Psychological Assessments in Child Welfare Practice

A Brief Primer

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So many assessments!

Psychoeducational Evaluation

Mental Health Assessment

Neuropsychological Evaluation

Psychiatric Evaluation

Psychological Assessment

Today's plan…

- Overview and definitions of the various types of behavioral health and psychometric assessments in which kids involved with Child Welfare often participate.
- Overview of the process of completing a psychological assessment.
- Discussion of the ways in which the specific referral questions and clinical hypotheses hinder, derail, shape, enhance, inform, and/or limit the assessment goals and foci.
- Case example, to illustrate all of the above.
- Discussion of strategies, mindsets, and considerations to ensure that vulnerable children in the Child Welfare system actually *benefit* from the psychological assessments in which they participate.

Assessment Goals

Psychiatric Evaluation	Typically, these consist of medically focused interviews designed to identify specific symptoms and arrive at a DSM-5 diagnosis. Often used to determine whether medical/psychopharmacological treatments are indicated. Conducted by physicians or nurse practitioners with psychiatric training.
Mental Health/Behavioral Health Assessment	Typically interview-based intake assessments utilized to determine whether a child meets program criteria for mental health treatment and to inform therapy plan/goals. Often conducted by Qualified Mental Health Professionals working in community mental health centers.

Assessment Goals

Psychoeducational Evaluation

Typically, the use of psychological tests to identify barriers to educational functioning/progress and determine whether child meets eligibility criteria for Special Education Services. Often completed by School Psychologists employed by the district.

Neuropsychological Evaluation

Usually a multi-method process involving medical records review, interviews with patient and collateral sources, biobehavioral observations, and psychological tests to identify the cognitive symptoms of medical/physical problems, (ex. Traumatic Brain Injury, effects of chemotherapy, Alzheimer's Disorder). Provided by psychologists with specialized training in medical issues, and used to inform medical treatment for "physical" health conditions.

Assessment Goals

Relationship Assessment

Also called things like "bonding assessments" or "attachment assessments" or "parent-child interaction studies" within the Child Welfare world. (In the civil sector, aspects of Custody Evaluations for Family Court can fall within this category).

The procedures involved really vary in these types of assessments. Also, the psychologist often focuses on the relationship from the child's experience or the parent's experience, rather than both.

When done from a child-focused perspective, the assessment may identify the child's primary attachment figure, identify the degree to which the child experiences their emotional needs being met, etc. ***A child-centered relationship assessment does not general provide information about parental capacity!***

Assessment Goals

Psychological Assessment

Multi-method process of gaining information about an individual's social, cognitive, developmental, emotional, personality, behavioral, adaptive, and/or educational functioning. Often involves a combination of clinical interviews (with client and collateral sources), review of relevant records, direct observations of behavior, and administration/interpretation of psychological tests.

Psychological assessments can be used to answer a variety of questions. Specific procedures and applications of the data will vary depending upon the context, the referral questions, and the individual's clinical needs. These assessments are provided by psychologists with specialized understanding of general psychometrics as well as the unique needs of the populations they serve.

The context and questions determine the scope of information that will be provided!

- A Custody Evaluation focused on identifying parental custody in a divorce situation may or may not provide any information about whether a child has a learning disability.
- A psychological evaluation for a child placed in a psychiatric unit of a hospital may primarily address immediate safety issues and differential diagnosis, and not long-term psychosocial needs.
- A psychological assessment conducted for the sole purpose of considering intellectual giftedness is probably not going to provide any information regarding the likelihood of major depression.
- If a comprehensive assessment is conducted for the stated purpose of identifying a child's clinical issues and treatment needs, the resulting report will likely be silent on the subjects of visitation, permanency needs, sibling relationships, etc.

Shaping referral questions and/or considering the scope/applicability of a given assessment

- Recognize that there is no one kind of "psychological evaluation" or type of "psychological test."
- Reflect on the purpose for which psychological data was sought. Why was it needed? How is it to be used? How does the information change folks' understanding of and/or planning for a child?
- Consider the questions the psychologist was asked, about what was (and wasn't!) requested in an assessment process.
- Know that different psychologists have different familiarity with, knowledge of, and comfort with the Child Welfare system, which will affect their approaches to working with this population.

In addition…

- I use a process approach, in which initial data is used to inform subsequent decisions about assessment goals. If first-wave results include "red flags" for certain conditions/issues that weren't initially on anyone's radar, we are able to adjust the assessment procedures to examine/consider those.

In general, I favor erring on the side of being overly comprehensive when assessing children involved with the Child Welfare system, rather than completing cursory or brief assessments with this population. But I recognize there are barriers preventing many psychologists from doing this.

How does a psychologist decide what to include in assessment procedures? (meaning, how do ***I*** decide what to measure and how to measure it)

Information provided by parents/guardians:

- In most of my work, this involves information gained from parents in an initial 90-minute interview, combined with information provided by the referral source (usually a psychiatrist, a therapist, or a school).
- In work with children in the state's custody, I often rely on information provided by the DHS caseworker (the guardian) combined with information obtained from an interview with the foster parents (the primary caregivers). Often, the child's treatment provider(s) have specific things they are hoping to learn as well.
- Using this information, I try to identify the explicit questions being posed, as well as develop my own clinical hypotheses about what kinds of information would be beneficial to the child.

Problematic questions/practices in DHS-referred psychological assessments:

Issue	Example
The question that has no psychologically-sound answer.	"How long can this child wait for permanency?" "Is this child adoptable?"
The custody question.	"Should this child be placed with his mother or his aunt?"
The "silly" question.	"Do you recommend this child be returned to a home characterized by neglect, physical abuse, and domestic violence?"

Problematic questions/practices in DHS-referred psychological assessments:

Issue	Example
The question that is secretly about someone else.	"Is this child able to be safely parented by her mother?"
The question that localizes responsibility for permanency decisions in the child.	"Is this child able to make the transition to an adoptive home, out of state?"
The (infamous to psychologists) referral question list.	It has like 5 kitchen sinks…

Problematic questions/practices in DHS-referred psychological assessments:

Issue	Example
The bait-and-switch.	A child is scheduled for an individual assessment with a psychologist. The day before the first appointment, the psychologist receives a list of questions including requests for all kinds of information regarding the quality of the kiddo's relationships with mom, with dad, and with siblings, as well as his parents' ability to provide a safe home that can meet the child's attachment and mental health needs.

Problematic questions/practices in DHS-referred psychological assessments:

Issue	Example
The horse that has already left the barn question.	"Should these children be raised together as siblings?" [regarding kids 3 to 6 years of age who have been placed in separate homes for 3 years]
The irrelevant question.	"What are this child's IQ and adaptive scores? Does he qualify for IDD services" [regarding high-functioning child with previously-measured Full Scale IQ of 119]

Some other considerations:

- Psychological assessment is usually *not* an appointment-specific service. Seeing a child on one day ≠ the assessment was completed that day.
- Those 1400 pages of records are not going to review themselves! Let folks know about such things early in the scheduling process.
- The more questions that are asked, and the more domains of functioning covered, the longer the assessment process is likely to take.
- Clarifying questions at the time of service request and scheduling helps ensure that adequate time is budgeted for the assessment, and avoids additional delays in turnaround.

Framing questions: Some things a psychologist can weigh-in on.

- Would there be negative effects on this child if we deferred permanent placement for another 3 years, until her mother completes her current sentence?
- Does this child have any emotional or behavioral characteristics that make adoption planning more or less complicated? What kinds of supports should be in place to increase the success of an adoptive placement?
- There have been conflicting views regarding this child's mental health status and needs. Can you assist with clarifying the child's diagnosis and any complicating cognitive factors? What treatment strategies might be beneficial?
- This child still hasn't learned to read. Is she affected by unrecognized learning disabilities?

A psychological assessment example.

Pavel, a 11-year-old boy, is referred for psychological assessment.

- He was adopted from a Ukrainian orphanage at age 1 ½, but was removed from his adoptive parents' care at age 2 ½ due to "abusive discipline practices." His adoptive parents eventually relinquished parental rights.
- Pavel was diagnosed with posttraumatic stress disorder and reactive attachment disorder at age 3, shortly after he came into the state's care.
- After a series of 4 placement changes between the ages of 3 and 5, Pavel has been living in the same foster home. This was a "permanent foster home" under an APPLA agreement.
- Pavel and his foster family have been working with the same Community Mental Health Center therapist for 6 years now. Early on, the family completed 2 courses of Child Parent Psychotherapy (CPP); Pavel then transitioned to individual therapy.

Framing questions: Some things a psychologist can weigh-in on.

- Who is this child's primary attachment figure?
- How would placement in a different home with different caregiver(s) affect this child right now?
- Are this child's social challenges better explained by something other that a reactive attachment disorder diagnosis?
- Does this child have a developmental/neurodevelopmental disorder, such as IDD, ASD, or FASD? If so, what level of supports does he need?
- How does living in her current foster home affect this child? What would be the impact if we moved her to an adoptive placement with relatives out-of-state? If such a move were to occur, how should we structure the transition plan?

More about Pavel

- He reportedly made a lot of progress in treatment, particularly CPP– he became able to use his foster parents as sources of soothing/comfort; he started to regulate his mood better; his tantrums all but ceased; he demonstrates empathy for others.
- Over the course of his current placement, Pavel's school performance improved dramatically. He successfully "graduated" from a self-contained SED classroom into his mainstream programming in his neighborhood school (albeit with a still pretty extensive IEP).
- Academically, he slowly began to meet state benchmarks in most measured areas. At his last IEP review (in 4th grade), his team therefore concluded that he no longer needed special education services.
- The reports of Pavel's progress were so heartening that DHS was considering him "potentially adoptable," and was looking at changing his permanent plan from APPLA to one of adoption.

Why an assessment at this time?

- Despite earlier progress, Pavel's school performance really deteriorated over the most recent academic year (his first year in middle school). He failed to meet expectations in multiple subjects.
- His 6th grade teachers are variously describing Pavel as disrespectful in class, as defiant of directions (to do work, to leave his peers alone), and as strolling out of class whenever he feels like it.
- Pavel often doesn't turn in homework (even when it's complete!), he lies about homework, and decides to leave books at school even when he needs them at home. His foster parents and therapist are worried that he's begun self-sabotaging.
- At home, Pavel is reportedly more irritable and anxious than he has been over recent years. He snaps at others, has punched holes in walls, worries at bedtime to the point he can't sleep, and is once more very emotionally reactive.
- When not irritated or angry, Pavel is still very affectionate and cuddly with his foster family. His foster mom noted that he actually seems a bit more needy for hugs and attention than he has in the recent past.

Goals for this assessment.

- Identify whether active symptoms of PTSD/RAD are present, and, if so, provide guidance about what is triggering or reactivating those.
- Identify whether Pavel is demonstrating symptoms, traits, and associated features of a mood disorder.
- Consider potential causes of his recently changing behavior and academic functioning (to include consideration of DHS's hypothesis).
- Explore other hypotheses, that may not be directly reflected in the referral question.

Key questions, as posed by people in Pavel's life.

- Is Pavel having a resurgence of PTSD and RAD?
- How can we address his newest RAD behaviors in therapy?
- Is Pavel developing a bipolar disorder?
- Why is Pavel failing at school? Does he have a learning disability?
- How can we help Pavel?
- What kind of permanent home does Pavel need?
- Are Pavel's foster parents exaggerating or contributing to his problems, to keep him from being adopted? Should Pavel stay in a home that does this?

Additional hypothesis: Could another, as yet unidentified disorder or developmental issue be at play?

- Pavel's background indicates a very elevated risk for neurodevelopmental disorders (including attentional deficits and delays in executive functioning), and it does not appear that this possibility has been directly assessed in the past.
- When he was younger, attachment disturbances and trauma symptoms were so intense they could have easily eclipsed other issues (a phenomenon known as "diagnostic overshadowing").
- Certainly, Pavel's decompensation coincided with questions about changing the permanency plan, but there are other factors in the mix (discontinuation of SPED; transition to middle school; onset of puberty).

One example of reframing Pavel's behaviors: RAD/PTSD, or ADHD?

Overt Complaint	ADHD Symptom?
• Rude/disruptive in class.	• Unable to inhibit impulses?
• Doesn't care about getting to class on time.	• Can't track time or navigate organizational demands?
• Decides not to turn in work and/or leaves things at home.	• Often forgetful in daily tasks? Loses things?
• Lies about having schoolwork.	• Avoids tasks requiring sustained mental effort?
• Irritable, mean, and volatile at home in the evenings.	• Mentally exhausted after school day?

Assessment procedures (continued) :

- Behavior Assessment System for Children- Parent Rating Scales and Teacher Rating Scales
- Conners Rating Scales- Parent Forms and Teacher Forms
- Millon Pre-Adolescent Clinical Inventory
- Rorschach Inkblot Test
- Trauma Symptom Checklist for Children
- Wechsler Individual Achievement Test

This is actually a LOT of data…

Assessment procedures :

Interviews with Pavel

Interview with Pavel's foster parents

Interview with Pavel's therapist

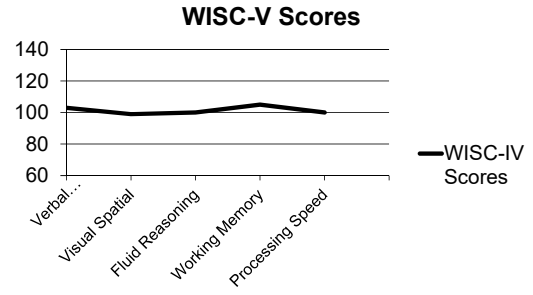
Review of approximately 300 pages of clinical, educational, and child-welfare records

Psychological testing, to include:

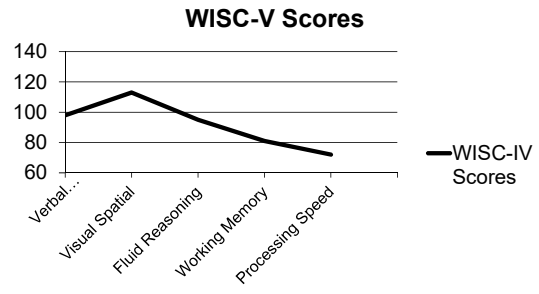
- Wechsler Intelligence Scale for Children (WISC-V)
- Children's Memory Scale
- Conners Continuous Performance Test.
- Delis-Kaplan Executive Function System
- Comprehensive Test of Phonological Processing

Just looking at WISC-V data...

For comparison, here are the test scores for a **typically-developing** 11-year-old.



Pavel's scores on this instrument…



Some additional findings.

Test Results	Implications
Conners Continuous Performance Test: 5 elevated scales.	High probability of moderate to severe deficits in attention, concentration, and impulse inhibition.
CTOPP Phonological Awareness Composite=80; Rapid Symbolic Naming Composite=74	Mild to moderate delays on phonological processing and speeded naming.
Delis Kaplan Executive Function System Tower Test=7; Trail Making Switching=6; Color Word Interference Inhibition=6 and Inhibition/Switching=5	Delays in multiple areas of executive development, including cognitive flexibility, anticipatory planning, and behavioral inhibition.

Implications of Pavel's WISC-V scores:

Index score	Implication
Verbal Comprehension Index=98	On-target language-based reasoning and comprehension.
Visual Spatial Index=113	Above average capacities for visual-spatial reasoning.
Fluid Reasoning Index=95	On-target problem solving and pattern recognition.
Working Memory Index=81	Low Average/Very Low capacities for "holding" information in mind.
Processing Speed Index=72	Delays in information processing efficiency.

Yet more results…

Test Results	Implications
WIAT Reading Comprehension and Fluency Composite=87; Basic Reading Composite=81	Reading abilities below grade level and below intellectual level, consistent with effects of phonological processing deficits (dyslexia)
Trauma Symptom Checklist for Children scores within normal limits	No significant trauma symptoms from Pavel's perspective
Children's Memory Scale Visual Memory=118; Verbal Memory=91	Learns most efficiently through visual-spatial channel

And finally:

Test	Findings
Millon Pre-Adolescent Clinical Inventory	Experiencing intense internal conflict between dependency and autonomy; Heightened anxiety; Self-criticism/dissatisfaction; Attention problems
Rorschach Inkblot Test	Situational stress and coping overload; Intact reality testing; Generally good capacity to form close relationships; Compares self unfavorably to others.

Diagnosis.

In this case, as in many psychological assessment cases, the diagnosis/es may be the ***least*** interesting bit(s).

At this point, are there things a DSM-5 diagnostic label would tell you that would give you more useful information?

Areas to address for Pavel

- Reduce stress levels and internal arousal by (1) adjusting external demands (2) decreasing ambiguity about his future and (3) helping him develop self-regulatory strategies
- He needs accommodations to work around his neurodevelopmental differences and delays (in processing speed, attention/concentration, shifting, anticipatory planning)
- ***Immediately*** request school-based eligibility determination, to consider reinstating/redeveloping IEP.
- He needs educational therapy/tutoring to address phonologically-related reading problems (e.g., Orton-Gillingham)
- Do not recommend conceptualizing current behaviors as a re-triggering of earlier PTSD or RAD, but rather as understandable reactions to current circumstances
- Super **bad** plan to consider removing him from the very relationships that have allowed him to organize healthy attachments

That being said, Pavel clearly met criteria for the following DSM-5 diagnoses.

Attention-deficit/hyperactivity disorder, predominantly inattentive type

Generalized anxiety disorder/Overanxious disorder of childhood (likely related to ongoing developmental effects of early-childhood attachment trauma)

Adjustment disorder with mixed disturbance of emotions and conduct.

Specific learning disorder, with impairment in reading, with impairment in reading fluency, comprehension, and phonological decoding (*developmental dyslexia*)

Things to remember about diagnoses:

- They actually tell us very little about the person; knowing the details "behind" the diagnosis often drives a greater child-centeredness when planning interventions and supports.
- There is a risk of seeing the child as the diagnosis. "She's ADHD" or "He is depressed" vs. "She has ADHD" or "He's a boy currently affected by depression."
- Diagnosis is not destiny! Most psychiatric disorders, particularly psychiatric disorders of childhood, are *not* chronic, lifelong conditions!

How can we ensure kids benefit from psychological assessments?

Help systems know when not to refer.

Sometimes, the answers to questions are already available (e.g., folks don't need a psychologist to tell folks it would be bad to place a child in a home "characterized by abuse, neglect, and domestic violence.")

Help shape the referral questions!

Help everyone avoid generic "we need a psych eval" referrals.

By getting *specific* with why the assessment is needed, with what folks want to learn, and with how the data will be used, you are far more likely to get your (and the child's) needs met.

Use the psychologist. If the data isn't comprehensible, if it doesn't lead to practical knowledge/solutions, or it doesn't seem relevant to the situation at-hand, my profession hasn't done its job. Get us to clarify!

How to interpret psychological test results.

- First, and unless you have advanced training in psychometrics and psychology, I do not recommend you try to interpret psychological test results at all!
- Second, I encourage you to discourage other people involved in the case from trying to interpret psychological test results either.
- Third, get the psychologist him/herself to debrief the results with the relevant parties, and (depending on the child's age) with the kid. That is part of our job, and it is best practice in psychological testing. I'm not sure how we got to a point where we often don't do this for kids in the child-welfare world, but it's time we started demanding to!

How can we ensure kids benefit from psychological assessments?

The issues of varying community resources.

The number of treatment providers, the services offered, and the percentage of those providers who work with the Oregon Health Plan really vary from community to community across Oregon!

Sometimes, the best evidence-based treatment or the ideal support services for a child/family is not currently available in that child's community. The response is sometimes (often) one of throwing up one's hands in helplessness, and concluding that the help can't be provided.

Know where to advocate for change here!