOCIAL

¿Hay una carencia de un ser querido para ayudar al estudiante a sobrevivir? Y N

¿El estudiante se siente alineado, solitario? Y N

(4) HISTORIA DE COMPORTAMIENTO O ACCIONES DE ALTO RIESGO

¿El estudiante toma riesgos peligrosos o exhibe un control pobre de sus impulso?

*Utilice esta lista de comprobación como una guía exploratoria con los estudiantes que usted esta preocupaod. Cada sí levanta el nivel el riesgo, pero no hay una cuenta que indica alto riesgo. Una historia de intento de suicidio preocupa, por supuesto, está es una razón suficiente para tomor acción. El alto riesgo también se asocia a los planes muy detallados (cuando, donde, cómo) que especifican un método mortal y fácilmente disponible, un momento específico, y una localización donde es muy poco probable qu el acto sería interrumpido. Otros riesgos indicadores incluyen cuando el estudiante hace arreglos finales y provee informacion sobre una pérdida crítica y reciente. Debido a la naturaleza informal de este tipo de entrevista, no debe ser archivada como parte de los expedientes regulares de la escuela de un estudiante.

PASOS A SEGUIR
DESPUES DE LA EVALUACIÓN DE RIESGO SUICIDA–LISTA

(1) Como parte del proceso de evaluación, lo mas posible será hecho para discutir el problema con el estudiante de una manera abierta y sin ningun juicio. (Tenga presente que tan seriamente devaluado y desanimado un estudiante suicida se siente. Por lo consiguiente, evite decir cualquier cosa que desagrade o que devalúe al estudiante, mientras que transmite empatia, cariño, calor humano y respecto.) Si el estudiante se ha opuesto en hablar sobre el asunto, vale la pena hacer otro esfuerzo porque cuanto más el estudiante hable, es más probable que el estudiante tome carta en el asunto para solucionar el problema.

(2) Explique al estudiante la importancia y su responsability sobre al romper el privilegio de confidencialida en el caso que hay riesgo de suicidio. Explore si el estudiante preferiría tomar la iniciativa o quisiera estar presente durante el proceso de informar a los padres u otras personas involucrada.

Brief Description of Copyrighted Instrument

Children's Depression Inventory (CDI)

Developed by Kovacs and Beck (1977) for use with children (6-18 years of age), this instrument is probably the most commonly used tool to look at severity of symptoms. It is not a diagnostic procedure. That is, just because a student scores high doesn't mean they are clinically depressed. It does mean they have a lot of concerns that need to be discussed. The survey has 27 items. For each item the student has 3 choices from which to select. For example, "(a) Things bother me all the time, (b) Things bother me many times, (c) Things bother me once in a while." The inventory has good internal reliability.

The CDI items and administrator instructions can be found in J.G. Schulterbrandt and A. Raskin (1977). *Depression in children: Diagnosis, treatment, and conceptual models*. NY: Raven Press. The CDI is published by Multi-Health Systems, Inc., 908 Niagara Falls Blvd., North Tonawanda, NY 14120-2060. Phone number: (800) 456-3003.

Excerpts from... *Pediatrics*
May, 2001

Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool.

Lisa M. Horowitz

http://pediatrics.aappublications.org/cgi/content/full/107/5/1133

...Unrecognized suicidality in emergency department (ED) settings is an especially important problem for several reasons. First, increasing numbers of children and adolescents now present to hospital EDs with mental health concerns, primarily self-destructive behavior. Second, ED staff are increasingly being given the responsibility of triaging children and adolescents with mental health problems to crisis intervention and appropriate follow-up treatments. Finally, unrecognized suicidality in the ED is associated with substantial morbidity, potential mortality, and increased health care utilization and costs...

SOS High School
Suicide Prevention Program

Screening for Mental Health, Inc. (SMH) is the non-profit organization that spearheaded mental health screening in 1991 with its flagship National Depression Screening Day program.

"*The SOS High School Suicide Program is an invaluable contribution to efforts to prevent suicides among our nation's youth. The program teaches teens the connection between mental illness and suicide, and how to get help for themselves or their friends. It has been shown to actually increase help-seeking by students in need. At a time when national statistics indicate that suicide is the third leading cause of death among young people between the ages of 15-24, school systems across the country should strongly consider implementing such programs*."

David Satcher, M.D., Ph.D.
United States Surgeon General

For more information
www.mentalhealthscreening.org/highschool/index.aspx

National Center for Education in Maternal and Child Health
http://www.mchlibrary.info/alert/archives.html
March 19, 1999

excerpt from...

MCH Alert

SAMHSA ISSUES NEW PRACTICE GUIDELINES ON IDENTIFYING AND TREATING ADOLESCENT SUBSTANCE ABUSE

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) issued two new best practice guidelines to aid in improving the early identification and treatment of adolescent substance abuse. The guidelines are part of a series of Treatment Improvement Protocols (TIP) regularly produced by CSAT. The new TIPs respond in part to the growing number of adolescents receiving treatment. From 1991 to 1996, the number of adolescents under age 18 receiving substance abuse treatment in the United States on any given day almost doubled, from 44,000 to 77,000.

The first guideline, Screening and Assessing Adolescents for Substance Use Disorders (TIP #31), describes warning signs of substance use disorders for adolescents. It explains when to screen and when to move forward into a professional assessment of the adolescent, and how to involve the teen's family. For example, the guideline recommends screening for teens who come to emergency rooms with trauma injuries, or who suddenly are prone to accidents, injury, or gastrointestinal disturbances.

The other guideline, Treatment of Adolescents With Substance Use Disorders (TIP #32), stresses crucial differences between treating adults versus adolescents. It outlines available treatment options for adolescents including 12-step programs, residential community programs and family therapy. It notes that "the treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social and moral development,...gender, ethnicity, disability status, stage of readiness to change, and cultural background."

The full series of Treatment Improvement Protocols are available through the National Clearinghouse for Alcohol and Drug Information on the Internet at
https://ncadistore.samhsa.gov/catalog/results.aspx?h=publications&topic=103
or by phone at (800) 729-6686.

Being Specifically Alert to Substance Abuse Indicators

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

The type of indicators usually identified are

- a *prevailing pattern* of unusual and excessive behaviors and moods
- recent *dramatic* changes in behavior and mood.

School staff and those in the home need to watch for

- poor school performance; skipping or ditching school
- inability to cope well with daily events
- lack of attention to hygiene, grooming, and dress
- long periods alone in bedroom/bathroom apparently doing nothing
- extreme defensiveness; negative attitudes; dissatisfied about most things; argumentative
- frequent conflicts with others; verbally/physically abusive
- withdrawal from long-time friends/family/activities
- disregard for others; extreme egocentricity
- taking up with new friends who may be drug users
- unusual tension or depressed states
- seems frequently confused and "spacey"
- often drowsy
- general unresponsiveness to what's going on (seems "turned off")
- increasing need for money; disappearance of possessions (e.g., perhaps sold to buy drugs); stealing/shoplifting
- excessive efforts to mislead (lying, conning, untrustworthy, insincere)
- stooped appearance and posture
- dull or watery eyes; dilated or pinpoint pupils
- sniffles; runny nose
- overt indicators of substance abuse (e.g., drug equipment, needle marks)

In the period just after an individual has used drugs, one might notice mood and behavioral swings -- first euphoria, perhaps some unusual activity and/or excessive talking, sometimes a tendency to appear serene, after a while there may be a swing toward a depressed state and withdrawal. Sometimes the individual will stare, glassy-like at one thing for a long time.

To be more specific about a few indicators of abuse categorized by some common substances that are abused:

Amphetamines (stimulants)

- excessive activity
- rapid speech
- irritability
- appetite loss
- anxiety
- extreme moods and shifts
- erratic eating and sleeping patterns
- fatigue
- disorientation and confusion
- increased blood pressure and body temp.
- increased respiration
- increased and irregular pulse
- tremors

Cocaine (stimulant, anesthetic)

- short-lived euphoria followed by depression
- nervousness and anxiety
- irritability
- shallow breathing
- fever
- tremors
- tightening muscles

Inhalants

- euphoria
- intoxicated look
- odors
- nausea
- drowsiness
- stupor
- headaches
- fainting
- poor muscle control
- rapid heartbeat
- anemia
- choking

Cannabinoids (e.g., marijuana, hash, THC)

- increased appetite initially
- decreased appetite with chronic use
- euphoria
- decreased motivation for many activities
- apathy, passivity
- decreased concentration
- altered sense of time and space
- inappropriate laughter
- rapid flow of ideas
- anxiety; panic
- irritability, restlessness
- decreased motor skill coordination
- characteristic odor on breath and clothes
- increased pulse rate
- droopy, bloodshot eyes
- irregular menses

Narcotics (e.g., opium, heroin, morphine, codeine, methadone, and other pain killers)

extreme mood swings
poor concentration
confusion
insensitivity to pain
drowsiness/decreased respiration
slow, sallow breathing
decreased motor coordination
itchiness
watery eyes/pinpoint pupils
lethargy
weight loss
decreased blood pressure
possible needle marks
as drug wears off nausea & runny nose

Barbiturates, sedatives, tranquilizers (CNS depressants)

decreased alertness
intoxicated look
drowsy
decreased motor coordination
slurred speech
confused
extreme mood swings
erratic eating and sleeping patterns
dizzy
cold, clammy skin
decreased respiration and pulse
dilated pupils
depressed mood state
disinhibition

Hallucinogens (effecting perceptions; e.g., PCP, LSD, mescaline)

extreme mood alteration and intensification
altered perceptions of time, space, sights, sounds, colors
loss of sense of time, place, person
decreased communication
panic and anxiety
paranoia
extreme, unstable behaviors
restlessness
tremors
nausea
flashbacks
increased blood pressure
impaired speech
impaired motor coordination
motor agitation
decreased response to pain
watery eyes

SUBSTANCE ABUSE CHECKLIST*

It is essential to remember that many of the symptoms of substance abuse are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

Student's Name _____ Age _____ Birthdate _____

Date: _____ Interviewer _____

(Suggested points to cover with student, parent, other informed sources)

(1) Substance Use

Has the individual used substances in the past? Y N

In the last year or so? Y N

Does the individual currently use substances? Y N

How often does the individual	Never	Once in a while	About Once a Week	Several Times a Week	Every Day
drink beer, wine or hard liquor?	1	2	3	4	5
smoke cigarettes?	1	2	3	4	5
smoke marijuana (pot)?	1	2	3	4	5
use a drug by needle?	1	2	3	4	5
use cocaine or crack?	1	2	3	4	5
use heroine?	1	2	3	4	5
take LSD (acid)?.	1	2	3	4	5
use PCP (angel dust)?	1	2	3	4	5
sniff glue (huff)?	1	2	3	4	5
use speed?	1	2	3	4	5
other? (specify)_____	1	2	3	4	5

Has the individual ever had treatment for a substance problem? Y N

Has anyone observed the individual with drug equipment, needle marks, etc.? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Because of the informal nature of this type of assessment, it should not be filed as part of a student's regular school records.

(2) Recent Dramatic Changes in Behavior and Mood

Have there been major changes recently with respect to the individual's

relationship with family members?	Y	N
relationship with friends?	Y	N
performance at school?	Y	N
attendance at school?	Y	N
participation in favorite activities?	Y	N
attitudes about things in general?	Y	N

(3) Prevailing Behavior and Mood Problems

Have any of the following been noted:

poor school performance	Y	N
skipping or ditching school	Y	N
inability to cope well with daily events	Y	N
lack of attention to hygiene, grooming, and dress	Y	N
long periods alone in bedroom/bathroom apparently doing nothing	Y	N
extreme defensiveness; argumentative	Y	N
negative attitudes	Y	N
dissatisfied about most things	Y	N
frequent conflicts with others	Y	N
verbally/physically abusive	Y	N
withdrawal from long-time friends	Y	N
withdrawal from family	Y	N
withdrawal from favorite activities	Y	N
disregard for others; extreme egocentricity	Y	N
taking up with new friends who may be drug users	Y	N
unusual tension or depressed states	Y	N
seems frequently confused and "spacey"	Y	N
often drowsy	Y	N
general unresponsiveness to what's going on (seems "turned off")	Y	N
increasing need for money	Y	N
disappearance of possessions (e.g., perhaps sold to buy drugs)	Y	N
stealing/shoplifting	Y	N
excessive efforts to mislead (lying, conning, untrustworthy, insincere)	Y	N
stooped appearance and posture	Y	N
dull or watery eyes; dilated or pinpoint pupils	Y	N
sniffles; runny nose	Y	N

LISTA DEL ABUSO DE LA SUBSTANCIAS*

Es esencial recordar que muchos de los síntomas del abuso de las sustancias son características comunes de la gente joven, especialmente en la adolescencia. Esto significa que precaución extrema se debe ejercitar para evitar la interpretación o estimatización incorreta de un joven. *Nunca* sobrestime el significado de algunos indicadores.

Nombre del Estudiante _____ Edad _____
Fecha de Nacimiento _____

Fecha _____ Entrevistador _____

(Puntos sugeridos a cubrir con los estudiantes, padres, y otras referencias)

(1) El Uso de Sustancias

¿Ha la persona usado sustancias en el pasado? Y N

¿Durante el año pasado? Y N

¿Está la persona usando sustancias actualmente? Y N

Que tan frequente la persona?	Nunca	De vez en Cuando	Una Vez por Semana	Varias Veces a la Semana	Todos Los Dias
¿Bebe Cerveza, vino, o licor?	1	2	3	4	5
¿Fuma cigarrillos?	1	2	3	4	5
¿Fuma marijuana (pot)?	1	2	3	4	5
¿Usa una droga con jeringas?	1	2	3	4	5
¿usa cocaina or crack?	1	2	3	4	5
¿usa heroina?	1	2	3	4	5
¿Toma LSD (acido)?.	1	2	3	4	5
¿usa PCP (angel dust)?	1	2	3	4	5
¿sniff glue (huff)?	1	2	3	4	5
¿usa speed?	1	2	3	4	5
other? (specify)_____	1	2	3	4	5

¿Ha sido tratado la persona por abuso de drogas? Y N

¿Alguien ha observado a la persona con instrumentos de drogas, marcas de agujas, etc? Y N

*Use esta lista como una guía exploratoria con estudiantes que usted esta preocupado. Por la naturaleza informal de esta evaluación, no debe ser archivado como parte de los expedientes regulares del estudiante en la escuela.

.

(2) Cambios Dramáticos Recientes en Comportamiento y Ánimo

Ha habido cambios importantes recientemente con respecto al individuo

¿relación con los miembros de la familia? Y N

¿Relación con los amigos? Y N

¿Rendimiento en la escuela? Y N

¿Asistancia en la escuela? Y N

¿Participación en actividades favoritas? Y N

¿Actitudes acerca de cosas en general? Y N

(3) Problemas Prevalentes del Comportamiento y el Humor

Se ha observado algo de lo siguiente:

desempeño escolar pobre Y N

ausencia en la ecuela Y N

inhabilidad de hacer frente bien a acontecimientos diarios Y N

Falta de higiene, la limpieza, y el vestir Y N

Mucho tiempo solo en el cuarto/baño aparentemente haciendo nada Y N

defensividad extrema; controvertido Y N

actitudes negativas Y N

descontento sobre la mayoría de las cosas Y N

conflictos frecuente con otros Y N

verbalmente físicamente abusivo Y N

alejarse de los viejos amigos Y N

alejarse de la familia Y N

alejarse en hacer actividades favoritas Y N

indiferencia para otros; egocentricida extrema Y N

Hacerce amigo de personas que puedan usar drogas Y N

tensión inusual o estados depresivo Y N

parece confundido y perturbado Y N

a menudo soñoliento	Y	N
insensibilidad general a lo que está pasando (como apagado)	Y	N
necesidad de dinero	Y	N
desaparición de posesiones (e.g., quizás vendido para comprar drogas)	Y	N
robar/robar en tienda	Y	N
esfuerzos excesivos para engañar (mentir, manipulación, insincero)	Y	N
aspecto y postura inclinada	Y	N
ojos lloroso; pupilas dilatadas	Y	N
nariz que moquea	Y	N

Information on a Sample of Substance Abuse Assessment Tools

Substance abuse usually is defined with respect to an individual's inability to control use and continued use despite adverse consequences. Assessment tools in this area are meant to help identify these concerns.

In their 1994 measurement review article entitled "Assessing adolescent substance use: A critique of current measurement instruments,"* Leccesse and Waldron conclude that clinicians approaching the task of assessing adolescents are confronted with a dilemma.

> Despite the intensity of investigative efforts, . . . the field of adolescent substance abuse has been characterized as more remarkable for what we do not know than what we do know. This is especially true in the area of assessment. Most instruments are still in the developmental stages and their effectiveness for problem identification, diagnosis, and treatment planning is largely unknown. Moreover, assessment practices in many adolescent treatment facilities seem to involve either unstandardized, locally developed measures or instruments developed and normed for adults. Both of these practices are potentially problematic. . . .

These authors also caution that

> Some ambiguity exists regarding what constitutes problem substance use in adolescents. National survey data show that experimentation with some drugs (e.g., alcohol, Tobacco) is statistically normal. That is, by late adolescence, more youth have tried these substances than have not. In the case of alcohol, 90% of all high school seniors have had some drinking experience. The majority of adolescents who experiment with drugs do not become addicted. Moreover, most adolescents appear to "mature out" of problem use with a sharp drop in drug use after age 21. Alternatively, some researchers have argued that, to a degree, drug use has developmental, adaptational utility for adolescents. For example, substance use could serve to signal independence from parents and identification with peers, or opposition to or deviation from societal norms and values, both of which could be viewed as normal exploration of identity issues.
>
> However, substance use could also serve as an attempt to cope with stress associated with adolescence, or could signal a lack of regulation, reflecting less psychological health. Similarly, used as a method of gaining autonomy, as a method of negative attention seeking or gaining contact with parents, or as a way of influencing family structure, adolescent substance use could be a concomitant of family pathology. . . .
>
> Research findings do suggest that use of substances during the teen years can interfere with crucial developmental tasks . . . (and can) precipitate problems by increasing the likelihood of arrest for substance-related offenses and increasing adolescents' exposure to risky situations such as driving while intoxicated, engaging in unprotected sex, and confronting violent exchanges.

*Source: *Journal of Substance Abuse Treatment, 11,* 553-563. References cited by these authors related to the above points are included at the end of this section.

A Brief, Annotated Listing of Substance Abuse Assessment Tools

Some of the following are designed as quick screening instruments; others are used either after a youngster is identified by a screening device or in place of screening when feasible. Screening tools are relatively inexpensive and quick to administer, but they also are quite limited in their validity. Moreover, if cut-off scores are set too low, screens detect many youngsters who should not be identified (false positives).

More comprehensive instruments are designed for use in making diagnoses and planning specific interventions. All instruments in this area have limited psychometric validation; a few have generated better data than the rest. Special note is made of those rated in a fairly recent review as being better than the rest in terms of available reliability and validity findings.

Screening Tools

Unless otherwise indicated, the following are relatively brief, paper and pencil, self-report questionnaires.

Adolescent Drinking Index (Psychological Assessment Resources; Harrell & Wirtz, 1989)

Consists of 24 items focusing on loss of control and psychosocial and physical symptoms.

Adolescent Drug Involvement Scale (Moberg, 1983)

Adaptation of the Adolescent Involvement Scale (Mayer & Filstead, 1979) to focus more broadly on general substance abuse; includes a frequency of use checklist.

Client Substance Index (Olympic Counseling Services; Moore, 1983)

Consists of 113 items designed to measure 28 chemical dependency symptoms outlined by Jellinek. Scores are converted into 4 categories -- no problem, misuse, abuse, and chemically dependent.

Drug Abuse Screening Test -- Adolescent version (Skinner, unpublished)

Adaptation of an adult version (Skinner, 1982); consists of ten yes/no questions related to hard drug use.

Drug and Alcohol Problem Quick Screen (Schwartz & Wirtz, 1990)

Respondent answers "yes," no," or "uncertain" to 30 brief items asking about (a) her/his own substance use, (b) parents' and friends' substance use, (c) participation in risky behavior, (d) conflict with parents, (e) misbehavior at school, (f) beliefs about alcohol and drug use, and (g) symptoms of depression. Individuals scoring six or more are seen as "high-risks." The items are listed in an article by the instruments developers (see Schwartz & Wirtz, 1990).

Drug Use Screening Inventory (Tarter, 1990; Tarter & Hegedus, 1991)

Focuses on problems with substance use, physical and mental health, and psychosocial adjustment using 149 yes/no items written at a fifth grade reading level; takes approximately 20 minutes. No cut-off scores have been established. The items are listed in an article by Tarter (1990). This is one of two screening instruments judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Perceived Benefit of Drinking & Drug Use Scales (Petchers & Singer, 1987; Petchers, Singer, Angelotta, & Chow, 1988)

Consists of 10 items -- 5 parallel alcohol and drug statements about reasons people might use substances. Respondent chooses whether or not s/he agrees with each of five stated reasons. Those who agree with many of the “positive” stated reasons are seen as likely to be problem users, but no cut-off score is established. Items are available in Petchers et al. (1988).

Personal Experience Screen Questionnaire (Western Psychological Services; Winters, 1992)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. This measure consists of 40 items focusing on psychosocial functioning, substance problem severity, and frequency and onset of use; includes items to detect social desirable responding. Takes about 10 minutes. No cut-off score established. This is one of two screening instruments judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Substance Abuse Screening Test (Slosson)

Designed to screen out students, ages 13-18 years and older, who are **unlikely** to have a substance abuse problem. Those not screened out are seen as appropriate "at risk" referrals. Consists of 30 self-report yes/no items; also includes an Observation Report to be filled out by an adult who is familiar with the student. Can be administered by any appropriately sanctioned and supervised adult; takes about 10 minutes. Available from Slosson Educational Publications, Inc., P.O. Box 280, East Aurora, NY 14052.

Substance Abuse Subtle Screening Inventory Adolescent (Miller, 1990)

Consists of 81 items and takes about 20 minutes. 55 true/false items are used as indirect measures (designed to appear unrelated to substance use); the rest ask about the frequency of occurrence of specific situations involving substance use. Available from the SASSI Institute, 4403 Trailridge Road, Bloomington, IN 47408.

Tools for Diagnosis and Treatment Planning related to Substance Abuse

Adolescent Assessment and Referral System (National Institute on Drug Abuse; Rahdert, 1991)

A battery of screening measures and clinical guides for diagnosis and treatment referral. The screening battery, called the *Problem Oriented Screening Instrument for Teenagers,* consists of 139 yes/no items designed to measure functioning related to substance use (and nine other areas -- physical health, mental health, family relationships, peer relationships, educational status, vocational status, social skills, leisure and recreation, aggressive behavior/delinquency). A set of items designated as "red flags," including all substance use items, are seen as indicating the need for further assessment. That is, a yes response on any of these items designates the youngster at risk. Instrument and guides are available with a manual at no charge through the National Clearinghouse for Alcohol and Drug Information.

Adolescent Chemical Health Inventory (Renovex)

Consists of 122 items focusing on severity of direct and indirect substance use problems. Includes items to check on the degree that responses are influenced by a desire to be socially appropriate.

Adolescent Diagnostic Interview (Western Psychological Services; Winters & Henly, 1993)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. It is a structured diagnostic interview covering symptoms indicating abuse or dependence as specified in the Diagnostic Statistical Manual of the American Psychiatric Association related to diagnosis of psychoactive substance use disorders. Explores use history for several drug categories and covers level of functioning and psychosocial stressors. Takes about 45-60 minutes. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Adolescent Drug Diagnosis (Friedman & Utada, 1989)

A 150-item structured interview -- modeled after an adult measure called the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980). Besides substance use, the measure focuses on severity of problem and "need for treatment" related to medical, school, employment, social, family, psychological, and legal matters. Used in diagnosis and treatment planning (and for research). Takes about 45-60 minutes. Contact Belmont Research Center, 4081 Ford Road, Philadelphia, PA 19131. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Adolescent Problem Severity Index (Metzger, Kushner, & McLellan, 1991)

A semistructured interview also modeled after the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980); can be administered by an interviewer or a computer. (Special training -- about six hours -- is recommended.) Besides substance use, treatment needs are assessed related to legal, family relationships, school and work, medical, psychosocial adjustment, and personal relationships. Both total number of risk factors in each area and severity are scored and combined into a composite indicating need for treatment. Takes approximately 45-60 min to complete. Contact David Metzger, Ph.D., Addiction Research Center, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19115.

Adolescent Self-Assessment Profile (Wanberg, 1991)

Consists of 203-item multiple choice questions focusing on substance use and 5 other general areas of concern (family, mental health, peer influence, school problems, deviant behavior). These yield raw scores for 20 scales scores which can be converted to decile ranks defining degree of problem severity. Contact Kenneth W. Wanberg, Ph.D., Center for Alcohol/Drug Abuse Research and Evaluation, 5460 Ward Road, Suite 140, Arvada, CO 80002.

Personal Experience Inventory (Western Psychological Services; Winters & Henly, 1989)

This is part of a consortium developed assessment package called the *Minnesota Chemical Dependency Adolescent Assessment Profile*. Designed for treatment planning, this instrument consists of 276 items written at a fifth-grade reading level and focused on onset and frequency of drug use, severity of drug problem, personal risk factors, environmental risk factors, several other problem areas (e.g., physical and sexual abuse). Includes items to detect social desirable responding. Yields scores for five problem-severity scales: personal involvement, effects from drug use, social benefits of drug use, personal consequences of drug use, and polydrug use. Takes about 45-60 minutes. Can be administered by computer. This is one of three instruments used for diagnosis and treatment planning judged by Leccese and Waldron (1994) as having the *best reliability and validity findings* as of their review.

Substance Involvement Instrument (Aladar)

Part of an assessment package that includes sociodemographics and drug use history, this 60 item measure focuses on the extent of substance use involvement, with 20 items that are "behavioral indicators" designed to reflect the progressive nature of dependency. Contact Aladar in Lacy, WA.

Teen-Addiction Severity Index (Kaminer, Bukstein, & Tarter, 1991)

Adapted from the *Addiction Severity Index*, this measure yields seven subscales: chemical use, school status, employment-support status, family relationships, legal status, peer-social relationships, and psychiatric status. In each area, both the respondent and interviewer use a 5 point scale to indicate problem severity and need for treatment. Takes about 30-45 minutes and is to be administered only by trained personnel. Contact Y. Kaminer for more information.

Something a Little Different

Teen Health Advisor (Paperny, Aono, Lehman, Hammar, & Risser, 1990)

This is a computer program designed to be a relatively nonthreatening way of eliciting information on high-risk behaviors **and** provide feedback in the form of advice or referral sources. It covers such areas as general health, communication skills, emotional issues, substance use, teen pregnancy, contraception, and sexually transmitted diseases. Paperny et al. (1990) suggest the approach is more effective in gathering sensitive information than a clinical questionnaire. Data from studies conducted in Hawaiian public schools are available from the first author. The computer program can be ordered from: Teen Health Computer, 2516 Pacific Heights Road, Honolulu, HI 96813.

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II. Examples of Screening Children & Youth

C. Screening at-risk groups:

1. Crisis screening
2. Disruptive behaviors
3. Juvenile justice
4. Dropouts

A Crisis Screening Interview

Interviewer_____ Date_____

Note identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

_____

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Born in U.S.? Yes No If No, how long in U.S.?

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

In answering, please provide as much details as you can. At time, I will ask you to tell me a bit more about your thoughts and feelings.

1. Where were you when the event occurred?
   (Directly at the site? nearby? out of the area?)

2. What did you see or hear about what happened?

3. How are you feeling now?

4. How well do you know those who were hurt or killed?

5. Has anything like this happened to you or any of your family before?

6. How do you think this will affect you in the days to come?
(How will your life be different now?)

7. How do you think this will affect your family in the days to come?

8. What bothers you the most about what happened?

9. Do you think anyone could have done something to prevent it? Yes No
Who?

10. Thinking back on what happened,	not at all	a little	more than a little	very
how angry do you feel about it?	1	2	3	4
how sad do you feel about it?	1	2	3	4
how guilty do you feel about it?	1	2	3	4
how scared do you feel?	1	2	3	4

11. What changes have there been in your life or routine because of what happened?

12. What new problems have you experienced since the event?

13. What is your most pressing problem currently?

14. Do you think someone should be punished for what happened? Yes No
Who?

15. Is this a matter of getting even or seeking revenge? Yes No
Who should do the punishing?

16. What other information do you want regarding what happened?

17. Do you think it would help you to talk to someone about how you feel about what happened?
Yes No Who? How soon?

Is this something we should talk about now? Yes No What is it?

18. What do you usually do when you need help with a personal problem?

19. Which friends and who at home can you talk to about this?

20. What are you going to do when you leave school today?
If you are uncertain, let's talk about what you should do?

A Crisis Screening Interview

Entrevistador_____ Fecha _____

Identifique el Problema:

¿Está el estudiante solicitando ayuda? Yes No

¿Si no, cuáles son las circunstancias que han traído al estudiante a la entrevista?

Nombre del Estudiatne_____ Edad _____ Fechad de Nacimiento_____

Sexo: M F Grado _____ Clase Actual _____

Pertenencia étnica _____ Idima Primario _____

Estamos interesado sobre cómo las cosas van para usted. Nuestra charla nos ayudará hoy a discutir qué va MUY BIEN y qué no va tan bien. Si usted quisiera que guardara lo que hablamos en secreto, asi lo haré -- a excepción de esas cosas que necesite discutir con otras personas para ayudarle.

Al contestar, por favor proporcione las respuestas los más detalladamente posible. Ocasionalmente, pediré que usted me diga algo más sobre sus pensamientos y sentimientos.

1. ¿Dónde estaba usted cuando ocurrió el acontecimiento? (¿Directamente en el sitio? ¿cerca? ¿fuera del área?)

2. ¿Qué usted vio u oyó hablar cuando sucedió el incidente?

3. ¿Cómo se siente usted ahora?

4. ¿Que tan bien conoce a los que estubierón implicado?

5. ¿Algo similar ha sucedido a usted o a cualquiera de su familia antes?

6. ¿Cómo usted piensa que esto lo afectará en los días por venir? (¿cómo su vida será diferente ahora?)

7. ¿Cómo usted piensa que esto afectará a su familia en los días por venir?

8. ¿Qué es lo que más le molesta de lo que sucedió?

9. ¿Usted piensa que alguien habría podido hacer algo para prevenirlo? Si No

Quién?

10. Pensando en lo que sucedió,	Nada del todo	un poco	Más que un poco	Mucho
¿Que tan enojado se siente sobre lo que sucedio?	1	2	3	4
¿Que tan triste usted se siente?	1	2	3	4
¿Que tan culpable usted se siente?	1	2	3	4
¿Que tan asustado usted se siente?	1	2	3	4

11. ¿Qué cambios han habido en su vida o rutina debido a lo qué sucedió?

12. ¿Qué nuevos problemas usted ha experimentado desde el acontecimiento?

13. ¿Cuál es su problema más acuciante actualmente?

14. ¿Usted piensa que alguien debe ser castigado por lo qué sucedió? Si No
¿Quién?

15. ¿Es ésta una cuestión de conseguir venganza? Si No
¿Quién debe ser castigado?

16. ¿Qué otra información usted desea con respecto a lo qué sucedió?

17. ¿Usted piensa que le ayudaría el hablar con alguien sobre cómo usted se siente sobre lo que sucedióó?

Si No ¿Quién? ¿Que tan Pronto?

¿Es esto algo que nosotros debamos de hablar ahora?
Si No ¿Qué es?

18. ¿Qué usted hace generalmente cuando usted necesita ayuda con un problema personal?

19. ¿Qué amigos y quién en la casa puede usted hablar sobre esto?

20. ¿Qué usted va a hacer cuando usted sale de la escuela hoy? ¿Si usted está incierto, hablemos de lo que usted debe hacer?

Excerpt from *Journal of the American Academy of Child and Adolescent Psychiatry* Oct, 1999

Identification of Elementary School Children at Risk for Disruptive Behavioral Disturbance: Validation of a Combined Screening Method.

Charles D. Casat, Norton & Madeline Boyle-Whitesel.

...Public school systems are among the most predictable and extensive providers of mental health services for children. Federal mandates, such as Section 504 of the Rehabilitation Act of 1973 and the Individuals With Disabilities Education Act of 1975, dictate identification and interventions within the schools to ensure optimal learning opportunities, including children with emotional and behavioral problems. Such behaviors are a significant and growing problem and represent a barrier to the child's learning, exerting a direct negative impact on learning for those displaying this dyscontrol (Adelman, 1996), as well as asserting an indirect negative effect on the learning environment for other students in the classroom. However, school special services budgets have not grown proportionately, and available school psychology/guidance counselor resources are severely strained in meeting both the mandates and the children's needs...

Effective implementation of school-based mental health prevention and early intervention services requires the use of feasible methods that would allow for the rapid screening identification of children with developing externalizing behavioral disturbances (August et al., 1995). This early identification is especially urgent, given the high potential for adverse outcomes (e.g., development of conduct disorder, school dropout, teenage pregnancy; violence and delinquency; and substance abuse) in later childhood and adolescence (Loeber, 1990, 1991; Offord, 1989; Olweus, 1979) and the high costs to the individual and community associated with these adverse outcomes. Use of suitable screening methods would greatly enhance the approach to planning for application of SBS in a uniform manner.

We used a stepwise approach to identification of the presence of disruptive behavioral disturbance, choosing to identify those children who showed high cross-situational scores for externalizing behaviors to minimize occurrence of false-positives...

The current study provides evidence that the IOWA Conners is feasible as an easily administered classroom survey questionnaire that may be used as a rapid and valid screener across an entire elementary school population. This screening strategy, using the IOWA Conners in combination with the CASQ, identifies children with cross-situational disturbance who are at high risk for current occurrence of externalizing behavioral disorders. In practice, children identified by this screening method must be further evaluated using classroom observation and other instruments such as the TRF (Achenbach, 1991b) or the Behavioral Assessment System for Children (Reynolds and Kamphaus, 1992). Attention should be given to identifying evidence of cross-situational disturbance using ratings from parents, such as the CBCL or the parent form of the Behavioral Assessment System for Children, as the likely need for intervention increases for children exhibiting high levels of problem behaviors in multiple settings (Loeber, 1990). A measure of functional impairment such as the CAFAS (Hodges and Gust, 1995) and/or the CGAS (Shaffer et al., 1987) is also necessary. When seeking to identify the children most in need of mental health services, the use of a conservative threshold of 2.0 SD on the IOWA Conners and CASQ might be most appropriate. Such a level would have high predictive value, with lessened occurrence of false-positives, and would further conserve resources of mental health professionals for individual, group, family, and medication services interventions.

The combined screening approach described in this article can aid in identification of child needs, facilitate planning for classroom prevention and early intervention efforts, and support efficient allocation of specialized resources (Lochman et al., 1995). It should be stressed that the results of this investigation are subject to replication and extension in a larger application study of this model, in which information also must be systematically gathered on age, sex, race, and SES, to reduce potential bias and improve utility.

Brief Description of Copyrighted Instruments

Behavior rating instruments provide another basis for gathering information on students from a variety of sources (e.g., parents, teachers). Many instruments are available, some better than others. The better ones are relatively reliable and useful in providing information on the severity and pervasiveness of behavior problems; some also provide useful information on positive functioning. Such instruments can be helpful in diagnosing psychological disorders, but alone they have limited diagnostic validity. Two of the most commonly used ones are briefly described here in case you want to pursue them.

Child Behavior Checklists (CBCL)

Developed by Achenbach and Edelbrock (1983), this has become one of the most used set of behavioral instruments for assessing children's behavior problems (nine areas) and social competencies (three areas). Used with children aged 4 to 16, it focuses on problem behavior areas that carry the following descriptive (not diagnostic) labels -- Depressed, Social Withdrawal, Somatic Concerns, Schizoid/Obsessive, Hyperactive, Sex Problems, Delinquent, Aggressive, and Cruel. In general, the behaviors measured differentiate *externalizing* behavior (directed outward -- poor behavior control, etc.) and *internalizing* behavior (directed inward -- anxiety, depression, etc.). Scores for problem areas are meant to distinguish (a) withdrawn behavior, (b) somatic complaints, (c) anxious/depressed, (d) social problems, (e) thought problems, (f) attention problems, (g) delinquent behavior, (h) aggressive behavior, and (i) sex problems. Areas of social competency are descriptively labeled to distinguish school, social, and activity settirgs. A profile is plotted to provide percentile ranks and T-scores for the student's performance. The accompanying manual discusses scoring and interpretation. Machine scoring has also been developed. Test-retest reliabilities are reported at .89 for a 1 week interval. The instrument has versions for parents, teachers, and a direct observer. There is also a Youth Self Report form for older students (up to age 18). Available from Thomas Achenbach, Department of Psychiatry, Univ. of Vermont, 1 So. Prospect St., Burlington, VT 05401.

Conners Rating Scales

This is a general screening instrument with forms for teacher and parent to rate problem behaviors seen as related to attention deficits and hyperactivity. Used with children and youth from 3-17 years of age, it is relatively short and easy to administer. This has made it popular with school personnel.The accompanying manual offers information on scoring and interpretation. This instrument can be purchased from Multi-Health Systems, 908 Niagara Falls Blvd., North Tonawanda, NY l4l20-2060. Phone number (800) 456-3003.

http://findarticles.com/p/articles/mi_hb179/is.200105/ai_n5572485
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Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice Youths.

Authors: Grisso, Fletcher, Barnum, Cauffman, Peuslchold

This report describes the development of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), a brief screening measure to identify youths with potential mental, emotional, or behavioral problems at entry points in the juvenile justice system...

Whereas 18% to 22% of children and adolescents in the U.S. have a mental or emotional disorder (Brandenburg et al., 1990; Costello, 1989), a much greater proportion of youths in the juvenile justice system have such disorders (Kazdin, 2000; Otto et al., 1992). This proportion is about 70% to 80% when conduct disorder and substance abuse disorders are included and about 40% to 50% when those disorders are excluded (Teplin et al., 1998)...

As a screening tool, the MAYSI-2 was not intended for identification of clinical disorders defined by DSMIV criteria. Its objective was to identify youths who report symptoms of distress (e.g., "depressed mood") that are characteristic of disorders among youths, or manifest feelings or behaviors (e.g., suicide potential) that might require immediate intervention early on in the care and management of youths charged with or convicted of delinquent behaviors...

Moreover, although sensitivity and specificity were adequate for identifying youths who scored high on criterion measures of mental distress, the results suggest that the instrument yields more false positives than would be desirable for purposes of making long-range treatment plans. Therefore, the instrument's appropriate use is as a first-level screen that is followed by further inquiry (e.g., sensitive questioning by detention staff or clinical consultation) for youths who exceed specified scoring criteria, aimed at identifying youths who may need emergency or relatively short-term clinical intervention focused on their immediate needs (e.g., suicide prevention, psychoactive medication, short-term intensive counseling).

Precisely what criteria should be used to signal intervention will be determined by juvenile justice facilities as a matter of policy. A high score on Suicide Ideation alone might be sufficient reason to trigger a set of staff precautions. However, our research thus far does not provide empirically based recommendations for interventions specific to MAYSI-2 criteria (for example, whether high scores on combinations of scales may suggest particular interventions)...

Drs. Grisso and Fletcher are with the University of Massachusetts Medical School, Dr. Barnum is with the Boston Juvenile Court Clinic, Dr. Cauffman is with the University of Pittsburgh, and Dr. Peusthold is with the Hennepin County District Court.

Excerpts from *Juvenile Justice* Volume VII, Number 1, April 2000

Youth With Mental Health Disorders: Issues and Emerging Responses

by Joseph J. Cocozza and Kathleen Skowyra

Mental Health Screening - http://www.ncjrs.gov/html/ojjdp/jjjnl_2000_4/youth_3.html

...One of the major obstacles in recognizing and treating youth with mental health disorders in the juvenile justice system is the lack of screening and assessment. All youth in contact with the juvenile justice system should be screened and, when necessary, assessed for mental health and substance abuse disorders. The screening should be brief, easily administered, and used to identify those youth who require a more comprehensive assessment to further define the type and nature of the disorder. The screening also should occur at the youth's earliest point of contact with the juvenile justice system and should be available at all stages of juvenile justice processing.

A major obstacle has been the absence of reliable, valid, and easy-to-use screening tools to help the juvenile justice system identify signs of mental illness. Grisso and Barnum (1998), however, recently developed a new tool, the Massachusetts Youth Screening Instrument (MAYSI). It is a short, easily administered inventory of questions that has been normed and tested on a number of juvenile justice populations and appears to provide a promising, standardized screen for use in juvenile justice settings (i.e., probation intake, detention, correctional facilities).

Excerpts from *Juvenile Justice* Volume VII, Number 1, April 2000

Suicide Prevention in Juvenile Facilities

by Lindsay M. Hayes

Intake Screening and Ongoing Assessment - http://www.ncjrs.gov/html/ojjdp/jjjnl_2000_4/sui_4.html

Intake screening and ongoing assessment of all confined youth are critical to a juvenile facility's suicide-prevention efforts. Although youth can become suicidal at any point during their confinement, the following periods are considered times of high risk (National Commission on Correctional Health Care, 1999):

-During initial admission.
-On return to the facility from court after adjudication.
-Following receipt of bad news of after suffering any type of humiliation or rejection.
-During confinement in isolation or segregation.
-Following a prolonged stay in the facility.

Intake screening for suicide risk may be included in the medical screening form or on a separate form. The screening process should obtain answers to the following questions:

-Was the youth considered a medical, mental health, or suicide risk during any previous contact or confinement within this facility?
-Does the arresting or transporting officer have any information (e.g., from observed behavior, documentation from the sending agency or facility, conversation with a family member or guardian) that indicates the youth should currently be considered a medical, mental health, or suicide risk?
-Has the youth ever attempted suicide?
- Has the youth ever considered suicide?
-Has the youth ever been or is the youth currently being treated for mental health or emotional problems?
-Has the youth recently experienced a significant loss (e.g., job, relationship, death of a family member or close friend)?
-Has a family member or close friend ever attempted or committed suicide?
-Does the youth express helplessness or hopelessness and feel there is nothing to look forward to in the immediate future?
-Is the youth thinking of hurting or killing himself or herself?

To make a thorough and complete assessment, the intake process should also include procedures for referring youth to mental health or medical personnel. Following the intake process, a procedure should be in place that requires staff to take immediate action ion case of an emergency. If staff hear a youth verbalize a desire or intent to commit suicide, observe a youth engaging in self-harm, or otherwise believe a youth is at risk for suicide, they should constantly observe the youth until appropriate medical, mental health, or supervisory assistance can be obtained.

Excerpts from *Journal of the American Academy of Child and Adolescent Psychiatry* Dec, 1999
http://findarticles.com/p/articles/mi_hb179/is_199912/ai_n5571926

Using the Suicide Risk Screen to Identify Suicidal Adolescents Among Potential High School Dropouts.

Elaine Adams Thompson and Leona L. Eggert

...Youths at risk for school dropout, like their "out-of-school" counterparts, are at elevated suicide risk and more likely than the general population to experience drug involvement, risky behaviors, family strain, emotional distress, and exposure to violence (Centers for Disease Control, 1994; Thompson et al., 1994). Ironically, the complexities of their lives often obscure their suicide vulnerability...

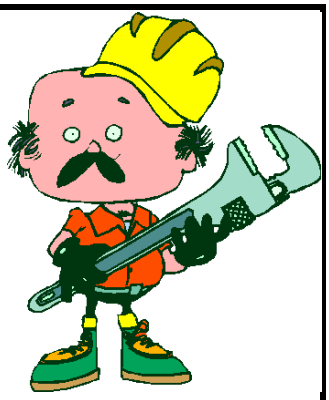
Clinical Implications

Indicated prevention requires identification of high-risk individuals prior to manifestations of clinical diagnosis. This study demonstrated the feasibility of identifying suicide-risk youths needing support and prevention services through a brief screening protocol, the SRS. Although general administration may be costly, the screen could be used effectively with high-risk populations in schools or in other settings, such as school-based or community-based teen clinics. Immediate follow-up, of course, will be essential to any screening program.

The SRS identifies suicide-risk youths, but at the expense of overidentification. Nevertheless, broad-based identification remains important. Among potential high school dropouts, suicide risk is linked to other crucial psychosocial risk factors--known precursors of depression and suicidal thoughts--likely to be revealed in a postscreening interview (cf. Larzelere et al., 1996; Shaffer, 1996). The results also substantiate the importance of specific risk factors. For instance, school personnel, parents, and others often discount teenagers' verbalizations about suicide, but the findings reiterate the importance of suicidal threats as a consequential warning sign.

Finally, our experiences revealed that youths were readily engaged in the screening questionnaire and follow-up MAPS interview, candid in their responses, and typically relieved to talk with someone concerned about their well-being. Responses from parents and/or other caring adults, even in some of the most difficult and chaotic situations, were universally positive and proactive with respect to the teenagers' needs. Thus, identifying suicide-vulnerable youths to assess their needs has the potential of enhancing parent-adolescent relations as well as providing opportunities for reducing suicide-risk behaviors.

III. General Screening Tools



Often it is feasible to directly discuss matters with a student and arrive at a reasonable picture of problems and next steps. When students are uncertain or reluctant to share their concerns or a staff member is somewhat inexperienced, a semi-structured instrument can be helpful in exploring the matter with the student. To provide additional data, a parent questionnaire or an extensive student self-report can be useful. Behavior rating instruments provide another basis for gathering information on students from a variety of sources (e.g., parents, teachers). And screening of suicide risk and for post-crisis trauma often require a more specialized focus. Finally, it helps to have a checklist that gives a functional picture of the student's problems and service needs.

In the first part of Section III, you will find:

A. Informal tools for screening

1. By self

- an **Initial Counseling Interview**
  (for use with all but very young students)
- a **Student Initial Questionnaire**
  (for use with young students)
- a **Sentence Completion Instrument for Students**
- a **Student Self-Report of Current Personal Status**
- **Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems**

2. By others

- a **Parent/Guardian Questionnaire**
- a **Child/Youth Community Functioning Evaluation**

In the second part of Section III, you will find:

B. Research - based screening instruments

*For a fuller discussion of assessment related to psychosocial and mental health concerns in schools, you may want to obtain a copy of the introductory packet on *Assessing to Address Barriers to Student Learning* -available from the Center for Mental Health *in* Schools at UCLA.

Initial Counseling Interview

(for use with all but very young students)

Interviewer _____ Date_____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

_____

Questions for student to answer:

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Born in U.S.? Yes No If No, how long in U.S.?

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing? What are your main concerns?

(2) How serious are these matters for you at this time?

1	2	3	4
very serious	serious	Not too serious	Not at all serious

(3) How long have these been problems?

___ 0-3 months ___4 months to a year ____more than a year

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order to deal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

Ejemplo de una Entrevista Inicial de Asesoramiento

(para el uso con todos pero no con estudiantes muy jóvenes)

Entrevistador_____ Fecha_____

¿El estudiante está buscando ayuda? Si No

¿Si no, cuáles fueron las circunstancias que a traído al esutdiante a la entrevista?

Preguntas para que el estudiante conteste

Nombre de el Estudiante _____ Edad_____
Fecha de Nacimiento_____

Sexo: M F Grado_____ Colocación actual_____

Nació en los Estados Unidos? Si No Si no, ¿Cuanto tiempo ha estado en los Estados Unidos?

Pertenencia étnica_____ Lengua Primaria_____

Estamos interesado sobre cómo las cosas van para usted. Nuestra charla nos ayudará hoy a discutir qué va MUY BIEN y qué no va tan bien. Si usted quisiera que guardara lo que hablamos en secreto, asi lo haré -- a excepción de esas cosas que necesite discutir con otras personas para ayudarle.

(1) ¿Cómo describiría su situación actual? ¿Qué problemas usted está experimentando? ¿Cuáles son sus preocupaciones principales?

(2) ¿Qué tan serios son estos problemas para usted en este momento?

1	2	3	4
Muy serio	Serio	No muy serio	No serio del todo

(3) ¿Por cuanto tiempo éstos han sido problemas?

___ 0-3 meses ___ 4 meses a un año ___ más que un año

(4) ¿Qué usted piensa originalmente que causó estos problemas?

(5) ¿Piensan otras personas (padres, profesores, amigos) que hubierón otras causas? ¿Si es así qué dicen que eran?

(6) ¿Qué otras cosas actualmente están haciendo duro ocuparse de los problemas?

(7) ¿Qué usted ha intentado ya para ocuparse de los problemas?

(8) ¿Por qué usted piensa estas cosas no fucionarón?

9) ¿Qué le han aconsejado hacer?

(10) ¿Qué usted piensa ayudaría a solucionar los problemas?

(11) ¿Cuánto tiempo y esfuerzo usted desea poner en solucionar los problemas?

1	2	3	4	5
Nada del todo	No mucho	Sólo un poco	Halgo Bastante	Mucho

(12)¿Qué tipo de ayuda usted desea?

(13) ¿Qué cambios usted está esperando?

(14) ¿Qué tan esperanzado está usted en solucionar los problemas?

1	2	3	5
Muy esperanzado	Algo esperanzado	No tan esperanzado	Nada esperanzado

¿Si usted no está esperanzado, por qué no?

(15) ¿Qué más debemos saber de modo que podemos ayudar?

¿Hay otras asuntos que usted desee discutir?

Student Initial Questionnaire

(for use with very young students)

Interviewer _____ Date_____

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

_____

Questions for student to answer:

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____ Current Placement _____

Born in U.S.? Yes No If No, how long in U.S.?

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

A Sentence Completion Instrument for Students

Name _____ Date_____

Age _____ Birthdate _____

To complete the following sentences, write down the first thought that comes to your mind. (Items can be read to the student and responses recorded if necessary.)

(1) I wish I could _____

(2) I think I am a _____

(3) In school, my teacher _____

(4) I wish my friends would_____

(5) I don't like others who _____

(6) When nobody cares, I _____

(7) I don't like school because _____

(8) I like myself when _____

(9) I want my mother to _____

(10) I don't like to _____

(11) I like others who _____

(12) I am scared by _____

(13) Brothers are _____

(14) Being an only child _____

(15) When I am sick _____

(16) The worst thing I ever did _____

(17) Sisters are _____

(18) I feel worse when_____

(19) My friends don't understand that _____

(20) I like computer games because _____

(21) I want my father to _____

(22) I wish my mother would _____

(23) I cry when _____

(24) Making friends is hard if _____

(25) When I get mad, I _____

(26) When mom and dad fight _____

(27) I like girls who _____

(28) When I am punished, I usually _____

(29) My father makes me angry when _____

(30) Other people would hate me if _____

(31) Nobody can force me to _____

(32) I was bawled out when _____

(33) Being told what to do is _____

(34) The best thing about getting older is _____

(35) I like cartoons (tv, movies, funnies) because _____

(36) I wish I were younger because _____

(37) My mother makes me angry when _____

(38). It isn't right for students to _____

(39) The worst thing about getting older _____

(40) Grownups make me mad when _____

(41) I remember when I _____

(42) When I grow up I _____

Student Self-Report of Current Personal Status

(If the student wants, the items can be read aloud by an interviewer.)

Date_____ Are you seeking help? Yes No

Student's Name _____ Age _____ Birthdate _____

Sex: M F Grade _____

Born in U.S.? Yes No If No, how long in U.S.?

Ethnicity _____ Primary Language _____

We are concerned about how things are going for you. The following questions will help us learn what's going O.K. and what's not going so well. If you want us to keep your answers secret, we will do so -- except for those things that we need to discuss with others in order to help you. Please try to answer all of the questions. If there is a question you do not understand, circle the question number and we will explain it to you later. If you don't want to answer a specific question, you don't have to.

1. What are your favorite activities and sports?

2. What do you like best about school?

3. What don't you like about school?

4. Do you plan to graduate from high school? ___yes ___no ___don't know

5. Do you plan to attend college? ___yes ___no ___don't know

6. What type of job are you preparing yourself for?

7. How do you and your parents get along? (Check one)

___good ___some problems ___a lot of problems ___don't have any parents

8. How do you and your brothers or sisters get along? (Check one)

___good ___some problems ___a lot of problems ___don't have any parents

9. Do you have a real close friend? ___ yes ___ no

10. Do you have a boyfriend/girlfriend of the opposite sex? ___ yes ___ no

11. How much TV do you watch a day?
___ none ___less than 1 hour ___1 to 2 hours
___ 3-4 hours ___more than 4 hours

12. Think about things that have happened over the last 12 months. Look over the following items, and check **each** thing that has happened to you during that time.

	YES	NO
a. got one or more failing grades on a report card.	___	___
b. had a problem with alcohol or drugs	___	___
c. a divorce, separation or death in your family	___	___
d. lost a close friend or relationship	___	___
e. was involved in a serious crime	___	___
f. had a serious problem getting along with family or others	___	___
g. was involved in a violent fight.	___	___
h. had some other serious problem or loss	___	___

13. Last semester you got

____ mostly D's and F's ____ mostly B's and C's
____ mostly C's and D's ____mostly A's and B's

14. About how many days were you absent last semester? _____
About how many of these days were you actually sick? _____

15. About how many classes did you cut (skip -- not go to) last semester? _____

16. Are you receiving special help in school with your classwork? ___ yes ___ no

Most teenagers go through hard times when they feel nervous, depressed, angry or upset.

17. During the past month, how often did you feel nervous or "stressed out"?

____Never ___Several times
____Once or twice ___Almost everyday

18. During the past month, how often did you feel depressed?

____Never ___Several times
____Once or twice ___Almost everyday

19. During the past month, how often did you have trouble sleeping at night?

____Never ___Several times
____Once or twice ___Almost everyday

20. How often do you think about hurting yourself?

___Often ___Sometimes ___Never

21. How often do you think of ending your life?

___Often ___Sometimes ___Never

22. How happy are you with the way things are going in your life?

___Very ___Somewhat ___Not at all ___Don't know

22. How often, if ever, do you do the things below? (In answering, **circle** the number for each item)

	Never	Once in a while,	About Once a Week	Several Times a Week	Every Day
a. drink beer, wine or hard liquor?	1	2	3	4	5
b. smoke cigarettes?	1	2	3	4	5
c. smoke marijuana (pot)?	1	2	3	4	5
d. use a drug by needle?	1	2	3	4	5
e. use cocaine or crack?	1	2	3	4	5
f. use heroine?	1	2	3	4	5
g. take LSD (acid)?.	1	2	3	4	5
h. use PCP (angel dust)?	1	2	3	4	5
i. sniff glue (huff)?	1	2	3	4	5
j. use speed	1	2	3	4	5

23. Have you ever gone to a counselor to discuss problems you were having?
___yes ___no ___don't remember

24. Would you be interested in seeing a counselor to discuss problems?
___yes ___no ___don't know

25. Would you be interested in participating in group "rap" sessions?
___yes ___no ___don't know

Students often have questions or concerns about many things. Is there anything in particular that you want to discuss with someone?

Thank You For Completing This Survey

(Use of the following questions depends on existing school policy and obviously are not meant for all students.)

26. Have you ever had sexual intercourse (done it, had sex)? _____Yes ____No

If you have **never** had sexual intercourse (done it, had sex), we would appreciate your answering the following items. (You can check as many reasons as are true.)

You have **never** had sexual intercourse (never done-it or had sex) because

___(a) It is wrong to have sex before marriage
___(b) My church says it is wrong outside of marriage
___(c) I am just not ready
___(d) I am waiting for the right person to do it with
___(e) I am waiting until I get married
___(f) I am waiting until I get older
___(g) I don't want to get pregnant/get someone pregnant
___(h) I don't want to get a disease
___(i) I don't want to get AIDS
___(j) My parents would be very upset if I did
___(k) I would be embarrassed to have sex
___(l) I don't have a girl/boyfriend to have sex with
___(m) I don't know how to get protection
___(n) I would be embarrassed to get protection
___(o) I would be embarrassed to use protection
___(p) I don't have enough money to buy protection
___(q) Using protection might make me sick or mess up my body
___(r) Other reason (what:

27. Did you or your partner use anything or do anything to stop a pregnancy from happening the last time you had intercourse (did it, had sex)?

____Yes ____No

If **YES**,

What kind of protection or method of birth control did you or your partner use? (You can check as many reasons as are true.)

___(a) Birth control pills
___(b) Condoms (rubbers) alone
___(c) Birth control pills with condoms (rubbers)
___(d) Condoms (rubbers) with foam, jelly, cream or inserts
___(e) Foam, jelly, cream or inserts alone
___(f) IUD (loop, coil)
___(g) Diaphragm (pronounced DI-A-FARM)
___(h) Rhythm (have sex only during the safe time of the month)
___(i) Withdrawal (pulling out before sperm comes out)
___(j) Douche (washing out after sex)
___(k) Sponge
___(1) Other (what: _____)

If **NO**,

What are the reasons you and your partner **did not** use protection or do something to stop a pregnancy from happening the last time you had intercourse (did it, had sex)? (You can check as many reasons as are true.)

___(a) I just didn't think I would get pregnant (get my partner pregnant)
___(b) I didn't think I had sex often enough to get pregnant (get my partner pregnant)
___(c) I didn't expect to have sex, it was a surprise
___(d) I/my partner wants to get pregnant
___(e) It is wrong to use protection
___(f) I didn't know how to get protection
___(g) I left it up to my partner to do something
___(h) My partner refused or didn't want us to use protection
___(i) I thought any parents had to be told
___(j) I was afraid my family would find out if I used protection
___(k) I thought it was dangerous to use protection
___(1) I felt uncomfortable going to a strange clinic
___(m) I was afraid to be examined
___(n) I just didn't get around to it
___(o) The protection I (my partner) used before gave us problems
___(p) I was embarrassed to get protection
___(q) I was embarrassed to use protection
___(r) Other (what: _____)

28. Have you ever had VD or a sexually transmitted disease?

____Yes ____ No ____not sure

If YES (Check as many reasons as are true.)

(1) Gonorrhea (clap)
(2) Herpes
(3) Syphilis
(4) Chlamydia (NG)
(5) Trichomoniasis (trick)
(6) Yeast infection
(7) Other types Names:_____)
(8) I don't know the names

MALES ONLY:

29. Are any of your girlfriends pregnant by you right now?

____Yes ____No ____Don't know

30. Have other girlfriends become pregnant by you? _____Yes ___No ____don't know
If yes, How many? _____

31. How many children do you have? _____

(CHECK HERE ___IF YOU DO NOT KNOW)

THANK YOU FOR COMPLETING THIS SURVEY

FEMALES ONLY:

29. Are you pregnant right now?

____Yes ___No ____Don't know

30. How many times have you been pregnant? _____ times

31. How many children do you have? _____

THANK YOU FOR COMPLETING THIS SURVEY

Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems

To explore what's going well and what's not, you will want to ask about current status related to various aspects of a student's daily life. To this end, Henry Berman, MD, proposes an approach to interviewing that he calls HEADS (**H**ome, **E**ducation, **A**ctivities, **D**rugs, and **S**exuality). This acronym is meant to guide the interviewer in exploring key facets of a young person's life, especially those that may be a source of trouble.

Borrowing and adding to this framework, the following areas and topics might be explored with respect to current status. *Where problems are identified, past circumstances related to the area and topic can be further discussed to help clarify duration, possible causes, and past or current efforts to deal with them.*

Home & Health?

Place of residence?

Where does the student live and with whom?
Physical conditions and arrangements in the residence?
Family status, relationships, and problems? (separation, loss, conflict, abuse, lack of supervision and care, neglect, victimization, alienation)

Physical health?

Developmental problems?
Somatic complaints?
accident proneness?
Indications of physical or sexual abuse?
Indications of eating problems?
Recent physical injury/trauma?

Emotional health?

Anxieties?
Fears?
Frustration?
Anger?
Frequent and extreme mood swings?
Self-image? (degree of: perceived sense of competence/efficacy; sense of worth; feelings of personal control over daily events; feelings of dependency on others; gender concern; self-acceptance; defensiveness)
Isolation or recent loss?
Hopes and expectations for the future?
If unhappy, is s/he depressed?
If depressed, is s/he suicidal?
psychic trauma?
symptoms of mental illness? (hallucinations, delusions)

Education?

School functioning?
School attended, grade, special placement?
Learning? (level of skills)
Performance? (daily effort and functioning, grades)
Motivation? (interests, attendance)

Relationships at school?
Behavior? (cooperation and responsiveness to demands and limits)
Special relationships with any school staff? (anyone really liked or hated)

Plans for future education and vocation?

Activities?

Types of interests? (music, art, sports, religion, culture, gang membership)

Responsibilities? (caring for siblings, chores, job)

Relationships with peers?
Any close friends?
Separation/loss?
Conflict?
Abuse?
Neglect?
Victimization?
Alienation?

Relationships with other adults?

Involvement with the law?

How individual usually spends time?

Drugs?

Substance use? abuse?

Sexuality?

Active sexually? (informed about pregnancy and STD prevention?)

Considering becoming active sexually?

Is, has been, or currently wants to be pregnant?

You will also want to use the contact to **observe** aspects of the student/family that can shed additional light on these matters. These include

Appearance: dress, grooming, unusual physical characteristics

Behavior: activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

Expressive Speech: fluency, pressure, impediment, volume

Thought Content: fears, worries preoccupations, obsessions, delusions, hallucinations

Thought Process: attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g., planning)

Cognition: orientation, vocabulary, abstraction, intelligence

Mood/Affect: depression, agitation, anxiety, hostility absent or unvarying; irritability

Suicidality/Homicidality: thoughts, behavior, stated intent, risks to self or others

Attitude/Insight/Strengths: adaptive capacity, strengths and assets, cooperation, insight, judgement, motivation for treatment

In assessing possibilities and motivation for addressing problems, you will want to explore

- desirable and desired, long-terms outcomes
- barriers that may interfere with reaching such outcomes
- immediate needs and objectives for intervention.

And you will want to clarify the student's, parents', and school's role in the process, and any other assistance that is needed, feasible, and desired.

Parent/Guardian Questionnaire

It will help us to discuss matters if you will take some time to respond to the following items. You can do this on your own or we can do it together.

Our policy is to treat your responses as confidential, for use only by those professionals working to help your youngster. Exceptions to confidentiality, of course, must be made in cases where a child has been abused or is at a serious risk of harming self or others.

Student's Name _____ Date _____

Birthdate _____ Grade _____

Your Name _____ Relationship to student _____

Who does the student live with (check all that apply)

____ mother ____ father ____ step mother ____ step father

____ grandmother ____ grandfather ____ other relative (specify)_____

____ foster family ____ Other (specify) _____

Is the student adopted? ___Yes ____No

School Situation

What are your concern's about the student's schooling?

Home Situation

When was the last time you moved? _____

How often have you moved in the last 3 years? _____

Have any of the following occurred?

	Yes	No	When?
parents separated or divorced	___	___	_____
a death or other major loss	___	___	_____

other major events that may have upset the student

Specify *Date*

What does the student do at home that concerns you?

What current or past events or problems at home do you think may have caused the student to act in ways that concern you?

When the student does something wrong, how is s/he disciplined?

When not at school, what types of things does s/he usually do? How does she spend her time?

What are her/his special interests?

What, if any, are her/his chores and responsibilities?

Health Situation

Has the student ever been hospitalized? ____Yes ____No
Specify problem *Dates*

Student's **major** current or past **physical health** problems (if any)
Specify problem *Dates*

Student's current or past **mental health** problems (if any)
Specify problem *Dates*

What medications does the student take?

Has the student ever had a special

educational exam? ___Yes ____No

psychological exam? ___Yes ____No

neurological exam? ___Yes ____No

Has the student ever experienced a major physical injury and trauma? ____Yes ____No
Specify *Dates*

Has the student ever experienced a major psychological trauma? ____Yes ____No
Specify *Dates*

Many of the following will not apply to your child. We ask them of everyone so that we will not miss something of importance.

Does the student have a job? ___Yes ____No
If so, what is it and how m any hours does s/he work?

Student's current or past problems with drugs, alcohol, or other substances:
Specify problem *Dates*

Student's current or past involvement with gangs:
Specify problem *Dates*

Student's current or past problems with the law:
Specify problem *Dates*

Has there ever been a report made that the student was abused? ____Yes ____No

Some older students are active sexually:

Is this the case with your child? ____Yes ____No

If not, do you think s/he may become active soon? ____Yes ____No

Does the student have a good understanding about pregnancy and disease prevention? ____Yes ____No

Has s/he been involved with a pregnancy? ____Yes ____No

Finally, what are some specific matters you want to discuss?

Child/Youth Community Functioning Evaluation

In each box designate: Resource = R, Strength = S, Need = N, and Not applicable = X.
For special problems, circle applicable response.
*One of these areas must indicate Need (n) to demonstrate Service Necessity.

SUPPORT

1. Basic Support
__a. food
__b. clothing
__*c. shelter: home, foster home, residential placement, semi-independent living, independent living
__d. access to transportation

2. Psychosocial Support
__a. supportive caretaker relationship with child
__b. caretaker involved with support or self-help group (as appropriate)
__c. caretaker involvement in counseling
__d. reunification counseling referral
__e. respite care
__f. client linkage w/special or other support group
__*g. Required to maintain current level of functioning
__*h. Required to obtain psychiatric treatment/care
__i. Other _____

3. Financial Resources
__no need
__a. caretaker employment
__b. AFDC, SSI, SSA
__c. Medi-Cal, Medicare, insurance
__d. other

4. Linguistic/Cultural
__no need
__a. parent or child needs interpreter
__b. ESL class (parent)

HEALTH

1. Physical Health
__a. yearly physical exam
date of last exam _____
__b. yearly dental exam
date of last exam _____
__c. compliance with prescribed meds
__d. required immunizations
__e. physical therapy
__f. nutrition
__g. other _____

2. Physical/Developmental Disabilities
__no need
__a. ambulatory support
__b. visual support: glasses
__c. auditory support: hearing aids, special phone
__d. speech evaluation/therapy
__e. Regional Center
__f. other _____

3. Protective Services
__no need
__a. protection from abuse
__b. protection from neglect
__c. protection from self
__d. conservatorship

COMMUNITY/SCHOOL

1. Advocacy Needs
__a. school: Special Education services
__b. assessment: AB3632 or SB370
__c. legal and civil rights
__d. coordination of services between other human service agencies
__e. assistance in obtaining needed services
__f. other _____

2. School/Vocational
__no need
__a. school functioning
__b. school registration
__c. job training (age appropriate)
__d. job placement
__e. transitional/supported employment
__f. sheltered workshop
__g. occupational therapy (SCROC)
__h. social/recreational involvement skills (age appropriate)
__i. Other _____

Special Problems
__a. potential for violence
__b. suicidal
__c. substance abuse
__d. gangs
__e. none of the above
__f. other _____

Describe community functioning impairment: _____
_____
_____
_____

_____ _____
Signature & Discipline Date

III. General Screening Tools

B. Research based screening instruments

- The reliability and validity of a screening Questionnaire for 13 DSM-IV Axis I disorders in psychiatric outpatients.
- The DISC Predictive Scales (DPS): Efficiently Screening for Diagnosis
- Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample
- Improving screening for mental disorders in the primary care by combining the GHQ-12 and SCL-90-R subscales
- A self-report scale to help make psychiatric diagnoses: the Psychiatric Diagnostic Screening Questionnaire
- False Positive Results: A Challenge for Psychiatric Screening in Primary Care
- False positives, false negatives, and the validity of the diagnosis of major depression in primary care.
- Diagnostic errors of primary care screens for depression and panic disorder.

The reliability and validity of a screening Questionnaire for 13 DSM-IV Axis I disorders (the Psychiatric Diagnostic Screening Questionnaire) in psychiatric outpatients.

Zimmerman M et al.

Journal of Clinical Psychiatry 1999 Oct;60(10):677-83

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10549684&dopt=Abstract

Excerpt:

"BACKGROUND: The purpose of this study was to examine the reliability and validity of a new multidimensional screening instrument for 13 DSM-IV Axis I disorders." " CONCLUSION: The PDSQ is a reliable and valid measure of multiple DSM-IV disorders that is brief enough to be incorporated into routine clinical outpatient practice without disruption, yet lengthy enough to be a psychometrically sound instrument."

The DISC Predictive Scales (DPS): Efficiently Screening for Diagnoses

Christopher P. Lucas, M.D. et al.

Journal of American Academy of Child and Adolescent Psychiatry, 40:4, April 2001

http://cjb.sagepub.com/cgi/content/refs/34/6/830

Excerpt:

"Conclusions: The DPS can accurately determine subjects who can safely be spared further diagnostic inquiry in any diagnostic area. This has the potential to speed up structured diagnostic interviewing considerably. The full DPS can be used to screen accurately for cases of specific DSM-III-R disorders. J. Am. Acad. Child Adolesc. Psychiatry, 2001, 440(4): 000-000." "An alternative strategy to save valuable interviewer time and reduce subject burden has been adopted in a number of interviews." "Bringing highly predictive questions to the front of an interview or a diagnostic section has been proposed to increase reporting (Kessler et al., 1994) or speed up the course of an interview (Kaufman et al., 1997)." "By developing the DPS and focusing on only those items found to be significant predictors of disorder, it is possible to reduce the numbers of stem questions from 206 (DISC symptom scales using all possible stems) to 76 for both Parent DPS and Youth DPS." "Using simply the gate items, one can accurately determine which subjects do not have a particular diagnosis". "With a total mean administration time of less than 10 minutes, the DPS are potentially a set of very cost-effective diagnostic tools."

Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample

Robert Goodman, PhD et al.

The British Journal of Psychiatry (2000) 177:534-539,2000

http://bjp.rcpsych.org/cgi/content/full/177/6/534

Excerpt:

“Community screening programs based on multi-informant SDQs could potentially increase the detection of child psychiatric disorders, thereby improving access to effective treatments." "This study examines how well the SDQ can predict child psychiatric disorders in a large British community sample." "The SDQ is a brief questionnaire that can be administered to the parents and teachers of 4- to 16-year-olds and to 11- to 16-year-olds themselves (Goodman,1997, 1999; Goodman et al, 1998)." "Besides covering common areas of emotional and behavioral difficulties, it also enquires whether the informant thinks that the child has a problem in these areas and, if so, asks about resultant distress and social impairment." "The findings of this study suggest that the SDQ could potentially be considered for a community-wide screening program to improve the detection and treatment of child mental health problems. At present, only a minority of children with psychiatric disorders reach specialist mental health services —— around 20% or less according to many studies Offord et al, 1987; Burns et al, 1995; Leaf et al, 1996; Meltzer et al, 2000)."

Improving screening for mental disorders in the primary care by combining the GHQ-12 and SCL-90-R subscales.

Schmitz N et al.

Compr Psychiatry 2001 Mar-Apr;42(2):166-73

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11244154&dopt=Abstract

Excerpt:

“The 12-item General Health Questionnaire (GHQ-12) is a widely used screening questionnaire for common mental disorders. Unfortunately, the GHQ-12 generates many false presumptive positives and forces the employer to expend resources on confirmatory testing. Therefore, the aim of the present report was to investigate a two-stage questionnaire screening design in a primary care setting.” “The SCL-90-R subscales Depression, Obsessive-Compulsive, and Somatization were identified as factors associated with the GHQ-12 classification. Therefore, a significant improvement in screening performance of the GHQ-12 is obtained by combination of the test results. The approach may reduce artifact due to high scoring tendencies not associated with psychological disorder. Copyright 2001 by W.B. Saunders Company”

A self-report scale to help make psychiatric diagnoses: the Psychiatric Diagnostic Screening Questionnaire

Zimmerman et al.

Arch Gen Psychiatry 2001 Aug;58(8):787-94

http://archpsyc.ama-assn.org/cgi/content/full/58/8/787

Excerpt:

"BACKGROUND: The Psychiatric Diagnostic Screening Questionnaire (PDSQ) is a brief, psychometrically strong, self-report scale designed to screen for the most common DSM-IV Axis I disorders encountered in outpatient mental health settings. In the present report, we describe the diagnostic performance (sensitivity, specificity, and positive and negative predictive values) of the PDSQ in an outpatient setting." "CONCLUSIONS: The PDSQ is a diagnostic aid designed to be used in clinical practice to facilitate the efficiency of conducting initial diagnostic evaluations. From a clinical perspective, it is most important that a diagnostic aid have good sensitivity, so that most cases are detected, and high negative predictive value, so that most noncases on the measure are indeed noncases. Our results indicate that most of the PDSQ subscales were able to achieve this goal."

False Positive Results: A Challenge for Psychiatric Screening in Primary Care

A. C. Leon, Ph.D., L. Portera, M.S., M. Olfson, M.D., M.P.H. M.M. Weissman, Ph.D., R.G. Kathol, M.D., Leslie Farber, Ph.D., D.V. Sheehan, M.D., M.B.A., and A. M. Pleil, Ph.D.

American Journal of Psychiatry 154:10, October 1997.

http://ajp.psychiatryonline.org/cgi/content/abstract/154/10/1462

Excerpt:

... Conclusions: Although the positive predictive values for specific mental disorders are in line with those of other medical screens, false positive results are not uncommon. This may be due in part to the sensitivity of brief screening instruments to nonspecific symptoms.

The recent expansion of prepaid medical care has heightened interest in screening procedures that promise rapid identification of patients who need more detailed clinical assessments. A fundamental objective of a medical screen is to detect a substantial proportion of cases without incorrectly labeling a disproportionate number of noncases.

Thus, it appears that many false positive screen results stem from other psychiatric morbidity or from subsyndromal mental disorders.

Our data indicate that many of the patients with false positive results may have needed increased clinical attention; but for other conditions.

False positives, false negatives, and the validity of the diagnosis of major depression in primary care.

Klinkman MS et al.
Arch Fam Med 1998 Sep-Oct;7(5):451-61
http://archfami.ama-assn.org/cgi/content/full/7/5/451

Excerpt:

OBJECTIVE: To explore the issues of diagnostic specificity and psychiatric "caseness" (i.e., whether a patient meets the conditions to qualify as a "case" of a disease or syndrome) for major depression in the primary care setting.

CONCLUSIONS: Misidentification of depression in primary care may be in part an artifact of the use of the psychiatric model of caseness in the primary care setting. Our results are most consistent with a chronic disease-based model of depressive disorder, in which patients classified as false positive and false negative occupy a clinical middle ground between clearly depressed and clearly nondepressed patients. Family physicians appear to respond to meaningful clinical cues in assigning the diagnosis of depression to these distressed and impaired patients.

Diagnostic errors of primary care screens for depression and panic disorder.

Leon AC
Int J Psychiatry Med 1999;29(1):1-11
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10376229&dopt=Abstract

Excerpt:

OBJECTIVE: As the health care reimbursement system has changed, brief screens for detecting mental disorders in primary care have been developed. These efforts have faced the formidable task of identifying patients with mental disorders, while at the same time minimizing the number of misclassified cases. Here we consider the balance between sensitivity and positive predictive value. Primary care patients with false positive and false negative results on screens for depression and panic disorder are compared with regard to comorbidity and functional impairment.

CONCLUSIONS: A substantial number of patients with either false positive or false negative screen results met diagnostic criteria for other mental disorders. Given the nominal burden of follow-up assessments for patients with positive screens, these data suggest that erring on the side of sensitivity may have been preferable when algorithms for these screens were selected.

IV. The Screening Process

In this section you will find...

1. **Request for Assistance**

2. **Exploring the Problem with the Student/Family**

   This is a general guide designed to provide an overview of the types of information you might pursue to learn a bit more about a student's problem.

3. A Few Guidelines for Interviewing

   Ten points to keep in mind as you set out to do an interview.

4. A Basic Interview Format

   A generic set of steps to follow in conducting an interview with a student identified as a problem at school.

5. **Record of Respo92nse to Request for Assistance in Addressing Concerns about a Student/Family**

6. **Record of Contact with Referrer**

*For a fuller discussion of assessment related to psychosocial and mental health concerns in schools, you may want to obtain a copy of the introductory packet on *Assessing to Address Barriers to Student Learning* -- available from the Center for Mental Health in Schools at UCLA.

Request for Assistance in Addressing Concerns about a Student/Family

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. Use this form if a student is having a *significant* learning problem, a *major* behavior problem, or seems *extremely* disturbed or disabled.

Student's Name _____ Date:_____

To: _____ Title: _____

From: _____ Title: _____

Apparent problem (check all that apply):

___ physical health problem (specify) _____

___ difficulty in making a transition
( ) newcomer having trouble with school adjustment ( ) trouble adjusting to new program

___ social problems
( ) aggressive ( ) shy ( ) overactive ( ) other _____

___achievement problems
( ) poor grades ( ) poor skills ( ) low motivation ( ) other _____

___ major psychosocial or mental health concern

( ) drug/alcoh. abuse	( ) pregnancy prevention/support	( ) self esteem
( ) depression/suicide	( ) eating problems (anorexia, bulim.)	( ) relationship problems
( ) grief	( ) physical/sexual abuse	( ) anxiety/phobia
( ) dropout prevention	( ) neglect	( ) disabilities
( ) gang involvement	( ) reactions to chronic illness	

Other specific concerns

Current school functioning and desire for assistance

Overall academic performance
( ) above grade level ( ) at grade level ( ) slightly below grade level ( ) well below grade level

Absent from school
( ) less than once/month ( ) once/month ( ) 2-3 times/ month ( ) 4 or more times/month

Has the student/family asked for:

information about service	Y	N
an appointment to initiate help	Y	N
someone to contact them to offer help	Y	N

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).

Exploring the Problem with the Student/Family

The following general guide is meant to provide an overview of the types of information you might pursue in order to learn a bit more about a student's problem.

In general, you will want to explore

What's *going well*?

What's *not going so well* and *how pervasive and serious* are the problems?

What seems to be the *causes* of the problems?

What's *already been tried* to correct the problems?

What *should be done* to make things better?

(What does the student/family think should be done? Do the causes shed any light on what needs to be done? Does what's already been tried shed any light? What are the student/family willing to try? How much do they truly think that things can be made better?)

The following pages outline specific areas and topics that might be explored in understanding the nature and scope of the problem(s). This is followed by a few examples of the many tools that are available to structure interviews.

Obviously, in a brief session, only a limited amount of information can be gathered. Choices must be made based upon your understanding of the problem(s) identified and the population you serve.

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually will need both a signed informed consent from a parent or legal guardian. And, even if it is required, it is good practice to get the student's assent as well.*

*Your school may want to obtain a copy of the introductory packet on *Confidentiality and Informed Consent* -- available from the Center for Mental Health in Schools at UCLA.

Explorar el problema con el Estudiante/Familia

(una descripción del tipos de información que usted puede averiguar para aprender un poco más sobre el problema del estudiante)

En general, usted deseará explorar

¿Qué va bien?

¿Qué no va tan bien y que tan penetrante y serios son los problemas?

¿Qué parece ser las causas de los problemas?

¿Qué se ha intentado para corregir los problemas?

¿Qué se debe hacer para hacer las cosas mejores?

(¿Qué la familia del estudiante piensa que se debe hacer? ¿Las causas dan ha conercer alguna luz sobre qué se necesita hacer? Lo que ya se intento dan ha conocer alguna luz? Qué quiere el estudiante y la familia intentar? ¿Qué tanto ellos creen que las cosas se pueden hacer mejores?

Obviamente, en una sesión breve, solamente una cantidad de información limitada puede ser recopilada. Las opciones se deben hacer basado en la comprensión del problema(s) identificado y de la población que usted sirve.

Las áreas y los asuntos específicos que pudieron ser explorados en entender la naturaleza y las causas del problema(s) y ejemplos de las muchas herramientas que están disponibles para estructurar entrevistas pueden ser encontrados en nuestro paquete de la ayuda del recurso llamado *Screening/Assessing Students: Indicators and Tool*. Esto se puede descargar de nuestro Web site en el siguiente *url:*
http://smhp.psych.ucla.edu/pdfdocs/assessment/assessment.pdf

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually will need both a signed informed consent from a parent or legal guardian. And, even if it is required, it is good practice to get the student's assent as well.*

** Your school may want to obtain a copy of the Resource Aid Packet on Screening/Assessing Students: Indicators and Tools.-- available from the Center for Mental Health in Schools at UCLA.*

A Few Guidelines for Interviewing

(1) Use a private space.

(2) Start out positive and always convey a sense of respect. (Ask about the good things that may be going on in the student's life, and express an appreciation for these.)

(3) Start slowly, use plain language, and invite, don't demand or be too directive and controlling. In this regard, the initial emphasis is more on conversation and less on questioning.

(4) Indicate clear guidelines about confidentiality (Is it safe for the individual to say what's on his/her mind?)

(5) Convey that you care (empathy, warmth, nurturance, acceptance, validation of feelings, genuine regard).

(6) Be genuine in your demeanor and conversation.

(7) With students who are reluctant to talk, start with relatively nonverbal activity, such as drawing and then making up a story or responding to survey questions that involve choosing from two or more read responses. With younger students, you can also try some "projective questions," such as "If you had three wishes...", "If you could be any animal...", "If you could be any age ...", "If you were to go on a trip, who would you want to go with you?" and so forth. There are also published games designed to elicit relevant concerns from children.

(8) In exploring concerns, start with nonsensitive topics.

(9) Listen actively (and with interest) and at first go where the individual is leading you.

(10) To encourage more information, use open-ended questions, such as "What was happening when she got angry at you?" and indirect leading statements, such as "Please tell me more about..." or direct leading statements such as "You said that you were angry at them?" (Minimize use of questions that begin with "Why;" they often sound confrontative or blaming?)

A Basic Interview Format

Start out on a positive note

- Ask about the good things that may be going on in the student's life (e.g., Anything going on at school that s/he likes? Interests and activities outside of school?)

Slowly transition to concerns

- Ask about any current concerns (e.g., troubles at school? at home? in the neighborhood? with friends? how long have these problems been evident?)
- Explore what the student/family think may be causing the problem(s).
- Explore what the student/family think should be done to make things better.
- Explore what the student/family might be willing to try in order to make things better.

Expand exploration to clarify current status, problems and their causes related to

- home situation and family relationships
- physical health status
- emotional health status
- school functioning, attitudes, and relationships
- activities and relationships away from school

If appropriate and feasible explore sensitive topics

- involvement with gangs and the law
- substance use
- sexuality

Add any favorite items you think are helpful.

Move on to explore

- What's already been tried to correct the problems
- What the student/family think should be done to make things better and are willing to try

Finally

- Clarify whether they truly think that things can be made better.

Record of Response to Request for Assistance in Addressing Concerns about a Student/Family

Name of student _____

Name of staff member who made contact with student _____

Date of contact with student _____.

The following are the results of the contact:

Follow-up needed? Yes ___ No ___

_____

If follow-up:

Carried out by _____ on _____
(name of staff member)

Results of follow-up:

Was permission given to share information with referrer? Yes ___ No ___

If yes, note the date when the information was shared. _____

If no, note date that the referrer was informed that her/his request was attended to._____

Record of Contact with Referrer

Date: _____

To:

From:

Thank you for your request for assistance for _____.
(name)

A contact was made on _____.

Comments:

V. Resources

The following pages are
from our website
and can be accessed at:

http://smhp.psych.ucla.edu

Quick Find On-line Clearinghouse

http://smhp.psych.ucla.edu/qf/p1405_01.htm

TOPIC: Assessment and Screening

The following reflects our most recent response for technical assistance related to this topic. This list represents a sample of information to get you started and is not meant to be exhaustive.
(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Center Developed Documents, Resources and Tools

Policy & Program Reports & Briefs

- **Screening Mental Health Problems in Schools**

Center Brief Report

- **Mental Health of Children and Youth and the Role of Public Health Professionals**
- **Mental Health of Children and youth: The Important Role of Primary Care Health Professionals**

Continuing Education Module

- **Addressing Barriers to Learning: New Directions for Mental Health in Schools (Continuing Education Module)**

Introductory Packets

- **Assessing to Address Barriers to Learning (Introductory Packet)**
- **Cultural Concerns in Addressing Barriers to Learning (Introductory Packet)**
- **Evaluation and Accountability (Introductory Packet)**
- **Least Intervention Needed: Toward Appropriate Inclusion of Students with Special Needs (Introductory Packet)**

Newsletters

- Labeling Troubled Youth: The Name Game (Newsletter, Summer, '96)
- Response to Intervention (Newsletter, Fall, 2006)

Quick Find

- Substance Abuse
- Needs and Assests Assesesment and Mapping

Quick Training Aid

- Assessment & Screening (Quick Training Aid)

Resource Aid Packet

- Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What It Needs
- Screening/Assessing Students: Indicators and Tools

Technical Aid Packet

- School-Based Client Consultation, Referral, and Management of Care

Net Exchange Responses

- Assessment Instruments

Other Relevant Documents, Resources, and Tools on the Internet

- Assessing the Mental Health of Adolescents
- Assessment: High Stakes/Competency
- Assessment of Suicidal Behaviors and Risk Among Children and Adolescents
- Authentic Teaching and Assessment: Policy and Practice. Examples from the Field. Annual National Center for Restructuring Education, Schools, and Teaching Affiliates' Meeting
- Bright Futures in Practice: Mental Health Publication
- Building Tests To Support Instruction and Accountability: A Guide for Policymakers
- "Development of the Yale Children's Global Stress Index (YCGSI) and its application in children and adolescents with Tourette's Syndrome and obsessive-compulsive disorder"
- "Developmental assessment of competence from early childhood to middle adolescence"
- "Diagnostic Errors of Primary Care Screens for Depression and Panic Disorder"

- The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- "Evidence-Based Assessment of Child and Adolescent Disorders: Issues and Challenges"
- ETS Test Collection Database
- "False Positives, False Negatives, and the Validity of the Diagnosis of Major Depression in Primary Care"
- Guidelines for Student Assistance Program Implementation
- "High School Exit Exams: Pros and Cons"
- "High Stakes: Testing for Tracking, Promotion, and Graduation"
- The Impact of High-Stakes Tests on Student Academic Performance: An Analysis of NAEP Results in States With High-Stakes Tests and ACT, SAT, and AP Test Results in States With High School Graduation Exams
- "Mental Health Assessments in Juvenile Justice: Report on the Consensus Conference"
- Mental Health Assessments "Evidence-Based Assessment of Child and Adolescent Disorders: Issues and Challenges"
- National Center for Health Statistics Survey Measures Catalog: Child and Adolescent Mental Health
- No Child Left Behind Act: Most Students with Disabilities Participated in Statewide Assessments, but Inclusion Options Could Be Improved
- No Child Left Behind: Implications for Special Education Students and Students with Limited English Proficiency
- Performance-Based Assessment
- Quality Assessment & Improvement Resource Packet (CSMHA- Univ of Maryland)
- Should K-12 Students Be Required to Complete State-Sanctioned Minimum Skills Tests?
- "State High School Exit Exams: Put to the Test" (Center on Education Policy)
- Student performance standards and aligned assessments
- The Debate over National Testing (2001)- ERIC Digest
- Things to Watch Out for When Assessing Suicide Risk (San Francisco Suicide Prevention Community Crisis Line)

Screening Resources

- Child Find Screenings: A Guide for Parents (taken from Boulder Valley PSD, CO)
- "Detecting Suicide Risk in a Pediatric Emergency Department: Development of a Brief Screening Tool"
- An Initial Line of Inquiry Protocol
- Insight on the News: Should schools use behavioral screening to find 'at risk' children?
- Making Early Developmental Screenings Routine
- "Mental Health Screening Instruments for Use in Juvenile Justice"
- Massachusetts Youth Screening Instrument for Mental Health Needs of Juvenile Justice

Youth
- Pediatric Screening & Intervention Project (Center for Disease Control and Prevention)
- President's New Freedom Commission on Mental Health: Recommendations for Screening and Treating Children and Subsequent FY2005 Appropriations
- "Screening Aimed at Preventing Youth Suicide"
- Screening, assessment and treatment planning for persons with co-occurring disorders.
- Screening and Assessing Adolescents for Substance Use Disorders Treatment Improvement Protocol (TIP) Series 31 (SAMHSA)
- "Screening and Assessing Mental Health and Substance Use Disorders among Youth in the Juvenile Justice System"
- "Screening for Depression Across the Lifespan: a Review of Measures for Use in Primary Care Settings"
- Screening for Depression: Recommendations and Rationale (US Preventive Services Task Force)
- Screening for Suicide Risk: Recommendations and Rationale (US Preventive Services Task Force)
- State Trends: Legislation Prohibits Mental Health Screening for Children (NMHA)
- "Using the Suicide Risk Screen to Identify Suicidal Adolescents Among Potential High School Dropouts"
- Where to Turn: Confusion in Medicaid Policies on Screening Children for Mental Health Needs
- Youth Risk Behavior Survey (State of Montana Office of Public Instruction)

Clearinghouse Archived Materials

- Assessment for Children with Emotional or Behavioral Disorders and Their Families.
- Assessment of Students' Mental Health.
- Functional Behavioral Assessment For Students With Individualized Educational Programs
- Intake and Assessment
- Outcome Measures: Evaluating the Outcome of Children's Mental Health Services: A Guide for the Use of Available Child and Family Outcome Measures
- Problem Checklist-Adolescent Report
- Screening for Mental Health Problems in Children
- Student Rating Scale
- Talking Heads - Interviewing Adolescents
- Teen Health Risk Survey
- Use of Structured Assessment Tools in Clinical Practice

Related Agencies and Websites

- **Assessment and Evaluation**
- **Center for Effective Collaboration and Practice (CECP)/ American Institute for Research**
- **Center for Promotion of Mental Health and Juvenile Justice (V-DISC)**
- **Evaluation Assistance Center East (EAC East)**
- **The Georgetown University Center for Child and Human Development**
- **Institute for Child Health Policy (University of Florida)**
- **National Association of School Psychologists (NASP)**
- **National Center for Research on Evaluation, Standards, and Student Testing**
- **National Youth Screening Assistance Project - MAYSI-2**
- **School Psychology Resources**
- **Screening for Mental Health, Inc.**
- **The Evaluation Center**

Relevant Publications that Can Be Obtained through Libraries

- ***Assessment and Culture: Psychological Tests with Minority Populations.*** **. By Gopaul-McNicol & Armour-Thomas. (2002). San Diego: Academic Press.**
- ***The Child Behavior Profile: Boys aged 12-16 and girls aged 6-11 and 12-16.*** **By Achenbah, T., & Edelbrock, C. (1979).** ***Journal of Consulting & Clinical Psychology, 47(2),*** **pp. 223-233.**
- ***Cross Assessment of a School-Based Mental Health Screening and Treatment Program in New York City.*** **By P.Chatterji, et al. (2004).** ***Mental Health Services Research, 6,*** **pp. 155-166.**
- ***Diagnostic errors of primary care screens for depression and panic disorder.*** **By Leon AC, Portera L, Olfson M, Kathol R, Farber L, Lowell KN, & Sheenan DV. (1999).** ***International Journal of Psychiatry in Medicine, 29(1),,*** **pp. 1-11.**
- ***False Positive Results: a Challenge for Psychiatric Screening in Primary Care.*** **By Leon AC, Portera L, Olfson M, Weissman MM, Kathol RG, Farber L, Sheenan DV, & Pleil AM. (1997).** ***American Journal of Psychiatry, 154(10),*** **pp. 1462-4.**
- ***Improving Screening for Mental Disorders in the Primary Care by Combining the GHQ-12 and SCL-90-R Subscales.*** **By Schmitz, Kruse & Tress. (2001).** ***Comprehensive Psychiatry, 42 (2),*** **pp. 166-73.**
- ***Mental health screening in schools.*** **by Weist, M.D., Rubin, M., Moore, E., Adelsheim, S., Wrobel, G.** ***J Sch Health.*** **2007; 77: 53-58.**
- ***Moral Competence and Character Strength Among Adolescents: The Development and Validation of the Values in Action Inventory of Strengths for Youth.*** **by Park, N. & Peterson, C. (2006). Journal of Adolescence.**
- ***Positive Psychological Assessment: A Handbook of Models and Measures.*** **by Lopez, S.J., Snyder, C.R. (2004). American Psychological Association. Washington, DC.**
- **Practitioner's guide to empirically based measures of school behavior. (2003). Edited by M. Kelley, G. H. Noell, and D. Reitman. New York: Kluwer Academic/Plenum Pub.**
- ***The Reliability and Validity of a Screening Questionnaire for 13 DSM-IV Axis I disorders (the***

Psychiatric Diagnostic Screening Questionnaire) in Psychiatric Outpatients. **By Zimmerman M, & Mattia JL. (1999).** ***Journal of Clinical Psychiatry, 60(10),,*** **pp. 677-683.**

- ***A Self-Report Scale to Help Make Psychiatric Diagnoses: the Psychiatric Diagnostic Screening Questionnaire.*** **By Zimmerman & Mattia. (2001).** ***Archives of General Psychiatry, 58(8),*** **pp. 787-94.**
- ***Short Screening Scale for DSM-IV Posttraumatic Stress Disorder.*** **By Breslau N, Peterson EL, Kessler RC, & Schultz LR. (1999).** ***The American Journal of Psychiatry, 156(6),*** **pp. 908-11.**
- ***Should We Screen for Depression? Caveats and Potential Pitfalls.*** **By J.C.Coyne, et al. (2000).** ***Applied & Preventive Psychology, 9,*** **pp. 101-121.**
- ***Social and Personality Assessment of School-aged Children: Developing Interventions for Educational and Clinical Use.*** **Edited by J.F. Carlson & B.B. Waterman. (2002). Boston: Allyn and Bacon.**
- ***Special Section: Developing Guidelines for the Evidence-Based Assessment of Child and Adolescent Disorders.*** **Mash, E.J. & Hunsley, J. (Eds.). (2005).** ***Journal of Clinical Child and Adolescent Psychology, 34(3).***
- ***Using the Strengths and Difficulties Questionnaire (SDQ) to Screen for Child Psychiatric Disorders in a Community Sample.*** **By Goodman R, Ford T, Simmons H, Gatward R, & Meltzer H. (2000).** ***The British Journal of Psychiatry, 177(6),*** **pp. 534-539.**
- ***Youth Suicide Risk and Prevention Interventions: A Review of the Past 10 Years.*** **(2003).** ***Journal of the American Academy of Child & Adolescent Psychiatry, 42(4),*** **pp. 386-405.**

We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.

If you haven't done so, you may want to contact our sister center, the Center for School Mental Health at the University of Maryland at Baltimore.

If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.

Appendix

A. Excerpt from:
Nursing Assessment of School Age Youth: A Series of Self Study Modules

B. Screening Mental Health Problem in School

C. Response to Intervention

Nursing Assessment of School Age Youth:
A Series of Self Study Modules ©

Nursing Assessment of School Age Youth (NASAY) is a series of self-study continuing education offerings for nurses that is designed to augment assessment skills of nurses who provide care for school-age children and youth in community settings. The curriculum was designed for school nurses but the principles and skills can be used by public health nurses, home health care nurses, and professional nurses, who practice in a variety of community settings. Each module in the series includes a manual, videotape, and tests for self-assessment of learning, as well as information for obtaining continuing education credit for registered nurse licensure.

Nursing Assessment of School Age Youth:
Psychosocial Screening

Written by Howard S. Adelman, Ph.D. and Linda Taylor, Ph.D.
Co-Directors, Center for Mental Health in Schools
Department of Psychology at the University of California, Los Angeles (UCLA)

The purpose of this module is to enhance the skills of the school nurse in assessing psychosocial and mental health barriers to learning. Increasingly, school nurses find it necessary to do assessments and interventions that were not part of their original professional preparation; this is especially so in the arena of social functioning and mental health.

Instructions
Each section has specific objectives and focusing questions to guide reading and review.

1. Begin by surveying and browsing through the material.
2. Study Section I thoroughly.
3. Utilize the material in boxes to think in greater depth about the information in Section I.
4. Complete test questions for Section I on pages 21-22.
5. Study Section IL
6. Utilize the material in boxes to think in greater depth about the information in Section II.
7. Complete test questions for Section 11 on pages 62-63.

Prerequisites
Module 1, "Nursing Assessment of School Age Youth: Using the Nursing Process," provides the framework for the subsequent modules. Contact hours for subsequent modules will not be awarded until Module 1 has been successfully completed and verified by the NASN office.

Continuing Education Contact Hours for Nurses (4 hours)
Upon satisfactory completion of the module, four (4) hours are available. The National Association of School Nurses is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center, Commission on Accreditation.

After completing the self-study course and post-test, mail the following to NASN, Attention Continuing Education, P.O. Box 1300, Scarborough, ME 04070-1300:

1. Completed application/evaluation form on page 64
2. Post-test on pages 21-22, 62-63 answered with 75% accuracy
3. Check or money order (made payable to NASN) $10.00 Member/ $15.00 Non-Member

Four (4) continuing education contact hours will be awarded upon satisfactory completion. Contact hours for this module *will* be denied without verification of completion of Module 1. Nurses are also encouraged to review a textbook of physical assessment to be assured of the background knowledge needed to complete this module. If the publication is more than three years old, contact NASN to determine if the continuing education offering has been relaced or retired.

For Additional information, contact the National Association of School Nurses
Telephone (207) 883-2117; Fax (207) 883-2683, or e-mail NASN@aol.com

Contents

When it comes to mental health and psychosocial problems, a school nurse doesn't have to look very hard to find them. A school nurse's functions related to dealing with such problems begin with providing *direct services* and *instruction*. Effective pursuit of such functions requires working with others in carrying out services and programs. This encompasses efforts to *coordinate, develop, and provide leadership related to relevant programs, services, resources, and systems*. It also involves connections with community resources.

Because school nurses are "inundated" with students who need assistance for mental health and psychosocial concerns, a key service many find themselves providing is the identification and processing of such students. Major tasks in carrying out this service are

- initial problem identification
- screening/assessment
- client consultation and referral
- triage
- initial case monitoring

Nurses also must be prepared to respond to students' psychological *crises*. With respect to primary prevention and treatment, they often find themselves providing

1. mental health education
2. psychosocial guidance and support (classroom/individual)
3. psychosocial counseling

They also are a valuable resource for ongoing case monitoring.

Initial Problem Identification

Nurses identify many mental health problems when students either come to their office or are in the process of being screened for other health problems. Such problems also come to the nurse's attention during attendance and discipline reviews, assessments for special education placement, and crisis interventions, or as a result of others (staff, parents, students) raising concerns about a given youngster.

In this last respect, part of a nurse's job may be to educate teachers, peers, parents, and others about appropriately identifying and referring students. Of course, some students come seeking help for themselves.

How should you handle all this?

If there are accessible referral resources at the school (e.g., a school psychologist, a counselor, a social worker, a school-based health center with a mental health professional) or in the community, the answer may be to help a student connect with such an individual - assuming it is not something you can handle without making a referral. Of course, when other professionals are not available, or when a student will not follow through, your only choice is to decide whether to do something more yourself.

If you decide to proceed, you will want to assess the problem for purposes of triage and consult with the student and concerned others.*

Connecting a Student with the Right Help

The process of connecting the student with appropriate help can be viewed as encompassing four facets:

1. screening/assessment
2. client consultation and referral
3. triage
4. initial case monitoring.

TEACHER: Yes, Chris, What is it?

CHRIS: I don't want to scare you, but my dad says if I don't get better grades someone is due for a spanking.

Screening to Clarify Need

Most of the time it will not be immediately evident what the sources of a student's problems are or how severe or pervasive they are. As you know, the causes of behavior, learning and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be emotionally based; behavior problems and hyperactivity often arise in reaction to learning difficulties; problems with schooling may be due to problems at home, reactions to traumatic events, substance abuse, and so forth. It is especially hard to know the underlying cause of a problem at school when a student is unmotivated to learn and perform.

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*As a follow-up aid for you and your school, two resource packets are available from the Center for Mental Health in Schools at UCLA. One is entitled Screening/Assessing Students: Indicators and Tools and the other focuses on Substance Abuse. Both include instruments you can use and provide further discussion of wharfs look for in screening. Examples of some tools from these packets are included at the end of this section.

This, then, becomes the focus of initial assessment - which essentially is a screening process. Such screening can be used to clarify and validate the nature, extent, and severity of a problem. It also can determine the student's motivation for working on the problem. If the problem involves significant others, such as family members, this also can be explored to determine the need for and feasibility of parental and family counseling.

Comments on Screening/Assessment and Diagnosis

•When someone raises concerns about a student with you, one of the best tools you can have is a structured referral form for that person to fill out. This encourages the referrer to provide you with some detailed information about the nature and scope of the problem. (An example of such a form is provided at the end of this section.)

•To expand your analysis of the problem, you will want to gather other available information. It is good practice to gather information from several sources, including the student. Useful sources are teachers, administrators, parents, sometimes peers, etc. If feasible and appropriate, a classroom observation and a home visit also may be of use. You will find some helpful tools in the accompanying materials.

•You can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, significant emotional problems (such as appearing depressed and possibly suicidal), or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses.(in this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students - more on this in Part B of this section.)

•In doing all this, you will want to try to clarify the role of environmental factors in contributing to the student's problems.

Remember:

•Students often somaticize stress; and, of course, some behavioral and emotional symptoms stem from physical problems.

•Just because the student is having problems does not mean that the student has a pathological disorder.

Screening: A note of Caution

Formal screening to identify students who have problems or who are “at risk” is accomplished through either individual of group procedures. Most such procedures are *first-level* screens and are expected to overidentify problems; that is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and proscribe remediation and special treatment. Screening data are primarily meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time there is a need to guard against tendencies to see *normal variations* in students’ developments and behavior as problems.

Screens do not allow for definitive statements about a student’s problems and need. At best, most screening procedures provide an indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

It is essential to remember that many factors that are symptoms of problems are also common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can be inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other frequently seen individual differences.

•The student may just be a bit immature or exhibit behavior that is fairly common at a particular development stage. Moreover, age, severity, pervasiveness, and chronicity are important considerations in diagnosis of mental health and psychosocial problems. Below are a few examples to underscore these points.

•The source of the problem maybe stressors in the classroom, home, and/or neighborhood. (Has the student's environment been seriously looked at as the possible culprit?)

•At this stage, assessment is really a screening process such as you do when you use an eye chart to screen for potential vision problems. If the screening suggests the need, the next step is referral to someone who can do detailed assessment to determine whether the problem is diagnosable for special education and, perhaps, as a mental disorder. To be of value, such an assessment should lead to some form of prescribed treatment, either at the school or in the community. In many cases, ongoing support will be indicated, and often the school can play a meaningful role in this regard.

Age	***Common, Transient Problem***	***Low Frequency, Serious Disorder***
0-3	Concern about monsters under bed`	Sleep Behavior Disorder
3-5	Anxious about separating from parent	Separation Anxiety Disorder (crying & clining)
5-8	Shy and anxious with peers (sometimes with somatic complaints)	Reactive Attachment Disorder
	Disobedient, temper outbursts	Conduct Disorder Oppositional Defiant Disorder
	Very active and doesn't follow directions	Attention Deficit-Hyperactivity Disorder
	Has trouble learning at school	Learning Disabilities
8-12	Low self-esteem	Depression
12-15	Defiant/reactive	Oppositional Defiant Disorder
	Worries a lot	Depression
15-18	Experimental substance use	Substance abuse

Screening Mental Health Problems in Schools

Long-standing policy controversies have heated up as a result of increasing proposals for using schools to screen for mental health problems (e.g., depression screening).

This brief highlights the following issues:

- How appropriate is large-scale screening for mental health problems?
- Will the costs of large-scale mental health screening programs outweigh the benefits?
- Are schools an appropriate venue for large-scale screening of mental health problems?

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA,

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email: smhp@ucla.edu **website: http://smhp.psych.ucla.edu**

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U45 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

Issue: *Screening Mental Health Problems in Schools*

New federal initiatives seek to increase the scope of mental health screening. The emphasis is on identification of those with mental health problems and those at risk for such problems. A major focus is on depression and suicidality. The intent is to find and treat as many problems as possible before they become severe and to reduce the numbers diagnosed with a mental illness. For a variety of reasons, schools are a prominently mentioned venue for large-scale screening programs.

Few argue against the *intent* of efforts to find, treat, and prevent. Issues arise related to the appropriateness of large-scale screening for mental health problems, whether the costs of such large-scale screening outweigh the benefits, and about whether schools are an appropriate venue for such programs. Embedded in these issues are arguments about rights to privacy and informed consent, how good first-level mental health screens are, how likely good follow-up assessments will be used to identify errors, how available treatment will be for most who are identified, how negative the consequences will be with respect to stigmatization and self-fulfilling prophecies, and the role of schools related to public health concerns.

Examples of what one hears:

Screening is essential to improving how we respond to mental health problems.

Large-scale screening identifies too many kids as having a mental illness who do not.

Schools make it possible to screen a lot of kids quickly and at less cost than community programs.

Once begun, large-scale screening at schools will end up as a mandated requirement for all students.

It is irresponsible, unethical, and immoral not to find and help students who are experiencing mental health problems.

Mental health screening infringes on the rights of families, over-identifies some subgroups in the student population, and results in self-fulfilling prophecies.

Based on the research evidence to date, there is a great deal more research that must be done before policy makers should invest in the enterprise of large-scale screening for suicidality and clinical depression among children and adolescents.

There is not enough available and accessible treatment for most students currently referred for mental health treatment.

Positions:

- Advocates for large-scale MH screening in schools see major benefits to individuals and society of finding many more students with problems in order to treat them before the problems become severe. In citing benefits for screening children and adolescents, the assumption is that those identified will receive effective treatments. Based on this assumption, key benefits claimed are preventing problems from becoming worse and enhancing student success at school, which generates other benefits for students, their families, and their teachers and for the society in terms of future productivity and which reduces costs because there is less need for intensive treatments and special education.

  In citing benefits for using schools as a venue for public health programs, as compared to other community venues, matters of ready access and reduced costs are stressed, as well as the benefits to schools of having students with problems treated.

- Those who oppose large-scale screening raise a host of concerns (i.e., potential costs). For some, there is a fundamental fear that society will mandate such screening and thereby interfere with what should remain a personal family matter and will violate rights to privacy, consent, and parental control. Others are concerned that screening will increase referrals for nonexistent treatment resources and that the dollars budgeted for screening will reduce the dollars allocated for treatment. Still others point to the evidence that available screening methods used in schools produce too many errors (e.g., false positive identifications, inappropriate over-identification of subgroups such as some ethnic groups and boys with externalizing problems and girls with internalizing problems). Relatedly, they argue there will be insufficient follow-up assessment resources to correct for false positive identifications. And, some argue there are significant costs resulting from self-fulfilling prophecies and stigmatization.

  In arguing against using schools, there is the social philosophical argument that mental health is one of those matters that should remain a domain for family, not school, intervention. More pragmatically, it is argued that scarce school time and resources should not be used for matters not directly related to teaching. Others point to the lack of enough competent school personnel to plan, implement, and evaluate large-scale screening.

Examples of documents covering the issues:

(a) Discussions that Explore Both Sides

>>*Screening Aimed at Preventing Youth Suicide* (2005)
by Ellie Ashford for the National School Board Association's School Board News
http://www.nsba.org/site/print.asp?TRACKID=&VID=55&ACTION=PRINT&CID=682&DID=36189

Provides a quick overview for school boards of some of the controversies and places them in the context of current events.

>>*Screening for Depression: Recommendations and Rationale* (2002)
by U.S. Preventive Services Task Force for Agency for Healthcare Research and Quality
http://www.ahrq.gov/clinic/3rduspstf/depressrr.htm

and

>>*Screening for Suicide Risk: Recommendation and Rationale* (2004)
by U.S. Preventive Services Task Force for Agency for Healthcare Research and Quality
http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm

These two reviews summarize the Task Force's recommendations on screening for depression and suicide risk and the supporting scientific evidence. With respect to depression screening of children and adolescents, they recognize the evidence on the accuracy and reliability of screening tests is insufficient to recommend for or against routine screening of children or adolescents .... The benefit of routinely screening children and adolescents for depression are not known .... The predictive value of positive screening tests is lower in children and adolescents than in adults...."

With respect to screening for suicide risk, the USPSTF found "no evidence that such screening reduces suicide attempts or mortality ... limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk ... insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality ... no studies that directly address the harms of screening and treatment for suicide risk. As a result, the USPSTF could not determine the balance of benefits and harms of screening for suicide risk in the primary care setting."

Further, they note: "The potential harms of screening include false-positive screening results, the inconvenience of further diagnostic work-up, the adverse effects and costs of treatment for patients who are incorrectly identified as being depressed, and potential adverse effects of labeling. None of the research reviewed provided useful empirical data regarding these potential adverse effects."

>>*Youth Suicide Risk and Prevention Interventions: A Review of the Past 10 years* (2003)
Journal of the American Academy of Child & Adolescent Psychiatry, 42(4): 386-405.

With specific reference to the likelihood that school-based MH screening will balance Type I and Type II errors in favor of false positives, this review states: "The few studies that have examined the efficacy of school-based screening (Reynolds, 1991; Shaffer and Craft, 1999; Thompson and Eggert, 1999) found that the sensitivity of the screens ranged from 83% to 100%, while the specificities ranged from 51 % to 76%. Thus, while there are few false negatives, there were many false-positives .....

>>*Screening and Assessing Adolescents for Substance Use Disorders*
Treatment Improvement Protocol (TIP) Series 31
from SAMHSA's Center for Substance Abuse Treatment
http://www.health.org/govpubs/bkd306/

Outlines many of the concerns related to screening substance abuse. Most of what is discussed relates to issues raised with respect to depression and suicide prevention screening (e.g., when to screen, when to assess, how to involve the family, legal issues of screening, including confidentiality, duty to warn, and how to communicate with other agencies, etc.).

>>*Assessment of Suicidal Behaviors and Risk Among Children and Adolescents* (2000)
by David B. Goldston, Ph.D., Wake Forest University School of Medicine
Technical report submitted to NIMH under Contract No. 263-MD-909995.
http://www.nimh.nih.gov/suicideresearch/measures.pdf

This major review helps to understand the state of the art related to instruments used for large-scale screening. See the summary and recommendations (pp. 198-201). Among his conclusions: " ... as part of the validation procedures for measures of suicidal behavior, it is common to demonstrate that the suicidal behavior instrument correlates in a predicted way with other related constructs such as depression and hopelessness (convergent validity). However, there has been insufficient attention paid to discriminate validity, or the degree to which suicidal behavior does not correlate with constructs with which it should not. There also has been insufficient attention paid to issues of incremental validity, or the degree to which a test provides information not available elsewhere. "...studying the clinical characteristics of juvenile suicidal attempts has not been a particularly fruitful exercise to date. Empirical data about the clinical characteristics of suicidal attempts have not been shown to be related to course or response in therapy, have not been used to demonstrate that certain types of therapy are any more or less effective with specific suicidal behaviors, and have not been found to be related to future behavior. Beyond simply using instruments that assess clinical characteristics of suicidal attempts for descriptive purposes, there is a need to better understand the significance of those clinical characteristics." ...."Unfortunately, there are a limited number of prospective studies which have identified risk factors with predictive utility that might be candidates for potential intervention (it makes sense to intervene with variables that portend later risk, rather than current or past risk). There are even fewer studies in which assessment measures have been administered on multiple occasions and which might yield data on the effects of repeated test administrations. And it almost goes without saying that there is a paucity of controlled intervention studies with suicidal youths - studies which might yield clues about the usefulness of different measures related to suicidality."

(b) For and Against One Side or the Other

>>*President's New Freedom Commission on Mental Health: Recommendations for Screening and Treating Children and Subsequent FY2005 Appropriations* (2004)
by C. S. Redhead, Domestic Social Policy Division and F. Larkins, Information Research Division, Congressional Research Service
http://www.psych.org/downloads/CRSMemoOnScreening.pdf

The New Freedom Commission makes clear its position on screening minors. With special emphasis on early detection as one of the goals of the newly "transformed mental health system," they offer short discussions on segments of the recommendations' language that emphasize the centrality of parental notification and confidentiality for appropriate treatment delivery.

>>*Should we screen for depression? Caveats and potential pitfalls* (2000)
by J.C. Coyne, et al.
Applied & Preventive Psychology, 9, 101-121.

While recognizing the value of screening in many instances, this analysis reviews why screening cannot serve as an efficient basis for preventing depression.

>>*Action Alert: Mental-health screening of children* (2004)
by the Liberty Committee
http://www.thelibertycommittee.org/update09.07.04.htm

This political action group adamantly argues against mandatory mental health screening of children stating that it is another violation of parental rights (and a means for pharmaceutical companies to make a profit at the cost of children).

>>*State Trends: Legislation Prohibits Mental Health Screening for Children* (2005)
http://www.nmha.org/shcr/issuebrief/childrenScreening.cfm

and

>>*Threats to Early Intervention and Prevention for Youth in Schools*
by the National Mental Health Association
http://www.nmha.org/shcr/issuebrief/childrenScreeningTalkingPoints.cfm

These documents from the National Mental Health Association (NMHA) raise concerns about legislation designed to prohibit MH screening of children and argue that screening is as essential to early intervention and prevention.

>>*Challenges to Providing Mental Health Services for Hispanic Non-English Speakers* (2005) – A Policy Brief
by the Hispanic Federation
http://www.hispanicfederation.org/res/Pub%20download/Punto%20de%20Vista%20Mental%20Health.pdf

This brief highlights the urgent need to provide culturally competent mental health services to the Latino/Hispanic population. While not focused specifically on screening and schools, it underscores additional issues relevant to policy related to the mental health screening of students (e.g., concerns about communication related to informed consent, cultural appropriateness of screening instruments and their interpretation, lack of services for such populations when they are identified).

>>*Cross assessment of a school-based mental health screening and treatment program in New York City.* (2004) by P. Chatterji, et al.,
Mental Health Services Research, 6, 155-166.

Report estimates the cost of a school-based mental health screening and treatment program located in a middle school in a low-income, largely Hispanic neighborhood in New York City,

aimed to screen all students in Grades 6-8 for anxiety, depression, and substance use disorders. The cost of the screening program ranged from $149 to $234 per student and the cost of the treatment program ranged from $90 to $115 per session. The total cost ranged from $106,125 to $172,018 for the screening program and from $420,077 to $468,320 for the treatment program.

Summary of Key Issues

Arguments for Screening

- Finding many more problems in order to treat them before they become severe
- Preventing problems from becoming worse
- Reducing costs because of less need for intensive treatments and special education
- Enhancing student success at school and related benefits for students, families, teachers, society
- While not perfect, current screening procedures are good enough

Pro Arguments for Schools as Venue

- Schools provide ready access and reduce costs
- Schools are a direct beneficiary because screening and effective treatment enhances student success at school

Arguments Against Screening

- Fear that society will mandate such screening and thereby interfere with what should remain a personal family matter
- Potential violations of rights to privacy, consent, and parental control
- There are insufficient treatment resources to handle increased referrals
- Available screening methods for use in schools produce too many errors (e.g., false positive identifications, inappropriate over-identification of subgroups of students)
- There is a lack of sufficient follow-up assessment resources to correct errors
- Large-scale screening is too costly
- The dollars budgeted for screening will reduce the dollars allocated for treatment.
- Problems will be worsened through self-fulfilling prophecies and stigmatization

Con Arguments Against Schools as Venue

- MH is one of those matters that should remain a domain for family, not school, intervention.
- Scarce school time/resources will be used for matters not directly related to teaching
- There are not enough competent school personnel to plan, implement, and evaluate large-scale screening

For a sampling of resources related to the topics covered in this brief, see the Center's Online Clearinghouse Quick Finds – http://smhp.psych.ucla.edu/

Addressing Barriers to Learning

New ways to think . . .
Better ways to link

UCLA Center for Mental Health in Schools + Program and Policy Analysis

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Since the recent reauthorization of IDEA . . ., response to intervention (RTI) has become a major stimulus for discussion and action. ...schools are increasingly adopting an RTI logic to organize and deliver both academic and behavioral support for ***all*** students.
Jeff Sprague (2006)

Response to Intervention

The concept of *Response to Intervention* is finding its way into schools with a significant push from the federal government and with a particular emphasis on reducing inappropriate diagnoses for special education. For example, as stated in the 4/20/06 U.S. Department of Education Request for Special Education Research Grants, "RTI holds significant promise when it is conceptualized as a multi-tiered (typically three-tiers) systems approach that integrates general and special education."

Properly conceived and implemented, RTI is expected to improve the learning opportunities for many students and reduce the number who are diagnosed with learning disabilities and behavioral disorders. The intent is to use "well-designed and well-implemented early intervention" in the regular classroom as a way to deal with a student's problems. The aim also is to improve assessment for determining whether more intensive and perhaps specialized assistance and diagnosis are required.

The process calls for making changes in the classroom to address learning and behavior as they are noted. Student responses are used as data to identify other in-classroom strategies as needed. The process continues until it is evident that a student's problems cannot be resolved through classroom interventions alone.

A core difficulty involves mobilizing unmotivated students (and particularly those who have become actively disengaged from classroom instruction). If motivational considerations are not effectively addressed, there is no way to validly assess if a student has a true disability or disorder.

RTI is currently being operationalized across the country. While there will be variability in practice, the tendency is to proceed as if all that is needed is more and better instruction. Clearly, this is a necessary, but insufficient emphasis. Therefore, the following intervention concepts are proposed as guides in operationalizing RTI.

First, ensure an optimal teaching environment. This means *personalized* teaching. Then, the focus expands, if necessary, to meet needs for *special assistance* in the classroom.

When classroom interventions prove insufficient, some supportive assistance outside the classroom is added to the mix to help students remain in the regular program. Referral for special education assessment only comes after all this is found inadequate.

To spell this out a bit:

Step 1 involves *personalizing instruction*. The intent is to ensure a student *perceives* instructional processes, content, and outcomes as a good match with his or her interests and capabilities.

The first emphasis is on *motivation*. Thus:

Step 1a stresses use of motivation-oriented strategies to (re)engage the student in classroom instruction. This step draws on the broad science-base related to human motivation, with special attention paid to research on intrinsic motivation and psychological reactance. The aim is to enhance student perceptions of significant options and involvement in decision making.

(cont. on p. 2)

Inside

The next concern is *developmental capabilities*. Thus:

Step 1b stresses use of teaching strategies that account for current knowledge and skills. In this respect, the emphasis on tutoring (designated as "Supplemental Services" in Title I) can be useful if the student perceives the tutoring as a good fit for learning.

Then, if necessary, the focus expands to encompass *special assistance*. Thus:

Step 2 stresses use of special assistance strategies to address any major barriers to learning and teaching, with an emphasis on the principle of using the least intervention needed (i.e., doing what is needed, but no more than that). In this respect, the range of strategies referred to as "Prereferral Interventions" and the programs and services that constitute student/learning supports are of considerable importance. (Again, the impact depends on the student's perception of how well an intervention fits his or her needs.)

> Note: Prereferral interventions identify regular classroom problems, identify the source of the problems (student, teacher, curriculum, environment, etc.), and take steps to resolve the problems within the regular classroom.

Building Capacity for RTI

Implied in all this is capacity building. There must be a process that ensures teachers have or are learning how to implement "well-designed early interventions" in the classroom. And, support staff must learn how to play a role directly in the classroom to expand the nature and scope of interventions.

Two capacity building concerns are particularly essential. One is professional development on how to implement the Step 1 and 2 interventions described above; the other involves ensuring classrooms and student support programs are designed in ways that allow enough time for implementation.

Central to all this is learning how to create a positive classroom climate. One that uses practices that enhance motivation to learn and perform, while avoiding practices that decrease motivation and/or produce avoidance motivation. Such practices include:

- regular use of informal and formal conferences with students to discuss options, make decisions, explore learners' perceptions, and mutually evaluate progress;
- a broad range of options from which learners can make *choices* about types of learning content, activities, and desired outcomes;
- a broad range of options from which learners can make choices about their need for *support* and *guidance* during decision making and learning processes;
- active decision making by learners in making choices and in evaluating how well the chosen options match their motivation and capability;
- establishment of program plans and mutual agreements about the ongoing relationships between the learners and program personnel;
- regular reevaluations and reformulation of plans, and renegotiation of agreements based on mutual evaluations of progress, problems, and learners' perceptions of how well instruction matches his or her interests and capabilities.

Teachers and support staff also must learn how to approach *special assistance* in a sequential and hierarchical manner. First, they must be able to use reteaching strategies to better accommodate individual needs and differences. They also must be prepared to teach prerequisite knowledge, skills, and attitudes the student may not have learned along the way. Finally, they must be able to play a role in addressing major barriers that are interfering with student learning and performance.

And, to ensure RTI strategies can be implemented in a personalized way, schools must promote the type of collaborative classrooms and grouping strategies that have the effect of turning big classes into smaller units.

More Research Please!

As stated in the 4/20/06 U.S. Department of Education Request for applications (84.324) Special Education Research Grants, "Despite the preference for RTI, the empirical research to support its application to district and school practices and systems is very limited." Nevertheless, the practice is seen as so important that the Department is investing significant resources to encourage the practice and to evaluate its impact.

Fortunately, the field doesn't have to wait for evidence since the weight of available findings support the concepts underlying operationalization of a broad RTI approach. For example, there is an extensive literature

supporting the application of intrinsic motivation theory to classroom instruction. And, with respect to special assistance, a broad range of supporting research has been culled from general and special education and the student support field.

Brief Commentary

If *Response to Intervention* (RTI) is treated simply as a problem of providing more and better instruction (e.g., the type of direct instruction described by the National Reading Panel sponsored by NICHD), it is unlikely to be effective for a great many students. However, if RTI is understood to be part and parcel of a comprehensive system of classroom and school-wide learning supports, schools will be in a position not only to address problems effectively early after their onset, but will prevent many from occurring.

By themselves, Response to Intervention strategies, especially if narrowly conceived, do not address major barriers to student learning. Such strategies must be broadly conceived and embedded in a comprehensive system of learning supports if they are to significantly reduce learning, behavior, and emotional problems, promote social/emotional development, and effectively reengage students in classroom learning. This will not only reduce the numbers who are inappropriately referred for special education or specialized services, it also will enhance attendance, reduce misbehavior, close the achievement gap, and enhance graduation rates.

A Few References

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Center News

RECENT CENTER REPORTS & PUBLICATIONS

Keep up with the latest Center resources check - *What's New* at http://smhp.psych.ucla.edu/review.htm

Here's a sample of what you can access there:

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"Call to Action: Student Support Staff: Moving in New Directions through School Improvement"

"The Relationship of Response to Intervention and Systems of Learning Supports"

"School Attendance Problems"

Journal Articles & Book Chapter

"School and Community Collaboration to Promote a Safe Learning Environment," July, 2006, *The State Education Standard, 7*, 38-42, National Association of State Boards of Education

"Systemic change for school improvement." *Journal of Educational and Psychological Consultation* (in press).

"Mental health of children and youth and the role of public health professionals." *Public Health Reports, 121.*

"Reorganizing student supports to enhance equity." In E. Lopez, G. Esquivel, & S. Nahari (Eds.), *Handbook of multicultural school psychology.*

Center resources now also available through ERIC – http://www.eric.ed.gov/

>ED492310 "Grade Repetition; Social Promotion; Public Education; Educational Policy; Classroom Techniques; Educational Practices; Intervention."

>ED492312 "Preschool Programs: A Synthesis of Current Policy Issues."

>ED490010 "Youngsters' Mental Health and Psychosocial Problems: What are the Data?"

>ED490007 "Another Initiative? Where Does it Fit? A Unifying Framework and an Integrated Infrastructure for Schools to Address Barriers to Learning and Promote Healthy Development."

>ED490004 "Addressing What's Missing in School Improvement Planning: Expanding Standards and Accountability to Encompass an Enabling or Learning Supports Component."

ED490008 "Resource-Oriented Teams: Key Infrastructure Mechanisms for Enhancing Education Supports."

ED491711 "Systemic Change for School Improvement: Designing, Implementing, and Sustaining Prototypes and Going to Scale."

ED490011 "Restructuring Boards of Education to Enhance Schools Effectiveness in Addressing Barriers to Student Learning."

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