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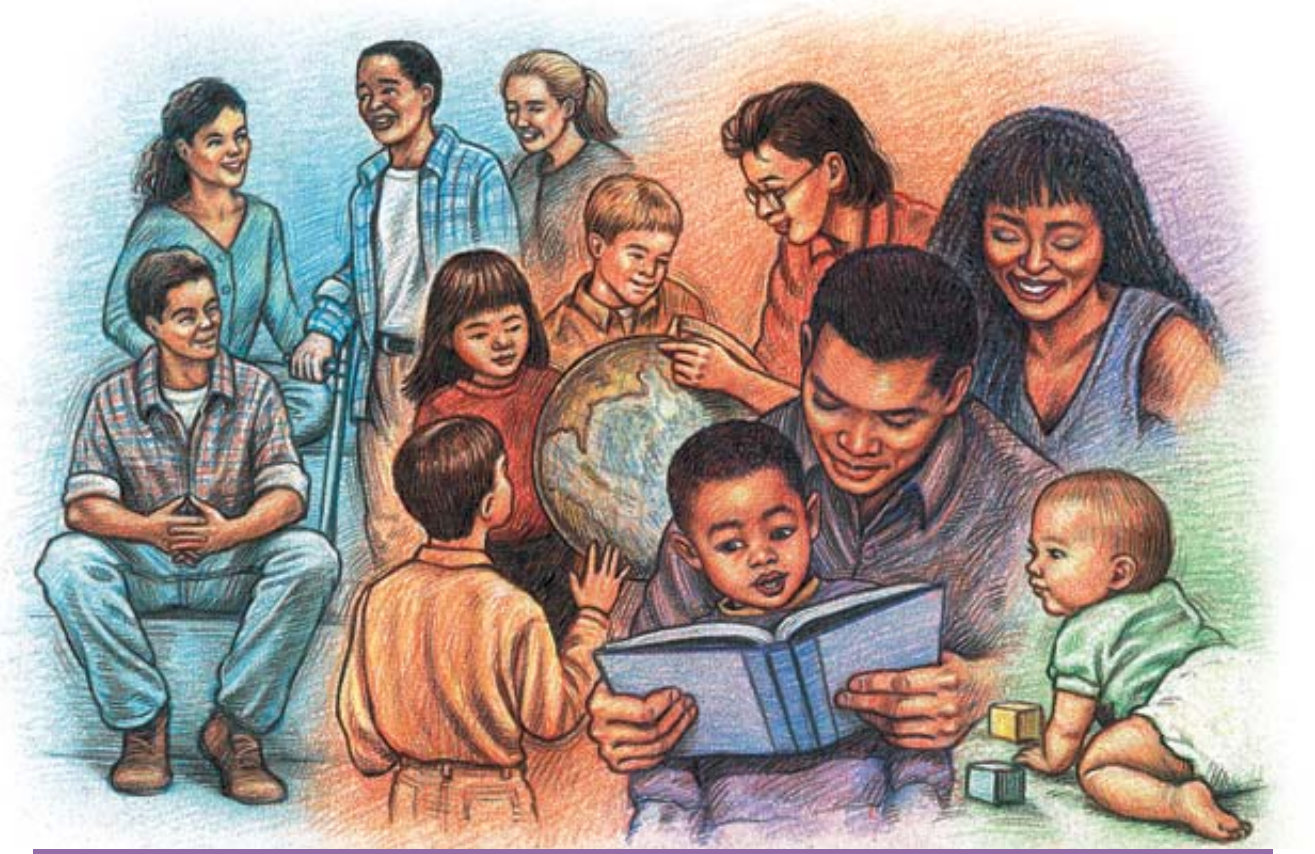
Georgetown University

Bright Futures in Practice

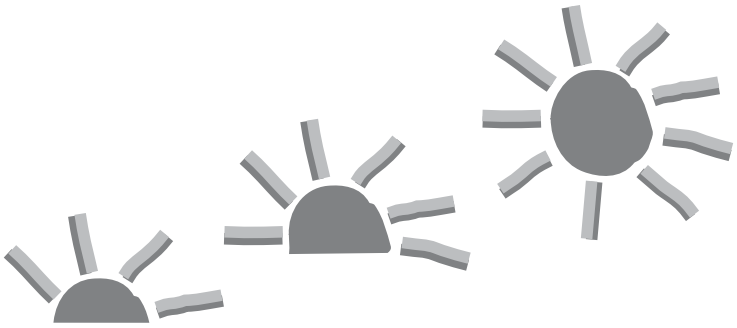


SELF • FAMILY • FRIENDS • COMMUNITY

MENTAL HEALTH

VOLUME II

TOOL KIT



Bright Futures in Practice: Mental Health

Volume II. Tool Kit

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Table of Contents

Introduction

This volume, *Bright Futures in Practice: Mental Health—Vol. II, Tool Kit,* is designed to accompany the narrative volume, *Bright Futures in Practice: Mental Health—Vol. I, Practice Guide.* Throughout the narrative volume, readers are directed to the tools in the *Mental Health Tool Kit* as further resources to aid in mental health screening, education, and direct management and in improving access to community resources. The *Mental Health Tool Kit* is divided into two sections, one with tools for health professionals, the other with tools for families. Each of these sections is organized developmentally with additional tools to address specific problems and disorders. Although tools may be placed in a particular developmental section, many of the tools can be used for more than one developmental stage. The tools cover topics such as documentation for reimbursement, helping siblings adjust to a new baby, preparing children for school, and the stages of substance use. The Tools for Health Professionals are designed for in-office use; the Tools for Families are designed to be distributed to families. As a complement to the narrative volume, the *Mental Health Tool Kit* can assist health professionals in providing mental health promotion messages; recognizing, diagnosing, and managing mental health problems and mental disorders in a primary care setting; and fostering partnerships with families and communities.

Copyright permissions have been obtained for most of the tools in the *Mental Health Tool Kit* so that they can be freely photocopied and used in practice as they appear. (The American Academy of Pediatric tools, pp. 127, 140, 148, may not be copied or distributed in any manner without the express written permission of the American Academy of Pediatrics.) Tools for Health Professionals, for example, might be copied for purposes of screening or record-keeping and kept in a child's or adolescent's chart. Tools for Families might be photocopied and distributed to families as educational materials.

Any use of the tools that involves alteration or adaptation of what is presented here requires permission from the source cited at the bottom of the tool. Because the *Mental Health Tool Kit* was designed to be duplicated, many worthy tools could not be included here for reasons of copyright. Contact information for some tools that could not be reprinted here is provided in the narrative volume. Other sources, such as the American Academy of Pediatrics' statement, *Developmental Surveillance and Screening of Infants and Young Children* (2001), summary tables by Glascoe (2000; 1999), and the Developmental-Behavioral Pediatrics Online Community Web site (http://www.dbpeds.org/articles/dbtesting), provide additional discussion of screening tools for developmental, behavioral, and emotional problems and also include ordering information.

The use of screening and assessment tools, checklists, parent reports, family handouts, and other tools can allow primary care health professionals to accomplish the goals of mental health promotion more efficiently. For example, the educational materials for families can be used as handouts to reinforce and expand on messages conveyed during the visit. The tools are intended for use by a broad range of health professionals (e.g., physicians, nurses, physician assistants). In the context of pediatric practice, these tools can enhance and strengthen the heart of child and adolescent health supervision—the interaction and relationship among the health professional and the child or adolescent and family.

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Tools for Health Professionals

Making Mental Health Supervision Accessible

Pediatric Intake Form

The Pediatric Intake Form can be used with each family entering your care and readministered annually. Individuals with low literacy skills or whose first language is not English may require assistance to complete the form.

SCORING

Reading the Pediatric Intake Form, also known as the Family Psychosocial Screen, as a whole can help the primary care health professional develop a general understanding of the history, functioning, questions, and concerns of each family.

In addition, specific areas of the Pediatric Intake Form can be scored to provide further insight into specific areas of a family's functioning.

PARENTAL DEPRESSION

Under the heading "Family Activities" are three questions that screen for parental depression. A positive response to two or more questions is considered a positive screen. For parents with a positive screen, it may be helpful to explore other symptoms of depression such as changes in appetite, weight, sleep, activities, energy level, and ability to concentrate; feelings of hopelessness; and suicidal ideation (suicidal thoughts) or suicidal intent. Reassuring parents that depression is common is helpful, as is noting the availability of treatment options provided by mental health professionals and the positive prognosis for the treatment of depression. (See Bridge Topic: Parental Depression, p. 303.)

SUBSTANCE USE

Under the heading "Drinking and Drugs" are seven questions that screen for parental substance abuse. A positive response to any of the first six questions is considered a positive screen. Parents with a positive screen should be asked about frequency of substance use and how their substance use affects their family. A physician's advice to quit smoking is often highly effective, but a physician's advice to stop abusing substances may be less so. Refer for further assessment and treatment as indicated.

DOMESTIC VIOLENCE

Under the heading "Family Health Habits" are four questions that screen for domestic violence. A parent who responds positively to any of these questions should receive further assessment and counseling, including exploration of the extent and patterns of violence, and discussion of safety issues for children and adolescents in the home (including gun storage). A parent may need assistance with making an escape plan and should be referred to hotlines or shelters. Health professionals should affirm that domestic violence is wrong but not uncommon. Victims need follow-up visits and ongoing support even if they return to the abuser. Forming a therapeutic relationship centered around the child's safety and well-being is recommended because children and adolescents are at risk for physical abuse in homes where there is domestic violence. (See Bridge Topic: Domestic Violence, p. 227.)

PARENTAL HISTORY OF ABUSE

Under the heading "When You Were a Child" are eight questions that screen for parents' histories of abuse. A background of abuse predisposes parents to disciplinary practices that may be abusive or too permissive. A positive response to any of the first four questions is considered a positive screen. The last four questions help gather additional information about disciplinary techniques and parents' need for counseling or parenting classes. (See Bridge Topic: Child Maltreatment, p. 213.)

SOCIAL SUPPORTS

Under the heading "Help and Support" are questions that screen for social support, a strong factor in reducing life stresses and parenting stresses. Adequate social support helps ensure that parents have appropriate models for parenting practices and disciplinary techniques. If the parent's answers to the first three questions indicate that she has access to fewer than two support persons or that she is less than satisfied with the support she has, the screen is considered positive. Offer referrals to parenting groups, social work services,

(continued on next page)

home visitor programs, or community family support services.

The Pediatric Intake Form also assesses a number of other risk factors for developmental and behavior problems. Risk factors include frequent household moves, being a single parent, having three or more children in the home, having less than a high school education, and being unemployed. Scoring four or more risk factors, including having mental health problems and an authoritarian parenting style (observed when parents use commands excessively or are negative and less than responsive to child-initiated interests), is associated with a substantial drop in children's I.Q. and school achievement. In such cases, children should be referred for early stimulation programs such as Head Start or a quality child care or preschool program.

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Kemper KJ, Carlin AS, Buntain-Ricklefs J. 1994. Screening for maternal experiences of physical abuse during childhood. *Clinical Pediatrics* 33(6):333–339.

Kemper KJ, Greteman A, Bennett E, et al. 1993. Screening mothers of young children for substance abuse. *Journal of Developmental & Behavioral Pediatrics* 14(5):308–312.

Kemper KJ, Kelleher KJ. 1996. Family psychosocial screening: Instruments and techniques. *Ambulatory Child Health* 1:325–339.

Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name nor your child's name will ever appear in any reports.

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Child's Name _____ Today's Date _____

Are you the child's
A. Mother
B. Father
C. Grandparent
D. Foster parent
E. Other relative
F. Other
G. Self (Are *you* the patient?)

How many times have you moved in the last year?
_____ times

Where is the child living now?
A. House or apartment with family
B. House or apartment with relatives or friends
C. Shelter
D. Other

Besides you, does anyone else take care of the child? If yes, who? _____ Yes No

Has child received health care elsewhere? If yes, what? _____ Yes No

Does the child have any allergies to any medications? If yes, what? _____ Yes No

Has the child received any immunizations? Yes No
Which ones? _____
Where? _____

Has the child ever been hospitalized? Yes No
When? _____
Where? _____
Why? _____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor

Do you have any concerns about your child's behavior or development? Yes No
If yes, what? _____
_____

What are your main concerns about your child?
_____
_____

How old are you?
_____ years old

Are you
A. Single
B. Married
C. Separated
D. Divorced
E. Other

What is the highest grade you have completed?
1 2 3 4 5 6 7 8 9 10 11 12 (High School/GED) 13 14 15 16 17 18 19
Some college or vocational school College graduate Postgraduate

FAMILY MEDICAL HISTORY

Do the child's mother, father, or grandparents have any of the following? If yes, who?

Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Lung problems (asthma) _____
Yes No Heart problems _____
Yes No Miscarriages _____
Yes No Learning problems _____
Yes No Nerve problems _____
Yes No Mental illness (depression) _____
Yes No Drinking problems _____
Yes No Drug problems _____
Yes No Other _____

FAMILY HEALTH HABITS

How often does your child use a seatbelt (carseat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? Yes No
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes No

In the past year, have you ever felt threatened in your home? Yes No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes No

What kind of guns are in your home?
A. Handgun B. Shotgun C. Rifle D. Other_____ E. None

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No

Do you currently smoke cigarettes? If yes, how many cigarettes do you smoke per day? Yes No

_____cigarettes/day

(continued on next page)

DRINKING AND DRUGS

In the past year have you ever had a drinking problem? Yes No

Have you tried to cut down on alcohol in the past year? Yes No

How many drinks does it take for you to get high or get a buzz? 1 2 3 4 5 6 7 or more

Do you ever have five or more drinks at one time? Yes No

Have you ever had a drug problem? Yes No

Have you used any drugs in the last 24 hours? Yes No
If yes, which one(s)
Cocaine Heroin Methadone Speed Marijuana Other:

_____

Are you in a drug or alcohol recovery program now? If yes, which one(s) Yes No

_____

Would you like to talk with other parents who are dealing with alcohol or drug problems? Yes No

WHEN YOU WERE A CHILD

Did either parent have a drug or alcohol problem? Yes No

Were you raised part or all of the time by foster parents or relatives (other than your parents)? Yes No

How often did your parents ground you or put you in time out?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often did your parents ridicule you in front of friends or family?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you hit with an object such as a belt, board, hairbrush, stick, or cord?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you thrown against walls or down stairs?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

Do you feel you were physically abused? Yes No

Do you feel you were neglected? Yes No

Do you feel you were hurt in a sexual way? Yes No

Did your parents ever hurt you when they were out of control? Yes No

Are you ever afraid you might lose control and hurt your child? Yes No

Would you like more information about free parenting programs, parent hotlines, or respite care? Yes No

Would you like information about birth control or family planning? Yes No

FAMILY ACTIVITIES

How strong are your family's religious beliefs or practices?
A. Very strong B. Moderately strong C. Not strong D. N/A

Do you have a religious affiliation? If so, what is your religion?

_____

How often do you read bedtime stories to your child?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often does your family eat meals together?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

What does your family do together for fun?

_____

How often in the last week have you felt depressed?
0 1–2 3–4 5–7 days

In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed? Yes No

Have you had two or more years in your life when you felt depressed or sad most days, even if you felt OK sometimes? Yes No

HELP AND SUPPORT

Whom can you count on to be dependable when you need help (just write their initials and their relationship to you):
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Who accepts you totally, including both your best and worst points?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Whom do you feel truly loves you deeply?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Source: Adapted, with permission, from Kemper KJ, Kelleher KJ. 1996. Family psychosocial screening: Instruments and techniques. *Ambulatory Child Health* 1:325–339. (*Ambulatory Child Health* published by Blackwell Science, http://www.blacksci.co.uk.)

Documentation for Reimbursement

Date _____

Attn: Case Manager
Ins. Company _____

Re: [Name of child or adolescent; dob]

To whom it may concern,

I saw [name of child or adolescent] on [visit date] for [diagnosis].

This letter documents the components of the services provided and billed with the diagnosis code of _____.

The following services were provided:

____ Parent conference regarding the diagnosis, etiology, management, and medical treatments of [diagnosis name]. This conference lasted approximately _____ minutes.

____ Face-to-face visit with child or adolescent for additional discussion and initiation of therapy. This visit lasted approximately _____ minutes.

____ Correspondence to the school [name of child or adolescent] attends.

____ Review of school records.

____ Phone consultation(s). These consultations lasted a total of approximately _____ minutes.

____ Other: _____

_____

_____

Should you have any additional questions or wish these services to be coded in a different way, please contact _____ in my office.

Thank you for your consideration.

Sincerely,

[Name of health professional]

Cite as: Hagan JF, Jr. 2002. Documentation for reimbursement. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit*. Arlington, VA: National Center for Education in Maternal and Child Health.

Selected General Medicine and Behavioral Current Procedural Terminology (CPT) Codes

PSYCHIATRIC THERAPEUTIC PROCEDURES (FACE TO FACE)

(Individual psychotherapy, insight oriented, behavior modifying, and/or supportive, in an office or outpatient facility.)

Code	Description
90804	20–30 minutes face to face with the patient
90805	with medical evaluation and management services
90806	45–50 minutes face to face with patient
90807	with medical evaluation and management services
90808	75–80 minutes face to face with patient
90809	with medical evaluation and management services

REVIEW TESTING: PSYCHOLOGICAL OR SCHOOL

Code	Description
90887	Not time related

PROLONGED PHYSICIAN SERVICES (WITHOUT FACE TO FACE)

Code	Description
99358	First 60 minutes
99359	Each additional 30 minutes

PROLONGED PHYSICIAN SERVICES (FACE TO FACE)

Code	Description
99354	First 60 minutes
99355	Each additional 30 minutes

PHYSICIAN SUPERVISION

(Work provided in a 30-day period to supervise multidisciplinary care modalities of patients to include development and/or review of care plan, review reports, communications, etc.)

Code	Description
99374	15–29 minutes
99375	30+ minutes

TEAM CONFERENCE (WITH OR WITHOUT PATIENT PRESENT)

Code	Description
99361	30 minutes
99362	60 minutes

CASE MANAGEMENT PHONE

Code	Description
99371	Brief call
99372	Intermediate call
99373	Complex call

PREVENTIVE COUNSELING

Code	Description
99401	15 minutes
99402	30 minutes
99403	45 minutes
99404	60 minutes

DIAGNOSTIC INTERVIEW

Code	Description
90801	Psychiatric diagnostic interview
99802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication

EVALUATION AND MANAGEMENT (E & M) CODES (EXISTING PATIENT CODES)

Code	Description
99211	Office visit (OV) minimal
99212	OV problem focused
99213	OV expanded focus
99214	OV detailed
99215	OV highly complex

See also

Tool for Health Professionals: Documentation for Reimbursement, p. 8.

Source: Adapted from Kirschner CG. 2000. *Current Procedural Terminology: CPT 2001* (standard ed., 4th rev. ed.). Chicago, IL: American Medical Association.

Selected Organizational Resources

Ambulatory Pediatric Association
6728 Old McLean Village Drive
McLean, VA 22101
Phone: (703) 556-9222
Fax: (703) 556-8729
Web site: http://www.ambpeds.org

American Academy of Child and Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, N.W.
Washington, DC 20016-3007
Phone: (202) 966-7300
Fax: (202) 966-2891
Web site: http://www.aacap.org

American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
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Web site: http://www.aafp.org

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141 Northwest Point Boulevard
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Fax: (847) 434-8000
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Web site: http://www.ama-assn.org

American Psychiatric Association (APA)
1400 K Street, N.W.
Washington, DC 20005
Phone: (888) 357-7924
Fax: (202) 682-6850
Web site: http://www.psych.org

American Psychoanalytic Association
309 East 49th Street
New York, NY 10017
Phone: (212) 752-0450
Web site: http://www.apsa.org

American Psychological Association (APA)
750 First Street, N.E.
Washington, DC 20002-4242
Phone: (800) 374-2721, (202) 336-5500
Web site: http://www.apa.org

Center for Effective Collaboration and Practice
1000 Thomas Jefferson Street, N.W., Suite 400
Washington, DC 20007
Phone: (888) 457-1551
Fax: (202) 944-5454
Web site: http://www.air.org/cecp

Center for Mental Health in Schools, University of California at Los Angeles
UCLA School Mental Health Project
P.O. Box 951563
Los Angeles, CA 90095-1563
Phone: (310) 825-3634
Fax: (310) 206-8716
Web site: http://smhp.psych.ucla.edu

Center for Mental Health Services (CMHS)
Knowledge Exchange Network (KEN)
P.O. Box 42490
Washington, DC 20015
Phone: (800) 789-2647
Fax: (301) 984-8796
Web site: http://www.mentalhealth.org

Center for School Mental Health Assistance (CSMHA)
680 West Lexington Street, 10th Floor
Baltimore, MD 21201-1570
Phone: (888) 706-0980
Fax: (410) 706-0984
Web site: http://csmha.umaryland.edu

(continued on next page)

Children's Defense Fund (CDF)
25 E Street, N.W.
Washington, DC 20001
Phone: (202) 628-8787
Web site: http://www.childrensdefense.org

Family Village
Waisman Center, University of Wisconsin-Madison
1500 Highland Avenue
Madison, WI 53705-2280

Family Voices
P.O. Box 769
Algodones, NM 87001
Phone: (888) 835-5669
Fax: (505) 867-6517
Web site: http://www.familyvoices.org

Federation for Children with Special Needs
1135 Tremont Street, Suite 420
Boston, MA 02120
Phone: (800) 331-0688
Fax: (617) 572-2094
Web site: http://www.fcsn.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
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Bethesda, MD 20894
Phone: (888) FIND-NLM (346-3656)
Web site: http://www.nlm.nih.gov/medlineplus

National Alliance for the Mentally Ill (NAMI)
Colonial Place Three, 2107 Wilson Boulevard, #300
Arlington, VA 22201-3042
Phone: (703) 524-7600
Fax: (703) 516-7238
Web site: http://www.nami.org

National Association of School Psychologists (NASP)
4340 East West Highway, Suite 402
Bethesda, MD 20814
Phone: (301) 657-0270
Fax: (301) 657-0275
Web site: http://www.naspweb.org

National Early Childhood Technical Assistance System
137 East Franklin Street, Suite 500
Chapel Hill, NC 27514-3628
Phone: (919) 962-2001
Fax: (919) 966-7463
Web site: http://www.nectas.unc.edu

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013-1492
Phone: (800) 695-0285
Fax: (202) 884-8441
Web site: http://www.nichcy.org

National Institute of Child Health and Human Development
31 Center Drive, Building 31, Room 2A32, MSC 2425
Bethesda, MD 20892-2425
Phone: (800) 370-2943
Web site: http://nichd.nih.gov

National Institute of Mental Health (NIMH)
6001 Executive Boulevard, #8184
Bethesda, MD 20892-9663
Phone: (301) 443-4513
Fax: (301) 443-4279
Web site: http://www.nimh.nih.gov

National Mental Health Association (NMHA)
1021 Prince Street
Alexandria, VA 22314-2971
Phone: (703) 684-7722
Fax: (703) 684-5968
Web site: http://www.nmha.org

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National Parent Network on Disabilities (NPND)
1130 17th Street, N.W., Suite 400
Washington, DC 20036
Phone: (202) 463-2299
Fax: (202) 463-9405
Web site: http://www.npnd.org

National Technical Assistance Center for Children's Mental Health
Georgetown University, Child Development Center
3307 M Street, N.W.
Washington, DC 20007
Phone: (202) 687-5000
Fax: (202) 687-1954
Web site: http://gucdc.georgetown.edu/cassp.html

National Women's Health Information Center (NWHIC)
8550 Arlington Boulevard, Suite 300
Fairfax, VA 22031
Phone: (800) 994-WOMAN (994-9662)
Web site: http://www.4woman.gov

New York University Child Study Center
550 First Avenue
New York, NY 10016
Phone: (212) 263-6622
Web site: http://www.aboutourkids.org

Office of Minority Health Resource Center (OMHRC)
P.O. Box 37337
Washington, DC 20013-7337
Phone: (800) 444-6472
Web site: http://www.omhrc.gov/omhrc/index.htm

Pediatric Development and Behavior
880 Sixth Street, South, Suite 340
St. Petersburg, FL 33701
Phone: (727) 502-8035
Fax: (727) 892-8244
Web site: http://www.dbpeds.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Parklawn Building, 13th Floor
Rockville, MD 20857
Phone: (301) 443-8956
Web site: http://www.samhsa.gov

U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, DC 20202-0498
Phone: (800) USA-LEARN (872-5327)
Fax: (202) 401-0689
Web site: http://www.ed.gov

ZERO TO THREE: National Center for Infants, Toddlers, and Families
2000 M Street, N.W., Suite 200
Washington, DC 20036
Phone: (202) 638-1144
Web site: http://www.zerotothree.org

Cite as: National Center for Education in Maternal and Child Health. 2002. Selected organizational resources. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Postcard Satisfaction Survey

Below are suggestions for a letter to families and possible questions for inclusion on a postcard satisfaction survey.

COVER LETTER

Dear _____,

Your child was recently seen in our practice. We would appreciate your input on how the visit went so that we can continue to improve the services we provide to families who use our practice.

Please circle your responses on the enclosed postcard and mail the postcard back to our office. Thank you very much for helping our practice do a better job serving you.

Sincerely,

[Insert practice name]

POSTCARD

[Postage paid and preaddressed to practice]

Please circle your response to each question and mail this postcard to our office.

	1 Not Very	2 Somewhat	3 Very
1. How nice were the staff?	1	2	3
2. How satisfied were you with how quickly you were seen?	1	2	3
3. How knowledgeable did your doctor seem?	1	2	3
4. How well did your doctor listen to you?	1	2	3
5. How well were your questions answered?	1	2	3
6. How included did you feel in making decisions about your child's care?	1	2	3
7. Overall, how satisfied were you with the visit?	1	2	3

Comments: _____

_____

_____

Thank you very much.

Name (optional): _____

Cite as: National Center for Education in Maternal and Child Health. 2002. Postcard satisfaction survey. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Referral for Services

PATIENT INFORMATION

Name _____ DOB _____ Gender _____

Parent's name(s) _____

Brief statement of problem(s): _____

_____

_____

_____

History of problem(s): _____

_____

_____

_____

Other diagnoses/medical problems: _____

_____

_____

_____

Relevant physical findings: _____

_____

_____

_____

Relevant laboratory/imaging/testing findings: _____

_____

_____

_____

Medications (current and relevant past): _____

_____

_____

_____

(continued on next page)

Referral for Services (continued)

Developmental history: _____

_____

_____

_____

Family/housing: _____

_____

School: _____

_____

Community/peers/justice system: _____

_____

Substance use: _____

Interventions for problem(s) (current and past): _____

_____

_____

_____

We request that you:

_____ Evaluate for diagnosis

_____ Evaluate for management/treatment options

_____ Assume management/treatment for stated problems

Additional comments: _____

_____

_____

_____

Thank you very much.

Please contact us by: ( ) telephone ( ) fax ( ) e-mail ( ) postal mail

Practice contact information: _____

_____

_____

Please notify us if the patient does not keep the appointment.

Cite as: National Center for Education in Maternal and Child Health. 2002. Referral for services. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

INSTRUCTIONS FOR USE

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

INSTRUCTIONS FOR SCORING

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

REFERENCES

Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasability study. *Archives of Pediatric and Adolescent Medicine* 153(3):254–260.

Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201–209. Web site: http://psc.partners.org.

Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.

Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4–5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139–146.

Pediatric Symptom Checklist (PSC)

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

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fights with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits the doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score _____

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

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

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			

Cultural Competence Assessment—Primary Care

The Cultural Competence Assessment—Primary Care (CCA-PC) can be administered to families to elicit feedback about their experiences with their children's health care. Knowledge of a family's experiences and perceptions is a critical factor in improving cultural competence in the practice setting.

The CCA-PC was developed through focus groups and cognitive interviews with a diverse group of families. Psychometric data are not available at this time. Individuals who wish to use the instrument for research purposes should contact Sarah Hudson Scholle, Pediatrics and Health Services Administration, University of Pittsburgh, in advance and should be willing to provide descriptive data on the sample and psychometric analyses (or to provide a dataset with such information so that psychometric analyses can be conducted).

CONTACT INFORMATION

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Pediatrics and Health Services Administration
University of Pittsburgh
3811 O'Hara Street, Suite 430
Pittsburgh, PA 15213
Phone: (412) 624-1825
Fax: (412) 624-2360
E-mail: schollesh@msx.upmc.edu

Cultural Competence Assessment—Primary Care

Thinking about your child's health services, please circle the response that describes how often each of these statements is true for you and your child.

	Never	Rarely	Sometimes	Most of the time	Always
1. My child's health professional understands how I see my child's problems.	1	2	3	4	5
2. My child's health professional respects our family's values and customs.	1	2	3	4	5
3. My child's health professional treats other parents better than me.	1	2	3	4	5
4. When I speak with my child's health professional, I feel respected.	1	2	3	4	5
5. My child's health professional helps us get services that we need from other agencies or health care providers.	1	2	3	4	5
6. My child's health professional accepts my family as important members of the team that helps my child.	1	2	3	4	5
7. I feel comfortable discussing with my child's health professional any alternative therapies that my child is using or that we are considering using (e.g., herbal medicine, chiropracty, religious healing).	1	2	3	4	5
8. My child's health professional includes me in making decisions about my child's care.	1	2	3	4	5
9. My child's health professional encourages me to help evaluate my child's progress.	1	2	3	4	5
10. Other children get better services than my child.	1	2	3	4	5
11. My child's health professional seems to be comfortable interacting with my child.	1	2	3	4	5
12. The location of services works for my child and our family.	1	2	3	4	5

Source: Adapted, with permission, from Switzer GE, Scholle SH, Johnson BA, et al. 1998. The Client Cultural Competence Inventory: An instrument for assessing cultural competence in behavioral managed care organizations. *Journal of Child and Family Studies* 7(4):483–491.

School Consultation

Health professionals can enhance child and adolescent health by interacting with school personnel in a variety of ways. Collaboration may range from communicating about a particular student to providing direct care or consultation at school. The number of school-based health centers, where health professionals provide on-site care, has increased dramatically over the last 25 years from less than 100 in the early 1980s to approximately 1,400 currently (Friedrich, 1999; Center for Health and Health Care in Schools, 2001). Approximately one-third to one-half of all visits to school-based health centers are related to mental health problems. Effective collaboration requires an understanding of the framework in which consultation will occur, and the development of consultation skills.

UNDERSTANDING THE FRAMEWORK

Several key questions can help clarify a school's expectations for consultation.

- What is the school seeking from the health professional?
  - Input regarding a specific student, such as information about specific needs or illnesses, recommendations to improve a student's health, reassurance about safety concerns (see discussion of confidentiality below).
  - Consultation about broader concerns, such as advice regarding school health policies, education about particular health concerns (e.g., adolescent pregnancy, depression).
- Who will be involved in the consultation, and to whom will the health professional report?
  - Knowledge of the school's organizational structure is useful in avoiding potential areas of conflict and developing possible solutions (e.g., knowing which school personnel to approach to access school resources to meet a child's or adolescent's needs). Health professionals may work with a number of school personnel including school administrators, regular classroom teachers, special education teachers, school nurses, social workers, and school psychologists.
  - An awareness of the needs and interests of all parties involved in the consultation facilitates the development of effective interventions.
- What are the relevant ethical or legal issues?
  - Confidentiality of students and school professionals should be preserved.
  - When information needs to be shared, appropriate consent should be obtained.
- How can school personnel be empowered to address pertinent questions?
  - Encourage school professionals to consider relevant biological, psychological, environmental, and social factors for each student. School professionals may need help in identifying and understanding these factors.
  - Facilitate school professionals' efforts to develop a solution rather than having an outside party "fix" the problem.

DEVELOPING SCHOOL CONSULTATION SKILLS

The following approaches can be helpful in consulting with school personnel:

- Develop a collaborative approach.
  - Assess what school personnel perceive as the problem. Appreciate their point of view. Recognize that they may be under numerous and sometimes competing pressures from school officials, parents, cost constraints, and state testing standards.
  - Remember that the primary function of schools is to educate children and adolescents. Placing your efforts in the context of helping the

(continued on next page)

school to facilitate the child's or adolescent's ability to learn is a useful perspective.

- Always ask questions to gather further information and also to convey that you are attempting to understand all of the complexities of a given situation.
- Work with school professionals to collaborate on solving problems rather than issuing directives.
- When proposing interventions, adopt an approach that decreases potential resistance, for example:
  - "You've probably already tried or thought about . . ." (acknowledges effort made by the school professionals).
  - "This may be difficult to try, but . . ." (decreases fear of personal failure, and encourages school professionals to surpass expectations).

■ Empower school professionals and support their abilities to handle concerns.

- Validate school professionals' perceptions before proposing solutions.
- Cultivate respect for everyone in the school system, including students, parents, teachers, support staff, and administrators.
- Build connections among school personnel and among other community resources.

■ Help school professionals recognize where they may be getting "stuck."

- Help others see the student differently. Frame the problem so that school personnel can understand, empathize, and work with the student (e.g., a student who skips school to avoid feeling humiliated in class).
- Explore where good intentions went awry. "Backtracking" to a well-intentioned effort made by a student, parent, or teacher, even if the effort led to a negative outcome, can clarify important underlying issues and help identify alternative solutions. For example, a student who cheats on an exam because he fears doing poorly in class would benefit from recognition that he desires a good grade but may need more educational support to gain the skills and knowledge to do well on a test.
- If the involved parties are unable to work together toward a solution, reconsider possible underlying fears and biases. Unexpressed fears may lead to behaviors or reactions that appear irrational. Explore what concerns may be making them uncomfortable.
- Expand the school professionals' skills. Look for every opportunity to help school professionals solve their own problems and develop skills (e.g., teaching students how to negotiate disputes among themselves; educating teachers about what symptoms a student with a given illness or disorder may exhibit).
- Propose solutions that appeal to goals shared by all parties (e.g., how to support a student who is struggling academically but wishes to attend college).
- Clarify reasonable expectations for change. Often, consultees have unrealistic expectations of how quickly changes will occur; help them to reframe these expectations in a feasible context.

REFERENCES

The Center for Health and Health Care in Schools (formerly Making the Grade). 2001. *School-Based Health Centers: Results from a 50-State Survey. School Year 1999–2000.* Washington, DC: The Center for Health and Health Care in Schools (formerly Making the Grade). Web site: http://www.healthinschools.org/sbhcs/survey2000.htm.

Friedrich MJ. 1999. 25 years of school-based health centers. *JAMA* 281(9):781–782.

Cite as: Bostic JQ. 2002. School consultation. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Infancy

0–11 Months

Age-Specific Observations of the Parent–Child Interaction

The following observable behaviors are indicators of a growing secure attachment between parent and child. These interactions may also serve as a guide for behavior for families in which attachment concerns may be present.

Developmental Period	Supportive Parental Interactions	Positive Infant Responses
Newborn	■ Looking frequently at the infant ■ Having specific questions and observations about the individual characteristics of the infant ■ Touching, massaging, or gently rubbing the infant ■ Attempting to soothe the infant when the infant is upset	■ Looking content ■ Signaling needs ■ Feeding well ■ Responding to parent's attempts to soothe
1 month	■ Talking to and smiling at the infant during the exam ■ Holding the infant during most of the visit ■ Comforting the infant effectively during stressful parts of the exam ■ Differentiating among different types of crying ■ Describing the infant's routine	■ Turning head toward parent's voice ■ Looking well cared for ■ Looking content ■ Responding to parent's attempts to soothe ■ Appearing well-nourished ■ Searching for faces and actively regarding surroundings
2 months	■ Describing feeling more confident with the infant ■ Describing the infant's routine ■ Talking to the infant and looking at the infant ■ Describing the infant's likes and dislikes	■ Gaining weight at an appropriate pace ■ Smiling
4 months	■ Having fun with the infant ■ Thinking the infant is wonderful in one or more ways ■ Bringing toys and objects to amuse the infant ■ Naming specific games played with the infant ■ Describing funny or surprising behaviors that the infant does ■ Describing the infant's personality ■ Anticipating the infant's response to a particular event (e.g., undressing, a shot)	■ Recognizing parents ■ Having a well-shaped head as opposed to occipital flattening ■ Showing delight in social play with movement, smiles, giggles, and positive vocalizations ■ Looking well-nourished

(continued on next page)

Developmental Period	Supportive Parental Interactions	Positive Infant Responses
6 months	■ Holding the infant for most of the exam ■ Comforting the infant after distress ■ Bringing and offering toys or appropriate objects ■ Responding to the infant's bids for attention ■ Allowing the infant to explore with his mouth ■ Tolerating the infant's exploration of the parent's face, hair, and so forth while setting limits in a positive way	■ Demonstrating awareness of the presence of strangers ■ Looking to the parent for comfort ■ Anticipating and adjusting to lifting and carrying ■ Babbling
9 months	■ Allowing the infant to explore the environment safely ■ Being mindful of safety risks in the office (e.g., does not leave the infant unprotected on exam table) ■ Describing a good leave-taking ritual ■ Describing a comfortable bedtime routine and routine in case of nightwaking ■ Getting the infant to wave, play peek-a-boo, or play other games ■ Handling limit-setting comfortably	■ Demonstrating awareness of the presence of strangers ■ Looking to the parent for comfort ■ Reacting to separation from parent ■ Babbling syllables (e.g., ma-ma, da-da) ■ Smiling at his own image in the mirror ■ Responding to her name ■ Pointing at objects
1 year	■ Reading books to the child ■ Bringing age-appropriate toys ■ Reporting safety-proofing the house ■ Using appropriate limit-setting (e.g., moving the child away, distracting the child with an alternative activity) ■ Having appropriate behavioral expectations ■ Interpreting the child's behavior or utterances	■ Exploring the environment ■ Showing signs of using the parent as home base while exploring, checking back as necessary ■ Being able to self-soothe ■ Responding to his name ■ Sharing or using toys interactively with adults ■ Looking well cared for

Cite as: Dixon S, Stadtler A. 2002. Age-specific observations of the parent–child interaction. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Fostering Family Adjustment Prenatally

Prenatal or preadoption discussion might include the following questions:

- What is the most exciting aspect of your pregnancy?
- What is the most anxiety-provoking aspect of your pregnancy?
- What do you imagine your baby will be like?
- What do you imagine you will be like as a parent? Is there someone you would like to imitate or not imitate as a parent?
- What are the plans for delivery or when you go to bring your adopted baby home? What will the father's role be? Will there be other support for the mother?
- What will the new baby's arrival mean for your lives? How will it affect your relationships? How will it affect your participation in activities or employment?
- Who will be available for support when the baby comes home?
- What does this baby mean to your family?
- If you plan to return to work, who will care for the baby at that time?
- How have you prepared your other children for or otherwise involved them in this pregnancy and birth?

For families that have dealt with special circumstances (e.g., infertility workup, adoption process, previous miscarriage, depressive symptoms, medical complications such as gestational diabetes or preeclampsia), consider asking the following question:

- How has the_____ (infertility workup, adoption process, previous miscarriage, depressive symptoms, medical complication, etc.) affected your anticipation of and preparation for becoming new parents?

See also

Tool for Families: Helping Siblings Adjust to the New Baby, p. 71.

Cite as: Stadtler A. 2002. Fostering family adjustment prenatally. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Infancy Checklist

The following list highlights key topics to consider in promoting infant mental health. These topics may be discussed selectively during office visits, depending on the needs of the infant and family.

Self

- ❑ **Temperament, including**
  - ☐ Uniqueness of the infant's temperament
  - ☐ "Goodness-of-fit" between infant temperament and parenting style and expectations

Self: Regulation

- ❑ **Feeding, including**
  - ☐ Breastfeeding
  - ☐ Solid foods
  - ☐ Self-feeding
  - ☐ Feeding difficulties
- ❑ **Sleep, including**
  - ☐ Sleep patterns
  - ☐ Bedtime routines
- ❑ **Infant distress, including**
  - ☐ Body language
  - ☐ Crying

Family

- ❑ **Family formation, including**
  - ☐ Preparation for the new infant
  - ☐ Preparing older children for the arrival of the infant
  - ☐ Support for parents in the first year
  - ☐ Postpartum mood disorders
  - ☐ Families at risk for social-emotional difficulties
- ❑ **Attachment, including**
  - ☐ Reading infant cues
  - ☐ Providing nurturing responses

Community

- ❑ **Stimulation, including**
  - ☐ Play
  - ☐ Cognitive development
  - ☐ Stimulating environments
- ❑ **Child care, including**
  - ☐ Selecting a child care provider
  - ☐ Concerns about child care

Bridges

- ❑ **Opportunities for early identification and intervention, including**
  - ☐ Anxiety disorders
  - ☐ Child maltreatment
  - ☐ Domestic violence
  - ☐ Insecure attachment
  - ☐ Mental retardation
  - ☐ Mood disorders
  - ☐ Parental depression
  - ☐ Pervasive developmental disorders
  - ☐ Postpartum mood disorders

Notes

Cite as: National Center for Education in Maternal and Child Health. 2002. Infancy checklist. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Early Childhood

1–4 Years

What Can Your Child Do?

Health professionals can gain a further sense of a child's strengths, as well as any areas of concern, by reviewing the questionnaire on the following page with parents. This process also serves as a useful tool for discussing parental expectations and ways of building self-esteem.

What Can Your Child Do?

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

CHILD'S NAME:	HAS DIFFICULTY WITH	IS OK AT	IS GOOD AT	EXCELS AT
Running and jumping				
Playing with a ball				
Using a pen/pencil/crayon				
Putting things together and taking them apart				
Dancing				
Singing				
Appreciating music				
Understanding what others say				
Learning from stories				
Counting				
Being interested in how things work				
Making a convincing argument				
Being sensitive to the feelings of others				
Trying hard				
Expecting things to go well				
Playing make believe				
Having a sense of humor				
Getting along with people				
Managing anger				
Adjusting to changes				
Other				

Cite as: Howard BJ. 2002. What can your child do? In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

How to Help Families Stop Spanking

Spanking is no more effective than other forms of punishment, yet it has many potential adverse effects on children, including increased anger, aggression, sibling rivalry, later delinquency, lower cognitive abilities, decreased self-esteem, and increased vulnerability to stress. Parents who spank often have difficulty changing to other methods of discipline on their own and may need help in thinking through alternative approaches.

- Be aware that even parents who believe in spanking do not like doing it.
- The best way to stop spanking is to never start, but parents can also stop spanking in about 3 weeks.
- Ask if the parents would be willing to discipline without spanking.
- Help parents set reasonable rules for their child. (See Tool for Families: Principles of Limit Setting, p. 81.)
- Make sure the parents are noticing and acknowledging their child's good behaviors. If they are not, teach them methods of positive reinforcement. (See Tool for Families: Charting Positive Behavior, p. 83.)
- Make sure the parents are spending enough individual time with their child. If they are not, teach them about special time. (See the following Tools for Families: Guidelines for Special Time, p. 82; Communicating with Children, p. 84.)
- Meet with the child's parents (both, if possible) to discuss discipline.
  - Ask each parent what they do when their child misbehaves and how it works. Get specific examples.
  - Ask each parent how they were disciplined when they were growing up and what they decided about the kind of discipline they would use as parents.
  - Ask who else disciplines the child and how.
  - Ask what happens if parents disagree on how to handle a discipline situation. Advise parents on the importance of not interfering in the discipline of the other: "Whoever starts, finishes." (If one parent has concerns about discipline being overly harsh, further evaluation is required.)
  - Teach the parents use of time out (see Tool for Families: Time Out, p. 88), and determine the most likely three behaviors for which they anticipate needing it. Help them choose serious enough problems, such as aggression.
  - Request that both parents agree to use time out and not spank for 3 weeks. If one disagrees, that parent should agree not to interfere, to limit any spanking to certain misbehaviors, and to only use the hand on the buttocks for one spank. That parent is likely to change when he or she sees the other parent's success.
  - Be available by telephone for questions. Schedule a follow-up appointment in 3 weeks. Request that parents call before then if problems occur.
  - Report any suspected abuse, but also offer continued discipline education to the family.

Cite as: Howard BJ. 2002. How to help families stop spanking. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Suggested Child Interview Using a Human Figure Drawing As a Conversation Piece

Due to copyright permissions restrictions, this tool is not available on the Web. Please see print version of the publication.

Risk Factors for Dyslexia

Risk factors for dyslexia include the following:

- ❑ History of language delay
- ❑ History of not attending to the sounds of words (trouble playing rhyming games with words, or confusing words that sound alike)
- ❑ Family history of specific reading difficulty

To help identify children at risk for dyslexia at the time of school entry, look for children who have difficulty with the following:

- ❑ Letter identification (naming)
- ❑ Letter-sound association (e.g., identifying words that begin with the same letter from a list: doll, dog, boat)
- ❑ Phonologic awareness (e.g., identifying the word that would remain if a particular sound were removed: if the "k" sound were taken away from "cat")
- ❑ Verbal memory (e.g., recalling a sentence or a story that was just told)
- ❑ Rapid naming—quickly naming a continuous series of familiar objects, digits, letters, or colors
- ❑ Expressive vocabulary or word retrieval (e.g., naming single pictured objects)

See also

Bridge Topic: Learning Problems and Disorders, pp. xx–xx;

Tool for Families: Learning Disabilities: Common Signs, p. 143.

Source: Adapted, with permission, from Shaywitz SE. 1998. Dyslexia. *The New England Journal of Medicine* 338(5):307–312.

Early Childhood Checklist

The following list highlights key topics to consider in promoting mental health in early childhood. These topics may be discussed selectively during office visits, depending on the needs of the child and family.

Self

- ❑ **Sleep patterns and bedtime routines**
- ❑ **Eating, including**
  - ☐ Healthy eating
  - ☐ Self-feeding
  - ☐ Picky eating
  - ☐ Family meals
- ❑ **Toilet learning, including**
  - ☐ Signs of readiness
  - ☐ Parents' concerns
  - ☐ Children's fears
- ❑ **Self-care, including**
  - ☐ Encouragement of independence in feeding, dressing, and bathing
- ❑ **Emotions, including**
  - ☐ Increasing self-control
  - ☐ Tantrums
  - ☐ Aggression
  - ☐ Fears

Family

- ❑ **Parent-child relationship, including**
  - ☐ Self-esteem
  - ☐ "Goodness-of-fit" between parents' expectations and child's temperament
  - ☐ Praise
  - ☐ Limit setting
  - ☐ Discipline
- ❑ **Sibling relationships, including**
  - ☐ Preparation for new siblings
  - ☐ Cooperation
  - ☐ Conflict resolution

Friends

- ❑ **Playmates (typically 3 years of age and older)**

Community

- ❑ **School readiness**
- ❑ **Child care**

Bridges

- ❑ **Opportunities for early identification and intervention, including**
  - ☐ Anxiety disorders
  - ☐ Attention deficit hyperactivity disorder (ADHD)
  - ☐ Child maltreatment
  - ☐ Domestic violence
  - ☐ Learning disorders
  - ☐ Mental retardation
  - ☐ Mood disorders (depression and bipolar disorder)
  - ☐ Obesity
  - ☐ Oppositional and aggressive behaviors
  - ☐ Parental depression
  - ☐ Pervasive developmental disorders

Notes

Cite as: National Center for Education in Maternal and Child Health. 2002. Early childhood checklist. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

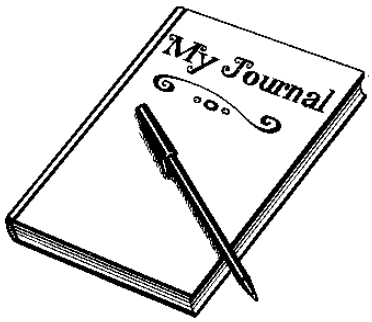
Middle Childhood

5–10 Years

About My Feelings

This is a sheet you can fill out and share with your parents and/or health professional. Your answers will help them learn more about you and how you respond to different situations.

Things that make me *angry:*



When I am *angry,* I . . .

Things that make me *happy:*

When I am *happy,* I . . .

Things that make me *sad:*

When I am *sad,* I . . .

(continued on next page)

When I am *picked on,* I . . .

_____

_____

Things that make me feel *hurt:*

_____

_____

When I am *afraid,* I . . .

_____

_____

When I *care about* people, I . . .

_____

_____

Things that make me *proud* of myself:

_____

_____

_____

My name _____ Date _____

Source: Adapted, with permission, from Buchanan B, Yarnevich A. 1994. *What to Do When Kids Say "NO!"* Kansas City, MO: Health Education Consultants. Web site: www.aboutkidsmentalhealth.org.

My School Sheet

This is a sheet that you can fill out with your parents and share with your health professional. It will help your parents and your health professional learn more about what school is like for you and ways that they can help you feel good about school and learning.

FUN AND LEARNING OUTSIDE OF SCHOOL

Things I am good at doing:

_____ _____ _____

Things I would like to learn/read about with my family:

_____ _____ _____

Places I would like to visit with my family (ideas: parks, museums, libraries):

_____ _____ _____

MY FRIENDS

Friends who go to my school:

_____ _____ _____

Friends who live near me:

_____ _____ _____

Things I like to do with my friends in school:

_____ _____ _____

Things I like to do with my friends outside of school:

_____ _____ _____

GOALS FOR SCHOOL

Early Elementary School (K–3)

What I am learning to do:

_____ _____ _____

What I am good at:

_____ _____ _____

(continued on next page)

What is harder for me:

_____ _____ _____

Late Elementary School (4–6)

My subjects:

_____ _____ _____

_____ _____ _____

Grades my parents expect me to get:

_____ _____ _____

Grades I want to get:

_____ _____ _____

Grades I think I'll get:

_____ _____ _____

STUDY TIME

Places that are comfortable for me to do homework:

_____ _____ _____

Favorite times of the day to study:

_____ _____ _____

Things that make it hard for me to study:

_____ _____ _____

ABOUT MY SCHOOL

Activities I enjoy most at school:

_____ _____ _____

How often my parents and teachers talk together:

_____ _____ _____

Cite as: Spratt E. 2002. My school sheet. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Homework Problems

Health professionals are frequently asked by parents for advice or help in handling conflicts with their child over homework. Providing effective guidance requires an understanding of potential factors that may be contributing to a child's difficulty with school or homework, and to parental frustration. The following table offers a framework for assessment and interventions regarding homework problems.

Assessment	Interventions
Is the child disorganized?	■ Suggest teaching the child time-management skills and memorization strategies, such as using acronyms. ■ Advise parents and teachers to check the child's backpack before he leaves home and school to ensure that he has what he needs. ■ Suggest using an assignment book routed daily between teacher and parent. ■ Consider having a duplicate set of books at home for easy reference. ■ Discuss dividing assignments that are not due for several days into segments and completing one step at a time.
Does the child have a learning disability, an academic skills deficit, a language disorder, or mental retardation?	■ Advise parents to request an educational management team meeting or, for a child who is eligible for special education services, an Individualized Education Program. ■ If a language disorder is suspected, refer the child for evaluation to a language pathologist and audiologist. ■ Refer a child who has significant difficulties with reading, spelling, or mathematics for a psychoeducational evaluation either through the school or privately.
Does the child have difficulty writing properly?	■ Refer the child for occupational therapy consultation as indicated. ■ Consider interventions such as allowing additional time to complete written work, permission to type homework on a computer, use of a tape recorder, printed lesson outlines or notes, use of test questions that require only short answers, and oral or taped examinations instead of written tests.
Is the child distractible or hyperactive?	■ Encourage homework breaks, use of lesson outlines, and checklists. ■ Suggest that siblings not engage in activities that compete for the child's attention during homework time (e.g., postpone video game playing until the homework period is over). ■ Advise parents to ask the school for an individual functional behavior assessment. ■ Assess the child for attention deficit hyperactivity disorder (ADHD).
Does the child have psychosocial or family problems?	■ Assess the child for psychosocial problems such as anxiety; depression; anger; obsessions and compulsions; aggressive, oppositional, defiant, or antisocial behaviors; a lack of social skills; somatic complaints; excessive worry; and substance abuse. ■ Assess the child for family problems such as marital discord, separation, divorce, remarriage, death, medical or psychiatric illness, chronic parental disability, substance abuse, family violence, child abuse, poverty, incarceration of a family member, parents' unemployment, and homelessness. ■ Provide interventions, including referrals, for mental health services as indicated.

(continued on next page)

Homework Problems (continued)

Assessment	Interventions
Does the parent-child relationship contribute to the problem?	■ Offer suggestions for improving parent-child interactions regarding homework, such as answering questions, providing a setting conducive to study, helping the child practice spelling and math, accompanying the child to the library, rehearsing oral presentations, helping select and design science fair exhibits, shopping for project materials, and praising the child's efforts and accomplishments. ■ In situations where parents are unable to assist their child with her homework or where tension between the parents and child over homework is excessive, suggest that an experienced teacher, peer, or mature high school or college student provide extra homework help. A few schools have optional programs in which children complete homework at school after regular hours under the guidance of a teacher.
Has the child lost the motivation to do well in school?	■ Recognize that, as a health professional, you can offer support, encouragement, and commendation of school success that can improve a child's motivation, particularly when there are few other positive adult influences in the child's life. ■ Consider drawing up a homework contract that is developed with both the parents' and the child's participation and approval. Keep a copy in the child's office chart, and give the original to the child to post at home. ■ Assess the child for underlying emotional difficulties.
What is the attitude of the child's peers toward school and homework?	■ Ask the child about his friends' attitudes toward school. Peers with positive attitudes toward school success can be a strong influence in fostering constructive educational outcomes, whereas peers with negative attitudes can contribute to decreased interest in schoolwork, underachievement, and the likelihood that the child will eventually drop out of school. ■ Encourage participation in weekend or after-school enrichment programs in the sciences, humanities, and arts that allow the child to explore stimulating topics with high-level instructors and interested peers. These courses can reinforce the idea that brain power is as admirable as muscle power. ■ If teasing or ridicule by peers appears to be contributing to a child's difficulties, encourage parents to collaborate with the child's teachers regarding approaches to this problem. ■ Consider referring the child for services that would facilitate social coping (e.g., social skills training, peer mediation).
How strong a positive influence are the child's teachers?	■ Suggest that the child spend time with a teacher with a hobby similar to her own or with an instructor in a particular area of interest, such as music, art, or physical education. ■ Encourage parents to participate in school activities and to know their child's teachers.
Does the child have too much homework or too many extracurricular activities?	■ Encourage parents who think their child has too much homework to discuss their concerns with the teacher, principal, or parent-teacher association. ■ If it seems that the child has too many after-school activities, talk to the parents and the child about how to prioritize.

See also

Tool for Families: Homework Tips, p. 119.

Tool for Health Professionals and Families: My School Sheet, pp. 40, 117.

Source: Adapted, with permission, from Green M, Sullivan P, Eichberg C. 1999. Homework conflicts, skirmishes, and wars. *Contemporary Pediatrics* 16(9):54–73.

School Basic Information Form

As _____'s health professional I am interested in his/her progress in school. To assist me in providing care, I would appreciate it if a school representative would complete the following form after obtaining appropriate permission from the family. Thank you for your assistance.

Child's name: _____

Current grade: _____

School name, address, phone, and fax:

_____

_____

_____

_____

Contact people at school: *Please circle preferred contact(s):*

	Name (and phone if different from above)	Best times to call
Teacher		
Principal		
Other		

Classroom type:

- ❏ Regular
- ❏ Learning disabilities (SLD)
- ❏ Developmental handicap
- ❏ Severe behavioral handicap (SBH/SED)
- ❏ Gifted and talented
- ❏ Other (please describe):

_____

_____

(continued on next page)

What concerns does the school have about this child? (check all that apply)

- ❑ Possible attention deficit (ADHD)
- ❑ Possible neurological problems
- ❑ Possible medical causes of learning problems
- ❑ Possible psychological/emotional problems
- ❑ Other (please specify):

_____

Is a learning disability or cognitive delay suspected?

- ❑ No learning disability/cognitive delay suspected
- ❑ Learning disability or low IQ suspected (please explain why):

_____

_____

Is this child's behavior a problem?

- ❑ No
- ❑ Yes (please describe):

_____

_____

_____

Does this child have a current Individualized Education Program (IEP) or Accommodation Plan (AP)?

- ❑ Yes, see attached copy (please include all psychological/educational assessments)
- ❑ Yes, but copy not available; IEP or AP was done on _____
- ❑ No current IEP or AP

To convey other information or to ask additional questions, please use the back of this form or attach additional sheets as necessary. Thank you very much for taking the time to complete this form. Please feel free to contact me with any questions. Following is my contact information:

Name: _____

Contact information: _____

_____

_____

Cite as: Needlman R. 2002. School basic information form. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Middle Childhood Checklist

The following list highlights key topics to consider in promoting mental health in middle childhood. These topics may be discussed selectively during office visits, depending on the needs of the child and family.

Self

- ❑ **Self-esteem, including**
  - ☐ Fostering success
  - ☐ Taking reasonable risks
  - ☐ Resilience and handling failure
  - ☐ Parental verbal abuse
  - ☐ Importance of supportive family and peer relationships to self-esteem
- ❑ **Self-image, including**
  - ☐ Body image
  - ☐ Prepubertal changes
  - ☐ Initiating discussions about sexuality and reproductive health

Family

- ❑ **What matters at home, including**
  - ☐ Expectations and limit setting
  - ☐ Family time together
  - ☐ Communication
  - ☐ Family responsibilities
  - ☐ Family transitions—divorce, blended families
  - ☐ Sibling relationships

Friends

- ❑ **Friendships, including**
  - ☐ Making friends
  - ☐ Aggression and bullying
  - ☐ Victims of bullying
  - ☐ Family support of friendships

Community

- ❑ **School, including**
  - ☐ Expectations for school performance
  - ☐ Homework
  - ☐ Child-teacher conflicts
- ❑ **High-risk behaviors and environments, including**
  - ☐ Absenteeism
  - ☐ Substance use (e.g., alcohol, tobacco, and other drugs)
  - ☐ Unsafe friendships
  - ☐ Unsafe community environments

Bridges

- ❑ **Opportunities for early identification, including**
  - ☐ Anxiety disorders
  - ☐ Attention deficit hyperactivity disorder
  - ☐ Child maltreatment
  - ☐ Domestic violence
  - ☐ Eating disorders
  - ☐ Learning problems and disorders
  - ☐ Mental retardation
  - ☐ Mood disorders: depressive disorders and bipolar disorder
  - ☐ Obesity
  - ☐ Oppositional and aggressive behaviors
  - ☐ Parental depression
  - ☐ Pervasive developmental disorders
  - ☐ Substance use disorders

Notes

Cite as: National Center for Education in Maternal and Child Health. 2002. Middle childhood checklist. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Adolescence

11–21 Years

Issues Checklist (Abridged)

ADMINISTRATION AND SCORING

Ideally, both parents and the adolescent should complete this questionnaire independently; at a minimum, at least one parent and the adolescent should complete the questionnaire. Respondents are asked to circle "yes" for topics they have discussed with their parents/son or daughter during the last 4 weeks and "no" for topics that have not come up. For each issue marked "yes," the respondent uses the rating scale to indicate how "hot" discussion of the issue is.

SCORING

1. Quantity of issues: Count the number of issues marked "yes."
2. Intensity of issues: For issues marked "yes," add intensity ratings and divide by the number of issues marked "yes" to obtain mean intensity rating.

INTERPRETATION

The Issues Checklist is meant primarily as a clinical tool for discussion. However, it has successfully discriminated between distressed families (i.e., those referred for treatment) and nondistressed families (i.e., those with no history of treatment and/or self-reports of satisfactory relationships) (see Robin and Foster, 1989). For rapid screening purposes, primary care health professionals should conduct further assessment when parents circle 15 or more items "yes" and/or have a mean intensity rating of 2 or higher, and/or when adolescents circle 13 or more items "yes" and/or have a mean intensity rating of 1.7 or higher. In addition to calculating the number of circled "yes" items and the mean intensity rating for each respondent, it can be helpful to compare areas where adolescent and parent ratings do not agree.

This instrument is based on one originally designed by Arthur L. Robin (1975) and further developed by Ronald Prinz. The unabridged version is published in Robin and Foster (1989).

REFERENCES

Robin AL. 1975. *Communication Training: A Problem-Solving Approach to Parent-Adolescent Conflict.* Unpublished doctoral dissertation. State University of New York, Stony Brook.

Robin AL, Foster SL. 1989. *Negotiating Parent-Adolescent Conflict: A Behavioral-Family Systems Approach.* New York, NY: Guilford Press.

Issues Checklist (Abridged)

DIRECTIONS

Circle "yes" for topics you have discussed with your parents/son or daughter during the last 4 weeks, and "no" for topics that have not come up. For each issue answered "yes," circle a number between 1 (calm) and 5 (angry) to answer the question, "How did you feel when you discussed this topic?"

			How Did You Feel When You Discussed This Topic?				
Have You Discussed?			**Calm**		**A little angry**		**Angry**
1. Telephone calls	yes	no	1	2	3	4	5
2. Bedtime	yes	no	1	2	3	4	5
3. Cleaning bedroom	yes	no	1	2	3	4	5
4. Doing homework	yes	no	1	2	3	4	5
5. Putting away clothes	yes	no	1	2	3	4	5
6. Using the television	yes	no	1	2	3	4	5
7. Cleanliness (washing, showers, brushing teeth)	yes	no	1	2	3	4	5
8. Which clothes to wear	yes	no	1	2	3	4	5
9. How neat clothes look	yes	no	1	2	3	4	5
10. Making too much noise at home	yes	no	1	2	3	4	5
11. Table manners	yes	no	1	2	3	4	5
12. Fighting with brothers and sisters	yes	no	1	2	3	4	5
13. Cursing	yes	no	1	2	3	4	5
14. How money is spent	yes	no	1	2	3	4	5
15. Picking books or movies	yes	no	1	2	3	4	5
16. Allowance	yes	no	1	2	3	4	5
17. Going places without parents (shopping, movies, etc.)	yes	no	1	2	3	4	5
18. Playing stereo or radio too loudly	yes	no	1	2	3	4	5
19. Turning off lights in house	yes	no	1	2	3	4	5
20. Using drugs	yes	no	1	2	3	4	5

(continued on next page)

Issues Checklist (Abridged) (continued)

Have You Discussed?			How Did You Feel When You Discussed This Topic? Calm		A little angry		Angry
21. Taking care of records, games, bikes, pets, and other things	yes	no	1	2	3	4	5
22. Drinking beer or other alcoholic beverages	yes	no	1	2	3	4	5
23. Buying records, games, toys, and other things	yes	no	1	2	3	4	5
24. Going on dates	yes	no	1	2	3	4	5
25. Who friends should be	yes	no	1	2	3	4	5
26. Selecting new clothes	yes	no	1	2	3	4	5
27. Sex	yes	no	1	2	3	4	5
28. Coming home on time	yes	no	1	2	3	4	5
29. Getting to school on time	yes	no	1	2	3	4	5
30. Getting low grades in school	yes	no	1	2	3	4	5
31. Getting in trouble at school	yes	no	1	2	3	4	5
32. Lying	yes	no	1	2	3	4	5
33. Helping out around the house	yes	no	1	2	3	4	5
34. Talking back to parents	yes	no	1	2	3	4	5
35. Getting up in the morning	yes	no	1	2	3	4	5
36. Bothering parents when they want to be left alone	yes	no	1	2	3	4	5
37. Bothering adolescent when he/she wants to be left alone	yes	no	1	2	3	4	5
38. Putting feet on furniture	yes	no	1	2	3	4	5
39. Messing up the house	yes	no	1	2	3	4	5
40. What time to have meals	yes	no	1	2	3	4	5
41. How to spend free time	yes	no	1	2	3	4	5
42. Smoking/spit tobacco	yes	no	1	2	3	4	5
43. Earning money away from the house	yes	no	1	2	3	4	5
44. What adolescent eats	yes	no	1	2	3	4	5

Source: Adapted, with permission, from Robin AL, Foster SL. 1989. *Negotiating Parent-Adolescent Conflict: A Behavioral-Family Systems Approach.* New York, NY: Guilford Press.

Anticipatory Guidance on Sex and Sexuality for the Adolescent

- Encourage adolescents to identify a supportive adult who can provide accurate information about sex.
- Make adolescents feel comfortable asking questions about physical changes during puberty, including variations they may notice from individual to individual.
- Assist adolescents in asking questions or getting information in an effort to educate themselves about preventing pregnancy and sexually transmitted diseases (STDs) and how to use different contraceptive methods.
- Acknowledge to adolescents that romantic and sexual feelings are normal. Discuss with adolescents that having sex should be delayed until they are mature enough to assume responsibility for sexual relations; the decision to have sex should be well thought out. Adolescents should not have sex if they do not want to.
- Emphasize that the safest way to prevent pregnancy and STDs, including HIV infection/AIDS, is to not have sexual intercourse.
- Encourage adolescents to learn ways to say "no" to sexual intercourse and to avoid situations that may increase pressure to engage in intercourse (e.g., using alcohol or drugs, attending unsupervised parties).
- Stress to adolescents that if they are engaging in sexual activity (i.e., oral sex, anal sex, vaginal sex) they should ask the health professional for an examination and a discussion of methods for preventing pregnancy and STDs. Adolescents need to learn how to negotiate safer sex and how to share feelings about sexuality with their partners.
- Emphasize to adolescents that they should practice safer sex by limiting the number of partners they have and by using latex condoms and other barriers correctly. Demonstrate and explain correct condom use with a model or illustration.
- Let adolescents know that if they are confused or concerned about their sexual feelings (for the same or the opposite sex), they can and should talk to a trusted adult or a health professional.

See also

Tool for Families: Talking to Your Teen About Sex and Sexuality, p. 127;

Tool for Families: Where to Find Resources on Adolescent Sexuality, p. 129;

Tool for Families: Teen Dating Violence, p. 130.

Source: Adapted, with permission, from Green M, Palfrey JS, eds. 2000. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd ed.). Arlington, VA: National Center for Education in Maternal and Child Health.

Adolescence Checklist

The following list highlights key topics to consider in promoting mental health in adolescence. These topics may be discussed selectively during office visits, depending on the needs of the adolescent and family.

Self

- ❑ **Self-esteem, including**
  - ☐ Parental support
  - ☐ Peer influence
  - ☐ Resilience and handling failure
- ❑ **Mood, including**
  - ☐ Stability of moods
  - ☐ Depression
  - ☐ Suicidal ideation (suicidal thoughts) and behaviors
- ❑ **Body image, including**
  - ☐ Physical appearance
  - ☐ Weight
- ❑ **Sexuality, including**
  - ☐ Sexual development/puberty
  - ☐ Sexual behavior
  - ☐ Sexual identity
  - ☐ Parental expectations and communication
  - ☐ Prevention of sexually transmitted diseases, including HIV/AIDS
  - ☐ Pregnancy
  - ☐ Sexual abuse and rape

Family

- ❑ **Independence and responsibility, including**
  - ☐ Importance of family support in adolescence
  - ☐ Increased independence
  - ☐ Increased influence of peers
  - ☐ Parental expectations and limit setting
  - ☐ Family conflict

Friends

- ❑ **Peer relationships, including**
  - ☐ Peer support
  - ☐ Peer influence

Community

- ❑ **School, including**
  - ☐ Transition from middle school/junior high school to high school
  - ☐ Academic success
  - ☐ Homework
  - ☐ Extracurricular activities
  - ☐ Absenteeism, dropping out
  - ☐ Transition from high school to college or work
- ❑ **High-risk behaviors and risk factors, including**
  - ☐ Substance use
  - ☐ Violent behaviors
  - ☐ Firearm use
  - ☐ Exposure to violence

Bridges

- ❑ **Opportunities for early identification and intervention, including**
  - ☐ Anxiety problems and disorders
  - ☐ Attention deficit hyperactivity disorder
  - ☐ Child maltreatment
  - ☐ Eating disorders
  - ☐ Learning problems and disorders
  - ☐ Mental retardation
  - ☐ Mood disorders: depressive and bipolar disorders
  - ☐ Obesity
  - ☐ Oppositional and aggressive behavior
  - ☐ Pervasive developmental disorders
  - ☐ Substance use

Notes

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Bridges

Vanderbilt ADHD Diagnostic Teacher Rating Scale

INSTRUCTIONS AND SCORING

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Inattention	Requires six or more counted behaviors from questions 1–9 for indication of the predominantly inattentive subtype.
Hyperactivity/ impulsivity	Requires six or more counted behaviors from questions 10–18 for indication of the predominantly hyperactive/impulsive subtype.
Combined subtype	Requires six or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional defiant and conduct disorders	Requires three or more counted behaviors from questions 19–28.
Anxiety or depression symptoms	Requires three or more counted behaviors from questions 29–35.

The performance section is scored as indicating some impairment if a child scores 1 or 2 on at least one item.

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The scale is available at http://peds.mc.vanderbilt.edu/VCHWEB_1/rating~1.html.

REFERENCE FOR THE SCALE'S PSYCHOMETRIC PROPERTIES

Wolraich ML, Feurer ID, Hannah JN, et al. 1998. Obtaining systematic teacher reports of disruptive behavior disorders utilizing DSM-IV. *Journal of Abnormal Child Psychology* 26(2):141–152.

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Name: _____ Grade: _____

Date of Birth: _____ Teacher: _____ School: _____

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

		Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often			
1.	Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting in line	0	1	2	3
18.	Interrupts or intrudes on others (e.g., butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3

(continued on next page)

Vanderbilt ADHD Diagnostic Teacher Rating Scale (continued)

	Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often			
20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

PERFORMANCE

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

0 = "Not At All"

1 = "A Little"

2 = "Some"

3 = "A Lot"

However, items 4, 8, 12, and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not At All"

2 = "A Little"

1 = "Some"

0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms.

Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

See also

Tool for Families: Symptoms of Depression in Adolescents, p. 126.

Tool for Families: Common Signs of Depression in Children and Adolescents, p. 147.

REFERENCES

Weissman MM, Orvaschel H, Padian N. 1980. Children's symptom and social functioning self-report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental Disorders* 168(12):736–740.

Faulstich ME, Carey MP, Ruggiero L, et al. 1986. Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *American Journal of Psychiatry* 143(8):1024–1027.

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

Edinburgh Postnatal Depression Scale (EPDS)

Due to copyright permissions restrictions, this tool is not available on the Web. Please see print version of the publication.

Edinburgh Postnatal Depression Scale (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Age: _____ Phone: _____

As you have recently had a baby, we would like to know how you are feeling. Please **check** the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☑ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Source: Reprinted, with permission, from Cox JL, Holden JM, Sagovsky R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782–786.

Stages of Substance Use and Suggested Interventions

Stages of Use	Interventions
Abstinence Child or adolescent does not use any drugs or alcohol.	■ Be aware of children and adolescents at risk for substance abuse: Family history of alcohol or drug abuse Early onset of conduct disorder or aggressive behavior History of attention deficit hyperactivity disorder, school difficulties, mood and anxiety disorders History of poor supervision, trauma, or abuse ■ Encourage and support continued abstinence. ■ Encourage activities that build on a child's or adolescent's strengths and self-esteem (e.g., sports, community activities, art and music classes, participation in faith-based organizations). ■ Discuss with the child or adolescent what she would do if she were pressured to use drugs or alcohol.
Experimental Use Child or adolescent infrequently uses tobacco, alcohol, or drugs. Substances are usually obtained from, and used with, friends. Although associated drug-related problems are uncommon, risks can be serious.	■ Educate the child or adolescent about potential consequences and health-related risks of tobacco, drug, or alcohol use, stressing the more immediate consequences (e.g., "If you continue to smoke, I believe it will affect your soccer performance"). ■ Stress the importance of not drinking or using drugs and driving, and of not riding with a driver who has been drinking or using drugs. ■ Develop a "rescue plan" with the child or adolescent and parents. A rescue plan should specify that the child or adolescent will receive a ride home if he finds himself in an unsafe situation, including being intoxicated or high, and the commitment that discussion about the behavior will take place at a time when it can be rational.
Regular Use Child or adolescent uses alcohol or drugs on an occasional but regular basis. "Social drinking" in adolescents often involves significant binge drinking.	■ See above interventions.
Problem Use Child or adolescent has experienced adverse consequences associated with use. Child or adolescent may have had problems with grades, detentions, or suspensions; parents or peers; motor vehicle crashes; injuries; or physical or sexual assaults.	■ Ask the child or adolescent to consider the link between problems she is having and alcohol or drug use. Remember that helping a child or adolescent become motivated to address her alcohol or drug use is an ongoing process, which begins with highlighting concerns about current behavior. ■ Discuss concerns and options for change. (See Tool for Health Professionals: Discussing Substance Use, p. 63.) ■ Consider an "Abstinence Challenge": "If you can agree to give up drugs/alcohol for a while, this will give us important information about your control over your use. If you can't do it, it probably means that your use has gotten to the point where you may need more professional help."

(continued on next page)

Stages of Substance Use and Suggested Interventions (continued)

Stages of Use	Interventions
Problem Use, *continued*	■ If the child or adolescent refuses an abstinence challenge, continue to follow up. For example, say, "You have heard what my concerns are. Will you at least give some thought to what I said and come back again to talk more?" ■ Develop a "rescue plan" with the child or adolescent and parents. A rescue plan should specify that the child or adolescent will receive a ride home if he finds himself in an unsafe situation, including being intoxicated or high, and the commitment that discussion about the behavior will take place at a time when it can be rational.
Substance Abuse Child or adolescent engages in ongoing use of drugs or alcohol, despite harm. Loss of control over use.	■ Continue to work with the child or adolescent and family until the child or adolescent is ready to engage in substance abuse treatment. See interventions above. Refer for the appropriate level of services, when ready to engage in treatment: *Outpatient Treatment*. Includes community and school resources, 12-step groups, peer-support groups, and individual counseling. May be used for children and adolescents who are motivated to change behaviors and are not physiologically addicted to substances. May also be used as a transition from more intensive treatment settings. (Sixty percent of teens who attended weekly community support groups after discharge from inpatient or residential substance abuse treatment programs remained drug-free for the first year.) *Partial or Day Hospital*. May be considered for children and adolescents who need more intensive structure and support in order to break the cycle of substance use but are motivated for treatment and are not physiologically dependent. Also used as a transition from more intensive treatments. *Residential Treatment*. Should be considered for children and adolescents who are unlikely to be able to stop drug or alcohol use if they remain in their home environment, including children or adolescents who may be at risk for withdrawal or those with a history of treatment failures in less restrictive settings. *Inpatient Treatment*. For children or adolescents who are at significant risk for withdrawal symptoms, who have serious psychiatric disorders or symptoms (suicidal, homicidal, psychotic, or acutely dangerous behaviors), or who have failed in other treatment settings.
Substance Dependency Child or adolescent is preoccupied with use. Development of tolerance or withdrawal symptoms. Increase in risk-taking and dangerous drug-related behaviors.	■ Refer to formal treatment program (residential or inpatient).
Secondary Abstinence The goal of substance use treatment is abstinence, as control over use is almost impossible to reestablish once lost.	■ Continue to follow the child or adolescent closely, and ensure that supports and treatment programs are maintained. ■ Relapse is part of the early process of recovery. Avoid stigmatizing or abandoning the child or adolescent if it occurs. ■ Relapse can be viewed as a learning opportunity; the level of supports and treatments can be reviewed and increased as indicated.

Source: Adapted, with permission, from Knight JR. 1997. Adolescent substance use: Screening, assessment, and intervention. *Contemporary Pediatrics* 14(4):45–72.

Discussing Substance Use

Addressing substance use is often an extended process requiring ongoing communication. One key is to target the discussion to the needs of the child or adolescent and his or her readiness to change. The following approaches have proven useful in communicating with children and adolescents about substance use.

The **FRAMES** mnemonic describes six principles of effective brief interventions (Miller and Sanchez, 1994).

F	**Feedback** on risk/impairment	Use child's or adolescent's own description of current problem. E.g., "You've told me your grades have dropped this year, and you were in an accident after drinking at a party."
R	Emphasis on personal **responsibility** for change	E.g., "I'd like to work with you, but it's up to you to take responsibility for changing things."
A	Clear **advice** to change	E.g., "I believe the best thing for you would be to stop using drugs and alcohol."
M	**Menu** of options for behavior change and treatment	E.g., "You could try stopping completely, or cutting down, or I could refer you to a specialist."
E	**Empathetic** counseling style	E.g., "I know that these things may be difficult to hear, but I'm worried about you. I care about your health and your future."
S	Faith in child's or adolescent's **self-efficacy** to change	E.g., "Even though this may be difficult to do, I believe in you and I know that you can do this if you try."

Interventions and communications addressing substance use can be more effective if health professionals take into account a child's or adolescent's readiness for change at a moment in time. Recognizing that a child or adolescent moves through stages of change (see table 1 on page 64) can help health professionals tailor their message and feel less frustrated when immediate change does not occur.

Table 1. Stages of Change and Goals of Intervention

Stages of Change (Prochaska and DiClemente, 1982; 1983)	Goal of Intervention	Discussion
Precontemplation The individual has not yet begun to consider change as an option. No personal "ownership" of problem behavior.	Raise doubts and increase awareness of risks and problems.	E.g., "Have you ever considered that you might not have been suspended from school if you hadn't been smoking pot?" E.g., "Did you know that car accidents, particularly those caused by drinking, are the number one cause of death for people your age?"
Contemplation Initial recognition of problem. Ambivalence about change.	Acknowledgment of ambivalence, evoking reasons for change, and tipping the balance in favor of change.	E.g., "It sounds like part of you wants to stop and part of you wants to keep on drinking," followed by discussion as presented in precontemplation above, building on the child's or adolescent's own reasons to desire change.
Determination Mind is made up to change, but individual does not yet actually do it.	Recommendation of treatment options and arranging follow-up visits or referral.	Recommend a nicotine replacement and make a referral to a smoking-cessation support group for tobacco smokers; recommend substance abuse counseling and a 12-step support program for alcohol and drug users.
Action Behavior is actually changed, but individual does not yet feel comfortable.	Ongoing support.	Praise progress; express confidence in the child's or adolescent's ability to maintain change. Problem solve to develop strategies to address challenging situations.
Maintenance New behavior requires less conscious effort. Relapse is an ongoing possibility.	Positive reinforcement and strategies to prevent relapse.	Praise progress; express confidence in child's or adolescent's ability to maintain change. Ask about experiences in social or challenging situations.

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Miller WR, Sanchez VC. 1994. Motivating young adults for treatment and lifestyle change. In Howard GS, Nathan PE, eds., *Issues in Alcohol Use and Misuse by Young Adults* (pp. 55–81). Notre Dame, IN: University of Notre Dame Press.

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Source: Adapted, with permission, from Knight JR. 1997. Adolescent substance use: Screening, assessment, and intervention. *Contemporary Pediatrics* 14(4):45–72.