NYC Early Childhood Mental Health Network - Use of Standardized Screening and Clinical Tools

January 6, 2017

Presented by the Early Childhood Mental Health Training & Technical Assistance Center and

NYC DOHMH, Bureau of Children, Youth, and Families

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Learning objectives

- Develop greater understanding for integrating use of standardized questionnaires into Early Childhood Therapeutic Centers' (ECTC) clinical assessments and school consultations
- Explore use and scoring of specific standardized questionnaires including those for parent screening
- Clarify reporting requirements to DOHMH

Today's Schedule

9-9:15	**Introduction and Overview**
9:15-10:35	Review of tools and protocols for clinical treatment at ECTCs
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation at EarlyLearn sites
12-1	Lunch (provided)
1-3	DECA Webinar
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Overview of tools required by DOHMH

- Treatment Tools and Protocols

Overview of tools required by DOHMH

- Mental Health Consultation Tools and Protocols for EarlyLearn Centers

Today's Schedule

9-9:15	Introduction and Overview
9:15-10:35	**Review of tools and protocols for clinical treatment at ECTCs –** PSI-SF, PHQ-9, Parent ACE, FACS
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for consultation at EarlyLearn sites
12-1	Lunch (provided)
1-3	DECA Webinar
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Components of mental health assessment

Basic components of mental health evaluation regardless of the age of the patient

- **What's going on now**? What are the problems? What are the strengths?
- Is there functional **impairment**?
- What is the **past history** of mental health issues and any prior treatment?
- **Additional information** that is crucial – medical history, social history, family history, developmental and educational history

Components of mental health assessment

- **Mental status exam** – clinician's observations of various aspects of how the patient presents right now
- Observation in another **environment** (like school) may be extremely helpful as well
- Sometimes some bloodwork or other **testing** (medical or developmental) is indicated to rule out other problems*
- **Standardized questionnaires** are also frequently used to help the clinician be a little more objective and to ensure all important aspects of symptoms are covered

*no mental health problems have specific tests that are diagnostic at this point, but there are medical problems that can masquerade as mental health issues

Special considerations - early childhood assessment

Mental health symptoms cannot be isolated from

- the parent-child relationship
- the environmental context
- child's physical and developmental status
- acute and chronic stressors
- biological features
- the mental health of the parent
- the parent's thoughts or attributions about the child

For a thoughtful and accurate evaluation the clinician will be collecting a lot of information, likely over several meetings with parent alone and also with parent & child

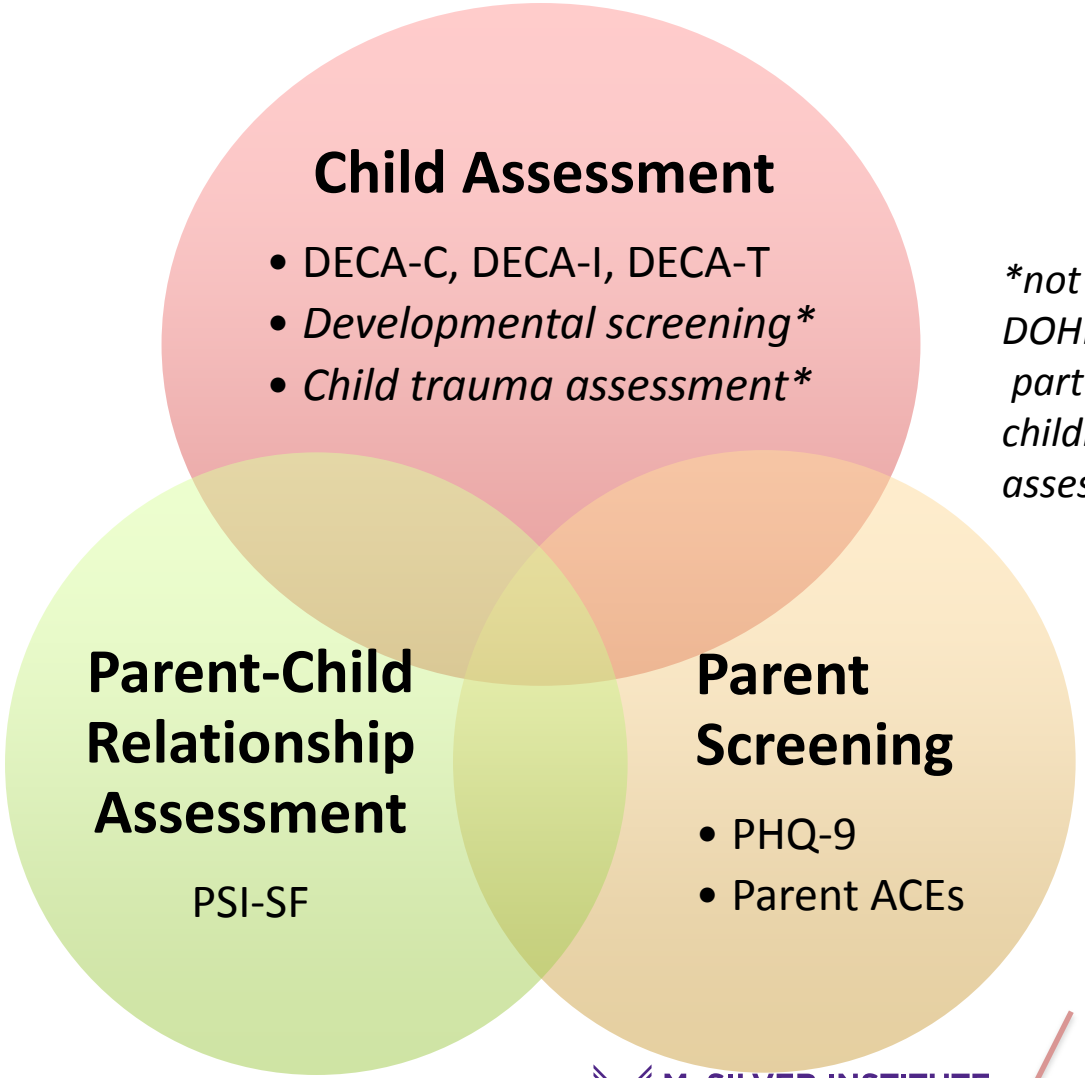
Use of standardized questionnaires

- Structured collection of information you need anyway
  - Normalizes – everybody gets asked same questions in the same way
  - Demystifies questions
  - Objective rating for you to measure effect of your treatment
- Allows collection of standardized information across patients for clinic and program analysis

Workflow for standardized questionnaires

- Some questions for workflow:
  - When do you do the questionnaires?
    - During intake, which intake session works best for each form?
    - When do you incorporate follow-up questionnaires during treatment?
  - Do you have parents self-administer on paper or have clinician incorporate into interview?
  - Either way, how do you introduce questionnaires to parents?
  - Who scores the questionnaires?
  - How does the clinician review the questionnaire results with the parents?
  - How are the questionnaires incorporated in the documentation of the overall assessment?

ECMH Network Assessment Tools



**not required by DOHMH but usually part of early childhood assessments*

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Overview of each instrument

This tool evaluates . . .

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

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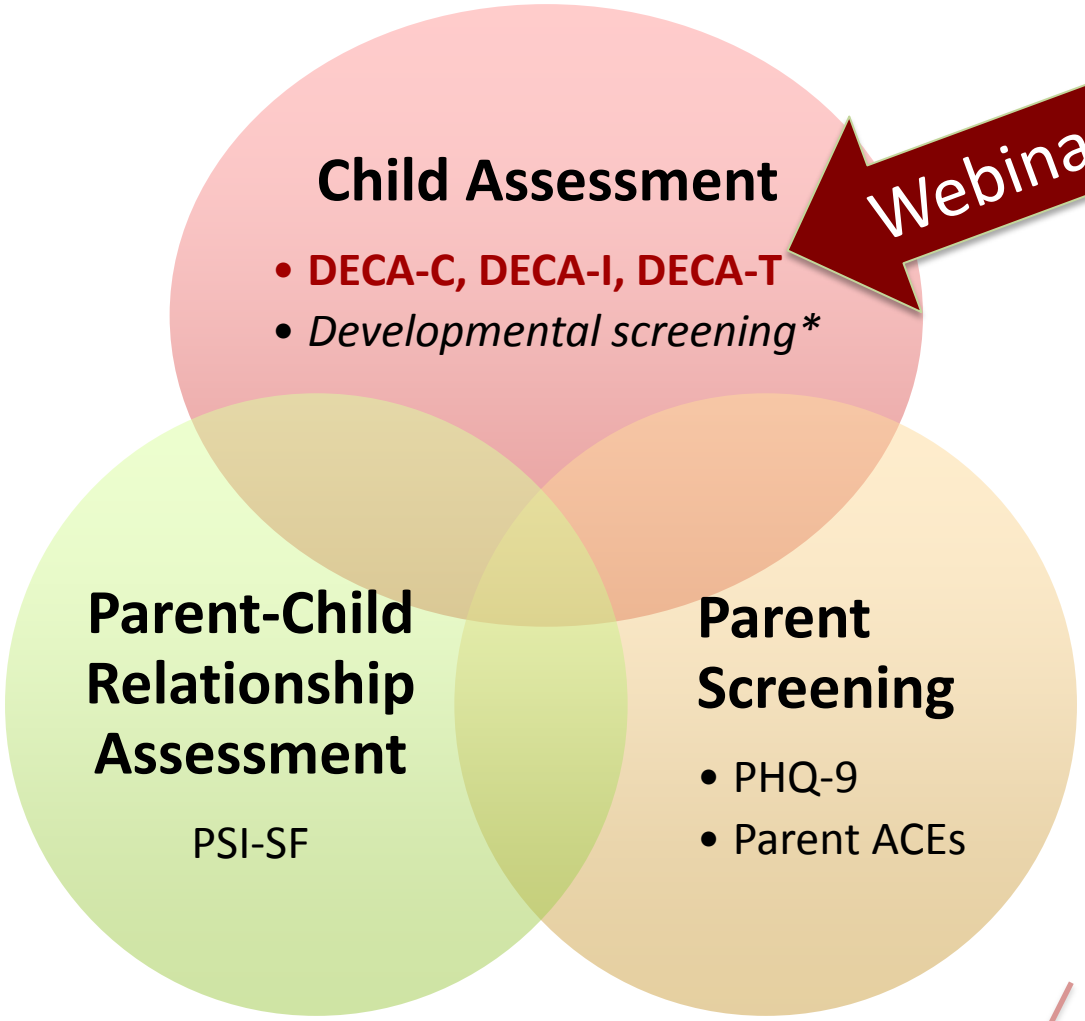
ECMH Assessment Tools



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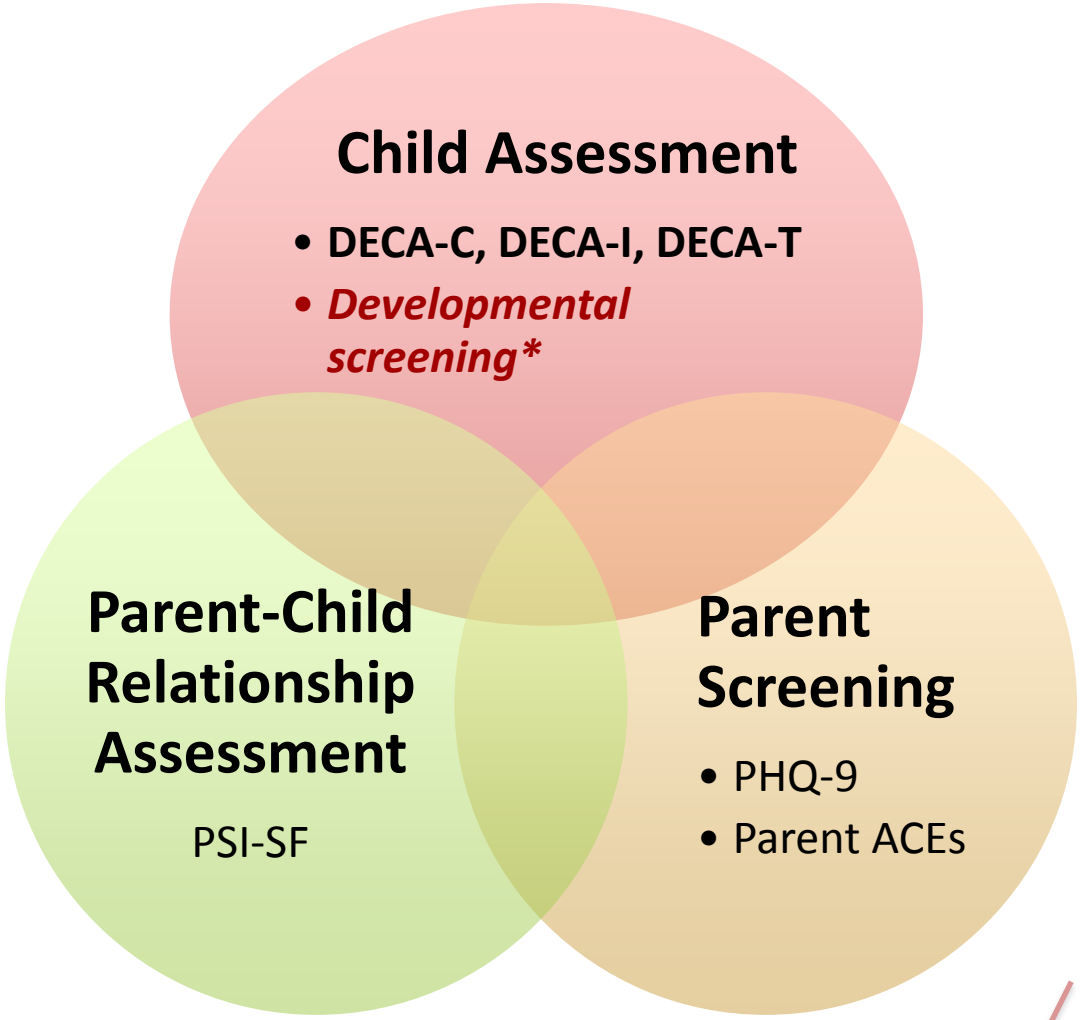
ECMH Assessment Tools



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Developmental Screening Tools

- DOHMH is not requiring that sites administer a developmental screening tool
- Clinical assessment may indicate this is needed
- Commonly used tools for developmental screening include the Ages & Stages Questionnaire, the SWYC Developmental Milestones, and the M-CHAT-R

Ages & Stages Questionnaire

- ASQ-3 available through Brooks Publishers
- Series of age-related questionnaires meant to be completed by parents in order to screen for developmental delays in children

  1 -66 months
- Assesses children in 5 domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal Social

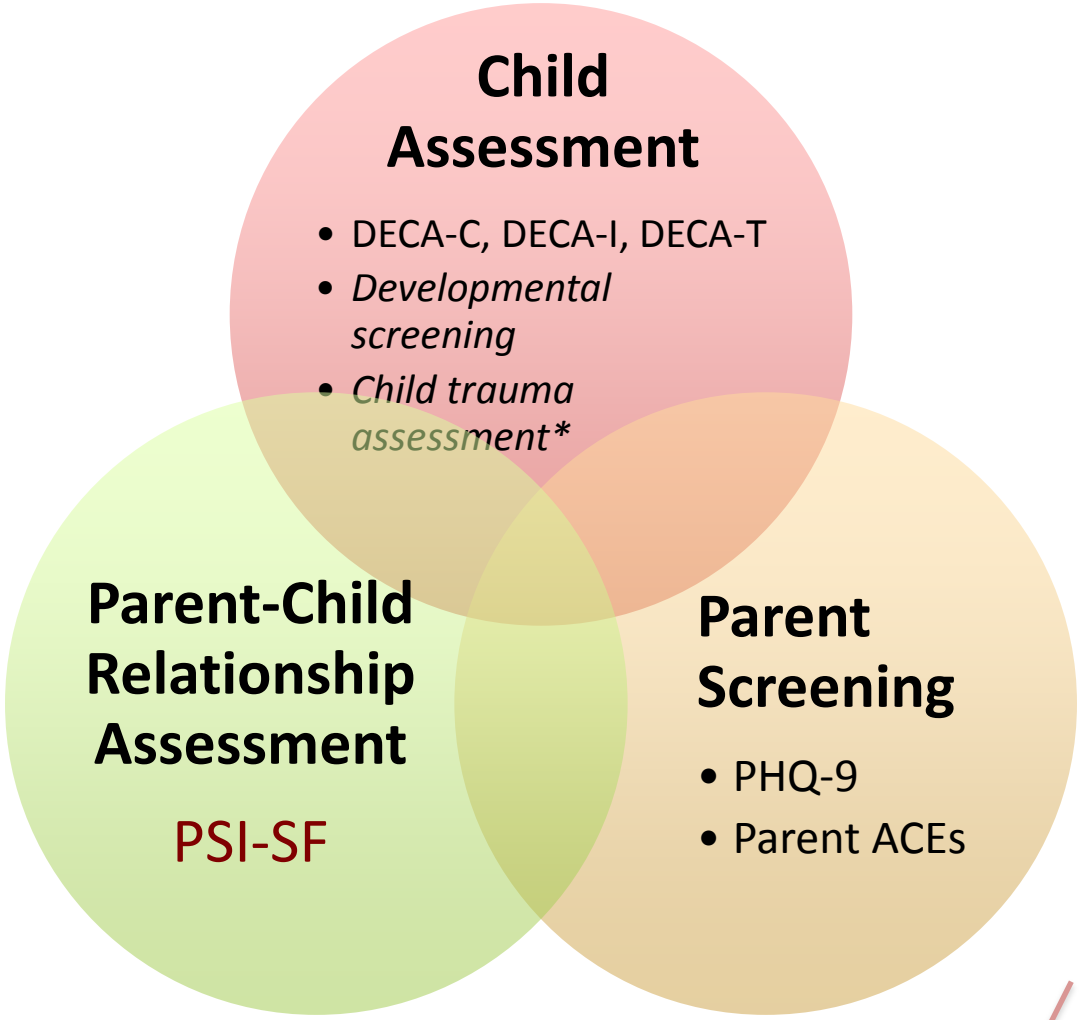
SWYC Developmental Milestones

- The Survey of Well-Being of Young Children is a publically available, comprehensive screening instrument for children under 5
- Every age-specific form (from 2 to 60 months) includes a section on developmental milestones
- At certain ages, a section for autism-specific screening is also included

M-CHAT-R

- The Modified Checklist for Autism in Toddlers-Revised is a 2 stage parent report screening tool to assess risk for autism spectrum disorder (ASD)
- Designed to identify children 16-30 months of age who should receive a more thorough assessment for early signs of autism or developmental delay
- Free, available on line, easy to administer (20 items) and score

ECMH Assessment Tools



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Parenting Stress Index: Short Form

Purpose: Early identification of parent-child systems under stress in order to put interventions in place to reduce stress

Underlying Assumption: Stress in the parent-child relationship, or parental stress or distress, particularly in early childhood, is a risk or contributing factor to children's emotional or behavioral problems

Additional Assumptions

- Stressors are multidimensional in source and type
  - Child characteristics
  - Parent characteristics
  - Situational/demographic life stress
- Stressors or sources of stress are additive

PSI:SF

- The PSI: Short Form is an abbreviated version of the original, full PSI Scale

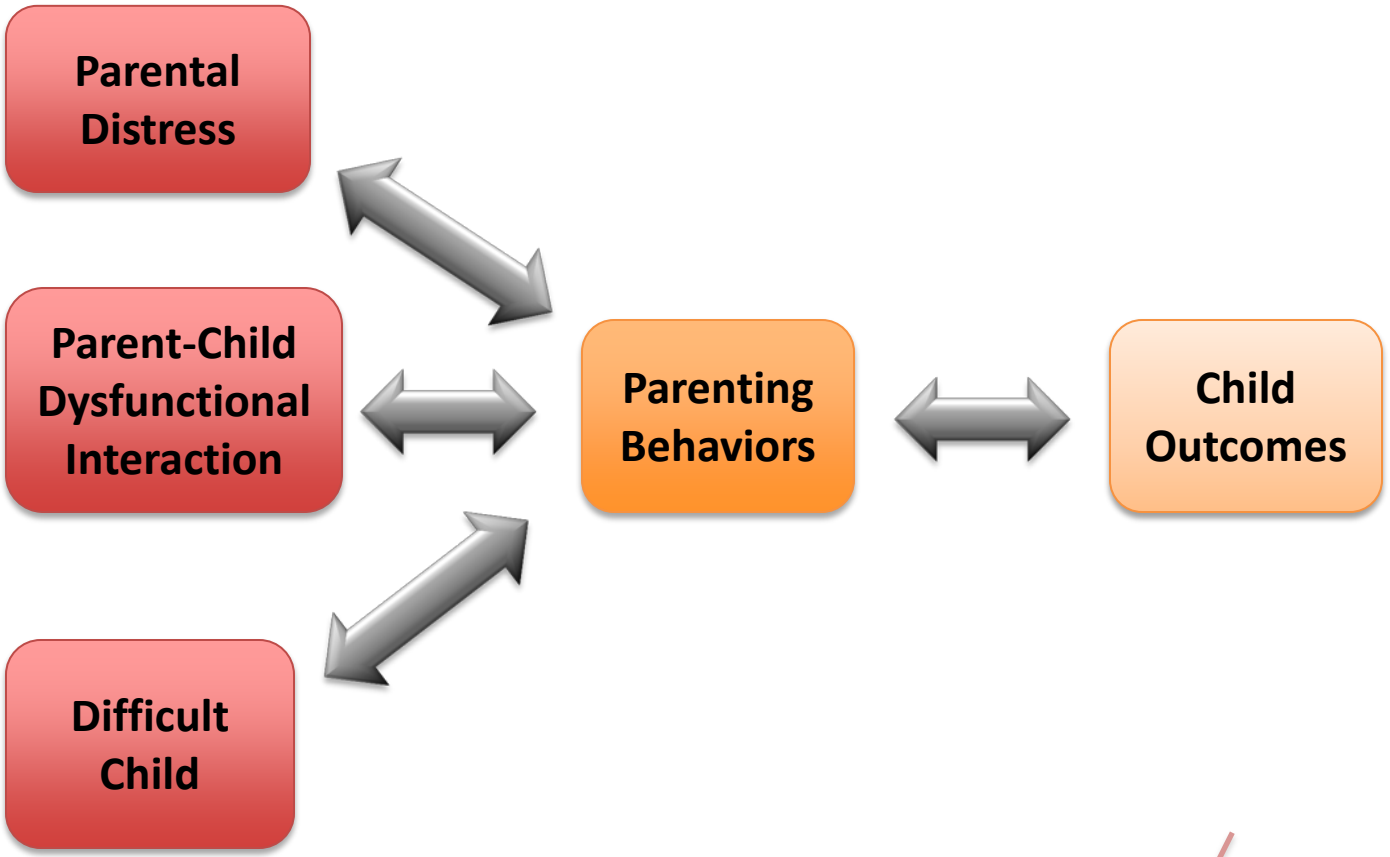
  36 items versus 101

- Can be used for children as young as 1 month of age

PSI-SF Scale Descriptions

- Parental Distress (PD): assesses the level of stress a parent reports as a function of personal factors related to parenting
- Parent-Child Dysfunctional Interaction (P-CDI): assesses the extent to which the parent perceives the child as not meeting expectations and finds that interactions with the child are not reinforcing his/her parenting role
- Difficult Child (DC): assesses the temperament or behavioral characteristics of the child that influence the parent-child relationship
- Total Stress: assesses the overall level of parenting stress experienced by the respondent

PSI Assumptions



Administration of PSI:SF

- Materials include the manual and the hand-scorable profile form
- The front page of the form contains instructions for completing
- Most items are scored by rating Strongly Agree; Agree; Not Sure; Disagree; and Strongly Disagree
- Three items require the respondent to choose a response from choices that appear below the question
- Parent should be instructed to X out item responses they want to change

Administration of PSI:SF

- Pages 2 and 3 include an area for recording demographic information, the 36 items, and an area for recording responses
- Provide parent with comfortable space for reading and recording answers
- Provide a pen or pencil
- Provide a short explanation of the form to the parent and explain instructions
- Ask if the parent would feel more comfortable if you read the items to him/her
- Remain close by in case parent has any questions about particular items

PSI-SF Explanation

- We have learned so much about the presence of stress in the lives of families with young children and about the need to be sure that parents' stress is addressed and relieved, whenever possible.

- We are asking you to complete this questionnaire so that we know all the ways we might be helpful to your child and family, and best support the relationship between you and your child.

- We will share the results with you when we review your child's treatment plan.

Scoring

- Tear off perforated strip at right side of record form and lift top portion to reveal scoring and profile sheet below. The demographic info and circled item responses are reproduced on this sheet.

- First, sum the responses to the seven light green shaded items (#s 1, 2, 3, 7, 8, 9 and 11) and write this value in box labeled Defensive Responding.
- Then calculate subscale scores. Each group of 12 items corresponds to a PSI-SF subscale.
  - Sum item responses for items 1-12 and record this value in box labeled PD
  - Sum responses to items 13-24 and record in box labeled P-CDI
  - Sum responses to items 25-36 and record in box labeled DC
  - Sum the raw scores for the PD, P-CDI and DC subscales and record this value in box labeled Total Stress

Profiling

- Transfer the 3 subscale scores and the Total Stress Score to the appropriate blanks at the bottom of the profile table.
- For each column, locate the raw score or range of raw scores in the body of the table and mark each place with an X.
- Look at the column at the far left or far right to locate the percentile that corresponds to each raw score or range of scores.
- Connect the X marks with a line to create a profile of the respondent's scores.
- Missing Data: Scores should not be calculated if more than one item is missing from any subscale.
- If only one is missing from a subscale, calculate the average of the responses that are given and use that value (round to the nearest whole number).

Interpretation

- Both T scores and percentiles are used as normative metrics.
- The primary interpretive framework is percentile-based. The profile table embedded in the record/profile form enables examiner to rapidly convert raw scores to percentiles.
- Tables for converting raw scores to T scores are provided in the Appendices of the manual (Appendix D).
- The normal range of scores is within the 16^{th} to 84^{th} percentiles.
- Scores in the 85^{th} to 89^{th} percentile are considered high.
- Scores in the 90^{th} percentile and higher are considered clinically significant.

Interpretation PSI-SF

Defensive Responding Scale: Assesses the extent to which the respondent answers with a strong bias to present the most favorable impression of him/herself or to minimize indications of problems or stress in the parent child relationship. An extremely low score – raw score of 10 or lower – suggests:

1. Parent trying to portray herself as a very competent person who is free of the emotional stresses normally associated with parenting
2. Parent is not invested in the role as parent and, therefore, is not experiencing the usual stresses associated with parenting
3. Parent is, in fact, a very competent person who handles the responsibilities of parenting well and has excellent relations with others, including his/her spouse.

When this score is examined in relation to other information obtained, the examiner is usually able to pinpoint the most likely explanation.

Interpretation PSI-SF

Total Stress:

- Provides an indication of the overall level of parenting stress person is experiencing. A score in the 91st percentile or above reflects clinically significant levels of stress

Parenting Distress (PD):

• The level of stress a parent is experiencing as a function of personal factors directly related to parenting (e.g. impaired sense of parenting competence, stresses associated with the restrictions placed on other life roles, conflict with the child's other parent, lack of social support, and depression.)

• When the PD score is the most elevated, and especially when PD score is above the 90th percentile and the DC score is below the 75th percentile, it is likely that the parent is experiencing personal adjustment problems that are at least partially independent of the parent-child relationship.

• Focus of professional services should be on interventions designed to assist parent in his/her personal adjustment

Interpretation PSI-SF

Parent-Child Dysfunctional Interaction (P-CDI)

- Focuses on parent's perception that child does not meet her expectations and that her interactions with the child are not reinforcing to her as a parent.
- Parent projects the feeling that the child is a negative element in her life.
- High scores suggest the parent-child bond is either threatened or has never been adequately established.
- Scores in the 96th percentile or higher suggest the potential for neglect, rejection, or episodes of physical abuse triggered by frustration

Interpretation PSI-SF

When considering risk for abuse, examiner should review Total Stress score and subscale scores

- If all three subscale scores are in the 91st percentile or higher, this interpretation is credible
- If PD subscale is in the 75th percentile or lower, parental loss of control is not likely
- If both P-CDI and DC subscores are in the 91st percentile or higher and PD score is in the 75th percentile or lower, it is likely parent is coping with very difficult behavior in child

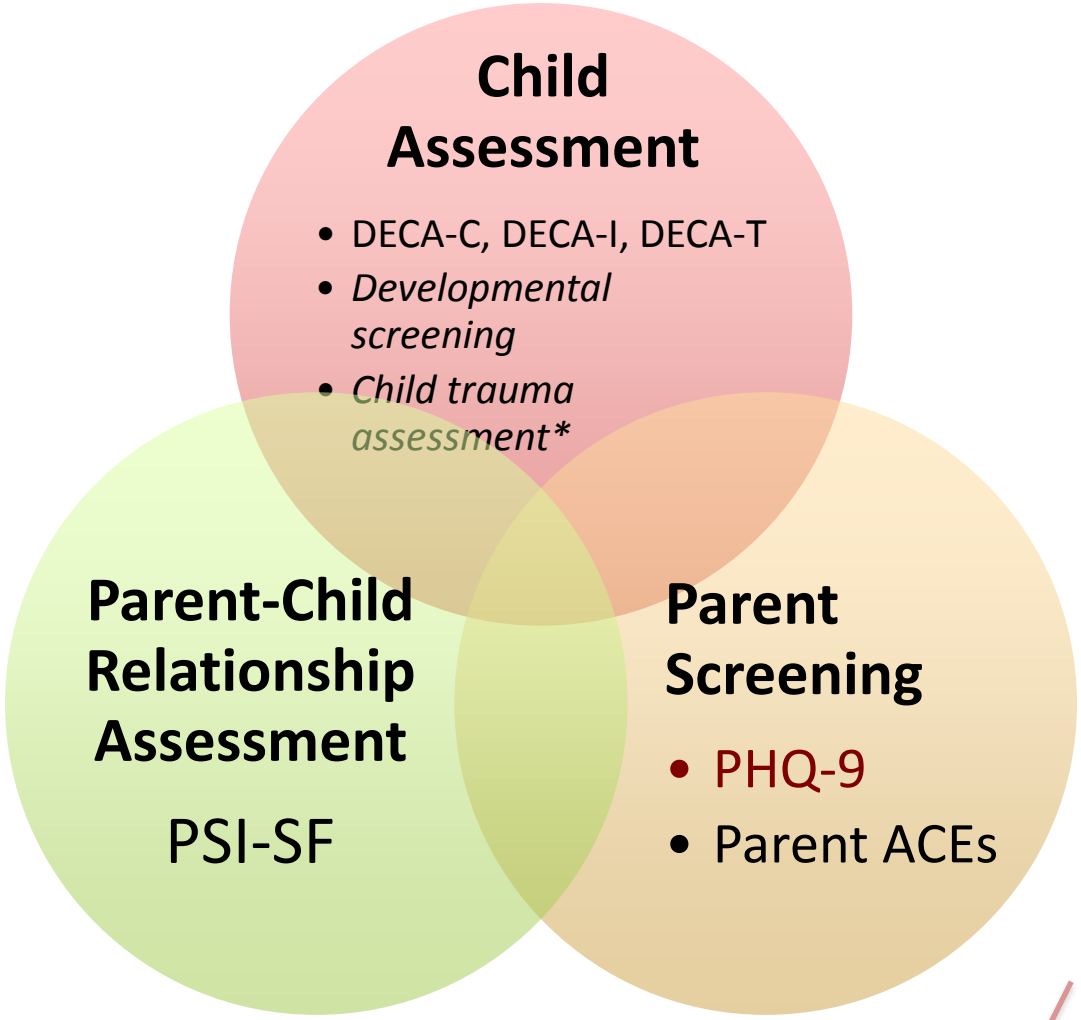
Difficult Child (DC)

- Focuses on the basic behavioral characteristics of children that make them either easy or difficult to manage
- High DC subscale scores produced by parents of children under 18 months suggest child may have significant difficulties with self-regulation
- If DC score is over 91st percentile, suggests parent is having a lot of difficulty managing the child's behavior.

PSI-SF Reporting to DOHMH

- Intake
- At 6-month treatment plan update (or at discharge if that occurs prior to 6 months)

ECMH Assessment Tools



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Stand up and stretch

- Now . . .
  - Sit down if you've screened for parent depression as part of your assessments in the past
  - Stand up if you feel this is challenging to do sometimes
  - Touch your elbow if you think paying attention to parent depression has been helpful in your work with a child in the past
  - Turn around
  - Sit down

Why is maternal depression important?

- DOHMH is requiring screening at intake
- But more importantly,
  - Parent mental health and functioning is vitally important to young children
  - Conversely, child symptoms may not improve if the mother's mental health is not addressed

National statistics about depression

- In any 2-week period, 7.6% of people age 12 and older are struggling with depression
  - 3% with severe symptoms

- Female:male rates of depression almost 2:1
  - In females from age 18-44, 1 in 10 depressed in the past year
  - Prevalence of maternal depression also 10% overall
  - History of depression, history of adverse childhood experiences, living in poverty, inadequate social support, homelessness and other factors are associated with increased risk of maternal depression
    - Some studies (for example, WIC in PA) find rates as high as 38%

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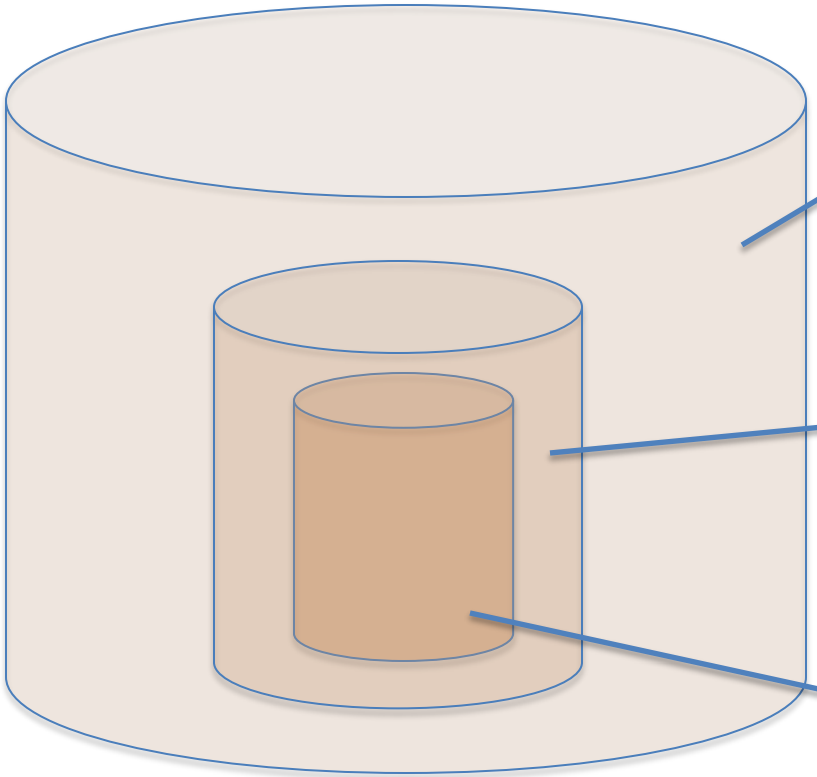
Postpartum blues versus depression

Postpartum blues	Postpartum depression
50-85% of women	10-20% of women
Starts 4-5 days after delivery, brief	Emerges anytime in the 2-3 months after delivery
Mood lability, tearfulness, irritability, anxiety	Depressed or irritable mood, sleep and appetite disturbance, etc.
Remits on it's own within 2 weeks of delivery – not really an illness	Could last for months and be associated with negative outcomes

Both postpartum blues and postpartum depression are thought to be related to shifts in hormones after delivery – and there are other risk factors for postpartum depression . . .

Maternal depression terms



Depression

Maternal depression

Perinatal depression

Antenatal depression

Postpartum depression

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Challenges associated with maternal depression in the postpartum period

- Negative effects for the mother
  - Social isolation, fatigue, difficulty maintaining basic level of function, etc.
- Interference with mother-infant bonding
  - Mothers are less active, more emotionally flat and disengaged
  - Mothers have less well-timed responsiveness and struggle with establishing predictable routines for their infants
  - Mothers demonstrate lower levels of warm acceptance
  - Mothers more likely to engage in obesity promoting feeding behaviors
  - Later on, children have more problems with social behavior, ADHD, and adolescent depression as well as evidence of developmental delays and more frequent insecure attachment. . .

https://www.ncbi.nlm.nih.gov/pubmed/26879925

Challenges Associated with Maternal Depression in Later Childhood

- Maternal depression may impact on child physical health
  - Increased use of acute care visits (emergency department) & decreased receipt of preventive services including well-child visits and up-to-date vaccinations
  - More problems with child using inhalers properly, forgetting doses of medication for asthma
- High rates of childhood mental health disorders
  - Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial
    - Depressed mothers, children age 7-17
    - Children - 34% current psychiatric disorder, 45% lifetime

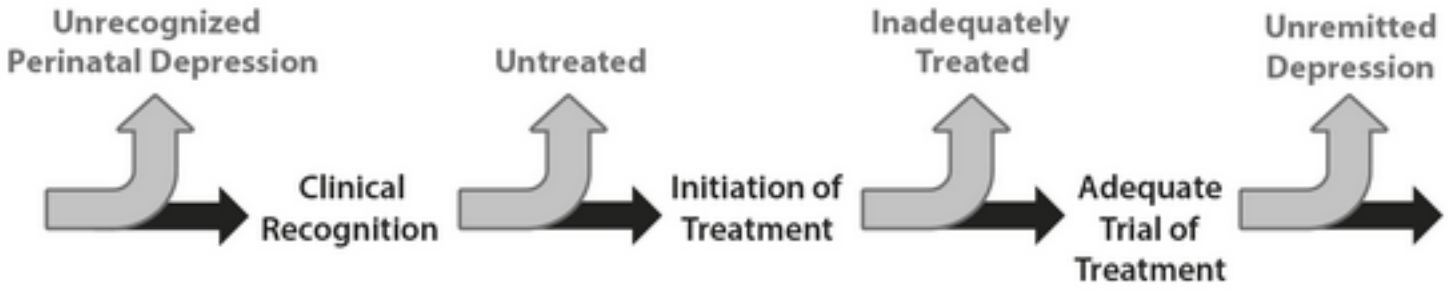
Maternal Depression – Treatment Helps!

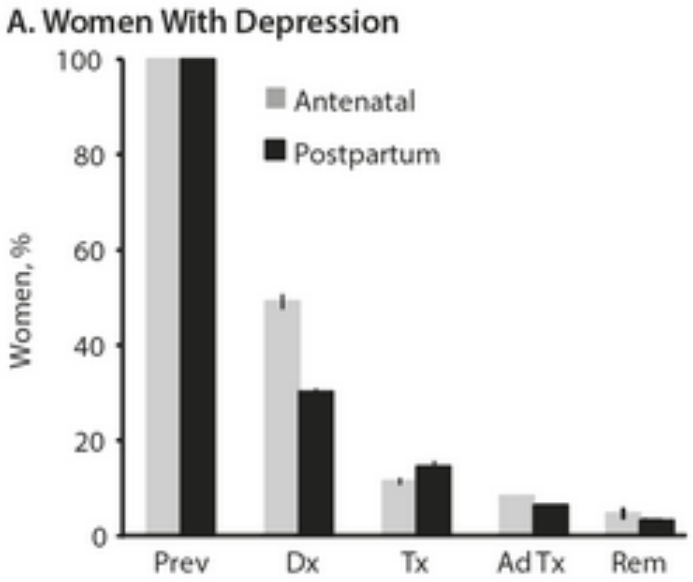
- Treating mother for her depression may help both mother and child . . .
  - 2006 & 2011 STAR*D reports - remission of maternal depression related to decreases in problem behaviors and symptoms in children
  - 2016 study – Brief IPT-MOMS psychotherapy improved maternal and child symptoms
  - Child Parent Psychotherapy studies have also noted improvement in maternal depression (and PTSD) at end of treatment in addition to positive child outcomes

Maternal Depression Often Not Addressed

- Perinatal depression treatment cascade (Cox, 2016)

Figure 1. The Perinatal Depression Treatment Cascade





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Patient Health Questionnaire-9

- Developed and studied in late 1990's
  - Based on 9 symptoms of major depression from DSM-IV (which are the same as DSM-5)
- Paper published in 2001 – "The PHQ-9: Validity of a Brief Depression Severity Measure"
  - Total of 6000 patients completed PHQ-9 while waiting to see doctor at appointment
    - 3000 in primary care medical (internal medicine or family practice)
    - 3000 in obstetric-gynecology practices
    - Compared to 580 who had f/u phone interview with SCID*
    - With cut-off score 10, sensitivity and specificity both 88% for major depression

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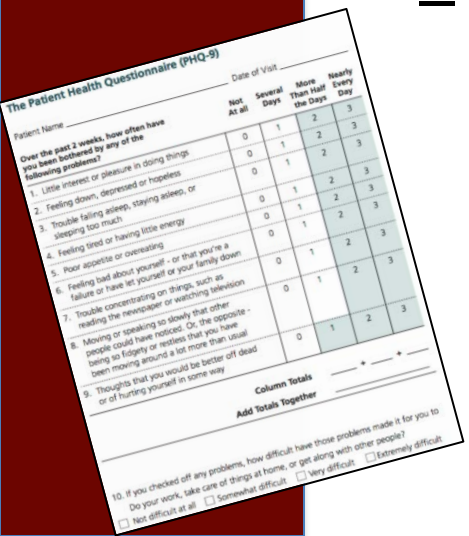
*Structured Clinical Interview for DSM-III-R

PHQ-9 Administration – Who and how?

- Designed to be self-administered by patient/parent on paper then scored/reviewed by clinician
  - Available in English, Spanish, other languages
  - 6th grade reading level
  - Caveats . . . coming up


The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Column Totals		+	+	=
Add Totals Together				

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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PHQ-9 Administration – When?

- Required by DOHMH during intake process
  - Which intake session?
- As clinically relevant – does not need to be reported to DOHMH
  - At treatment plan updates *(universal re-screening)*
  - If initial screen was positive *(selective re-screening)*
    - Treat to target
    - When you want to help parent understand the importance of getting treatment
    - Others ideas?

PHQ-9 Self-Administration - Caveats

- Study using PHQ-2 on paper VS. through scripted interview in pediatric well-child visits (Olson, 2005)
  - Paper-based screen had higher rates of identification (22.9%) than interview-based (5.7%)
  - In particular, by interview parents of children younger the age of 1 where less likely to screen positive (1.9%) than those of older children (8.5%)
- Other studies have also found that patients are more likely to disclose depression symptoms on paper (or computer)

PHQ-9 Self-Administration -

- However, not all parents will be able to manage the 6th grade reading level required or feel comfortable with the meaning of the questions
- Likert scales are initially confusing to some parents who have not encountered them before
- And although statistically many parents are more willing to disclose symptoms on paper some will specifically respond best in person, especially once they have gotten to know the clinic and clinician
- Quality Improvement . . .

PHQ-9 Administration - Suggestions

- Consider whether it will work best in your clinic and with your population to incorporate PHQ-9 screening into intake session #1 or #2
- Give parents the opportunity to complete the form on paper, but have clinician review with them as well and help if needed – and use clinical judgment about whether to use a more conversational style

PHQ-9 Administration – Describing to parents

- Whether on paper or in person, PHQ-9 screening will need to be introduced
  - They weren't expecting to be evaluated themselves
    - Although studies show that many accept this easily and are even appreciative you are considering their needs
  - Some will worry that they are going to be judged by the clinic and that there might be repercussions (such as reports to ACS)
  - Community stigma about mental health is very real plus parent may feel guilty about feeling depressed

Suggested intro on paper

"Depression is a common problem for many parents. Parents may not recognize they have depression or that treatment for depression will help them and their child. We want to assist you in getting help for depression if you need it. For this reason, we are asking all the parents who come to the clinic to respond to the following questions. Your child's clinician will confidentially review your answers with you."

Suggested intro in person

"Most of the evaluation today has been focused on what you are noticing with your child. Of course, that's why you are here, but parent health is extremely important for young children - so we ask every parent who brings a child to our clinic some questions, too. One of the most common health problems facing parents is depression."

Continue on next slide . . .

Suggested intro in person

If the parent already completed the PHQ-9 on paper –

- "I'd like to take a minute to review with you the questions you answered earlier about your mood. First of all, was it clear that these questions were about you?"
- Go over one or two questions with the parent to assure they understood questions/how to answer
- Ask if they had any questions about this form

Suggested intro in person

If the parent did not already complete the PHQ-9 on paper –

- "I'd like to take a minute to go through the questions on this form with you."
- Go over one or two questions with the parent to assure they understand questions/how to answer
- Ask if they have any questions about this form
- "Would you prefer to finish this on your own or go over the questions together?"

PHQ-9

The Patient Health Questionnaire (PHQ-9)

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Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
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4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Two ways to score the PHQ-9

- Major depressive disorder diagnosis
  - Answer to either question 1 or 2 is in the shaded area
  - A total of at least 5 answers are in the shaded area
- "Depression" more generally
  - See next slide
  - Less about specific diagnosis, more about symptoms/degree of impairment
- QUESTION 10 is not included in score

PHQ- Scoring

PHQ-9

- Score of 0-4 is usually normal
- Score of 5-9 minimal or mild symptoms
- Score of 10-14 is moderate depression
- Score of 15-19 moderately severe depression
- Score greater than 20 severe depression

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Column Totals	____	+ ____	+ ____	
Add Totals Together	_____			

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Reviewing PHQ-9 with parent

- "When I add up the answers you gave me, I see that the total is ____. That number often means that the person completing the form is (not/mildly/moderately/severely) depressed. How do you think that applies to the way you are feeling?"
- Go on to specific recommendations based on score

PHQ-9 Score 0-9

- **No/minimal/mild symptoms**
  - Use your clinical judgment about whether this score is accurate
    - Don't forget question 9
  - Psychoeducation – these are symptoms of depression, if you have more in future you should talk to me or one of your healthcare providers
  - Wellness strategies – it's ok to take time for self-care, spend time with supportive friends and family members, ask them for help sometimes
  - Re-screening
    - Upper end of score range

PHQ-9 Score 10-14

- **Moderate depression**
  - Everything from the prior slide
  - Plus discuss need for support and/or treatment
    - What does mom think would be helpful?
    - Add more pleasant activities to daily routine
    - Make plans to connect with people in support system
    - Relaxation activities to help manage stress
    - Could CPP or dyadic treatment be helpful enough?
    - If referral indicated, where can you refer?
  - Follow-up
    - Re-screening intervals

PHQ-9 Score 15-27

- **Severe depression**
  - Everything from the two prior slides
  - Plus parent probably needs treatment so discuss options
    - Psychotherapy such as Cognitive Behavioral Therapy (CBT) or Interpersonal Psychotherapy (IPT)
    - Support or psychotherapy groups
    - Medication – some are ok to take even while breastfeeding or pregnant
      - Maternal depression during pregnancy has associated negative outcomes especially if severe
    - Social supports – including referrals you could make
  - Follow-up
    - Re-screening and encourage engagement

Maternal depression – Helpful Resources

- 1-888-NYC-WELL

- Depression in Mothers: More Than the Blues – A Toolkit for Family Service Providers
  http://store.samhsa.gov/shin/content/SMA14-4878/SMA14-4878.pdf
- Postpartum Resource Center of New York
  https://postpartumny.org/#
- Postpartum Support International
  http://www.postpartum.net/

Maternal depression – Helpful Resources

- "Self-Care Program for Women with Postpartum Depression and Anxiety" http://www.bcapop.ca/uploads/9/9/0/1/9901389/reproductivementalhealthselfcareguide.pdf
- MGH Center for Women's Mental Health http://www.bcapop.ca/uploads/9/9/0/1/9901389/reproductivementalhealthselfcareguide.pdf

PHQ-9 Question 9 - Suicidality

Question 9

- Stratification
  - Passive
  - Active with no plan or intent
  - Active with plan but no intent
  - Active with plan and intent
  - Active with plan and intent and access to means
  - The “Will I be able to sleep?” rule
- Columbia Suicide Severity Rating Scale (CSSRS)

Maternal Depression – Associated Concerns

- Bipolar disorder
- Postpartum psychosis
- Other parental serious mental illness
- Anxiety symptoms/disorder

PHQ-9 – DOHMH Reporting

- As previously stated, DOHMH needs the total score on the PHQ-9 (question 1-9) at intake

What about the dads?

- Paternal depression
  - 8% in the first three months post-partum
  - Much less research but what there is indicates that fathers go through some of the same things as mothers in transitioning to parenthood

And other caregivers and foster parents

Applying the PHQ-9 to a case

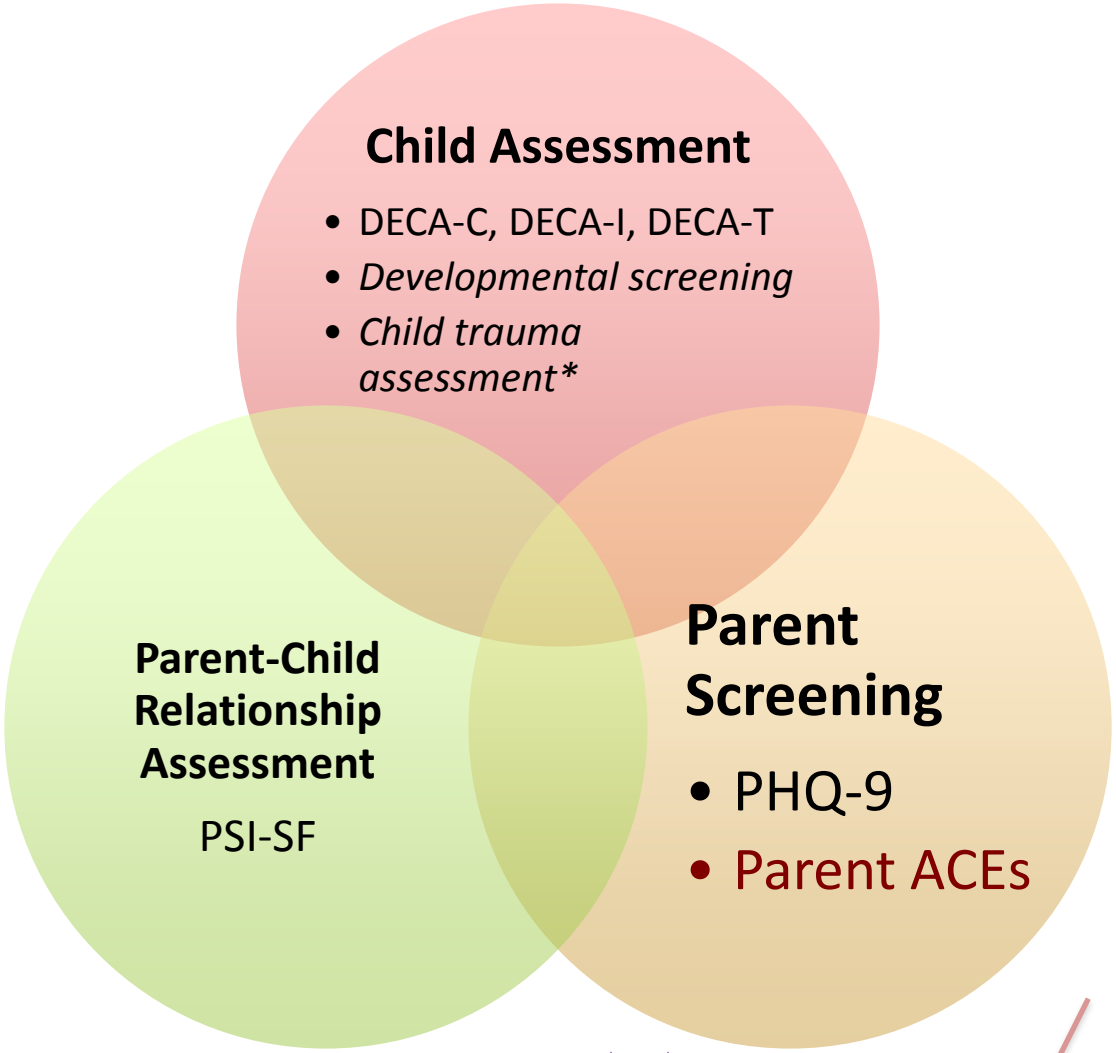
Rashonda age 3.5 years was referred to the clinic from her preschool. Teachers were worried about Rashonda's behavior. Mom doesn't think anything is wrong with Rashonda, but she decided to come in because Rashonda's pediatrician also thought it would be a good idea. She didn't fill in the PHQ-9 while she was in the waiting area – in fact she didn't complete any forms because she was so distracted by how excited and active Rashonda had been by the toys and people in the waiting area.

Applying the PHQ-9 to a case

What do you do next?
What might be your plan?

Once Rashonda and her mom were in an office with the intake clinician, Rashonda continued to be extremely active, while mom sat in the chair in the corner, answering the clinician's questions briefly but otherwise appearing quite withdrawn. She was willing to go through forms if the clinician read the questions. It because apparent that her PHQ-9 was elevated (20) and she had a score of 2 on question 9. At this point you have 15 minutes left in the appointment.

ECMH Assessment Tools



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Adult ACE Questionnaire

- Derived from the ACE Studies (Felitti & Anda) that documented that adverse experiences in childhood are common, and that there is a graded, incremental impact on mental and physical health problems experienced in adulthood as the number of adverse childhood experiences increase for any individual.
- Many of the public health problems of great concern (e.g. alcoholism, substance abuse, domestic violence, depression and suicide attempts) are people's attempts at solutions to the emotional states and struggles that result from these adverse experiences.
- Studies show that when a person has experienced 4 or more ACEs, their likelihood of engaging in high risk behaviors, and of having impaired mental health and physical health disorders, increases greatly compared to individuals with fewer ACEs.
- ACE Questionnaire now used widely in clinical settings to identify clients in greatest need for support services.

ACE Questionnaire

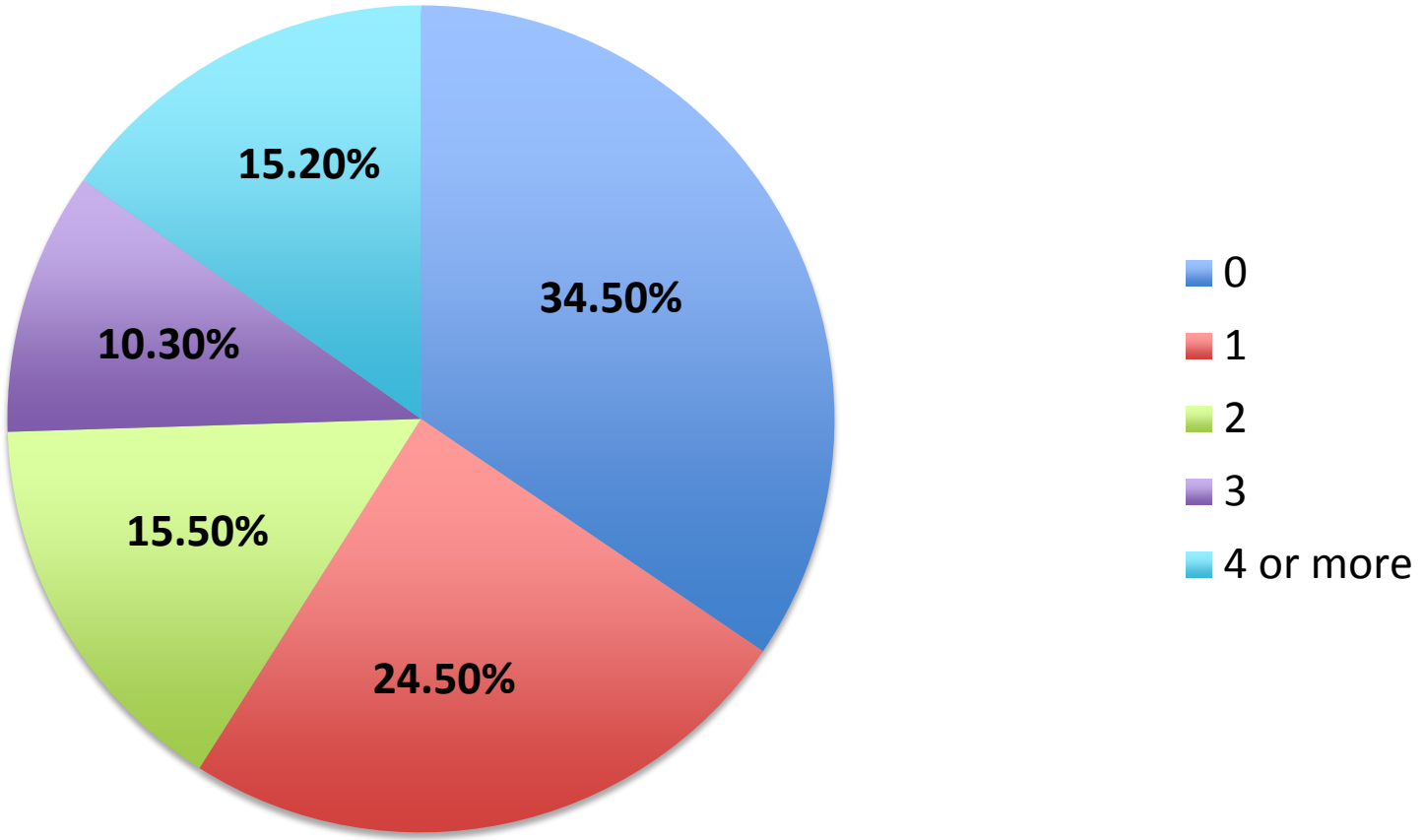
- Also used as a trauma screen (but does not include exposure to traumatic events outside the family)
- Sometimes considered by clinicians to be a more difficult assessment tool to administer due to the personal and sensitive nature of the inquiry, and the less obvious face validity for parents asked about their childhood experiences when bringing their children for clinical services
- Requires sensitivity in administration.
- Most parents ultimately appreciate this kind of inquiry, though it is expected that these questions may elicit strong reactions in parents.
- It is probably good to anticipate that with parents, and to place this part of the assessment in a second or third assessment session to benefit from growing rapport between parent and clinician. Extra time should be allotted in case parent needs support after administration.
- Variability in responses has been noted based on parents' trust of clinician and mode of responding (parent alone or parent with clinician)

ACE Questionnaire

Prevalence of ACEs in original study
(non-clinical, mostly middle class population in Southern California)

Number of ACEs	Women	Men	Total
	Percent (N=9367)	Percent (N=7970)	Percent (N=17,337)
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

ACE Score Prevalence for Women



For comparison – ACE 4 or more for men = 9.2%

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ACE Prevalence

- Can be expected to be higher in clinical populations
- Can be expected to be higher in poverty-affected individuals
- ECTCs will probably find a higher percentage of individuals with 4 or more ACEs than in the original study
- Some parents who have experienced all 10 ACEs
- ACE Questionnaire has been modified to now be used as a
- Child ACE Questionnaire.
- Not required by DOHMH but some clinicians have found benefit in
- administering following adult ACE Questionnaire
- National studies of children in foster care have found that a large percentage of these children have experienced 4 or more ACEs before they are two years old.

ACE Questionnaire Explanation

"The questions I am about to ask you are very personal in nature and ask about your childhood. We ask these questions because we know that our experiences growing up are very important. They affect our physical and emotional health and also influence the way we care for and think about our own children.

Your answers to these questions are confidential and will allow us to provide the appropriate services and supports for you and your child."

ACE Questionnaire Scoring

Scoring is done based on the presence or absence of these experiences in lives of parents before they were 18 years of age.

Frequency or chronicity is not a factor; just occurrence

Score 1 for each category of events.

The total possible number of ACEs is 10

ACE Interpretation

- Knowing parent's experiences of any of the adverse childhood events or conditions contributes to the relevant information to be considered in the clinical assessment.
- High number of ACEs may suggest additional levels of stress, possible trauma for parent, possibly reduced levels of social support, possible difficulties parenting.
- Useful to inquire if parent ever received therapeutic services to address specific or high number of ACEs,
- Considering child ACEs may stimulate parents' protective behaviors.

Brief increases in heart rate, mild elevations in stress hormone levels.

Serious, temporary stress responses, buffered by supportive relationships.

Prolonged activation of stress response systems in the absence of protective relationships.

http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

Parent ACE Questionnaire

Adult Adverse Childhood Experiences Questionnaire (ACE)

Today's Date: _____

First Name: _____ Last Name: _____

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __
6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __
10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: _ This is your ACE Score

Adapted from acestoohigh.com

Parent ACE Questionnaire

- Practice questions
- Practice checking in during questions
- Overlap with trauma and PTSD screening for CPP

Parent ACE Questionnaire

- Scoring
- Review with parent
  - Normalize – a lot of people have ACEs
  - This is part of your past, not who you are
  - Support health coping
  - Especially with parents of young children, emphasize how important it is that they can help their children have fewer ACEs
  - With high levels, consider PTSD and health overall

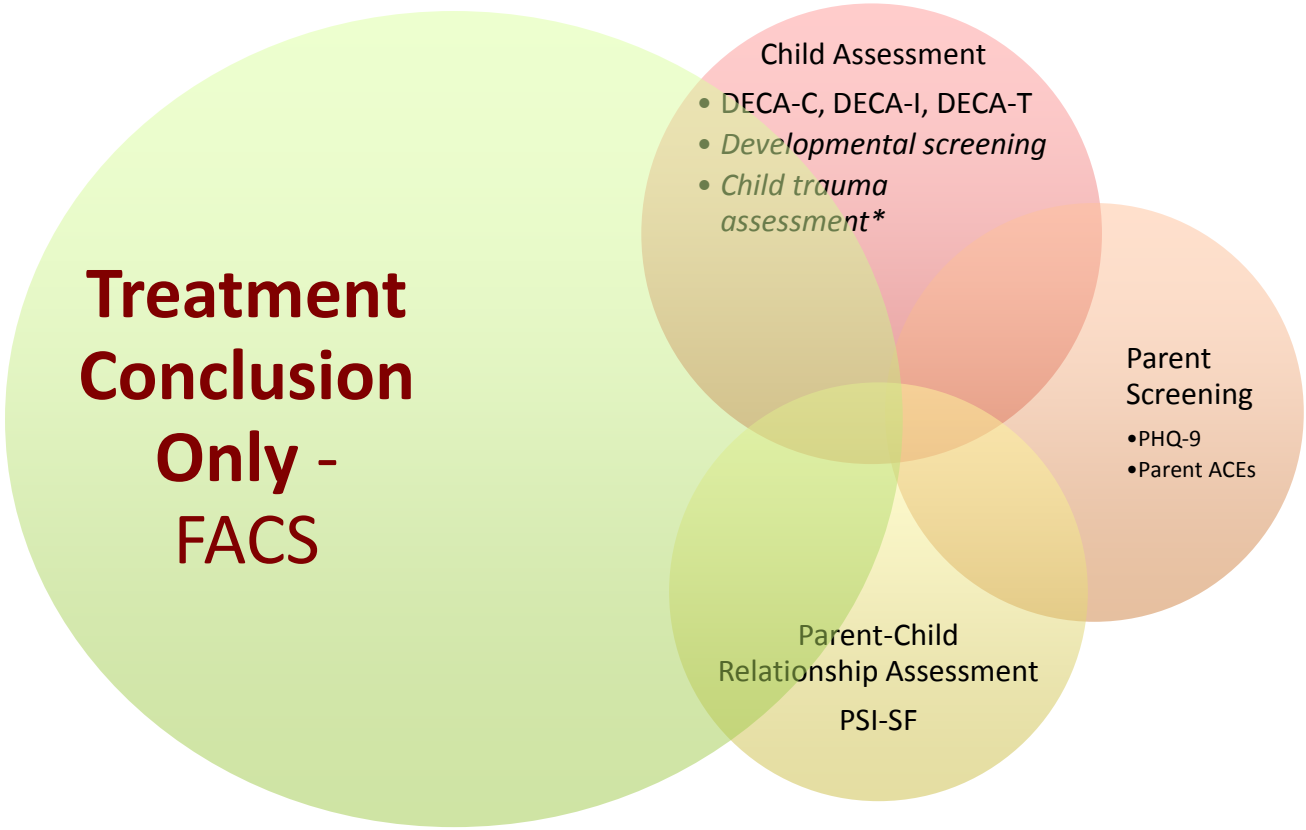
Parent ACE – DOHMH Reporting

- DOHMH requires score at intake

Parent ACE Questionnaire

- Quality Improvement
  - Is your screening effective?
  - What about when you find out about new ACEs during the course of treatment?

ECMH Assessment Tools



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Treatment Conclusion

- Family Assessment of Care Survey

Today's Schedule

9-9:15	Introduction and Overview
9:15-10:35	Review of tools and protocols for clinical treatment at ECTCs
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation at EarlyLearn sites
12-1	Lunch (provided)
1-3	DECA Webinar
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Today's Schedule

9-9:15	Introduction and Overview
9:15-10:35	Review of tools and protocols for clinical treatment at ECMH Network sites
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation at EarlyLearn sites
12-1	Lunch (provided)
1-3	DECA Webinar
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Mental Health Consultation Tools and Protocols

Consultation Tools and Protocols

- Before the first visit to the Early Learn (EL) Program
- First visit to EL site
  - First Visit Planning Guide & Helpful Information
  - Discussion Guide for First Visit to EL Site
  - Partnership Agreement
- Initial Assessment of the Classroom
  - Classroom Demographic Form
  - Classroom Observation Form (TBD)
  - Classroom SDQ

Classroom SDQ Form

This tool evaluates . . .

- The original Strengths and Difficulties Questionnaire - brief behavioral screening questionnaire for 3-16 years
  - Parent Version
  - Teacher Version
  - Adolescent Version
  - 25 questions
    - 20 difficulties items
    - 5 prosocial items

Impact Supplement and/or Follow-up Questions

Classroom SDQ Form

This tool evaluates . . .

- Classroom SDQ form pulls 2 questions from the Impact Supplement for each child in the classroom
  - **Do you think that [*child name*] has difficulties in any of the following areas: emotions, regulation, behavior or relationships with family, caregivers or peers?**
  - **<u>If YES</u>, do the difficulties put a burden on you or the class as a whole?**

Classroom SDQ Form

This tool evaluates . . .

- The individual score for each child is averaged for the entire classroom resulting in the following two indices
  - Classroom Behavioral Difficulties Index
  - Classroom Burden Index
- This will be used as a pre- and post-measure to assess the effectiveness of Early Learn Mental Health Consultation over the course of the program

Classroom SDQ

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

- When?
  - In the initial phase of consultation
  - At the conclusion of consultation
- Who?
  - The Mental Health Consultant will complete the form with the classroom teacher

Classroom SDQ

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

- How?
  - The Mental Health Consultant will need to first work with the teacher and/or administrator at the site to establish a time they can do this together
    - Depending on size of class 15-20 minutes
    - Should be outside of the classroom, not in front of children

Classroom SDQ

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

- Describing the assessment to the teacher (and administration)
  - "The purpose of this form is two-fold. First, it gives us a way to start a conversation about how you think things are going in your classroom now and how many children are struggling. Second, it provides a baseline so we can compare later on how the classroom has improved."

Classroom SDQ

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

Administering the assessment

- Have the teacher hold the prompt card with the two questions
- Go systematically through each child in the classroom, asking the teacher to rate the degree of difficulty and the degree of burden for each chart
- Check the appropriate box for each child as you go
- Ask for teacher comments at end

Classroom SDQ

Example card for Preschool Version

Classroom SDQ Questions for Teacher

Please reflect on each of the children in your classroom and check your answer to the following question:

Do you think that [*child name*] has difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people?

Answer choices:	No	Yes – minor difficulties	Yes – definite difficulties	Yes – severe difficulties

If YES, do the difficulties put a burden on you or the class as a whole?

Answer choices:	Not at all	A little	A medium amount	A great deal

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Classroom SDQ

PRESCHOOL STRENGTHS AND DIFFICULTIES CLASSROOM QUESTIONNAIRE

Adapted from: The Impact Supplement of the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999)

Date:
EarlyLearn Agency and Program Name:
Center/Site ID (i.e. Early Learn ID):
Class ID:
MHC ID:
ECTC Agency Name:

Please reflect on each of the children in your classroom and answer the following question:

Do you think that [*child name*] has difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people?

Circle the appropriate response for each child.

Column #:	A	B	C	D	E	F	G	H
					If YES, do the difficulties put a burden on you or the class as a whole?			
	NO	YES - Minor Difficulties	YES - Definite Difficulties	YES - Severe Difficulties	Not at all	A little	A medium amount	A great deal
Child 1	0	1	2	3	0	1	2	3
Child 2	0	1	2	3	0	1	2	3
Child 3	0	1	2	3	0	1	2	3
Child 4	0	1	2	3	0	1	2	3
Child 5	0	1	2	3	0	1	2	3
Child 6	0	1	2	3	0	1	2	3
Child 7	0	1	2	3	0	1	2	3
Child 8	0	1	2	3	0	1	2	3
Child 9	0	1	2	3	0	1	2	3
Child 10	0	1	2	3	0	1	2	3
Child 11	0	1	2	3	0	1	2	3
Child 12	0	1	2	3	0	1	2	3
Child 13	0	1	2	3	0	1	2	3
Child 14	0	1	2	3	0	1	2	3
Child 15	0	1	2	3	0	1	2	3
Child 16	0	1	2	3	0	1	2	3
Child 17	0	1	2	3	0	1	2	3
Child 18	0	1	2	3	0	1	2	3
Child 19	0	1	2	3	0	1	2	3
Child 20	0	1	2	3	0	1	2	3
Classroom Behavioral Difficulties Index: Sum of scores _____ / # children _____ = _____					**Classroom Burden Index:** Sum of scores _____ / # children _____ = _____			

Classroom Behavioral Difficulties Index:
Sum of scores _____ / # children _____ = _____

Classroom Burden Index:
Sum of scores _____ / # children _____ = _____

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Classroom SDQ

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

Scoring

- Follow instructions at bottom of chart to calculate indices
  - Classroom Behavioral Difficulties Index
  - Classroom Burden Index

Interpretation

- Index should range from 0-3
  - Higher score is more concerning

Classroom SDQ

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

Reviewing results with teachers

- Explain to the teacher that the index scores range from 0-3, with higher numbers indicating more problems
- Ask teacher whether the index scores make sense
- Ask teacher to reflect on goals for the classroom a few months from now

Report initial and final scores to DOHMH

Consultation Tools and Protocols

- Initial Assessment of the Child (for case-specific consultation only)
  - Primary Caregiver Consent
  - DECA-C/I/T

Consultation Tools and Protocols

- After Every Consultation Session
  - Consultation Note

Consultation Tools and Protocols

- At the end of the consultation period
  - DECA-C/I/T
  - Classroom Observation Form
  - Classroom SDQ
  - ECMHC Administrator's Impact Survey
  - ECMHC Teacher Impact Survey

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10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation at EarlyLearn sites
12-1	Lunch (provided)
1-3	DECA Webinar
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Group discussion

- Do you have a clear workflow in place at your agency for incorporating these questionnaires?
  - When might clinicians need to think about doing something differently?

Today's Schedule

9-9:15	Introduction and Overview
9:15-10:35	Review of tools and protocols for clinical treatment
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation
12-1	Lunch (provided)
1-3	**DECA Webinar**
3-4	Review of instruments for screening and assessment of early childhood trauma (optional)

Today's Schedule

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9:15-10:35	Review of tools and protocols for clinical treatment
10:35-10:45	Break!!!
10:45-12	Review of tools and protocols for mental health consultation
12-1	Lunch (provided)
1-3	DECA Webinar
3-3:30	**Review of instruments for screening and assessment of early childhood trauma (optional)**

Child Trauma Screening

Trauma epidemiology age 0-5	%
Lived with someone with alcohol/drug problems	6%
Witness to domestic violence	4%
Lived with parent/guardian who served time in jail	5%
Victim of sexual assault (Saunders 2014)	7%

Why is this important?

Although younger children typically have experienced fewer ACEs and other traumas than older children and adults, it is clear that they are exposed

- Economic hardship impacts 26% of children nationwide including those 0-5 (Child Trends 2014)
- Other ACE categories range from 1% (parent died) to 10% (parents separated or divorced) for children 0-5
- Pediatric sample age 2-5 years, 52.5% had experienced at least one severe traumatic stressor (Egger 2004)
- Intergenerational transmission of trauma

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Child Trauma Screening

Why is this important?

- Strong association between number of traumatic events and likelihood of emotional or behavioral disorder between age 3-5 (Egger 2004)
  - Without knowing what already happened, we are at high risk to misdiagnosis children
  - Treatment planning
    - Is this a CPP case?
  - Prevention - structured questionnaire helps parents understand what types of experiences they need to try to prevent their children having going forward – de-mystifies idea of “trauma”

Child trauma screening

- Brief group discussion
  - Have you previously included trauma screening as part of your assessment with children under 5?
  - What has your experience been?
  - What are the challenges or worries you have about doing this?

Common Concerns about Trauma Assessment

- Mandated reporting
  - It is important to be clear about your role as a mandated reporter
    - Confidentiality and its limits

Common Concerns about Trauma Assessment

- Worry that parent will think clinician is implying judgment by assuming there has been trauma
  - Opportunity to fall back on the "structured questionnaire" - everyone is asked the same questions, no preconceived ideas about who is asked or why
  - This also helps clinicians feel more at ease since asking about trauma exposure can feel awkward and intrusive

Common Concerns about Trauma Assessment

- Asking about child trauma has the potential to trigger parent since the same trauma has often been experienced by both parent and child

Psychoeducation –

Acknowledging the link between trauma and feelings

Setting up strategy for parent and also clinician to monitor reactions and pause/stop if needed

Child Trauma Assessment

This tool evaluates . . .

ACE and SEEK look mainly at family adversity

TESI-PRR, YCPC, TSCYC are officially focused on PTSD criteria

Numerous options for trauma and adversity assessment

- Adverse Childhood Experiences (ACEs) for children (Dr. Chinitz mentioned earlier)
- Safe Environment for Every Kid (SEEK)
- Traumatic Events Screening Inventory – Parent Report Revised (TESI-PRR)
- Young Child PTSD Checklist (YCPC)
  - Also includes developmentally appropriate versions of PTSD symptoms
  - Now DC:0-5 – training to come!
- Trauma Symptom Checklist for Young Children (TSCYC)

TESI-PRR

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

- When?
  - During intake, preferrably during the third intake session
- Who?
  - Parent completes with clinician
  - Child should not be present
- How?
  - Conduct as an interview, record responses on form

TESI-PRR

Administration

When? Who? How?

Describing the assessment to primary caregivers or teachers

Administering the assessment

Tell parent it's ok to pause or stop if overwhelmed. Check in periodically, too.

"I'm going to ask you some questions that we use with all families so that we can find out about th edifferent things that often happen to children and think about how this might affect them . . . a list of stressful thinkgs that kids can go through that can be very hard on them. . . I'll read an event and if [your child] hasn't experienced it, you'd just say no, but if he has, it would be good for us to talk about it, so I would know what happened." (Lieberman 2015)

TRAUMATIC EVENTS SCREENING INVENTORY- PARENT REPORT REVISED

Children may experience stressful events, which may affect their health and well-being. Please indicate *if* your child has experienced any of these potentially stressful events by answering the shaded questions. If the answer is yes, please answer the follow-up questions. If it's no, please go to the next shaded question.

If you have any questions or comments about any of the questions, we would be happy to talk to you about them.

SAMPLE ITEM *(instructions are in italics)*

A **Has your child ever had a doctor's visit?** *(Mark your answer in the next column. If yes answer the questions below.)* → ❑Yes ❑ No ❑ Unsure

If YES | How old was your child?

The first time:_____ **The last time:**_____ **The most stressful:**_____

Your child's age the first time s/he saw a doctor (even if s/he would not have remembered it).

Your child's age during his/her most recent doctor's visit.

Your child's age during the most stressful visit for your child (in your opinion).

Was your child strongly affected by one or more of these experiences? ❑ **yes** ❑ **no** ❑ **unsure**

(By strongly affected we mean: did your child seem: a) to be extremely frightened; b) to be very confused or helpless; c) to be very shocked or horrified, d) to have difficulty getting back to her or his normal way of behaving or feeling when it was over, OR e) to behave differently in important ways after it was over.)

1 1 Has your child ever ***been in*** a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, a fire, an incident where s/he was burned, an actual or near drowning, or a severe sports injury) → ❑Yes ❑ No ❑ Unsure

If YES | Identify the type of accident(s):_____

Victim's relationship to your child:_____ Did anyone die? ❑ yes ❑ no ❑ unsure

How old was your child? The first time:_____ The last time:_____ The most stressful:_____

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1 2 Has your child ever ***seen*** a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, a fire, an incident where someone was burned, an actual or near drowning, or a severe sports injury) → ❑Yes ❑ No ❑ Unsure

If YES | Identify the type of accident(s) _____

Victim's relationship to your child:_____ Did anyone die? ❑ yes ❑ no ❑unsure

How old was your child? The first time:_____ The last time:_____ The most stressful:_____

Was your child strongly affected by one or more of these experiences? ❑yes ❑no ❑unsure

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TESI-PRR

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

Scoring and Interpretation

- There is no scoring really for the TESI-PRR
- Any traumatic exposure cues clinician to also assess for PTSD symptoms
  - Young Child PTSD Checklist (YCPC) is commonly used

TESI-PRR

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

Reviewing results with parent

- If trauma is present, set the stage for treatment
  - Linking symptoms/behaviors to trauma exposure
  - Goal is to allow the child the opportunity to process what has happened with the support of parent and therapist

TESI-PRR

Scoring

Who? How?

Interpreting results

Reviewing results with parents or teachers

Reporting scores to DOHMH

Reporting – DOHMH supports trauma assessment as best practice as part of the young child mental health assessment, but does not require that you report on trauma assessment