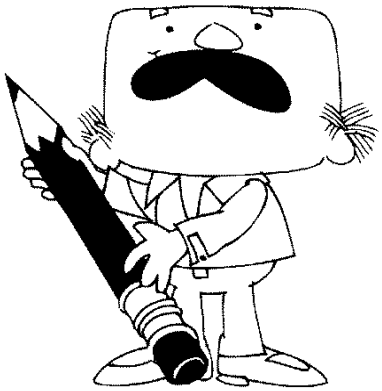
Resource Aid Packet

# *Screening/Assessing Students: Indicators and Tools*

**(Updated 2015)**



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# Preface

Those 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. Over a school year, many students not only are identified as having problems, they are diagnostically labeled. Sometimes the processes lead to appropriate special assistance; sometimes they contribute to "blaming the victim" – making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. Major ethical concerns arise when students are inappropriately assigned diagnostic labels and when systemic deficiencies are not addressed. This concern arises especially with respect to universal, first-level screening. Such screening involves using *broad-band* screening procedures. The focus is on all students in order to identify those "at risk" as well as those with existing problems. Because criteria scoring for first-level screens is set low, many false positive identifications are inevitable. To identify false positives and provide additional data on the rest, first-level screening is supposed to be followed by individual assessments. And the whole enterprise is meant to lead to corrective interventions.

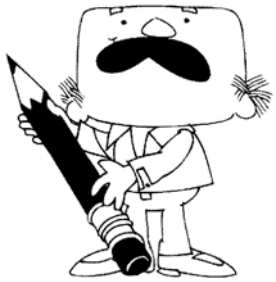
Types of screening include:

- Mass or universal screening: Involves screening all individuals in a certain category (for example, all students) without regard to risk status of individuals.
- High risk or selective screening involves risk populations only (e.g., subgroup and individual "case" identification based on the presence of risk factors)
- Multiphasic screening involves application of two or more screening tests to a large population at one time instead of carrying out separate screening tests for single problems.

It is common for school systems in many countries to screen students periodically for various physical health concerns (e.g., vision, hearing, dental screens). Screening for psychsocial and mental health concerns is more controversial.

Efficient and accurate identification and assessment help match students with interventions designed to address their current needs and prevent problems from getting bigger. This process calls for a range of assessment tools (e.g., observation ratings, surveys, tests, analysis of records such as attendance, grades, and test scores).

For more on all this, see the many resource link listed on the Center's Quick Find on *Assessment and Screening* at http://smhp.psych.ucla.edu/qf/p1405_01.htm .



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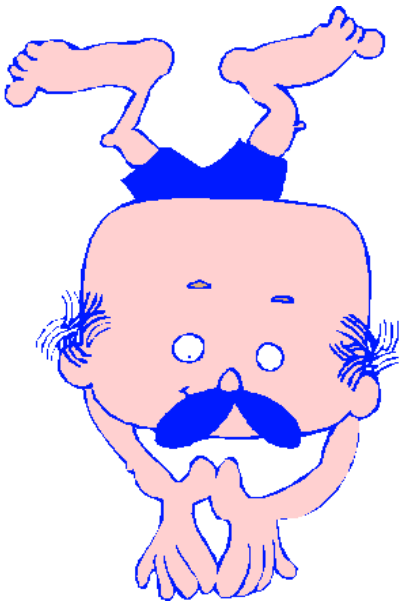


## I. Screening: Intro to early identification with follow-up interventions to prevent problems from escalating

A. Screening: a note of caution

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

C. Guidelines

## I. Screening Intro

# 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. Concerns include overdiagnosis, misdiagnosis, misprescribing, and creating a false sense that the benefits of screening outweigh the costs. 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 and to see screening as the best approach to identifying low incidence events.

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.

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

Reasonable concern for the well-being of children and adolescents and the need to address barriers to learning and teaching has led schools to deploy resources to deal with a variety of health and psychosocial matters (e.g., bullying, depression, suicide, ADHD, LD, obesity, etc.). Over time, agenda priorities shift, and resources are redeployed. Some of the activity is helpful; some is not; some has unintended negative consequences.

One of many issues raised:

> *How often are the ways in which students respond to and cope with the demands of growing up labeled as pathology and sensationalized?*

The problem is compounded by the tendency to generalize from extreme and rare incidents. While one school shooting is too many, fortunately few students will ever act out in this way. One suicide is too many; fortunately few student take their own life. Some young people commit violent crimes, but the numbers are far fewer than the news media conveys and are on a downward trajectory.

No one is likely to argue against the value of preventing violence, suicide, and other mental heath and psychosocial concerns. And, in recent years, schools have had to be increasingly vigilant about potential violent incidents on campus.

Yet, policy makers remain in conflict over whether schools should play an institutionalized role in universal first-level screening for psychosocial and mental health problems. Issues arise around:

> *Is such monitoring an appropriate role for schools to play?*
>
> *If so, what procedures are appropriate and who should do it?*
>
> *If so, how will schools avoid doing more harm than good in the process?*

In discussing these issues, concerns have been raised about (a) the lack of evidence supporting the ability to predict who will and won't be violent or commit suicide, (b) what will be done to those identified as "threats" or "at risk"– including a host of due process considerations, (c) whether the procedures are antithetical to the schools education mission, and (d) the negative impact on the school environment of additional procedures that are more oriented to policing and monitoring than to creating school environments that foster caring and a sense of community.

Concerns also arise about parental consent, privacy and confidentiality protections, staff qualifications, involvement of peers, negative consequences of monitoring (especially for students who are false positive identifications), and access and availability of appropriate assistance.

Examples of pro and con positions that are often heard:

- School staff are well-situated to keep an eye on kids who are "risky" or "at risk."
- Teachers can't take on another task and aren't qualified to monitor such students.
- Such monitoring can be done by qualified student support staff.
- Monitoring infringes on the rights of families and students.
- It's irresponsible not to monitor anyone who is "risky" or "at risk."
- It's inappropriate to encourage kids to "spy" on each other.
- Monitoring is needed so that steps can be made to help quickly.
- Monitoring has too many negative effects.

## Concern

### *Screening and Profiling*

On a regular basis, legislators at federal and state levels express concern about some facet of the agenda for mental health in schools. An ongoing debate focuses on the role of public schools in screening to identify mental health and psychosocial problems.

- With growing interest in expanding pre-school education programs comes an increasing reemphasis on *early-age screening for behavioral, emotional, and learning disabilities*, (e.g., enhancing Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and screening programs in Head Start and kindergarten.
- *Drug testing at school has long been advocated as a way to deter drug use.*
- *Student threat profiling to prevent school violence.*
- *Screening for suicide risk.*

Some stakeholders who are interested in primary and secondary prevention advocate for efforts to predict and identify problems early as essential to their approaches. In opposition, it is argued that large-scale screening programs produce too many false positives, lead to premature prescription of "deep end" interventions, focus mainly on the role of factors residing in the child and thus collude with tendencies to "blame victims," and so forth. As with most such debates, those in favor emphasize the benefits (e.g., “Screening let’s us identify problems early, and can help prevent problems such as suicide.”). Those against such screening stress various “costs.” For example, one state legislator is quoted as saying: “We want all of our citizens to have access to mental health services, but the idea that we are going to run everyone through some screening system with who knows what kind of values applied to them is unacceptable.”

With respect to drug testing at school, Lloyd Johnston and colleagues at the University of Michigan have reported the first major study (76,000 students nationwide) on the impact of drug testing in schools. They conclude such testing does not deter student drug use any more than doing no screening at all. Based on the study's findings, Dr. Johnston states "It's the kind of intervention that doesn't win the hearts and minds of children. I don't think it brings about any constructive changes in their attitudes about drugs or their belief in the dangers associated with using them." At the same time, he stresses" One could imagine situations where drug testing could be effective, if you impose it in a sufficiently draconian manner - that is, testing most kids and doing it frequently. We're not in a position to say that wouldn't work." Graham Boyd, director of the ACLU Drug Policy Litigation Project who argued against drug testing before the Supreme Court last year said, "In light of these findings, schools should be hard-pressed to implement or continue a policy that is intrusive and even insulting for their students." But other researchers contend that the urinalysis conducted by schools is so faulty, the supervision so lax and the opportunities for cheating so plentiful that the study may prove only that schools do a poor job of testing. Also noted is that the Michigan study does not differentiate between schools that do intensive, regular random screening and those that test only occasionally. As a result, it does not rule out the possibility that the most vigilant schools do a better job of curbing drug use.

Those arguing that schools should play this role emphasize that it is essential to monitor anyone who is at risk or a risk to others so that help can be provided quickly. Moreover, they believe school staff are well-situated to do so, and staff (and even students) can be trained to do it appropriately and with effective safeguards for privacy and confidentiality. And they suggest that positive benefits outweigh any negative effects.

As with many practices related to mental health in schools, a basic argument against monitoring students identified as a threat or at risk is the position that the practice infringes on the rights of families and students. Other arguments stress that teachers should not be distracted from teaching; moreover, teachers and other non-clinically trained school staff are seen as ill-equipped to monitor and make such identifications. And, it also is seen as inappropriate to encourage students to play such a role. Additionally, it is argued that existing monitoring practices are primarily effective in following those who have already attempted suicide or have acted violently and that monitoring others has too many negative effects (e.g., costs are seen as outweighing potential benefits).

**Summary of Key Issues as Applied to Suicide Screening**

*Pro*

- It is essential to monitor anyone who is a suicidal risk so that help can be provided quickly.
- School staff are well-situated to do so.
- Staff (and even students) can be trained to do it appropriately.
- Effective safeguards can be put in place for privacy and confidentiality.
- Positive benefits outweigh negative effects.

*Con*

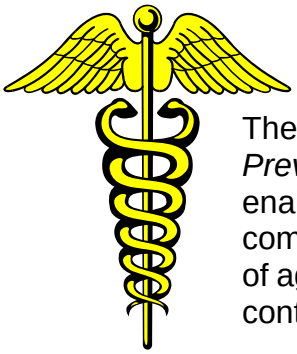
- The practice infringes on the rights of families and students.
- Teachers will be distracted from teaching.
- Teachers and other non-clinically trained school staff are ill-equipped to monitor.
- It is inappropriate to encourage students to play a monitoring role.
- Existing monitoring practices are mainly useful for following the very few students who have already attempted suicide.
- Negative effects outweigh potential benefits.

[

For more on all this, see the Center's Online Clearinghouse Quick Find topic:

*Assessment and Screening* – http://smhp.psych.ucla.edu/qf/p1405_01.htm

## C. Guidelines – an example:



The American Medical Association's (AMA) *Guidelines for Adolescent Preventive Services* (GAPS) provides 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 following excerpts are from the July 2015 update – online at
http://www.uptodate.com/contents/guidelines-for-adolescent-preventive-services

INTRODUCTION — The health status and health behaviors of adolescents have been monitored closely for many years [1-3].* Although improvement has been noted in certain indicators, compared with other age groups, adolescent health has failed to respond to the range of interventions developed for schools, communities, and the health system.

...

STRATEGY FOR PROVISION OF ADOLESCENT PREVENTIVE SERVICES — Most medical education prepares practitioners to identify and manage biomedical disease but may not prepare them to manage preventable disorders related to personal behavior, especially in adolescents [26]. When seeing adolescents for routine health evaluation, practitioners tend to focus on diseases or conditions with which they are familiar, rather than on health-risk behaviors and problems [27-29].

In addition to guidelines, therefore, practitioners need a strategy to help them integrate preventive services into routine medical care. The scheme presented in the Figure (algorithm 1) can help providers screen for a large number of potential health risks, identify those that need further assessment, and focus on those that are of immediate concern [30].

Step 1: Gather information and identify problems — The goal of this step is to identify indicators of all or a subset of the specific health risks and problems listed above. Data that are easy to obtain and have a high sensitivity for the issues of greatest concern are collected. Height, weight, and blood pressure are measured; questionnaires to assess health risks, habits, and behaviors can be completed in the waiting area. The use of questionnaires can save time and improve identification of problems [31,32].

The data that are gathered are used to guide the clinical interview and for further assessment. If no areas of concern are elicited, the practitioner can offer support and reinforcement for healthy behaviors. If, however, the indications are that the teen has a problem, such as being overweight or engaging in a health-risk behavior, then the practitioner goes to Step 2.

Step 2: Further assess — The goal of this step is to determine, for each potential problem identified in Step 1, whether the teen is at high, moderate, or low risk for adverse consequences. The problems identified by the screening information are further assessed with a complete history and physical

examination. If the problem presents an imminent and serious risk, then referral for specialty evaluation and management is appropriate

...

Step 3: Identify and prioritize problems together — Once the practitioner has determined the risk category for each of the problems, he or she should have a discussion with the adolescent to acknowledge the problems and prioritize the problem list. The existence of a therapeutic relationship between the practitioner and the adolescent will facilitate this discussion. Adolescents tend to respond to an approach that enlists their cooperation and involvement in the decision-making process. The practitioner can foster a therapeutic alliance by:

- Assuring the adolescent the information shared with the practitioner will remain confidential
- Listening to and valuing the adolescent's perspective
- Not responding to information regarding personal behaviors in a derogatory or punitive manner

The practitioner and the adolescent must come to an agreement regarding the type and severity of each problem. Although the practitioner might believe that smoking, monthly use of alcohol, and skipping breakfast are the top issues of concern, the adolescent may rank these behaviors in a different order or may not even view them as problems. Without the teenager's acceptance of the problem list and its prioritization, chances of compliance with the management plan are nil. Unless the behavior is life-threatening in the immediate future, the practitioner and the adolescent must negotiate what they will work on together. The negotiation process provides the occasion to determine whether the adolescent is ready to change his or her behavior and to identify opportunities for and barriers to change. This information is necessary to proceed to the development of a management plan.

Step 4: Solutions — Developing a management plan for the set of problems involves five steps:

- Negotiate the intervention – Discuss management options with the teen and determine, together, the best course of action. If the adolescent views the ultimate outcome to be too difficult, then negotiating more immediate, attainable objectives is reasonable. As an example, losing 2 pounds per month for six months may be more acceptable to a teen than losing 12 pounds as the long-term goal.

- Promote the teen's confidence that the management plan can work – Motivation to work on a behavioral change plan is key to success.

- Discuss strategies with the teen to overcome barriers to the management plan – Have the teenager identify a list of the barriers that he or she believes will interfere with the strategy for changing the behavior. Help plan ways to overcome the barriers.

- Develop a contract or verbal agreement with the teen regarding joint expectations.

- Follow up with the actions identified – The patient can make contact through electronic mail, telephone calls to office staff, and postcards prior to future office visits.

*See the references online at
http://www.uptodate.com/contents/guidelines-for-adolescent-preventive-services

**II. Examples of screening children & youth**

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

1. *Early and Periodic Screening, Diagnostic and Treatment* (EPSDT)

2. *Bright Futures in Practice*

### 1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Excerpted from: EPSDT - *A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* – http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services, or EPSDT. EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

EPSDT covers regular screening services (check-ups) for infants, children and adolescents. These screenings are designed to identify health and developmental issues as early as possible. States have the responsibility to ensure that all eligible children (and their families) are informed of both the availability of screening services, and that a formal request for an EPSDT screening service is not required. States must provide or arrange for screening services both at established times and on an as-needed basis. Covered screening services are medical, mental health, vision, hearing and dental. Medical screenings has five components:

- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders;
- Comprehensive, unclothed physical examination;
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
- Laboratory testing (including blood lead screening appropriate for age and risk factors);5 and
- Health education and anticipatory guidance for both the child and caregiver.

# 2. *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

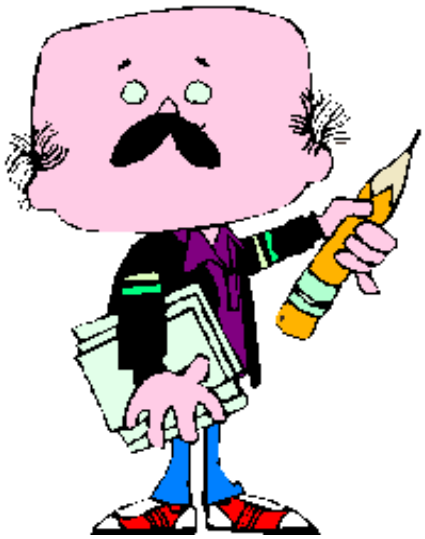
Si contesta sí, que servicios? _____
_____

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.

**II. Examples of screening children & youth** (cont.)

B. Screening all children and youth to identify risks

1. Being Alert to Indicators of Psychosocial and Mental Health Problems
2. Suicide Assessment
3. Substance abuse



# 1. 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
- cruel and bullying
- highly manipulative
- alienates others
- has no friends
- refuses to talk
- promiscuous
- excessively reactive and resistant to authority
- highly aggressive to others -- physically, sexually

---

**Indicators of Unusual Thinking**

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

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

---

*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.

**A Systematic Review of School-based Interventions Aimed at Preventing, Treating, and Responding to Suicide- Related Behavior in Young People.**

By J.1. Robinson, G. Cox, A. Malone, M. Williamson, G. Baldwin, K. Fletcher, & M. O'Brien (2013). In *Crisis, 34,* 164-182.
http://www.ncbi.nlm.nih.gov/pubmed/23195455


ABSTRACT

BACKGROUND: Suicide, in particular among young people, is a major public health problem, although little is known regarding effective interventions for managing and preventing suicide-related behavior.

AIMS: To review the empirical literature pertaining to suicide postvention, prevention, and early intervention, specifically in school settings.

METHOD: MEDLINE, PsycINFO, and the Cochrane Central Register of Controlled Trials (CCRCT) as well as citation lists of relevant articles using terms related to suicide and schools were searched in July 2011. School-based programs targeting suicide, attempted suicide, suicidal ideation, and self-harm where intent is not specified were included. No exclusion was placed on trial design. All studies had to include a suicide-related outcome.

RESULTS: A total of 412 potentially relevant studies were identified, 43 of which met the inclusion criteria, as well as three secondary publications: 15 universal awareness programs, 23 selective interventions, 3 targeted interventions, and 2 postvention trials.

LIMITATIONS: Overall, the evidence was limited and hampered by methodological concerns, particularly a lack of RCTs.

CONCLUSIONS: The most promising interventions for schools appear to be gatekeeper training and screening programs. However, more research is needed.

**Suicide Screening in Schools, Primary Care and Emergency Departments**

by Lisa M. Horowitz, Elizabeth D. Ballard, & Maryland Pao (2009).
In Current Opinion in Pediatrics, 21, 620–627.
http://europepmc.org/articles/PMC2879582

Abstract

Purpose of review – Every year, suicide claims the lives of tens of thousands of young people worldwide. Despite its high prevalence and known risk factors, suicidality is often undetected. Early identification of suicide risk may be an important method of mitigating this public health crisis. Screening youth for suicide may be a critical step in suicide prevention. This paper reviews suicide screening in three different settings: schools, primary care clinics and emergency departments (EDs).

Recent findings – Unrecognized and thus untreated suicidality leads to substantial morbidity and mortality. With the onus of detection falling on nonmental health professionals, brief screening tools can be used to initiate more in-depth evaluations. Nonetheless, there are serious complexities and implications of screening all children and adolescents for suicide. Recent studies show that managing positive screens is a monumental challenge, including the problem of false positives and the burden subsequently posed on systems of care. Furthermore, nearly 60% of youth in need of mental health services do not receive the care they need, even after suicide attempt. Schools, primary care clinics and EDs are logical settings where screening that leads to intervention can be initiated.

Summary – Valid, brief and easy-to-administer screening tools can be utilized to detect risk of suicide in children and adolescents. Targeted suicide screening in schools, and universal suicide screening in primary care clinics and EDs may be the most effective way to recognize and prevent self-harm. These settings must be equipped to manage youth who screen positive with effective and timely interventions. Most importantly, the impact of suicide screening in various settings needs to be further assessed.

# 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.

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***(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 |

**Screening, Brief Intervention and Referral to Treatment for Adolescents: Attitudes, Perceptions and Practice of New York School-Based Health Center Providers**.

By B.R. Harris, B.A. Shaw, B.R. Sherman, & H.A. Lawson (2015)
In *Substance Abuse, 16,* [Epub ahead of print]
http://www.ncbi.nlm.nih.gov/pubmed/25774987

ABSTRACT

BACKGROUND: Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been endorsed by the American Academy of Pediatrics as an evidence-based strategy to address risky substance use among adolescents in primary care. However, less than half of pediatricians even screen adolescents for substance use. The purpose of this study was to identify variation in SBIRT practice and explore how program directors' and clinicians' attitudes and perceptions of effectiveness, role responsibility, and self-efficacy impact SBIRT adoption, implementation, and practice in school-based health centers (SBHCs).

METHODS: All 162 New York State SBHC program directors and clinicians serving middle and high school students were surveyed between May and June 2013 (40% response rate).

RESULTS: Only 22% of participants reported practicing the SBIRT model. Of the individual SBIRT model components, using a standardized tool to screen students for risky substance use, referring students with substance use problems to specialty treatment, and assessing students' readiness to change were practiced least frequently. Less than 30% of participants felt they could be effective at helping students reduce substance use, 63% did not believe it was their role to use a standardized screening tool, and 20-30% did not feel confident performing specific aspects of intervention and management. Each of these factors was correlated with SBIRT practice frequency ($p<.05$).

CONCLUSIONS: Findings from this study identify an important gap between an evidence-based SBIRT model and its adoption into practice within SBHCs, indicating a need for dissemination strategies targeting role responsibility, self-efficacy, and clinician perceptions of SBIRT effectiveness.

## II. Examples of Screening Children & Youth

C. Screening at-risk groups:

1. Crisis screening

2. Juvenile justice

# 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?

**http://findarticles.com/p/articles/mi_hb179/is.200105/ai_n5572485**
Excerpted from the *Journal of the American Academy of Child and Adolescent Psychiatry*
May, 2001

# 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*, VII, 1**

## Youth With Mental Health Disorders: Issues and Emerging Responses

by Joseph J. Cocozza and Kathleen Skowyra (**2000)**
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):

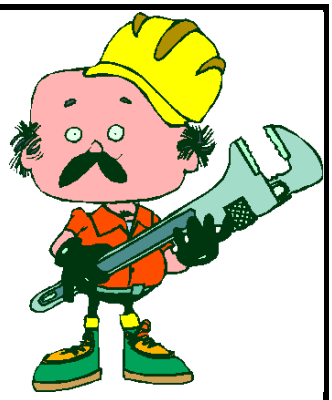
-During initial admission.
-On return to the facility from court after adjudication.
-Following receipt of bad news of after suffering any type of humiliation or rejection.
-During confinement in isolation or segregation.
-Following a prolonged stay in the facility.

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.

# 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. Formal tools and research on 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* - http://smhp.psych.ucla.edu/pdfdocs/barriers/barriers.pdf

# 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?

# 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?

# 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 (cont.)

B. Formal tools and research on screening instruments

- Table of Screening Tools and Rating Scales
- Using Systematic Screening Procedures to Identify Students Who Are Nonresponsive to Primary Prevention Efforts: Integrating Academic and Behavioral Measures
- Clinical Validity of the Me and My School Questionnaire.
- 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
- 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.

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## Table of Screening Tools and Rating Scales

Massachusetts General Hospital, School Psychiatry Program, MADI Resource Center

http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table_print.asp

This online resource is meant to indicate screening instruments "to help measure a young person's mental health symptoms, and/or measure progress after interventions are put in place at school or at home." For each instrument, the table indicates: the age range for the instrument, who completes the instrument, the number of items in the instrument and how long it takes to complete, and whether free access is available on line. To help the user decide whether an instrument might be appropriate to use with respect to a particular child, you can click on the DETAIL link next to the tool or scale. The DETAIL pages give more detailed information about the tool or scale, including a color-coded summary of who the instrument is designed for (i.e., parents, teachers, students, and/or clinicians). The DETAIL pages also provide direct links to view, download, or order the tools and scales. The DETAIL pages are organized by symptom, so, for example all the screening tools and scales for anxiety are on the anxiety DETAIL page.

Cautions are offered:

- Use of the screening tools and rating scales does not produce a diagnosis. Rather, the tools and scales point toward the types of mental health disorders that may be worthwhile to consider as a cause of a child's or adolescent's emotional or behavioral difficulties.

- A particular "score" does not mean that a child has a particular disorder – these screening tools and rating scales are only one component of an evaluation.

- Diagnoses should be made only by a trained clinician after a thorough evaluation.

- Symptoms suggestive of suicidal or harmful behaviors warrant immediate attention by a trained clinician.

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**Using Systematic Screening Procedures to Identify Students Who Are Nonresponsive to Primary Prevention Efforts: Integrating Academic and Behavioral Measures**

J.R. Kalberg, K. Lynne, & H.M. Menzies (2010).
*Education and Treatment of Children, 33,* 561-584.
http://eric.ed.gov/?id=EJ898557

Many school systems are adopting three-tiered models of prevention (e.g., Response to Intervention and Positive Behavior Support) to support an increasingly diverse student population (Sugai, Horner, & Gresham, 2002). A central feature of these models is that data are monitored to determine responsiveness. We offer this paper as a guide for researchers and practitioners in using multiple sources of data to support students with reading and behavioral challenges. Specifically, we provide an illustration of how one elementary school used an academic screener (Curriculum-Based Measurement; CBM) in combination with behavior screeners (Systematic Screening for Behavior Disorders [Walker & Severson, 1992] and the Student Risk Screening Scale [Drummond, 1994]) to identify students who were non-responsive to the primary prevention efforts. We provide information on the methodology that includes participants, training procedures, a description of the primary plan, and assessment schedule. Then we offer two illustrations of how the CBM and behavior screening data could be analyzed to identify students for targeted supports and directions for future applications. (Contains 2 figures.)

**Clinical Validity of the Me and My School Questionnaire: a Self-report Mental Health Measure for Children and Adolescents.**

P. Patalay, J. Deighton, P. Fonagy, P. Vostanis, & M. Wolpert (2014).
*Child and Adolescent Psychiatry and Mental Health, 8,* 17.
http://www.capmh.com/content/8/1/17

The *Me and My School Questionnaire* (M&MS) is a self-report measure for children aged eight years and above that measures emotional difficulties and behavioural difficulties, and has been previously validated in a community sample. This study assessed its clinical sensitivity to justify its utility as a screening tool in schools. Findings suggest that "the M&MS sufficiently discriminates between high-risk (clinic) and low-risk (community) samples, has good internal reliability, compares favourably with existing self-report measures of mental health and has comparable levels of agreement between parent-report and self-report to other measures. Alongside existing validation of the M&MS, these findings justify the measures use as a self-report screening tool for mental health problems in community settings for children aged as young as 8 years."

**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

"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**
R. Goodman, et al. (2000)
*The British Journal of Psychiatry, 177*, 534-539.
http://bjp.rcpsych.org/cgi/content/full/177/6/534

"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.**

N. Schmitz et al. (2001)
*Compr Psychiatry, 42,* 166-173.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11244154&dopt=Abstract

"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. 

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

Zimmerman et al. (2001)
*Archives of General Psychiatry, 58,* 787-794.
http://archpsyc.ama-assn.org/cgi/content/full/58/8/787

"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." This diagnostic aid for use in clinical practice can "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 positives, false negatives, and the validity of the diagnosis of major depression in primary care.**
M.S Klinkman et al. (1998)
*Archives of Family Medicine, 7,* 451-461.
http://archfami.ama-assn.org/cgi/content/full/7/5/451

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

“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 Response 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:

For more resources on all this, see the many resource link listed on the Center's Quick Find on *Assessment and Screening* at http://smhp.psych.ucla.edu/qf/p1405_01.htm .