Identifying Youth With Mental Health Conditions at School

ABSTRACT

School is a critical access point for services for many youth. Occupational therapy practitioners can collaborate with educational teams to identify youth with mental health concerns and conditions who would benefit from these services. This article examines the growing population of adolescents who are diagnosed with mental health conditions, the impact of mental health conditions on school performance, and ways that occupational therapy practitioners can collaborate with educational team members to identify adolescents with mental health concerns and conditions at school.

LEARNING OBJECTIVES

After reading this article, you should be able to:
1. Identify the symptoms of mental health issues
2. Define subjective well-being
3. Define prodromal symptoms
4. Recognize opportunities for occupational therapy practitioners to collaborate with other school personnel to address student mental health issues
5. Distinguish between internalizing and externalizing behaviors that may negatively impact occupational performance

INTRODUCTION

Approximately one out of every four to five youth in the United States between 13 and 18 years of age live with a known mental health condition that markedly impacts their school participation (National Alliance on Mental Illness, 2011). The incidence of significant emotional and behavioral disorders is believed to occur at more substantial rates than other common childhood diseases, such as asthma (Merikangas et al., 2010). However, these statistics do not account for youth who are struggling with undiagnosed mental health concerns (Rosen & Cowan, 2015) or the 75% to 80% of youth who have identified mental health needs but are unable to access services because of the inadequacy of existing delivery models (Stagman & Cooper, 2010). Fifty percent of adolescents with lifelong mental health conditions, such as anxiety disorders, behavior disorders, mood disorders, and substance use disorders, will experience onset prior to age 15 (Merikangas et al., 2010). For those youth who actually receive mental health support, it is extremely likely that such services will be provided at school by school-based mental health professionals (National Association of School Psychologists, 2015). In fact, data suggest that a student is 21 times more likely to reach out to a school-based mental health provider than a community-based mental health provider (Juszczak, Melinkovich, & Kaplan, 2003).

Early identification and treatment of adolescents’ mental health concerns is essential to their health and well-being and often considered to be a “prerequisite to learning and achievement” (Rosen & Cowan, 2015, p. 8). Therefore, there is a significant need for highly qualified personnel to address the mental health concerns of youth at school (Cunningham, Grimm, Brandt, Lever, & Stephan, 2012). The American Occupational Therapy Association’s (AOTA’s) position statement, Occupational Therapy’s Role in Mental Health Recovery (2016), identifies the school environment as a key mental health practice setting. Occupational therapy practitioners can fill a critical service gap by collaborating with school personnel to identify students at risk for mental health concerns (AOTA, 2010; Bazyk, 2011).

Occupational therapy practitioners use information about psychiatric disorders to better understand how these disorders negatively impact successful and satisfying engagement in meaningful occupations. Moreover, understanding symptoms of mental illness supports practitioners in identifying early warning signs and behaviors that may suggest the presence of or risk for a psychiatric condition. Early identification and intervention efforts delay, and in some cases eliminate, the onset of psychiatric disorders (Eklund et al., 2009; Feeney-Kettler, Kratochwill, Kaiser, Hemmeter, & Kettler, 2010).

MULTI-TIERED SYSTEMS OF SUPPORT

In recent years, various federal policies and programs have been approved that highlight the inextricable link between mental health, student learning, and academic outcomes (Stephan, Sugai, Lever, & Connors, 2015). The need to address children’s mental health at school has prompted many districts to adopt multi-tiered systems of support, and such systems are viewed as the current standard for implementing mental health services in schools. Such tiered systems of delivery have been successfully applied across a variety of domains within schools, including...
academic and social skills instruction, behavior management, special education, and school-based mental health services (Stephan et al., 2015). Many schools opt to use a three-tiered model. Tier I, also referred to as the universal level, focuses on schoolwide prevention and promotion, including screening, and it is thought to be effective for approximately 80% of students. Tier II is available for those students who are at risk for mental health concerns and may benefit from additional support but are not likely in need of intensive interventions. This tier traditionally offers group-based interventions and covers about 15% of all students. Lastly, Tier III interventions are provided to the 5% of students who have identified issues and/or conditions and need intensive and individualized programming. Student progress is continuously monitored so students can move between the tiers as their needs or situations change. This model presumes that no single tier will be effective or even necessary for every student and is inherently flexible, so that all students in the school can be provided with effective supports and services that are appropriately matched to whatever their needs may be (Bazyk, 2011).

Screening
Screening is a common Tier I activity. The purpose of screening is to quickly identify students who may need or benefit from additional assessment or more comprehensive supportive services. The proactive implementation of universal screenings is helpful in early identification of youth who are at risk for mental or behavioral health problems and related academic concerns (Nemeroff et al., 2008). Schools offer more potential than any other setting to reach the largest number of adolescents and provide the added benefit of already being connected to children's families. Strong federal support for developing school-based mental health screenings and early intervention practices is contained in the goals and recommendations within the President's New Freedom Commission on Mental Health report (2003; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007).

School-based mental health screening efforts have been shown to be useful in early detection and referral (Nemeroff et al., 2008). Educational outcomes related to reduced rates of school failure, suspension, expulsion, and dropping out have been positively correlated with school-based universal screening initiatives (Stephan et al., 2015). Nonetheless, early identification and intervention efforts remain inadequate due to few qualified mental health personnel with an appropriate background in crisis management, direct intervention, and screening (Moherek Sopko, 2006). Moreover, most schools that implement a school-based mental health screening program tend to use outside staff to administer assessments, making such initiatives costly and limited with respect to ongoing and long-term implementation (Kuo, Stoep, McCaulley, & Kernic, 2009). Because of training in mental health and a large school-based workforce, occupational therapy practitioners play a key role in the development and ongoing implementation of universal screening programs. A dual-factor universal screening model (i.e., screens for both characteristics of subjective well-being and prodromal symptoms) could help to identify at-risk adolescents before a crisis is encountered (Suldo & Schaffer, 2008).

DUAL-FACTOR MODEL
There are huge differences between a teenager who is not depressed or anxious and one who bounds out of bed in the morning with twinkling eyes; between an adolescent who says no to drugs and one who says yes to meaningful involvement in family, school, and community activities; and between one who costs society little and one who actually benefits it (Seligman et al., 2005)

Mental health is often seen as the absence of mental illness or distress. Although this framing of mental health is quite common and observed in many contexts, practitioners and scholars now believe that the mere absence of mental illness does not equal mental health (Antaramian, Huebner, Hills, & Valois, 2010). Keyes (2002) suggested that an individual's sense of social and emotional well-being is a gauge to whether they will experience mental health. Mental health, like mental illness, is characterized by a set of symptoms. Some symptoms of mental health include (1) functioning well in most aspects of life, (2) participating in kind and trusting relationships, (3) growing into the best version of oneself, (4) having a purpose or direction in life, (5) adapting the environment to support one's needs, and (6) having a sense of self-determination (Keyes, 2002).

Adolescence is accepted as a tumultuous time, and it is expected that typically developing adolescents will grapple with identity formation, autonomy in the face of authority, and peer pressure (Berger, 2015). However, when adults anticipate adolescence to be taxing, they tend to focus on identifying youth who exhibit signs of mental illness. In doing so, they may miss a substantial number of adolescents who are not happy, socially engaged, or in possession of a positive self-concept (Keyes, 2009).

The dual-factor model of mental health takes into consideration both the presence of mental illness symptoms and indicators of positive mental health (Antaramian et al., 2010). In applying the dual-factor model, mental health is not assumed by the mere absence of psychopathology, or symptoms of mental illness (Suldo & Schaffer, 2008). Rather, researchers and practitioners actively seek evidence of mental health by examining a child's sense of subjective well-being.

Subjective Well-Being
Subjective well-being (SWB) is the technical term for happiness and has three distinct components: (1) recurrent positive affect, (2) the absence or infrequency of negative affect, and (3) increased satisfaction with life (Suldo & Schaffer, 2008). Recurrent positive affect refers to the positive feelings and
emotions (e.g., joy, excitement) that an individual exhibits. Negative affect refers to the feelings and outward display of sadness, anger, guilt, shame, fear, and anxiety. The third component of SWB, life satisfaction, is the result of the individual’s beliefs and perceptions regarding the quality of his or her life circumstances (Antaramian et al., 2010). An individual’s self-evaluation of SWB is an important metric because it can be used to gain insights into his or her perceptions regarding protective factors; self-reported SWB has also been associated with competence and satisfaction at school (Suldo & Schaffer, 2008) as well as higher levels of resiliency and lower levels of internalizing and externalizing behaviors (Antaramian et al., 2010).

The concept of SWB is thought to be so critical to mental health that some scholars believe that school teams should regularly evaluate adolescents’ SWB in addition to screening for symptoms associated with mental illness (Huebner, Hills, Jiang, Long, Kelly, & Lyons, 2014). Screening for SWB and mental health concerns often serves as the foundation for delivering multi-tiered systems of support.

Prodromal Symptoms
Although it is typical for an adolescent’s emotions to change quickly (Neumann, van Lier, Frijns, Meeus, & Koot, 2011), distinguishing between typical behavioral fluctuations associated with mood, and symptoms of a more significant mental health concern can be difficult (Berger, 2015). Prodromal symptoms are observable behaviors that are associated with the onset of a diagnosable mental illness (Jackson, Cavanagh, & Scott, 2003; Kovacs & Lopez-Duran, 2010). A prodromal symptom is characterized by a change in an individual’s function or behavior; however, it is generally only with hindsight that the nature of the change and its association with the onset of a mental illness can be determined (Kovacs & Lopez-Duran, 2010). The length of the prodrome, or the period of time between when a change in function or behavior begins to the time of a full-blown episode of mental illness, can vary significantly, from a day or two to up to a year (Jackson et al., 2003).

Although adolescent mental health concerns are fairly common, youth often lack knowledge about how to recognize symptoms of mental health problems in themselves and how to seek help (Mental Health Association of Maryland, 2010; Wright et al., 2005). The stigma and discrimination generally associated with mental health conditions may prevent some adolescents from seeking help from their parents or school personnel (Mental Health Association of Maryland, 2010). In addition, some mental health conditions actually interfere with an adolescent’s performance may lead to anxiety or other internalizing behaviors that subsequently interfere with new learning and perpetuate poor academic outcomes. Even though students with internalizing behaviors shoulder as much risk for mental health issues as students with externalizing behaviors, research has repeatedly shown that adolescents with internalizing behaviors are much more likely to be overlooked, especially in school (Chavira, Stein, Bailey, & Stein, 2004). As a consequence, a student with internalizing behaviors is also far less likely to get referred for mental health services until becoming so distressed that he or she begins to present with disruptive and/or externalizing behaviors. According to Chavira et al. (2004), too much time has usually passed by this point to address or recover from much of the damage done to the adolescent’s self-esteem and overall well-being.

Externalizing Behaviors
Externalizing behaviors are visible to individuals outside of the person who is having difficulty. Adolescents who display externalizing behaviors often lack inhibition and are perceived by others as “acting out” (Vaughn, Salas-Wright, Delisi, & Maynard, 2013). Some examples of externalizing behaviors include verbal and physical aggression, violence, vandalism, truancy, sexual promiscuity, and theft. Adolescents who are oppositional and defiant are at a greater risk than the general population for poor relationships and problems with employment in adulthood (Burke, Rowe, & Boylan, 2014). During school, adolescents with externalizing behaviors are at a higher risk for dropping out (Mojtabai et al., 2015).

Oftentimes, the externalizing behaviors used by adolescents are viewed as problematic for teachers and addressed through behavioral methods, which are considered effective (Benner, Nelson, Sanders, & Ralston, 2012). However, externalizing behaviors are often associated with, among other factors, an individual’s perceptions of scholastic competence as well as feelings of rejection by peers (White & Renk, 2012). This suggests that although behavioral approaches may reduce the incidence of externalizing behaviors, they may not be sufficient in addressing the underlying mental health concern that causes the behaviors in the first place. In addition, children who display externalizing behaviors also may be experiencing
Although this behavioral dichotomy can be helpful in understanding how behaviors and symptoms may negatively impact occupational performance, it is often the case that adolescents present with both externalizing and internalizing behaviors (Godley et al., 2014). It is not uncommon for adolescents who engage in disruptive behaviors to also feel anxiety or depression (Godley et al., 2014). The effects of these behaviors often further weaken a young person’s ability to cope with life’s stressors and demonstrate resiliency in difficult life situations. For this reason, many adolescents with poor mental health turn to alcohol, illicit drugs, and other substances as a compensatory strategy and become increasingly vulnerable to developing a co-occurring substance use disorder. National survey data suggest that adolescents at risk for or diagnosed with a mental illness are twice as likely to develop a substance use disorder as their typical peers (Green et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), and the figure is likely even higher for adolescents diagnosed with a mood and/or behavioral disorder (Deas, Germaine, & Upadhyaya, 2006). Recent findings conservatively estimate that 5.5% of all adolescents who are currently receiving mental health services are also being treated for a co-occurring substance use disorder (SAMHSA, 2014). Not surprisingly, most comprehensive school-based mental health initiatives include universal and targeted alcohol and drug prevention programming (Onrust, Otten, Lammers, & Smit, 2016).

SCREENING TOOLS
The Student Risk Screening Scale for Internalizing and Externalizing Behaviors (SRSS-IE) (Lane & Menzies, 2009) is a tool that can be used by school teams to help identify changes in students’ behavior that can signal mental health concerns. The SRSS-IE is a 12-item questionnaire that asks the rater to rank the frequency that an adolescent displays specific internalizing and externalizing behaviors (see Table 1 on p. CE-5 for behaviors included in the SRSS-IE). The scale can be completed in a minimal amount of time, and many schools choose to use Microsoft Excel to collect and analyze data (Lane et al., 2015).

The Brief Multidimensional Students’ Life Satisfaction Scale (B-MSLSS; Seligson, Huebner, & Valois, 2003) is a five-item self-report that can be administered to children and adolescents through 12th grade to examine their sense of SWB (see Figure 1 for aspects of life satisfaction measured by the B-MSLSS). The B-MSLSS is based on the conceptual model of students’ life satisfaction developed by Huebner (1994). A 40-item scale based on this model, called the Multidimensional Students’ Life Satisfaction Scale (MSLSS; Huebner, 1994) is also available.

Case Examples: Piper
Piper was a 15-year-old female in 10th grade at a suburban public high school. Many of her teachers considered her to be a conscientious student who strived to get 100% on every assignment. Piper was enrolled in several honors courses, served as a volunteer tutor at the local library, and sang in a youth choir. Piper tried out for junior varsity cheerleading the first week of 10th grade but did not qualify for the squad. Since then, her teachers had noticed some concerning changes in her behavior, such as failing to turn in assignments, receiving detention for getting up and leaving class without permission on several occasions, and freezing during a recent small group in-class presentation. A phone call to her parents identified additional concerns at home. Her mother reported that Piper felt crushed and rejected and seemed preoccupied with the idea that she was not good at anything. As part of a school-wide mental health screening initiative, all 10th grade home-room teachers completed the brief SRSS-IE for Middle School and High School on each student. Piper’s screen suggested increased risk for internalizing behavior patterns, so she was referred to the Problem Solving Team (PST), which included the school occupational therapist. On the recommendation of the school psychologist, Piper completed a brief screening tool for generalized anxiety disorder (GAD), the GAD7 (Spitzer, Kroenke, Williams, & Löwe, 2006), and self-identified several days of feeling anxious, worrying excessively, having difficulty relaxing and sitting still for long, having trouble concentrating on tasks, and feeling easily annoyed by other people. Based on these findings, the team decided to provide Piper with ongoing monitoring and a Tier II intervention to address concerns related to anxiety.

The occupational therapist suggested that he meet with Piper to get a better sense of Piper’s interests in school-related activities, opinions about her own abilities to meet the demands of the student role, and her appraisal of overall life satisfaction and SWB. In addition, he hoped to provide the team with an occupational perspective of how anxiety warning signs could be negatively impacting Piper’s academic success and performance in non-academic occupations. The findings were remarkable for ineffective performance related to volition (e.g., beginning self-directed activity, engaging with peers during group work, staying engaged) and roles (assuming school-related roles). During the interview, Piper reported

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**Figure 1. Aspects of Life Satisfaction Measured by the B-MSLSS**

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<tr>
<th>Aspect</th>
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<tr>
<td>Family life</td>
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<td>Friendships</td>
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<tr>
<td>School experience</td>
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<tr>
<td>Yourself</td>
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<td>Where you live</td>
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that she worried that she was not smart enough to be an architect and would not get into a reputable college because she failed at becoming a cheerleader and earned an 85 on her first chemistry exam. She also reported turning down invitations to hang out with some of her close friends who made the cheerleading squad because she felt ashamed, feeling so overwhelmed in class that she could not concentrate, and skipping lunch to hang out alone under the basketball bleachers. When asked what kinds of activities she engaged in to relax, Piper said that she liked to sketch buildings and lighthouses but had stopped doing that since school started.

The occupational therapist recommended a Check In, Check Out routine coupled with a small-group, occupation-based 8-week intervention during the lunch period to support Piper in turning assignments in on time and working with peers on group projects. The occupation-based group was designed to use creative arts and crafts to create budget-friendly props for the school’s drama department. The group intentionally used materials that were difficult to work with and limited supplies to increase the likelihood of interaction between group members and ensure the likelihood of some imperfections in the final products.

During a debrief, participants were encouraged to discuss the relationship between the healthy pursuit of achievement and unhelpful perfectionism, and the importance of incorporating activities to cope with stress and anxiety into their daily routines. Piper reflected on how her fear of failure was making it difficult for her to turn in assignments on time and work with peers on group projects. The occupation-based group was designed to increase the likelihood of interaction between group members and ensure the likelihood of some imperfections in the final products.

Case Example: Jackson

Jackson was a 13-year-old eighth grader who attended his local public school. Jackson had always been perceived as a “class clown” and a student who caused disruptions to get out of completing assignments. Recently, the assistant principal had noticed that Jackson was getting more discipline referrals than usual for uncharacteristic infractions, such as swearing at teachers, stealing a student’s lunch, and kicking over a garbage can in the hallway. The assistant principal phoned Jackson’s father, who indicated that Jackson had recently become more argumentative and physically aggressive toward his two younger siblings at home.

As part of a schoolwide mental health screening initiative, the assistant principal spoke with each of Jackson’s teachers and then completed the SRSS-IE for Middle School and High School on Jackson. In addition to the concerns already noted by the assistant principal, the SRSS-IE showed that Jackson was also frequently cheating, being rejected by peers, and demonstrating a negative attitude. In addition, Jackson’s grades had dropped from straight Bs to straight Ds. Around the same time, Jackson and all of the students in his grade were asked to complete the B-MSLSS. The results of Jackson’s B-MSLSS indicated that he felt very unsatisfied with his friendships, his school experience, and himself.

The school’s PST reviewed Jackson’s screening results and decided to refer him to the school’s social worker for Tier II supports. The school social worker began meeting with Jackson on a weekly basis and learned that a new student had caused a falling out between Jackson and his best friend. Jackson’s former best friend was now sitting with the new student on the bus and spending all of his free time with him. Over the past several weeks, Jackson had missed his friend’s company as well as the academic support that this friend had provided. Because Jackson was frequently off-task during instructional time, Jackson’s friend had allowed him to copy his class notes while riding the bus to and from school. He also filled Jackson in on key details related to assignments. Jackson now believed himself to be extremely disorganized and unable to learn. This caused Jackson to have a lot of trepidation about entering high school, and he had contemplated dropping out.

The social worker shared her findings about Jackson’s case with the PST. The PST then recommended that Jackson begin short-term occupational therapy services to focus on note-taking strategies, organizational and long-term planning skills, and confidence in the student role. The occupational therapist began seeing Jackson twice a week during his study hall period. Over the course of the next 6 weeks, Jackson began using the note-taking, organizational, and long-term planning strategies that he learned with the occupational therapist. Jackson began receiving better grades, felt more confident in his classes, and

Table 1. Behaviors Included in the SRSS-IE

<table>
<thead>
<tr>
<th>Behaviors included on SRSS-IE</th>
<th>Type of behavior</th>
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<tbody>
<tr>
<td>Stealing</td>
<td>Externalizing</td>
</tr>
<tr>
<td>Lying, sneaking, cheating</td>
<td>Externalizing</td>
</tr>
<tr>
<td>Behavior problems</td>
<td>Externalizing</td>
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<tr>
<td>Peer rejection</td>
<td>Externalizing</td>
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<tr>
<td>Low academic achievement</td>
<td>Externalizing</td>
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<tr>
<td>Negative attitude</td>
<td>Externalizing</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>Externalizing</td>
</tr>
<tr>
<td>Emotionally flat</td>
<td>Internalizing</td>
</tr>
<tr>
<td>Shy or withdrawn</td>
<td>Internalizing</td>
</tr>
<tr>
<td>Sad; depressed</td>
<td>Internalizing</td>
</tr>
<tr>
<td>Anxious</td>
<td>Internalizing</td>
</tr>
<tr>
<td>Lonely</td>
<td>Internalizing</td>
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to her Check In plan and making time for sketching at school to her Check Out plan.
was less reliant on his peers for support. As a result of seeking less support from his peers, his relationship with his former best friend improved and Jackson began sitting near him on the bus.

CONCLUSION
Despite growing attention on school-based behavioral and mental health programs, approximately half of adolescents with untreated mental health problems quit school before graduating, making them the largest subgroup of students who drop out (Association for Child Mental Health, n.d.). Early identification and treatment of adolescents’ mental health concerns is essential to their health and well-being (Rossen & Cowan, 2015). Occupational therapy practitioners can collaborate with school teams to perform universal screenings in keeping with the dual-factor model of mental health.

REFERENCES


http://www.pbiscompendium.ssd.k12.mo.us/system-tools


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A. To get pricing information and to register to take the exam online for the article Identifying Youth With Mental Health Conditions at School, go to www.aota.org/cea, or call toll-free 877-404-2682.

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C. Answer the questions to the final exam found on page CE-8 by March 31, 2019.

D. On successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

Final Exam

Article Code CEA0317

Identifying Youth With Mental Health Conditions at School

March 27, 2017

To receive CE credit, exam must be completed by March 31, 2019.

Learning Level: Entry

Target Audience: Occupational Therapists and Occupational Therapy Assistants

Content Focus: OT Domain: Client Factors, Context and Environment; OT Process: Interventions

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1. Which of the following statements describes the three-tiered model of school mental health?
   A. It is conceptually organized around three progressively intensive tiers of service and supports.
   B. It focuses exclusively on 15% of students who have identified mental health concerns.
   C. It assumes that Tier I services should be effective for all students.
   D. It should only be applied to students who are receiving special education supports and services.

2. According to the article, somatization is:
   A. Another way of describing anxiety
   B. A clinical feature associated with fear of school mental health providers
   C. The experience of physical symptoms related to underlying psychological distress
   D. The point at which prodromal issues develop into psychiatric conditions

3. Universal and targeted substance use prevention programming is included in many school-based mental health initiatives because:
   A. Schools are the most common place where adolescents use drugs and alcohol.
   B. Students with or at risk for developing a mental illness are also at a higher risk for developing substance abuse problems.
   C. Alcohol and drug use is considered to be a major reason that students may develop a mental illness.
   D. Adolescents typically report their first episode of alcohol use in elementary school.

4. Which of the following prodromal issues could be classified as an internalizing behavior?
   A. Excessive worry
   B. Theft
   C. Physical aggression
   D. Being argumentative

5. Tier II interventions:
   A. Provided in community mental health centers
   B. Require proof of a psychiatric disorder
   C. Only address externalizing behaviors
   D. Typically use a small group format

6. Which of the following prodromal issues could be classified as an externalizing behavior?
   A. Withdrawing from peers
   B. Worrying
   C. Vandalizing
   D. Feeling anxious

7. Which of the following characteristics would not be included in a dual-factor screening for mental health?
   A. Absence of psychopathology
   B. Presence of prodromal symptoms
   C. Self-awareness of humor
   D. Perceived subjective well-being

8. Which of the following outcomes has been associated with a higher sense of subjective well-being?
   A. Satisfaction with school
   B. Better physical health
   C. Use of meditative practices
   D. Frequent social participation

9. The length of a prodromal period can vary from a day or two to up to a year.
   A. True
   B. False

10. Which of the following assessment tools could be used to screen for subjective well-being?
     A. Student Risk Screening Scale for Internalizing and Externalizing Behaviors
     B. Brief Multidimensional Students’ Life Satisfaction Scale
     C. The GAD7
     D. Pediatric Volitional Questionnaire

11. Which of the following is an example of a Tier I intervention that could be provided by an occupational therapist?
     A. Leading a small group for students with special needs on emotions
     B. Providing an in-service training to educators on self-regulation strategies
     C. Working one on one with a student to support the development of organizational skills
     D. Developing a work/break routine for a child with autism

12. Which of the following is a function of a problem-solving team?
     A. Reviewing screening data and making recommendations for interventions
     B. Implementing individualized education plans
     C. Developing transition plans
     D. Documenting the action steps taken to fulfill a school improvement plan