

Title: Youth Mental Health: Assessment to Intervention

Date & Time: Dec 1, 2023 01:00 PM Eastern Time

APA: Hello, and welcome to today's webinar, Youth Mental Health: Assessment to Intervention. This webinar is paid for by Pearson. Pearson Clinical Assessments provides reliable, well-validated tools that are trusted globally to help professionals like you improve the lives of your patients. Some important points before we get started. The presenters for today's webinar, Dr. Patrick Moran and Kathleen Woodward, have working relationships with Pearson and therefore have both a financial and an intellectual interest in Pearson assessment tools. The purpose of this presentation is to provide a balanced view on assessment and intervention in youth mental health. APA does not endorse any products or services. The content was created by Pearson and does not reflect the views of APA nor its editorial staff. Please email advertising at apa.org if you would like to learn more. Next, this program does not offer CE. However, we will email everyone watching live today a Certificate of Attendance.

Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in about two weeks' time. That email will also include a copy of the presentation slides. During our time today, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. If you have a question for our presenters, please type them into that Q&A box on your screen.

A link to the presentation slides will also be posted in the checkbox. If you miss them, we will email them to you with the recording in about two weeks' time. With that, I would like to introduce today's presenters. Dr. Patrick Moran has a Ph.D. in clinical psychology from the Pacific Graduate School of Psychology at Palo Alto University in California. He is a licensed clinical psychologist in Oregon and Washington and a certified school psychologist in Oregon.

Dr. Moran has been with Pearson Clinical Assessments for 18 years, providing consultation and training as the Sales Director for North America government and public safety customers. We also have Kathleen Woodward. She consults with school districts throughout the western and central U.S. and Canada on psychological and psychoeducational assessment practices.

She regularly presents on assessment-related topics for professionals in their organizational settings and at state and national conventions. As a school psychologist in the Colorado public school system, she was instrumental in developing and implementing response to intervention policies and procedures. Her work also focused on crisis response and threat risk assessment procedures, early childhood assessment, behavioral assessment and intervention, and program planning for preschool students diagnosed with autism spectrum disorder.

Current areas of research include assessment of executive functions and attention deficit hyperactivity disorder in children and adolescents, as well as universal screening for mental health in schools. She has been consulting since 2007 and has presented over 100 workshops for professional organizations. She is also an active

member of the National Association of School Psychologists. Welcome to both Dr. Moran and Kathleen.

Patrick Moran: Thank you.

Kathleen Woodward: Thank you so much for the introductions. We have a lot of content that we would like to cover in a short amount of time, so I'm going to dive right in. If you want to move to the next slide with the agenda. I'll be providing a brief overview of the current status of youth mental health in the US based on the most recently published research in this area.

While that information will be brief-- and excuse my voice, by the way, I'm recovering from COVID, so that's always fun, but while that information will be brief, it should provide you with a pretty good understanding of the available data and the additional research that's being conducted in this area. I'll then present a comprehensive assessment model as it pertains to emotional, behavioral, and mental health concerns.

Then I'll turn it over to Dr. Moran, who will be providing content specific to how the youth mental health crisis has impacted and is being addressed in community and healthcare mental health settings in terms of diagnostic assessment and treatment. He'll also touch on ADHD and its role in current status in the US as well. Next slide, please. Over the past year, I really like to start with this slide as it drives home an important message, that while we are in the midst of a youth mental health crisis, we are also experiencing a drastic shortage of mental health professionals.

The information here on this slide is provided on the National Association of School Psychologists website, and it presents data around the shortages of school psychologists by state. Based on the recommended ratio of one school psychologist for every 500 students. The national ratio for the 2021-2022 school year, which is the most recent data, was 1,127 students to one school psychologist, so more than double the recommended ratio.

You can see that those states on this map here that are highlighted in red have a state average greater than 2,000 students per school psychologist. This type of data is also available for other mental health providers in school settings. School social workers, school counselors, and others have equally impactful shortages, in addition to the shortages that we're experiencing in terms of mental health professionals in the community at large.

This is, of course, compounded by teacher shortages nationwide, too. We all know that the pandemic had been-- and everything associated with the pandemic, the closures and whatnot, had and continues to have a very serious impact on mental health, not only for our youth, our children, and adolescents but for the adults that are supporting those students and the youth in our community as well.

It's yet to be seen what the long-term impact is going to be, but all of us that are in the mental health space, are all involved in and witnessing the current state of mental health functioning and more and more research is being published that indicates that we're continuing to find ourselves in the midst of a crisis and that

school professionals and mental health professionals, specifically, are the frontline workers in this crisis.

Next slide, thank you. Let's take a look at some of the big-picture data. In the fall of 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association all declared that the pandemic-related decline in child and adolescent mental health had indeed become a national emergency. Those groups also noted at the time that suicide is the second leading cause of death for youth ages 10 to 24.

They, during that time and continuing today, had been seeing exceptionally high rates of loneliness, of anxiety, depression, trauma, suicidality, across our youth. We had more than 140,000 children in the US alone that lost a primary or secondary caregiver during the pandemic and youth of color were disproportionately impacted. According to the CDC, and I'll have a lot of stats that are coming out of CDC, they actually have some great research that they are conducting and presenting, but emergency department visits for suspected suicide attempts among adolescents jumped 31% in 2020 compared to 2019.

Then in February and March of 2021, a full year after that, emergency department visits for suspected suicide attempts were 51% higher among girls, specifically age 12 to 17, than during that same period, two years prior in 2019. Next slide, please. Mental health challenges are, in this country, in the US, the leading cause of disability and poor life outcomes in young people.

In recent years, we've seen substantial increases, as I just discussed, in certain mental health disorders in youth, including depression, anxiety, and suicidal ideation. In December of 2021, the U.S. Surgeon General issued an advisory on protecting youth mental health. He called it an urgent public health crisis that will require, "all hands on deck effort to address". The advisory includes a call to action by educators, by school staff, school districts

including, and I'm going to quote again, recognizing signs of changes in mental health and behavior and taking appropriate action to address the needs of students. The importance of screening is also highlighted as well as prevention and intervention efforts. Then that call to action extends not only to school professionals, of course, but it extends to healthcare and community organizations, family and caregivers, media organizations, governments at all levels, employers, and a variety of other organizations. It serves as a truly great resource. If you've not had a chance to read through the advisory, I encourage you to do so.

Take a look at it, take a look at the resources and the ways that depending on your discipline and your involvement in your community, how you can best help to mitigate the crisis that we're facing. Next slide, please. Here, I want to emphasize a few statistics, again, based on CDC data related to children age 3 to 17, both prior to and leading into 2020. What we saw at the time and what we're continuing to see, the percentages have not changed drastically since that time, is that approximately 4.5 million or 7.4% of youth in that age range have a diagnosed behavior problem.

About 4.4 million or 7.1% have diagnosed anxiety, and 3.2% or 1.9 million have diagnosed depression. What we also see with a number of these disorders is that they commonly occur together. A lot of comorbidity exists and having another disorder, having comorbidity is most common in children that have depression. When the student or child is diagnosed with depression, they're 75% more likely to also have anxiety and 50% of them also exhibit behavior problems.

Then for children that have anxiety diagnosis, 38% of those children also have behavior problems and depression. We know comorbidity is very high, not only with other emotional and behavioral concerns, but we also see high comorbidity with learning disabilities and other diagnoses. Life outcomes are certainly impacted by mental health diagnoses. Next slide, please.

Student mental health concerns, as we know or youth mental health concerns are not new. They've been around for a while and they've been progressing rapidly, but they are increasingly more prevalent. In March 2022, the US Department of Health and Human Services published a study in the American Medical Association's journal, JAMA Pediatrics, where they reported substantial increases in diagnoses of anxiety and depression in children and adolescents between 2016 and 2020.

Once again, prior to the pandemic information, but then diagnoses of anxiety grew 29% and diagnoses of depression grew 27% with the most significant growth actually occurring between 2019 and 2020. Once again, not specifically pandemic-related, we were already on a trajectory of increased and enhanced mental health concerns in our youth. We are continuing to see that trending upward as we are moving past sort of the pandemic-related closures and things that were significantly impactful on mental health. We're still continuing to see these rates rise.

Next slide, please. Before the pandemic, we saw mental health getting substantially worse in our high school students relative to the 3 to 17-year-olds, high school students were impacted the most. Like I said, the most recent data indicates that those concerns are continuing to grow. The most recent survey of high school students throughout the country indicated that 44% reported that they persistently felt sad or hopeless during the last year.

I want to state that again, 44% of high school students in the US reported they persistently felt sad or hopeless during the past year. That data was just published last year. Very new and concerning data. You can see, in addition to that data, if you're looking at the slide, that there are alarming rates of both physical and emotional abuse that were reported after the pandemic closures.

That relates back to the issues around the mental health declines that we were seeing in adults as well as in children and adolescents. All of the information that you see here really drives home the need for a very thorough history and historical context as you're assessing children and adolescents in this day and age. Really need to take a look at the big picture. How were they most impacted during that time, during the pandemic, and how is that extended into their current status?

That's part of the rationale here, but the statistics are also driving home the point that we, like I said, are facing a major crisis and it's not just around increases in anxiety

and depression, but the holistic view of our youth. As we're considering how we have traditionally addressed, or in some cases, maybe not addressed, mental health concerns, particularly anxiety and depression and suicidality, through assessment for special education in the schools or other services in the schools or through diagnosis and treatment in mental health and community settings, we now have to grasp the sheer magnitude of the number of youth that are experiencing mental health issues.

We need to therefore reconceptualize our assessment practices so that we can start to better identify and to be able to then treat those who are struggling and to provide the needed supports, potentially on a much larger scale. That's what we're faced with currently as mental health professionals. Next slide, please. Okay, and these here are some of the key findings of the Mental Health America Organization in their State of Mental Health in America report for 2023.

I'm just going to read over them quite quickly. Over 1 in 10 youth, so over 10% of youth experiencing depression that is severely impairing their ability to function at school or work, at home with family, or in their social life. 6.34% of youth in the US reported a substance use disorder in the past year. Nationally, 1 in 10 youth who are covered under private insurance do not have coverage for mental or emotional difficulties.

59.8% of youth with minor depression do not receive any mental health treatment. In South Carolina, I'm going to call them out, the lowest ranking state. Nearly 8 in 10 youth with depression do not receive any care. Only 0.718% of students are identified with emotional disturbance for an individualized education program or plan, an IEP in the school setting. Again, concerning statistics, not just about where are we with mental health, but how are those students being served? How are our youth accessing services and how can they access services?

There's clearly some barriers to that as well. Next slide, please. As you can tell by the slides, I want to provide a number of resources and places where you can follow up to gather more detailed information. I'm just touching on some different organizations and the work that they're doing. Please do follow up with some of these organizations and check it out in more detail.

This particular group, the Hopeful Futures Campaign, they partner with Mental Health America and many other organizations that are focused on improving the mental health of children and adolescents. They assembled a first-ever national report card that scores every state on policies that support school mental health with recommendations for how to improve.

Next slide, please. In addition to providing national statistics, like you can see here, they provide data for each state. The report cards provide data points around state-level statutes. While we know that context and unique circumstances exist in each state, and they should be considered, the report cards provide us with a great overview of school mental health policy in each state.

I want to give an example, next slide please, of, I'm just going to use Colorado here as an example, but if you visit their site, they have information for every state. Here you can see at quick glance the total number of K-12 students, approximate number

of students that are experiencing major depression or that have major depression diagnosis, and the number of those students who do not receive any treatment based on national survey level data. They also show the ratios of mental health professionals to students for school psychologists, school social workers, and school counselors.

Like I said, this is available for each state and gives you a general overview of where we are and how those students are being served. Next slide, please. There's eight report card policy categories, I'm just showing two of the eight here as an example. The categories are how many school mental health professionals, school family community partnerships, which I have highlighted, teacher and staff training, funding supports, well-being checks, healthy school climate, skills for life success, et cetera.

You can see, if you look at, for example, the school and family community partnerships, what current policies exist in that state, around that area, and what are some opportunities to influence policy development going forward. Each of the state-level report cards, like I said, also have suggestions on how to improve. Next slide, please. Then you can see how a state ranks over time relative to other states, which is followed up by those suggestions for improvement.

Okay. Child Mind Institute, another great resource. Next slide, please. Then the next slide, sorry, I'm going to fly through a couple of these. Then, Pearson, we have a mental health resource center. You can find a substantial amount of information and resources pertaining to mental health. I highly recommend taking a look at the 2023 industry report on K-12 mental health if you're interested in learning about how mental health-- what the impact was in schools.

Again, there's many organizations to look to and resources to explore to help both schools and communities, mental health professionals, families, and caregivers, et cetera, for all of us to get a better understanding of how to best support our youth in these times. Next slide, please. Part of the focus today is to take a look at how assessment and identification can be utilized and improved. Next slide.

As I mentioned, mental health issues need to be better identified in school settings and otherwise, so that our struggling youth can get their needed services and support. What we've decided in terms of our research, long-term research, but also relative to the current crisis, how can we improve assessment practices? Timely and accurate identification requires application of two best practices to move from our tradition of relying on clinical assessments that have static psychometric properties and then over to the application of a more fluid approach where we are utilizing identification for intervention purposes.

The first is a process that sort of expands the use of differential assessment processes and methods by including an expanded repertoire of tools and then the inclusion of new types of information that we need to gather. Like I said, history and context right now are crucial. We really need to get a good understanding otherwise, how are we going to identify 44% of our student, high school student population with a mental health disorder at this point? Could we? Probably.

We need to take a better look at how are we doing that. How are we addressing this currently and how can we change the way that we assess students so that we're not doing that? Then the second part of that is a more seamless process that connects our assessment results with interventions and services so that we can better guide the efforts that we're putting into intervention services. Okay. Next slide, please.

A comprehensive model of assessment when we're talking about emotional, behavioral, and mental health concerns includes universal screening to identify those students that could be struggling, that might be falling under the radar, might not be aware that they are struggling, followed by increasing levels of assessment, which could include gathering information through interviews and observations, utilizing parent, caregiver, teacher and student self-report rating forms, the typical piece that we get into when we're talking about diagnostic assessment.

We call that broadband assessment. From there, taking that a little step further and going in very deep, narrow-band assessment to determine, okay, yes, they were flagged as potentially having depression. This is what they're experiencing. How can we dig a little deeper and find out how that depression is manifesting itself in that particular child, for example? Therefore, how should we be intervening to best assist this individual instead of just blanket providing services that typically work for someone who's experiencing depression?

Then the last part of that, and where I think that we have faltered, both in schools and in community settings, is monitoring how effective those interventions are over time, and do we need to adapt the interventions or the treatment in order to better suit the needs of that specific child? That would be a comprehensive model on how can we align our assessment practices to match that. Next slide, please.

Before I get into that, I want to call out one thing really quick. This is the CASEL, the Collaborative for Academic and Social-Emotional Learning. This is our framework for SEL, and we know that social-emotional learning is an integral part of education and of human development. While it's an important component in education, screening for SEL and screening for mental health are not the same thing.

Utilizing generalized SEL curricula, which we see a lot of districts doing, great, that's wonderful, they're supporting overall health and satisfaction in life, however, that is not sufficient when it comes to mental health interventions specifically. SEL curricula does not treat anxiety and depression or suicidality. I really want to provide some clarification here, only because there does seem to be a lot of confusion around that, specifically in school districts, as they're adopting more and more SEL curricula.

There's some confusion around how that they might be addressing their mental health concerns through that, and I think they're two very different things, especially when you're talking about screening. Screening for SEL and screening for mental health, like I said, apples and oranges. Next slide, please. I want to also provide a disclaimer here. We are going to be talking about Pearson published assessment tools, we'll talk briefly about the BASC-3, the Beck Youth Inventory, the Brown Executive Function and Intention Scales, and the Advanced DECAF.

There are other assessment tools in the market that may also be relevant and applicable. I want everybody to be aware of that. We're using Pearson-published products as an example here. Next slide there, okay. This is an example how assessment tools can fit into a comprehensive assessment model. This can be applied to schools as well as healthcare and community mental health settings.

We're using the BASC-3, the Behavior Assessment System for Children, 3rd Edition, for those that are not familiar with the BASC-3. As an example here, as it aligns very well with our comprehensive assessment model because it's able to accomplish assessment at each of the individual areas, assessment, and intervention. Next slide, please. We also take a look at the stage gate model.

For example, the BESS, which is a screener version of the BASC, that is administered first. We want to do universal screening, like I said, to be able to capture those students who are struggling that may be flying under the radar. Once we have done a universal screening for all students either coming into schools or at schools or in the community mental health centers, then we're able to determine, are they at risk for mental health concerns?

It will pick up risk or no risk, and that's the extent of it. It truly is a screener. If they're not at risk, then we can exit them. We can address whatever short-term needs they may have. If they are indeed at risk, then we want to move on to a more comprehensive assessment. At that point, you would administer the BASC-3 parent-teacher rating forms and self-report and then determine, are they clinically significant in any of the identifying areas?

Once you've done that, do we need to then move over, if they are clinically significant, go into a more diagnostic assessment. At that point, we might employ more narrow-band assessments like the back-end inventories. We might employ more performance-based assessments to really dig into executive functions, for example. We have a way to determine different stages of assessment. Rather than just giving one standard assessment to all students, there is now a process that can help us differentiate those that are most at risk in the need of service versus those who are not. Next slide.

This is just an example of a report that school districts could get if they do a universal screening. That data can be aggregated or de-aggregated on a variety of variables all the way from the district level down to the individual student level. It just provides a quick snapshot to districts so that they can allocate resources for that. Next slide, please. Actually, I put in the same slide if you can switch to the next slide after that. Thank you.

I'm going to be real quick because I've already come up on my time allotment, but I do want to quickly talk about emotional disturbance and social maladjustment as that pertains to school settings related to IDA. Right now, because we're seeing such an increase in these symptoms related to depression, anxiety, and we're seeing, like I said, 44% of students experiencing this in a persistent manner for the last year, how does that pertain to how we assess for ED?

One of the things that's on there and one of the areas that we take a look at is general pervasive mood of unhappiness or depression. That ties into depression or a tendency to develop physical symptoms or fears associated with personal or school problems and that ties into anxiety. We're naturally going to see an uptick in those that we may identify for ED. Once again, we don't want to overwhelm the system with identifying all those students for special education, but rather, how do we address all of the needs of those students while not identifying them with long-term emotional disturbance? Next slide, please.

I'm sorry. I forgot to tell you to advance it. Go ahead two slides. Sorry about that. The BASC does address that as well and it looks at the emotional behavioral disorders probability index. Next slide. Then breaks down each of the individual criteria for the definition in IDEIA and takes a deeper look at those and determines whether or not that student might be clinically significant. The next few slides, if you could advance two slides, there, I provided some information that I really just want you to be able to reference as part of the slideshow when you receive a copy of the slides.

It's just a behavioral comparison of emotional disturbance versus social maladjustment, which is something critical in the schools to be able to discern whether or not a student is exhibiting behavioral issues because they have an emotional disturbance or they exhibiting that due to social maladjustment. The reason that matters is we can identify them as emotionally disturbed and provide services in a school setting if they have an underlying emotional disturbance.

If they do not, then we have different ways of managing those students. The next three slides just serve as a resource for that. If we could skip ahead, I'm sorry, all the way to slide 42, then I will round out my portion of the presentation. Go ahead and move forward one more after this one. Then I will turn it over to Dr. Moran to discuss challenges in the mental health and healthcare settings.

Current challenges that school psychologists are facing in identifying and supporting students that have an emotional and behavioral disorder, including all of those students that have currently have symptoms related to anxiety and depression are that we are needing to assess student regression behaviorally speaking due to interrupted supports. While that was more of a concern as we were coming out of school closures, there's still an impact and it's still being reported consistently, that behavioral concerns are on the increase in schools and have been since students returned to school after the pandemic.

Identification of additional mental health issues for students that were already identified. The expanded role that school psychologists have, their primary role isn't necessarily mental health supports, it's identification for special education services, in some cases, and supporting students with learning disabilities, and other types of areas that don't pertain specifically to mental health. Now, there's an increased focus in this area.

Then overwhelming and evolving responsibilities as well as a shortage of school psychologists as we've already covered, and then the increased need for assessment and identification. I know that was a lot of fast talking. I hope that it covered enough information for you on the status of our youth mental health crisis.

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We'll have some time for questions at the end. Now, I'm going to pass it over to Dr. Moran.

Patrick Moran: All right. Thank you, Kathleen. You can advance the slide. Go ahead and advance it again. I really want to hit on this idea that in the clinical practices that I think we have to really focus on what's going to have the most bang for the buck, and partly because there is such an overwhelming need right now. Regionally, in my area, some of the public sector institutions are saying, "Call back in 18 months," really just to get services. The idea here is that there's so much need and not enough services, so how do we hone in?

When we're taking assessments of children in the clinical practice outside of the school, even if the therapist, the [unintelligible 00:36:32] at the school is that we really want to do an extensive history. I always liked the Adlerian approach, which was while he was-- And early theorists out around there with the more analytical bank, psychoanalytic bank, you really pulled together families, and schools, and medical, and community services in such a way that you would really get a cohort of folks focusing on how to support children. We can go to the next slide.

How can we, as therapists or psychologists, be informed about this continuum of prevention to treatment? Many of us have been trained historically to really focus on the treatment services that kids get, but it's helpful for us, I think to understand the backdrop of how things develop. For example, from the prevention literature, there's this idea of universal prevention, and Kathleen talked a little bit about that with the [unintelligible 00:37:24], but these are things like wash your hands in the bathroom, that's the universal prevention.

What we really become involved at the therapist level, psychologist level, is that we are beginning to look at more of a tertiary prevention where we know there's an emerging problem but we don't necessarily see it manifesting into a full-blown problem. There's opportunities here for us to really work in collaboration with school systems or community mental health centers or other entities that we can link to to provide information, psychoeducation.

If you see these deep things beginning to emerge, a problem may be over the hill. Then there's this idea of indicated prevention, which is you see the problems beginning to emerge and it's beginning to cross over to the threshold of a clinical diagnostic area. I think this is helpful for us if we can appreciate this continuum of prevention because it also overlay the ideas of the ACEs. Hopefully, many of you are familiar with the ACEs reports that you can get which was based on a collaboration with Kaiser Foundation and the NIH to identify risk factors that contributed to actually early mortality.

Many of those risk factors start in early childhood or childhood such as family disillusion, incarceration, family history of mental health, family history of substance abuse, domestic violence exposure, and so on, and divorced family. With each of these ACEs indicators, you are increasing the risk of the development of problems later on, and that really is in the prevention world. Understanding that, I think as therapists, is that we can then come into our work with children and families with some background understanding. Next slide, please.

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There are many common symptoms also that that we can see that cross really three main domains. There's more, but these are the three ones we want to hone in on, which is the affective domain, physical domain, the cognitive domain. Various disorders will have components of all of these depending on the disorder. Some of those aspects in the cognitive domain such as attention problems, learning problems, may also have a direct correlation to some of their affective dysregulation issues and so on. Next slide.

As an example, these are just three commonly seen disorders of diagnostic conditions with children such as attention deficit, hyperactivity disorder, over anxious disorder, PTSD. Then more recently, the emotional dysregulation disorder that children are seeing, attachment disorders, and so on. All of these diagnostic areas have impact across these three main areas of affective, physical, and cognitive, and so our being able to accurately assess that and then the design interventions that we hone in on those what I like to call hotspots, sometimes you can be more productive with the services that you're providing. Next slide, please.

One of the things that I observed and many of my colleagues have observed is that with COVID and as Kathleen has mentioned, is that we saw an incredible spike in mental health symptoms of anxiety, depression, social problems, suicidality, and so on and that many of these students that are coming to us experienced delays in some of those critical social interactions that were essential in development during pre-adolescent and adolescent because everything converted to basically Zoom. All those school interactions that you would have even between classes, even during class, that you would've person to person was now removed.

We're really seeing this ripple effect down the line of some underdeveloped social acuity skills and social fluidity skills. The other thing is that we clearly saw an exacerbation of mental health problems that might not have manifested under other circumstances. These are the anxieties and depressions and the suicidal and so on, and that many of practitioners before COVID might have had difficulty getting referrals, but during COVID and afterwards is now we have wait lists for folks to get in because everybody's now recognizing the need for this additional support.

The service world has changed. We mentioned suicide ideation, a spike, and that a particular problem is that there's a flood of children now who are needing evaluations for ASD potentially on "The spectrum" that are having very difficulty times getting into the property evaluation process, and then designated services that would come from that. Next slide.

What do we need to do as clinicians to expedite the identification support? First of all, I think I like this concept of doing quick rapid assessment. Ideally, it would be great if everybody can get a full comprehensive evaluation if it was necessary and then you get targeted identification of issues, and then you plan your treatments around that.

That's not always practical. Sometimes what ends up happening is you get referrals in the services or from the schools or from insurances or whatever and you want to really hone in on some of those areas that you can be most actively effective early on. We, as clinicians, need to be able to target these as quickly as we can. Doing

interviews is great, but we also know the interviews rely historically [unintelligible 00:42:22] or reliability [unintelligible 00:42:23]. Also, parents also need a lot of support in how to assist their children and help manage mental health problems in their children.

As we all know, as clinicians, is that if a child comes in for a specific area of concern or issue, inevitably we have to work and consult with the parents. Particularly if they're at risk of some of these areas of the ACEs vulnerabilities I mentioned because these are often family system problems that are manifesting that need to be handled. I can't tell you how many problems the kids are having because parents that are divorced are not getting along well. One parent feels more supportive and less supportive of the child and the children know this.

Having the capacity to manage that is really important, that clearly, many families have trauma from COVID, from loss of jobs, maybe their own mental health issues that got exacerbated, death of family members, and so on. Then as I mentioned, more practitioners are needed to diagnose and then treat ASD or spectrum-related issues. Next slide.

Expedited identification is more important now than ever to do rapid assessment, to get prompt entry into care, use efficient reliable methods to identify needs, and then to use what you identify in these rapid assessments to retarget your treatment and then roll out best practice tools to facilitate those treatment, which we're not going to cover today because not enough time.

There are many resources that are available to working with children through really structured or semi-structured manualized approaches, which I'm not a big proponent of do manualized treatment, but it offers really good scaffolding around which you can modulate or moderate some of the targeted treatment efforts that you have. Then using multiple data input is also very important to get a well-rounded view of the child's struggle. Not just doing an evaluation or not just doing an interview or not just the history from the parents but really all of them. Next slide.

Some of the best practice tools that I use and have used is the Becks Family tools, the BASC which Kathleen mentioned. Then there are some executive functioning and the ADHD tools that are frequently used. The top three referrals that seem to come into clinical practice these days are issues around ADD, ADHD behavioral dysregulation, and depression, and anxiety. Actually, top four then ASD seem to be the four main referrals. Come on. Next slide, please.

Nice thing about the Beck Youth Inventories specifically is it really breaks it down into five main areas. The first one is the depression one. The thing about depression that's important to note folks is that depression is not necessarily predictive of suicide. Hopelessness is. Aaron Beck's research identified that in adults and young adults age 13 and older, is that those who are at risk for hopelessness in a longitudinal study that 75% of them had tried to commit suicide. Of that 75%, two-thirds are more successful. I always hone in on depression, and I hone in on demoralization. Beck Anxiety Inventory for anxiety, where part is the anxiety specific, obviously. Then go next slide, please.

Then Beck Youth Anger Inventory for some of those kids who maybe feel bullied or mistreated and maybe have negative thoughts about others and you want to act out in anger, which you often will see with kids who have ADD and ADHD as well. Then disruptive behavior component is really looking at more some of those express conduct disorder-related behaviors and then self-concept, which is a critical aspect of positive self-regard, positive self-esteem, and you want to be able to get an assessment of their internal sense of self-worth, particularly if you're suspecting hopelessness and demoralization. Next slide.

I'm going to finish up in about a minute, guys. Next slide, please. Some quick facts about ADHD that here on your slide. I'm not going to belabor this too much partly because it's already talked about and we're out of time. You have this available for your reference. Next slide.

Nice thing about the BASC is that it allows you to get a comprehensive data input from teachers, the self-report and parent report, and sometimes collateral. The really important thing about the self-report for kids that are old enough to do it is it often captures things that are not externalized behaviors such as anxiety and depression. That's one of the key reasons we would use it with youth. Whereas usually the parents and the teachers say, yes, we can identify the problems, but they don't necessarily know what's going on inside the child's black box. I use it a lot to identifying depression and anxiety, attention problems, chronic problems, and these kind of things. Next slide, please.

Then, as Kathleen mentioned, it also has clinical probability indexes, which are helpful for you for diagnostic purposes, and then shaping your treatment focus. Next slide, please.

Then, it also breaks down into core content scales to give you more specific details of focus as to how they're loading in their behavioral issues. Next slide, please. Really quickly, Thomas Brown used to manage the Yale Child Study Center. He created a series of scales for youth, which I like a lot. The thing I like about the Brown Scales is that they really focus on the executive function component of the ADD, ADHD spectrum.

He also takes into context motivation and context. You'll often hear he has great attention when he is doing this or that. That's because the child's interested in that. That's a classic feature of ADD, ADHD is that if they're into it, they can focus, but everything else is a mess. I'll use the Brown to really help identify that for the children and the parents in my work with them. Next slide, please. This is a summary of how Dr. Brown organizes his tool. You can have that available just to reference later. Next slide, please.

The other thing is that it's dimensional. It's not an all-or-nothing, yes, no response, and that it allows for situational variability and how he designs me the questions that he asked in his test. Next slide, please. Then the D-REF is an extension of the work that Dean Delis did with the active executive functioning tools. This is a report measure that also covers some of the same areas that we talked about with the Brown. It's really based on Dean Delis' model of executive functioning. I will use

these action in combination with each other when I'm looking at these issues with children.

I know we're going to go over so I think I'm going to go to the next slide if there's anything I need to hit on. I mentioned these are some other performance-based measures that the D-KEFS is something that you do give and face time with the child or adult and then NEPSY as well, which covers areas of executive functioning language, social-emotional components as well, has six areas that you want to hit on. Hammer through that very quickly, but let's go to the next slide and we'll open up for questions.

Moderator: Awesome. Thank you both so much. We've been getting some good questions in the Q&A box. Keep them coming if you have questions for our presenters. I'll start with combining some similar questions into one. As you mentioned earlier, a big challenge in schools is treatment given the shortage of mental health practitioners. How can this be addressed in the short term and how do you best align assessment with school-based treatment?

Kathleen: I'll take that one, Pat. That is multidimensional in nature, first of all. You have the idea that there's shortages, so then how do we address not only the assessment aspect of that, but the needs of all the students. One way that districts are approaching this is to provide more mental health services district-wide as an option for students, whether that's group services or classes that focus specifically on discussing mental health, working those topics into health classes that already exist. Really pushing that as a way to reduce the stigma around mental health and to bring it as a topic that students feel free to talk about.

The second part of that question, I think, pertains also to funding. Funding sources are changing. We're starting to see more pockets of funding dedicated specifically to finding mental health professionals, training mental health professionals, and helping schools, staff, whether that's teachers or other educators become more aware of mental health concerns in the classrooms.

There's some work that's starting to be done. We're obviously a long way from where we need to be right now. I think awareness is the biggest key to starting to address this crisis and being able to openly discuss the concerns that we see.

Patrick: Can I add one thing is many schools also have FQHCs, which are federally qualified health clinics that are often on campuses or associated with campuses where they have social workers and therapists who actually do work with kids. Those are also billable often through Medicaid. The schools would like to be able to have those because they can provide the services, but also get reimbursed if done appropriately.

The other thing I want to add about that is that many times you can get longitudinal care with kids because if you can get integrated into the school as a therapist to whatever degree, you can actually end up working with kids for sometimes six years. That can be some of the best developmental experiences they have, particularly if they're stressed communities and families and so on.

Moderator: Great. Thank you. We've gotten some questions on using assessments with some more specific disorders particularly substance use disorder, eating disorders, and students that are on the autism spectrum. If you all could speak to those three subgroups.

Patrick: The autism spectrum, there are a number of tools that are out there. We publish internally, obviously, the BASC is one that helps identify the presence of autism. We have a number that Pearson have. There's some other ones that are required for Medicaid reimbursement in some states. That would be-- What's that one? That's at the tip of--

Kathleen: The ADOS.

Patrick: ADOS, yes.

Kathleen: Published by WPS.

Patrick: Depending on where you are, those are critical threshold tests. The BASC is also frequently used in other measures as well. When you get to eating disorders, you're really getting into some intense dynamics that are often involved. Inevitably there's going to be some family issues that you're going to want to be able to address, family dynamic stuff. As a part of eating disorder, identification treatment, if you're familiar with it at all, is that there are some really rigid cognitive biases that the child suffering from eating disorders have.

You have to be able to work with them to begin to dismantle some of those rigid structures of self-appraisal that cause them a lot of this stress. Denial it's a very significant thing when it comes to eating disorder. There are targeted eating disorder inventories that are out there, that can also give you some insight into what their internal processes are, attitudes about themselves and food, these things are. What was the other one? It was eating disorders and what was the other one?

Moderator: It was eating disorders, autism, and substance use disorders.

Patrick: Substance use disorders is you can often find some early indicators of risk for that with the tools that are available. the BASC has it, the MPI has it. The A&D alcohol and drug treatment realm has a bunch of tools that are really best practice tools that have identified basically by SAMHSA, the NIH that have very structured approaches, which are typically intensive interviews with some testing.

Usually, it's more history that's aligned to the ASAM criteria, which is the American Society of Addiction Medicine. If you're going to really looking into identifying, diagnosing substance use, you really have to be familiar with the ASAM if you're going to be talking the language of what the industry provided and how they developed their treatment around it.

Kathleen: I just want to follow up quickly is that kind of evaluation looks very different in the schools, of course. Oftentimes is a referral out to community agencies, but it's a critical piece of identification within the background information and the interviews that you're doing in order to rule that out prior to making other types of classifications and identifications.

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Patrick: One more thing about that is many community mental health centers have grant funding programs to put prevention specialists in the schools. I talked about those prevention models. The universal tertiary indicated is they're working looking for this tertiary indicated use. Having relationships as a therapist with those [unintelligible 00:55:38] programs, you can really develop a pretty active practice in linking them to the necessary support they need in the community. Because schools will probably not treat alcohol and drug treatment per se, but with embedded counselors, they can do some of that. I've experienced though.

Kathleen: Yes, I agree.

Moderator: Great. Thank you. I think we have time for one more question. Again, I'm going to mash a few together here. Could you talk a little bit to how these instruments and assessments are used with culturally diverse students or students of non-white backgrounds? Is there any difference or how does that play into [unintelligible 00:56:15]?

Kathleen: I'll start with an answer to that and have you expand upon that Dr. Moran. As we're standardizing the tools, we are employing standardization methods that include all diverse backgrounds. We have different types of ways to gather that data and it's based on current census data. Now, that doesn't mean that every assessment tool is perfectly designed for specific groups of folks.

That is a piece that needs to be taken into context as well as the living situations in the culture from which they are originating. In the schools, certainly, there's a tendency to be because there's less time for diagnostic assessment. We're spending more time trying to gather information about whether or not a student could qualify for special education. It's more prescriptive in that way.

The assessment tools tend to be more broad. I think when you get into private practice or community mental health, you have the opportunity in a lot of cases to be more specific. Pat, I'll let you take it from there.

Patrick: I think to echo that, there are some tools that have been developed with culturally specific norms, particularly for IQ testing and these kinds of things and achievement testing. All the major developers have some of these to some degree. Inevitably what will happen is you'll have a private practitioner who's really knowledgeable in the content area for that cultural group.

They will basically have to take those assessments that are not necessarily developed specifically for that group and they'll have to filter the content based on their knowledge and experience within that appropriate cultural group. Those tend to be more complex assessments in many ways because they tend to be more nuanced based on your knowledge or that provider's knowledge of the community in which they're serving.

Now, this is probably going to be changing over time as we continue to expand and develop the use of Pearson because we have such an international footprint that we do provide the development of culturally specific tests in other countries, in other

nations, in South America and Central America. A lot of those will often make their way up here. It's an active dynamic issue for sure that the industry is focusing on.

I don't know if that answers the question. People are trying to do their best to service the needs as best they can with some of the limitations that are available. One final thing is I'll say that I've worked for years. 18 years I worked with the Native American community. A lot of what we would have to do is we didn't take a traditional approach is that we would really weave it into some of the traditions and spiritual practices of that community and how they would work with the children and youth.

Then being able to align some of those actions and activities with the language within that community was really important. I think if you don't have that direct experience yourself, having partnerships within the communities who service these folks, these kids, and the families can really give you a leg up as far as the competency in working with those groups. Because if they believe in you, then they accept you, and then they accept what you have to offer and provide and support. You can't just go in and say, "Here, I got the answers for you to do this." You really often have to partner and develop your validity as a provider.

Moderator: Awesome. Unfortunately, that is all the time we have for today. Thank you both so much for joining us and for your wonderful presentation. Thank you to everyone on the line for your participation and thank you to Pearson from making today's webinar possible. A recording of today's webinar will be emailed to everyone within the next two weeks and that email will also include a copy of the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. We ask that you please take that survey and give us your feedback. Thank you all again so much and we hope you have a wonderful rest of your day and a fantastic weekend.

Kathleen: Thanks, everybody.

Patrick: Thank you, everyone.

[01:00:24] [END OF AUDIO]