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Community Screening of Pediatric Behavioral and Emotional Disorders in Nebraska

"We need a wider range of screening in our community. I think you have a child sitting with you—like that is our goal to increase screening. So kids can be identified sooner...what I would say is how can we have something in our community..." [from one study participant]

Prepared by:

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Nebraska
Medical Center

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EXECUTIVE SUMMARY

In the United States, up to 20% of children will experience some emotional or behavioral issues at any given time, including depression, anxiety, attention deficit disorder, oppositional defiant disorder, learning disorders, autism, and other disorders. These issues have become even more pressing under the current COVID-19 pandemic when many children have to resort to remote learning and become isolated from each other. As part of the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) project, the present study aimed to identify current practices in the screening of behavioral or emotional disorders among children and youths in various community settings in Nebraska and coping strategies adopted by community organizations, including responses to COVID and referral pathways utilized when a child or youth is screened positive with behavioral or emotional disorders.

To meet this study's aims, we adopted a qualitative phenomenological approach in our data collection by conducting semi-structured interviews with 53 key informants from different community organizations in Nebraska. Study participants included school nurses, school counselors, school social workers, teachers, program managers, or directors at various educational settings, including early childhood education centers, schools, foster care organizations, Head Start programs, and evidence-based home visiting programs in different regions across Nebraska. Interview questions were developed to elicit participants' perspectives, context, and experiences of screening practices, referral pathways, training needs, COVID impact and responses, and recommendations related to behavioral or emotional disorders among children and youths that would likely inform the development of a model for integrated care.

Highlights of Findings

- Of the 53 key informants, nearly three-fourths claimed emotional or behavioral issues were concerns among children and families in their organizations. Attention deficit disorder and attention deficit hyperactive disorder were the most common concern among children of all ages.
- Many organizations screened children and families for various issues, such as interpersonal violence, social needs, and emotional and behavioral concerns; however, there were no consistent methods across similar organizations or age groups. Various methods were adopted to help address these identified issues, including referring to internal and external resources to address these issues.
- While many participants felt overall prepared to identify and address emotional or behavioral issues among children and youth, they did not identify crucial areas to improve, such as trauma-informed care and de-escalation techniques.
- Concerns regarding the current COVID-19 Pandemic as well as methods implemented to assist children and families were also discussed, in which almost all organizations offered virtual services and resources to help ease any abnormal behaviors at this time.
- Under the pandemic it was common for children to become stressed and anxious due to the disruption of routines and isolation from social networks.

- Participating key informants also reported extensive familial disruptions due to isolation, lack of economic security, food insecurity, and stress during the pandemic, and how these issues have negatively impacted emotional and behavioral health among children and adolescents in Nebraska.

Recommendations

Based on the significant findings from this study, we recommend that the following steps should be taken to better identify and address the behavioral and emotional issues among children and adolescents in Nebraska:

- 1. Proactively screen and assess all children for emotional, mental, and behavioral health issues.** Several key informants have recommended early screening for mental, emotional, and behavioral health issues among children and adolescents so that we do not have to wait until the issues are becoming more serious and challenging to address. This is especially important and necessary in the aftermath of the COVID-19 pandemic.
- 2. Create and disseminate age-appropriate, standardized screening instruments, and approaches throughout child-servicing community systems in Nebraska.** Children and adolescents often experience different screening levels with various approaches and instruments at different schools and even within the same school. A standardized, validated approach to screening would be more effective in detecting mental, emotional, and behavioral health issues among children and alleviate related disparities across school districts.
- 3. Define and clarify school's roles and processes in addressing mental, emotional and behavioral health issues among children and adolescents.** Various school system members expressed concerns and confusion regarding the school's role in identifying and addressing mental, emotional, and behavioral issues among children in the greater community context. Several key informants stated that an educational campaign among school staff, students, parents, and community providers would help direct children to the appropriate assistance programs and cut waiting time.
- 4. Work with parents and community partners to reduce stigma surrounding mental, emotional and behavioral issues among children and adolescents.** Many key informants have expressed concerns with the continual stigmatization of mental, behavioral, and emotional issues in families and communities, especially in communities of ethnic and racial minorities. It is suggested that medical and educational programs should develop more coordinated efforts to provide screenings to all students at child wellness visits and offer culturally appropriate education for parents.
- 5. Mobilize community resources and primary care linkages to provide coordinated care and to improve referrals.** Key informants expressed concern and frustration regarding the lack of communication among organizations serving children. The primary concern is to be able to create wrap-around services for children without duplicating services. To accomplish this goal, several informants suggested the need of encouraging parents to release children's health information to care-giving organizations to enable them to provide coordinated and integrated health services for children. There is also a need for educational programs to formalize partnerships with primary care providers to improve referrals for addressing mental and behavioral health issues among children and adolescents in Nebraska.

ACKNOWLEDGEMENTS

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The input and support from study participants, educational agencies such as early childhood education centers, schools, foster care organizations, Head Start programs, and evidence-based home visiting programs across Nebraska are also acknowledged.

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), 1 in 5 children experiences a mental health disorder (CDC, 2019). The CDC defines mental health disorders among children as serious changes in the way children typically learn, behave, or handle their emotions, which consists of a broad range of conditions, including attention-deficit/hyperactivity disorder (ADHD), depression, anxiety, substance use disorders, and obsessive-compulsive disorder (OCD), all with varying levels of severity (CDC, 2019). Children's social-emotional wellbeing and functioning is a crucial factor in their academic achievement. Children with significant social, emotional, and behavioral problems not only place themselves at risk for academic failure, but their problems can also interfere with the learning of others (Kremer et al., 2016).

Approximately 20% of children or adolescents in the U.S. experience mental health issues; many never receive care (Merikangas et al., 2011). A study sponsored by the National Institute of Mental Health (NIMH) observed that access to care for mental health services for adolescents is limited. Of those diagnosed with mental health disorders, only 36% received further treatment through counseling, medication, therapy, or other interventions (Merikangas et al., 2011). In the United States, it was estimated that 11% to 20% of children have a behavioral or emotional problem at any given time, and 37% to 39% of children will have behavioral or psychological problems diagnosed by the age of 16 (US Department of Health and Human Services, 2000; Costello et al., 2003). Even more concerning is that these disorders have not been adequately diagnosed and treated in the current U.S. health care system (Kim-Cohen et al., 2003; Jaffee et al., 2005). Understanding barriers to screening and access to mental and behavioral health services at the clinical, health care system, family, community, and societal level thus becomes crucial for addressing mental and behavioral health disorders among children.

Schools and early childhood education programs play a unique role in identifying mental and behavioral health disorders among children. There is evidence that universal screening at the school entry-level could successfully detect children likely to have behavioral problems and provide a means to develop timely targeted interventions (Siceloff, Bradley, and Flory, 2017). Despite the acknowledgment of the need for universal mental health screening among children and youths, less than 15% of schools implement procedures to evaluate students' mental health needs systematically (Bruhn, Woods-Groves, and Huddle, 2014). This likely reflects the limited availability of resources necessary to support universal screening of students' mental health status and needs, misconceptions, and other issues that reduce the acceptability of implementing these procedures in a school setting (Humphrey and Wigelsworth, 2016).

There are various evidence-based screening tools and methods that can be used to identify social, emotional, and behavioral issues in students across different age groups (O'Connors et al., 2020). The selection of a screening tool should be based upon whether the evidence-based instrument provides the appropriate information that the school desires and whether the tool is a good contextual fit for the school (SAMHSA, 2019). There are some commonly used screening tools such as Behavioral and Emotional

Screening System (BESS), Ages and Stages Questionnaire-Social Emotional (ASQ-SE), Pediatric Symptom Checklist (PSC-17), Screening for Child Anxiety Related Disorders (SCARED), NICHQ Vanderbilt Assessment Scales, Strengths and Difficulties Questionnaire (SDQ), Patient Health Questionnaire (PHQ-9), and Eating Attitude Test (EAT-26) (American Academy of Pediatrics, 2012; Williams, 2008). This study did not measure how extensively these screening instruments have been adopted by various educational and community programs in Nebraska.

The COVID-19 pandemic has caused tremendous disruptions to the daily life of children, families, communities, schools, and school mental health workforce (Dibner et al., 2020). Across the globe, to contain the COVID-19 transmission and to reduce the disease burden in the community, most countries have implemented the practice of social distancing (Van & Parolin, 2020). During the peak of the pandemic, most schools have been closed and transited to the home-based distance-learning models (Golberstein et al., 2020). As a result, children are compelled to stay home for prolonged periods due to lockdown and school closure, causing minimal or no communication or interaction with peers and reduced physical activities (Jiao et al., 2020). These factors influence children's mental health and emotional wellbeing, leading to wide-ranging mental health issues, such as anxiety, stress, depression, and sleeping problems (Ramchandani, 2020; Racine, 2020). The mental health impact has been even more significant among children with disabilities. Online platforms are often not well-suited for teaching children with visual impairments or hearing problems (Patel, 2020). Families and adults also have had adverse psychological outcomes due to the prolonged isolation, socioeconomic impacts, frustrations, fear and anxiety over COVID-19 (Loades et al., 2020). These issues point to the pressing need to prevent and treat mental and behavioral problems during and after the pandemic at family and community levels.

The high prevalence of mental and behavioral health disorders among children, in conjunction with the inadequacy of the health care system in detecting and treating these disorders, elevates the significance and necessity of identifying alternative settings and institutions whereby these disorders and their early signs and symptoms can be detected, which is essential from the perspective of primary prevention. For this purpose, it would be crucial to assess the status quo and capacity in mental and behavioral health screening, referral, and training in various community settings, including early care and education (e.g., Head Start for young children), schools at multiple levels, foster care, and evidence-based home visiting programs.

A unique advantage of developing and implementing mental and behavioral health screening in community settings lies in its economy of scale, serving many children simultaneously and thus reducing the cost on a per capita basis. Universal screening at school entry, across the school years, in-home visiting programs, and in foster care can effectively identify children at risk of developing mental and behavioral health issues and provide a basis for developing optimal targeted interventions. Despite the promise of school-based screening and intervention programs, not all schools, including early childhood education programs, have the readiness, willingness, and capacity to conduct proactive screening of mental and behavioral problems, let alone interventions or referral programs to address the disorders.

Based on survey data from 319 school administrators, special education coordinators, and school nurses in Nebraska, a recent report from the Nebraska CMS School Health Affinity Group (2018) documented the extent to which community partners assist local schools in making referrals for mental health and behavioral health needs of children and adolescents. It was found that over one third of schools work with community partners to facilitate mental health and behavioral health issues. Three-quarters of the 319 respondents indicated they did not believe there were adequate community resources available within a range of 25 miles to serve students with mental or behavioral health concerns. Despite the importance of these findings, this report was based on data collected from an online survey without collecting in-depth qualitative data related to these topics.

The purposes of our report are to identify and assess 1) current practices in screening behavioral, mental, and emotional problems among children and youths in Nebraska; 2) coping strategies including referral pathways utilized when a child or youth is screened positive with behavioral, mental, or emotional problems; and 3) impacts of the COVID-19 pandemic on the functioning of different community programs and how these programs have responded to the challenges.

DATA AND METHODS

Study Design

In this study, we adopted a qualitative approach in our data collection by conducting semi-structured interviews (Zoom or telephone) with key informants including school nurses, teachers, program managers, or directors at various educational settings, including early childhood education centers, schools, foster care organizations, Head Start programs, and evidence-based home visiting programs in different regions across Nebraska. This multi-perspective approach made it possible for us to assess similarities and differences in the perceptions and experiences of participants and to integrate suggestions from different organizations for improving screening and early identification of emotional or behavioral problems among children and youth. The qualitative phenomenological approach was chosen in order to comprehensively understand participant feelings, opinions, and experiences and to interpret the meaning of their actions that quantitative studies usually cannot capture. Our methodology focuses on an iterative process that seeks to understand and contextualize a participant's point of view by listening and purposeful questioning.

Study Participants

We used purposive and snowball sampling to recruit diverse participants involved in the delivery, management, and coordination of services for children and youths in Nebraska in various community settings. With the support from Nebraska DHHS, health departments across the state, school districts, and other organizations, we recruited 53 key informants representing school nurses, teachers, program managers, and directors at various educational settings, including early childhood education centers, schools, foster care organizations, Head Start programs, and evidence-based home visiting programs in different regions across Nebraska. In collaboration with the Public Health Division at the Nebraska Department of Health and Human Services, we identified and contacted potential participants representing different educational organizations through purposeful sampling to make sure the sample would represent various educational agencies across geographic regions in Nebraska and reflect experiences with children and youth at different ages. To be eligible, the participant should be 19 years of age or older and can effectively communicate in English.

Data Collection

Before the data collection, training was provided to three interviewers in terms of commonly used interview skills, technical issues related to zoom or phone interviews and how to record the conversations, and ethics in conducting qualitative research. An interview guide was developed to facilitate the training. Informed consent was emailed to potential participants before each interview to explain to them the study purpose, what participation in the study incurs, and foreseeable risk and benefit. Informed consent was

collected from those who were willing to participate. Interviews were conducted via Zoom or over the phone according to the convenience of participants on a pre-arranged day and time, with each interview on average lasting approximately 30 to 45 minutes.

During the interview, the interviewers asked participants a series of questions using the semi-structured interview guide with open-ended questions and additional probes when needed (Table 1). The questions were developed to elicit participants' perspectives, context, and experiences of screening practices, referral pathways, if any, perceived needs for training, and recommendations related to behavioral, mental, or emotional disorders among children and youths that would likely inform the development of a model for integrated care. Each interview was audio- or zoom-recorded and later transcribed for qualitative data analysis. The data were collected between May 2020 and August 2020. A gift card of \$40 was mailed to participants who completed the interview as compensation for their time.

Data analysis

A thematic analysis was conducted to illustrate the principles of framework analysis and broadly follow the five steps of familiarization: identifying a thematic framework, indexing, charting, and mapping and interpretation (Gale et al., 2013). The analysis consisted of multiple steps, including reading the transcription of participants several times to acquire a feeling for the participants and their responses, identifying significant phrases and restating them in general terms, formulating meanings and validating meanings through research team discussions to reach consensus, identifying and organizing themes into clusters and categories, and developing a full description of themes.

The rigor of the study was established by using robust qualitative research strategies to ensure credibility and trustworthiness. Two research members independently coded the transcripts using thematic content analysis, and the transcript was analyzed in two stages. First, each member independently analyzed the transcripts, applied initial codes, and later discussed their results and recoded the transcripts based on their discussion over the emerging themes. Second, the two research members compared their updated codes and established the themes based on their joint review of the codes. For this analysis, we used transcripts based on recorded interviews with 53 participants.

Table 1. Interview Guide and questions used for the interview

<p>1. Based on your best knowledge or estimates, how common do students in your program have behavioral or emotional concerns such as attention deficit hyperactivity disorder (ADHD), autism, learning disorder, oppositional defiant disorder (ODD), depression, anxiety, conduct disorder, or substance use?</p>
<p>2. Based on your observation, how has the COVID-19 pandemic impacted emotional and mental wellbeing of families/children in your program?</p>
<p>3. Has your program implemented any interventions to assist children and their families to cope with the COVID-19 pandemic?</p>
<p>4. How do you know if a child in your program/school might have a behavioral or emotional disorder?</p> <ul style="list-style-type: none"> a. Do you routinely screen for interpersonal violence and trauma? b. Do you routinely screen for social needs such as food insecurity, lack of transportation, safe housing? If so, do you use a standardized approach? c. Do you routinely screen for: Social and Emotional Development, Autism, and Blood Lead? d. Do you routinely screen for adolescent depression? e. Do you routinely screen for substance use among adolescents? f. Do you routinely screen for maternal or caregiver depression? g. Do you routinely screen for maternal or caregiver substance use?
<p>5. What is the procedure when a child is identified with a potential behavioral or emotional concern?</p>
<p>6. How do you handle referrals for families with a child with a potential behavioral or emotional concern?</p>
<p>7. How well do you think you and your colleagues are prepared or trained to cope with behavioral or emotional problems in your organization?</p>
<p>8. Based on your observation and knowledge, what should be done to better detect and address behavioral or emotional problems among children in your program?</p>

ETHICAL CONSIDERATIONS

The Institutional Review Board of the University of Nebraska Medical Center approved this study (IRB # 235-20-EX). Data collection from eligible participants only started after we had obtained informed consent. Participants could choose to withdraw from the study or refuse to answer specific questions based on their judgments at any time during the interview process.

Only de-identified data were used in the final project report and related dissemination of project findings.

ANALYSIS AND RESULTS

Demographics

Fifty-three key informants participated in semi-structured interviews between May and August 2020. Of these key informants, the majority were associated with school programs (39.6%), early education programs (16.7%), home visiting programs (16.7%), and foster care programs (3.8%) (Figure 1). The “Other” category accounted for 22.6% of the 53 organizations represented, which includes non-profit organizations, governmental agencies, tribal organizations, a federally qualified health center, and an independent living center. Within the “Other” category, non-profit organizations were the most prominent, accounting for 11.3% of the total organizations interviewed.

Figure 1: Key Informant Organizational Designation

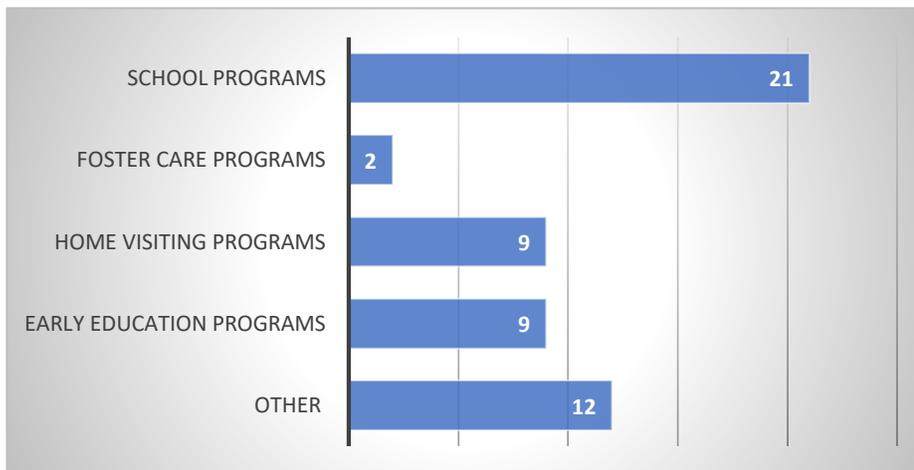
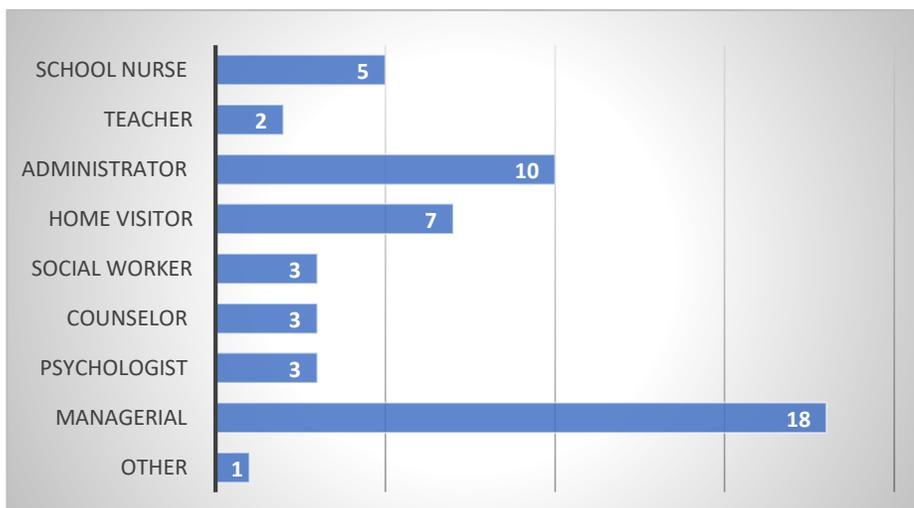


Figure 2: Key Informant Job Titles



The majority of informants held managerial positions within their organization (33.9%), such as supervisor, manager, director, or coordinator. Other main job titles included organization administrator (19.2%) and home visitor (13.5%). Within the 21 individuals that worked within the school system, the majority were school administrators (n = 7) and school nurses (n = 5). The other informants from schools included teachers (n=1), social workers (n=3), school counselors (n=3), and school psychologists (n=2). Early education program participants consisted of teachers, program directors, and administrators. Foster care organizations included two managerial individuals, one director and one supervisor.

On average, key informants worked at their current organization for approximately 6 to 10 years (28.8%), followed by 3-5 years (Figure 3). Duration of work at current organization among participants ranged from less than one year to over 30 years.

Figure 3: Key Informant Years of Experience at Current Organization

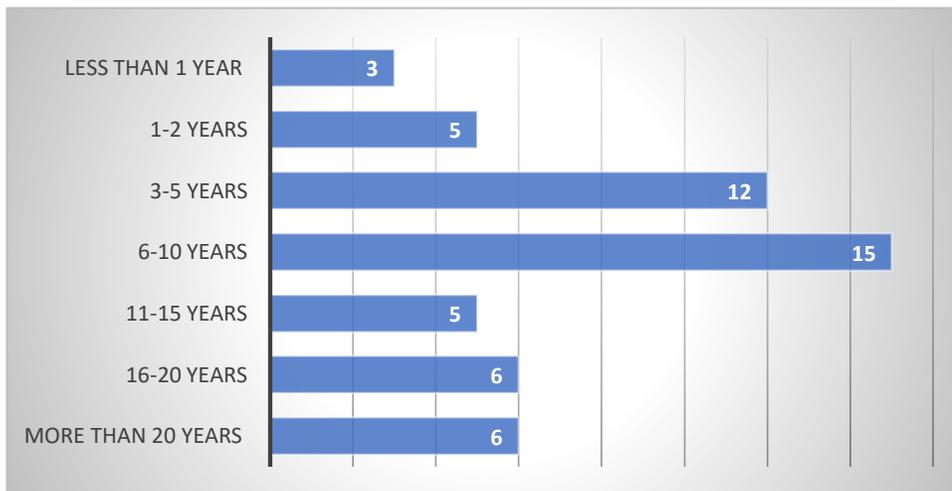
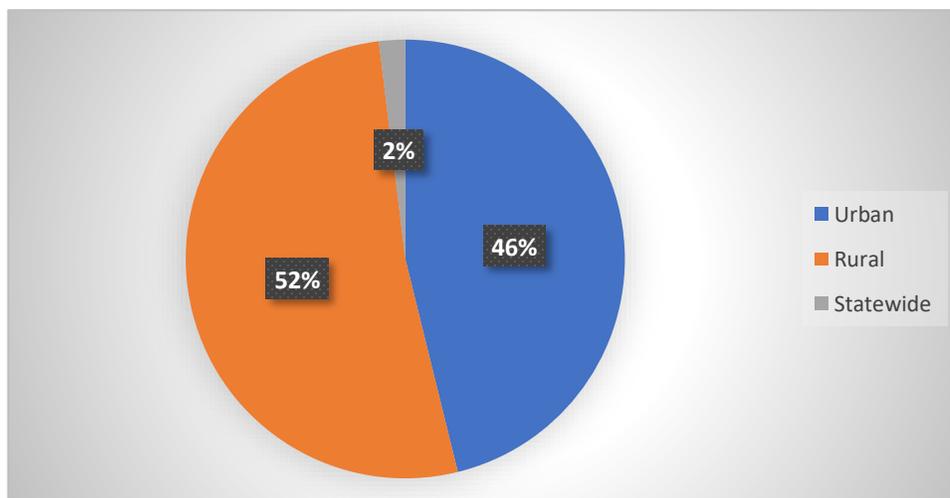


Figure 4: Organizational Location Urban-Rural Designation



Approximately 46% of the interviewees were employed in urban areas, while 52% worked in rural areas (Figure 4). One organization was designated with a statewide service area.

The average number of children and adolescents served by participating organizations was 1,054, ranging from 4 in an early education center to 15,000 in a federally qualified health center. Many key informants worked with children in the early childhood age group (0 to 5 years old), followed by school-aged children (6 to 12 years) and adolescents (13 to 19 years). Several organizations served individuals past the legal age of 19 into adulthood, and one organization offered services covering the lifespan of individuals (prenatal care thru death) (Figure 5).

Figure 5: Age Groups of Children and Adolescents Served

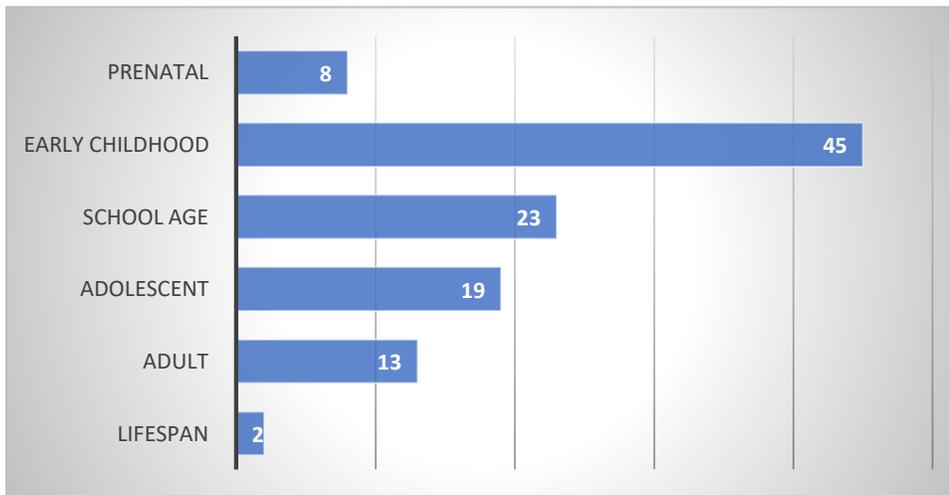
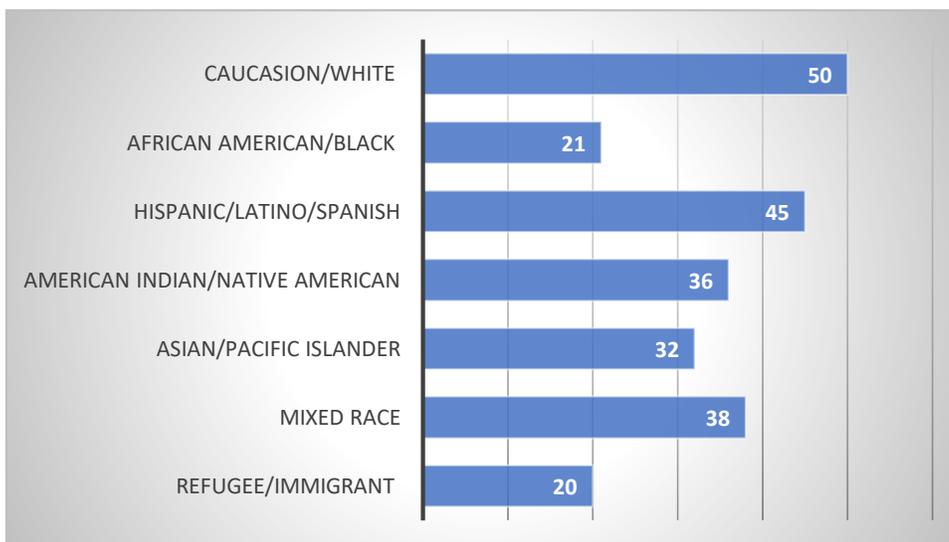


Figure 6: Racial and Ethnic Make-up of Children and Adolescents Served

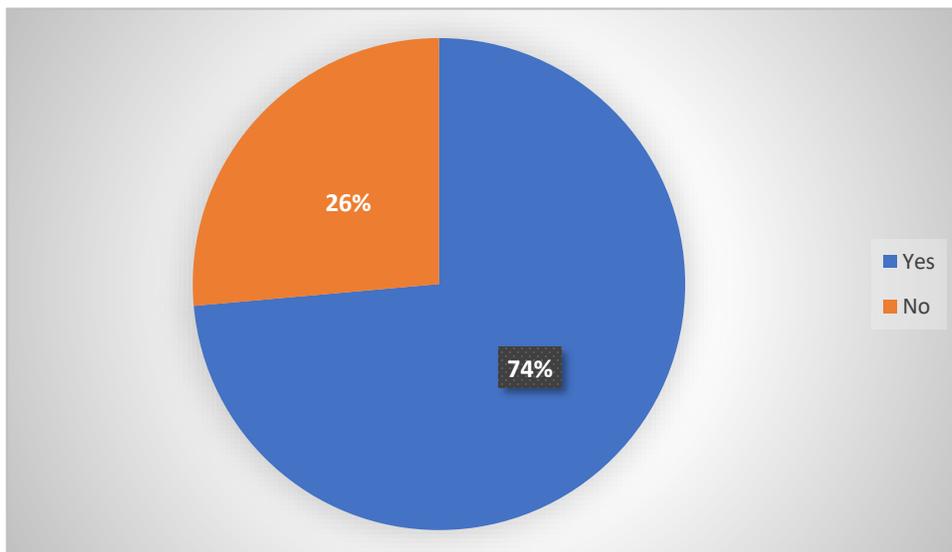


Key informants were asked to identify racial and ethnic groups that were represented within their organization. Figure 6 depicts the number of organizations that work with children and families of each specific race and ethnicity. The predominant racial background of children served was Caucasian/White (94.3%), followed by mixed-race (71.7%) (Figure 6). Approximately 85% of the participants reported that their organizations serve Hispanic or Latino children and youths. All racial and ethnic backgrounds were represented in the key informant organizations. About 37% of informants also stated they worked with refugees or immigrant families currently or within the organizational history.

Emotional and Behavioral Health Issues

Key informants were asked to identify how common behavioral or emotional issues were among children and adolescents in their program (Table 2). Thirty-nine or 74% of the key informants reported concern about students or children showing emotional or behavioral issues in their organization (Figure 7). This ranged from “Every student”, “Very common”, to “it’s a growing concern”.

Figure 7: Percentage of Key Informants Concerned with Emotional and Behavioral Issues



The ranges of these issues were dependent on organization type and age ranges served. The majority of key informants expressed that more than 20% of children and adolescents in their organization were showing emotional or behavioral concerns. Example of key informants’ perception are as follows:

“... as far as a generalized estimate, I've seen about maybe 50 or 60% [of children]. I mean, a lot.” [53]

“So, I think, again, speaking for the birth to five population, and since we have a primary responsibility for a child trying to identify children with disabilities, the percentage is going to be much greater in birth to five than it would be in K to 12. So, it's probably. It's approximately 50% of the children that we serve have either a verified disorder or disability or suspect them.” [28]

“...so our preschool we typically average about a third of the kids... so like 30 children that have come into the program with some kind of delay due to their development. As far as relating to behavior, I would say it would be maybe like out of those 30 kids, maybe 20 of them have some sort of behavioral challenges with their delay.” [46]

Some participants stated that while the diagnosed levels remained under 25%, the concern is that many more students and children are undiagnosed or have not been identified with an apparent behavioral or emotional problem using the established procedures. For example, one participant stated:

“If you run a report, at the school I'm at right now, I would say probably 25% of the students fall into that category. But they don't have like an official diagnosis.” [19]

Fourteen key informants expressed no or extremely limited emotional or behavioral concerns among children and youth. Several of these key informants mentioned the age of the children in their program as a potential explanation for the reason these concerns are not present. For example:

“That question is a little bit tricky because of their age. Some of those things usually aren't determined during birth to three.....” [45]

“I will say not very often, since we work with kids from zero to three, I feel that there's not a lot. It's hard to identify somebody that is having any kind of problem at that age.” [34]

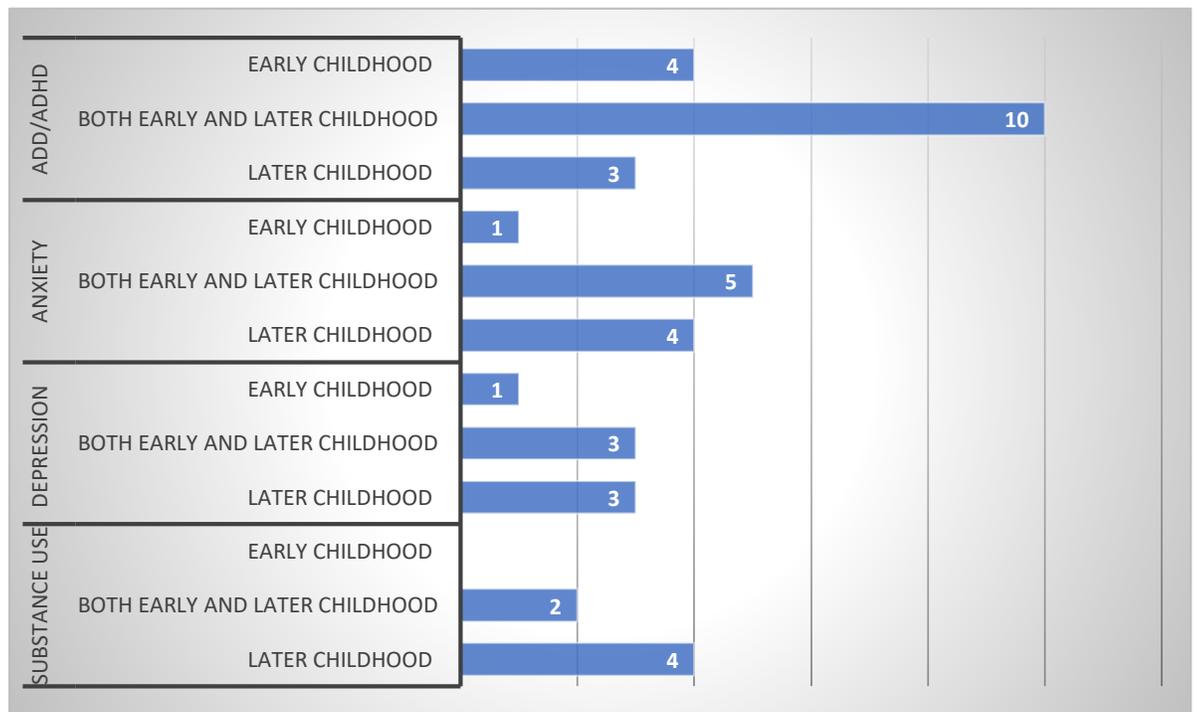
“I would say we're not seeing that, especially with the age of children we're working with right now.” [26]

There does appear to be a difference between responses regarding emotional and behavioral concerns due to differences in age ranges served by the organization. For example, most of the respondents who expressed concerns regarding emotional and behavioral problems worked with older children (school-aged children and older). Those who stated no concerns were more likely to work with children between the ages of birth and five years. In the “No Concern” group, nine respondents worked in early education programs, and the oldest age group represented was 13 years in the other organizations. In the “Concern” group, only six out of the 39 informants worked with the early education age group. Three of these organizations specifically developed programs to identify and address emotional and behavioral concerns in children.

The most common mental or behavioral health issues that were mentioned include ADD/ADHD (53.8%), anxiety (25.6%), depression (17.9%), and substance use (15.4%). Some of these issues were identified in older age groups, while others were scattered across different ages (Figure 8). Other mentioned issues include trauma-induced disorders, autism, developmental disabilities, and speech disorders.

Substance use, which included street drug usage, prescription drug abuse, and tobacco use, was identified as a concern among families and older age groups. While 16 key informants stated it was the least common concern, 10 other key informants said it was the most common concern. This finding may be due to differences in locations and age groups. The organizations that identified this as an issue usually served older, school-aged children or adolescents.

Figure 8: Common mental/behavioral health issues by age groups of children



Screening practices

All participants were questioned regarding their current screening practices based on the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) Screening and Referral Guide (Nebraska Department of Health and Human Services, 2020. Available at <http://dhhs.ne.gov/MCAH/PH-PB-4.pdf>).

Fifty-one key informants utilized screening in their organizations, while two organizations did not use any screening processes. All participants were asked if they screened for Interpersonal Violence (IPV) and social needs. Of these 51 interviewees, only 22 screened for IPV formally or informally. The majority of the organizations used the CDC's Adverse Childhood Experiences (ACES) Screener to identify any IPV at home. Otherwise, there is no consistent method to evaluate IPV and methods vary from recommended screeners, such as the Survey for the Well-Being of the Young Child (SWYC), and the STaT: three-question screener for IPV, informal methods, internally developed tools, to other known screeners.

Thirty-four participants stated there was some form of screening for social needs, such as food insecurity and transportation. Only 38.2% of those who screened for social needs did it in a consistent and standardized method. One organization utilized a tool specifically developed to screen for social needs. All other organizations incorporated social needs questions into intake needs assessed once at program entry.

Forty-seven organizations worked with early education groups, from birth to age 5. Within this group, 35 organizations screened for any social and emotional development and autism in this age group. The most common tool used for this assessment is the Ages and Stages (ASQ) and the Modified Checklist for Autism in Toddlers (M-CHAT). Other tools identified include the DC Emotional Tool, the CDC Milestone Checklist, the Developmental Assessment of Young Children (DAYC), the Behavior Assessment for Children (BASC), Childhood Autism Rating Score (CARS), Gilliam Autism Rating Scale (GARS), Social, Academic, Emotional Behavior Risk Screener (SAEBRS), the Zones of Regulation and Panorama Education Social Emotional Learning Assessment. Only six organizations provided direct blood lead level testing or resources to achieve testing. An additional seven organizations had methods in place to access blood level testing information if needed.

Eighteen organizations screened children in later childhood and adolescence for depression, suicide (13 organizations), and substance use (7 organizations). Five organizations used the PHQ-9 to screen for depression, while various tools were used for suicide. For example, schools tended to use internally developed or modified screening tools to address suicide concerns among students. Examples of these tools include the C-SSRS, the Student Risk Screening Scale (SRSS-IE), Behavioral and Emotional Screening System (BESS), the Suicide Risk Protocol, and a self-guided and

self-graded assessment tool. Only seven organizations had formal screening tools for substance use, including alcohol use, recreational drug use, prescription drug misuse, and tobacco consumption. These tools were also often internally developed or informal. Of the more formalized tools used, the Rapid Assessment for Adolescent Prevention Screening (RAAPS), the Adolescent Health Questionnaire (AHQ), and Substance use and dependence tools were the most common. Depression, suicide, and substance use were commonly only discussed if issues arose from teachers, students, self-reporting, and parental concerns were brought to the attention of the administration.

Twenty-two organizations working with mothers and caregivers provided screening regarding depression (n = 13) and substance use (n = 8). The most common tool utilized was CES-D (n = 9) and the EPDS (n = 3). Other tools administered to screen for depression included the SWYC, the PHQ-9, the Edinburg Depression Scale, the BESS, and post-partum depression. For maternal and caregiver substance use, organizations predominantly used the UNCOPE (n = 6), while only two organizations used a more informal approach.

Referral Process

The present study found that once a child or adolescent has been identified with a potential behavioral or emotional concern, there are predominantly two main procedural avenues. The first method identified is to resort to internal resources and strategies to address and provide services, while the second method is to refer the child or adolescent to outside resources. In this sample, those employed by the school system referred mainly to internal resources while home visiting and early education programs sought external referral processes. External referrals focused mainly on the child's pediatrician or primary care provider unless a specialist was previously identified. In all cases, parents are notified of any potential issues and next steps immediately upon identification of a concern; the level of parental involvement varies depending on the issue and organizational type. For example, in some schools, parents are informed of behaviors on a case-by-case basis. Some parents are interested in every incident in which their child shows an emotional or behavior issue, while other parents wish to be informed of overall trends. Parent preference is identified early in the intervention process with the school care team. In other instances, such as suicide intervention or behaviors that will result in self- or other-harm, parents are required to make contact with their child and seek treatment immediately. Most often, parental involvement expectations are outlined in the care plan initially and followed.

Internal referrals within the school systems often involve referrals to specialists within the school system. For example, students with behavioral or mental health issues are often referred to nurses, counselors, social workers, school psychologists, special education specialists, or administrators. Depending on the issue identified, plans may be developed that are limited to the classroom and interventions provided by the teacher. Other problems require the development of more structured intervention plans, outside resource identifications by social workers, or medical services such as therapy or speech pathology. In almost all school-based interventions, teams are developed to handle the issue in a

multi-faceted approach. Some examples of this are as follows:

“Let’s say someone is struggling in the classroom or has some behavior early, or I feel like there’s something going on at home. A lot of times we refer to community counseling. We have a Connections program. And so I will make a referral to the parent and contact the parent and ask them if they would like to sign up for Connections counseling, which oftentimes happens at school where the therapist comes to the school and works with their child or if they would rather they can set it up during non-school times if the parent is willing to take them.” [37]

“They might be looking at referring to our school-based licensed mental health practitioners or school social workers that are in the district, if there’s something that they can do. And then from there, we’d probably go on the advice of the doctors or what the next level professional, a school psychologist or whoever they were referred to.” [38]

All interviewees within the school system acknowledged they are not medical professionals, and therefore do not provide a diagnosis. Students are referred to outside resources for evaluation and diagnosis if a school provider is not available. If the school is included in the care plan for the child (i.e. informed of the diagnosis and treatment plan, including medications), the school providers will incorporate this into the care management plan. However, some key informants stated that children do not receive a formal diagnosis or information from care providers is not shared with the school.

External referrals from the school system are primarily directed to pediatricians or primary care providers. This may be in part due to school privacy acts, HIPAA regulations, and funding issues. One participant stated:

“If you’re seeking outside help besides what the special education program can provide...it’s very difficult to recommend because any recommendation of the district would wind up paying for it, so you have to be careful.” [18]

Other organizations, such as home visitation programs and early education programs, have established referral networks to statewide organizations, such as the Educational Development Network, or providers within specific healthcare systems, such as Boys Town Institution. Any other external referrals are mainly based on professional relationships that individual providers develop throughout the community. One example of the opinion of the referral process is:

“I think it’s pretty easy. We have this intake process, and maybe it’s easier for me because I’ve been doing it for 12 years, and I have a lot of connections with families and students trust me. I mean, I think if your families trust you, they’re pretty open. And so we usually make a lot of calls together and then when they feel comfortable, sometimes they’ll sign a release of information to get direct information for medical providers.”[42]

Many issues were noted in the referral process, such as age-appropriate resources, providers that accept Medicaid or sliding scales, transportation, availability, and waitlists. One provider expressed concern with age limitations on substance use and suicide treatment centers.

“I wish there [were] more services than we have and more opportunities for students to get earlier preventive intervention than before it becomes this out-of-control problem that they need inpatient care. Someone in another community had mentioned that there are often age limits to what they can get into certain programs.” [49]

Another issue that arose was the inconsistency of screening techniques used in different organizations. For example, one non-profit provider noted:

“...the assessment the Early Development Network uses to assess for delays is not the same tool we use and so ours doesn’t cross over. So we may see, you know, a big red flag [and] when they go in and assess [they] may not see it [identified issue].” [52]

Preparedness and Training

Key informants varied greatly on the belief of their preparedness to handle and address mental and behavioral health issues among children and adolescents in their programs. Often, the comfort level was tied directly to the number of years professionally associated with children and adolescents. For example, one key informant identified experience on the job as a better indicator of preparedness than job-related training. Other participants related formal secondary education as primary indicators of readiness.

Those who were more prepared to deal with mental and behavioral health issues reported more training, hands-on training, continuing education, and freedom to select training topics. These individuals tended to be employed within school programs for early childhood and older school-aged children. Areas that were identified as weak areas of training are as follows:

- Trauma-informed care
- Suicide identification and prevention
- Communicating with parents
- Mental health first aid
- Current special topics (i.e. COVID, BLM)
- Provider secondary trauma
- Conflict resolution
- Multi-tiered support systems
- Motivational interviewing
- Culturally appropriate training
- De-escalation techniques
- Data-driven programs
- Community resources
- Identifying social and emotional needs
- Restorative justice
- Substance use
- Observational assessments
- Job shadowing

Specific training programs that were identified as beneficial are as follows:

- MANDT
- FAST program
- FAST Training
- Pyramid model
- School-trauma network
- Project Harmony

Despite acknowledging that many school-associated providers receive training and need further training, there were some specific concerns regarding the amount of pressure this puts on frontline providers. For example, one school administrator stated:

“I don’t think I am as prepared as I should be. I don’t think I have enough tools in my toolbox to really help.” [17]

However, other concerns emerged when it came to expecting school providers to be the main line of referral.

“I didn’t think that we are prepared as much as we need to be... because they don’t want us to step into that mental health role.” [6]

“Every student is different, and every school is different... Challenges of the students vary from school to school. Now I am at full-time at one school, so I see a lot higher need, a lot more behaviors”. [19]

“I also feel like my school staff, my teachers especially, are frustrated with the number of things that they're being asked to be the experts on. They're well intentioned. They're not saying, I don't want to do this as my job. But there's, there's a number of different social, emotional behavior problems. And it's difficult to be really great at dealing with all of them every single day, and inevitably, even if you're really good at it, the kids are still going to fail sometimes, and they're still going to get out of the building, sometimes. Then they feel like they're not doing what they should be doing.” [38]

COVID-19 Pandemic and its Effects

The current COVID-19 Pandemic has posed unprecedented risks for both short- and long-term emotional and behavioral outcomes of many children and adolescents in Nebraska. Two key areas have been identified as primary concerns: direct issues emerging in children and concerns developing within the home/family.

The primary concern that has emerged for children has been stress and anxiety associated with the disruption of routines and isolation from social networks. Examples of this are as follows:

“She was just upset because her mom kept telling her they couldn't go anywhere, and she wanted to go. So, she just took off.” [16]

“The children’s social skills have almost completely diminished... I’m speaking on behalf of a child when she just stares at other children her age. She doesn’t really know how to interact other than the people that she knows, and she doesn’t know how to respond. She doesn’t know what is appropriate. Because she hasn’t had those opportunities.” [35]

“We know just on the remote learning that we had done, and data we collected, we saw a big loss in knowledge and skills amongst the kids who cannot be in in the classroom.” [41]

“It was hard for that many just being isolated from their friends and luckily there’s four of them so they can play with each other but were actually practicing the social distancing, not interacting with other families. Then that isolates the kids and they didn’t understand it at first...” [31]

“I think it’s been a huge barrier and a struggle as several of my students were receiving, you know medication and therapeutic services pretty regularly.” [49]

As seen in Table 2, other issues, such as language development and learning concerns have emerged in different age groups.

Table 2: Identified concerns due to COVID-19 based on age range

Age Group	Language development	Social Skills	Learning Issues	Stress/Anxiety	Behavioral Issues	Loss of healthcare services
Early Childhood	X	X			X	
Middle Childhood		X	X	X	X	X
Adolescents		X	X	X	X	X

In childcare centers that did not close due to the pandemic, there has not been a large change in behavioral or emotional status of children. However, there has been an increase in interest in the events of the outside world. For example:

“Since we work with such little ones, I don’t really see a big change because they don’t really necessarily understand what’s going on.” [16]

“A lot of them are now asking me every morning why I have to wear it [a mask]. They are kind of noticing, but it’s not really affecting anything going on [35].”

The second concern that has been reported was familial strife and home-life disruptions, especially among home visitation and school-based programs. Many familial disruptions are due to isolation, lack of economic security, food insecurity, and stress. For example:

“I think just the isolation that it caused, has especially affected some of our families if they don't have a lot of other people to count on. Um, and I've noticed some families really miss us not coming into the home, even though we were talking to them probably even more than we did when we were doing the home visits in the home. Um, they still miss that face to face contact. And if they don't have a lot of family or friends support, it's even more, um, it's more difficult for them right now.” [16]

“They don't have that in-person interaction. So, I mean, that alone affects their mental health.” [25]

“So instead of focusing on their child or development, things are focused on the COVID, so it definitely kind of took over for some families [COVID needs].” [25]

“An increase of some families that have had to be more involved with Child Protective Services.” [15]

“...and I think we haven't necessarily identified this directly yet, but I'm sure we've been having some issues along the lines of maybe some neglect and abuse that has occurred. You know, you're unemployed and how do I pay the bills and you want me to teach my kid at home too, and all of that becomes overwhelming for most people.” [41]

“Availability of where their child can go so that they could work or have some respite some time apart. I've seen it, it's gotten difficult because it's more time to spend together. Maybe they're trying to help school their older children.” [45]

“A lot of parents that we work with do have also ongoing mental health issues. And I feel like it's probably sparked more of that for the parents trying to deal with kids being at home full time and trying to just create some kind of routine for kids and, you know, keeping learning ongoing. I feel like it's probably impacted the parents more than the kids that I've seen.” [10]

“A lot of us were stuck at home with very few resources so we were not prepared to [help] families were not prepared or being at home.” [34]

Other concerns that most noticeably emerged as school is coming back into the session (whether virtual or in-person) is the use of older siblings to assist in younger sibling education. This adds unique stress to older children as they prepare for their educational needs as well as affecting family unit organization.

Programs have implemented a wide variety of interventions to help families adjust to the

COVID-19 Pandemic. Table 4 breaks these interventions into categories by organization type.

Table 4. Programs in Response to COVID-19 by Different Organizations

Organization Type	Virtual Services	In-Person Services	Social Need Resources	Medical Resources	Physical Resources	Other
Home Visiting	Phone Zoom Virtual activities	X%	X		Activity Packages Diapers Grocery cards Food items Household items	Health Education in multiple languages
Early Education	Phone Zoom	X	X	Mental health consultant on staff	EBT cards	Social Stories Modeling safe behaviors Webinars for educators
School Programs	Phone Zoom Group hang-outs	X%	X	X	X – Internet Hotspots	
Foster Care	Phone Zoom			Mental health resources		
Other	Phone Zoom	X%	X	X	X	

% In-person services resuming

Overall, moving services online has had positive impacts.

“We've had to do kind of a lot of triage, and a lot of just going back to meeting basic needs, needs of families making sure that they can pay rent...” [15]

“We'll continue to monitor basic needs and work in partnership with others, to make sure that the students in our schools have access to anything from like I said food, housing, or I would say we push the mental health piece of it at what we're planning on doing is incorporating social-emotional learning, training into our distance learning work. And at our 10 schools, our staff will intensively work with teachers, providers and parents to make sure that there's alignment with the curriculum.” [39]

“If we have families who are not comfortable sending their kids going back to the center, we will provide virtual learning opportunities then to those families and that we have a lot of contact with our family so that we're able to help them identify maybe some of their needs and being a part of a community action agency or even to make in house referrals for things like food pantries and rent and utility assistance and so forth.” [41]

“So our early childhood center, our emergency shelter, some of those day programs or site-based programs, those have continued to operate without disruption the entire this entire time, we just have had to make a lot of notice a lot of changes to what programming looks like, you know, staff, everyone having masks, just increasing our space to keep, you know, spread kids out, keep groups really small, you know, sanitation every few hours. So we've been doing a lot of that for those site-based programs.” [20]

“Children are resilient. A lot of them are acting the way that they usually act, but they're not able to go as many places or have the same type of schedule some of them. We're trying to use a lot of social stories to teach about mask-wearing and why we can't go to the places we may be used to go. I would say I've seen more social-emotional needs, but yet still caregivers are providing help that the child needs.” [45]

While the majority of interventions have had positive impacts, some issues have emerged. For example, some students have failed to interact online for several months. This has raised concerns that some children will fall through the cracks. Secondly, some services, such as well-child checks, have ceased or slowed dramatically. This has raised concerns that children may be exposed to more traumatic experiences. While there was no information provided to compare to pre-pandemic rates, there is concern that this will increase. Finally, some families are concerned with the prices of provided technology for student education, such as internet routers and Chromebooks. Parents are concerned with the cost of replacing technology if accidents happen.

STRENGTHS AND LIMITATIONS

This study has several limitations and strengths that are noteworthy. One study limitation is related to our use of convenience sampling, which calls for caution in generalizing our findings to various community settings in the whole state of Nebraska. Another limitation is that the interviews conducted via Zoom or phone may have elicited different responses than those performed in person or may restrict the interpretation of non-verbal responses by the interviewer. The use of purposeful and snowball sampling may also lead us to a wide range of participants representing various agencies across geographic regions in Nebraska who might hold similar views or experiences, although this strategy also facilitated our recruitment of participants beyond our networks. Despite these limitations, the strengths of the present report include the systematic approach used in sampling, data collection, and analysis to improve the reliability and validity of the analysis, checking of transcripts against audio-recordings and field notes taken, and triangulation among coders by consensus to ensure rigor and consistency. Another strength of the study is that we have interviewed a fairly large number of key informants from various agencies across Nebraska, which provided us with the rich data to comprehensively assess screening and referral practices associated with emotional and behavioral health issues among children and youth, and how these issues have incurred more unmet needs in both screening and referral services under the current pandemic.

RECOMMENDATIONS

Based on major findings from this study, it is recommended that the following steps should be taken to better identify and address the behavioral, mental, and emotional disorders among children and adolescents in Nebraska:

- 1. Continue NEP-MAP agenda to proactively screen and assess children and adolescents for mental, emotional, and behavioral issues.** Several key informants have expressed the need for early screening and interventions to address mental, emotional, and behavioral health concerns among children and youth. Often, these issues are overlooked by the system and they might become more challenging to be addressed later in life.
- 2. Create and disseminate a validated, standardized approach throughout child-serving community systems in Nebraska.** Children and adolescents often experience different levels of screening and interventions in different settings within the community. An evidence-based, standardized approach to screen, refer, and develop interventions would create a more rigorous intervention plan.
- 3. Define and clarify the role of the school in addressing the mental, behavioral, and emotional issues.** Various school system members expressed concern regarding the role of the school in identifying and addressing social and behavioral issues among children in the greater community context. Several key informants stated that a coordinated educational campaign among school staff, students, parents, and community providers would help direct children to the appropriate assistance and cut waiting times.
- 4. Work with parents and community partners to reduce stigma surrounding mental and behavioral issues.** Many key informants have expressed concerns with the continual stigmatization in families and communities, especially in communities of ethnic and racial minorities, of mental, social, behavioral, and emotional issues. Reducing and eventually eliminating these stigma requires concerted educational efforts to increase public awareness and knowledge in this area.
- 5. Mobilize community resources and primary care linkages to provide coordinated care and to improve referrals.** Key informants expressed concern and frustration regarding the lack of communication among organizations serving children and adolescents. The primary concern is to be able to create wrap-around services for children and adolescents without duplicating services. To accomplish this goal, several informants suggested the need of encouraging parents to release children's health information to care-giving organizations to enable them to provide coordinated and integrated health services for children and adolescents. There is also a need for educational programs to formalize partnerships with primary care providers to improve referrals for addressing mental and behavioral health issues among children and adolescents.

CONCLUSIONS

The high prevalence of mental and behavioral health problems among children and youths under the shadow of COVID-19 elevates the necessity to assess the screening and referral practices and processes in various community and organizational settings and the extent to which these practices and processes can meet the health needs. Based on qualitative data collected from 53 key informants across Nebraska, significant unmet needs included a lack of early screening and interventions, a standardized approach to screening, an educational campaign among school and community providers, as well as the lack of communication between schools and care providers to improve the referral process and to provide more integrated and coordinated care. Addressing these unmet needs calls for sustainable collaborations across organizations and system partners as well as coordinating efforts by Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) and other similar programs.

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