Pediatric Grand Rounds-20251205_072915-Meeting Recording

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Calderon, Delia started transcription

Ranch, Daniel 0:48

All right. It's 7:30, so we'll get started. Good morning, everybody, and thank you for joining in the University of Texas Health, San Antonio Pediatric Grand Rounds. As a reminder, the Grand Rounds participation code will be placed in the chat periodically, so you can just check there.

Also, please mute your devices as you log on so we don't interrupt Dr. Andrew's wonderful presentation. Otherwise, it is my great pleasure to introduce Dr. Ellen Andrews, who is a clinical psychologist and assistant professor in the Department of Psychiatry and Behavioral Sciences here at UT.

I'll add on a personal note that we connected because Doctor Andrews did a fantastic job helping out one of our patients with autism spectrum disorders having a difficult time integrating himself into our dialysis unit. Obviously the new change for him. So she did a wonderful job and our our team is extremely grateful for her help with that poor kid and he's.

Actually doing well, Doctor Andrews earned her doctoral degree in clinical psychology from UT Southwestern and then completed her postdoctoral fellowship at Boston Children's Hospital's Developmental Medicine Center before returning to San Antonio and joining UT.

The focus of Doctor Andrews' research has been on parent facing interventions for adolescent suicide prevention. Clinically, Doctor Andrews is housed in the Department of Psychiatry's NOW Clinic in the Behavioral and Wellness Center, and the focus of her clinical practice is the comprehensive psychological evaluation of youth ages 11 to 17.

So, Dr. Andrews, welcome and thank you.

Andrews, Ellen M 2:18

Thank you. Thank you so much for having me. It's so exciting to be here this morning. The purpose of my presentation today is to provide some introductory

information about psychological assessment so that you can better understand its purpose.
What it entails and understand the appropriate times to make a referral for your patients. So let's jump in.
All right. So as you all are likely aware, the incidence of mental and behavioral health diagnoses have been increasing over the recent years. And as these diagnoses have become more prevalent, barriers to mental health care have persisted. These barriers are include, but aren't limited to, the costs of treatment.
Limited insurance coverage for mental health and behavioral health specialists, stigma around mental health diagnosis and a shortage of mental health specialists overall. And we know that pediatrics providers are often the first medical providers that families turn to when children have mental and behavioral health concerns.
In 2015, pediatricians were found to be the sole physician managers for youth with mental health related diagnosis in the United States.
So just just this fall, the American Academy of Pediatrics released a report promoting the use of screenings for mental, emotional and behavioral health problems in pediatric settings. And the rationale for these screenings is that children who have been identified as having such problems are more likely to receive intervention.
And we know that interventions lead to improved outcomes for most youth. An additional reason to for the promotion of these screening tools is that they can help reduce cognitive and implicit biases that can contribute to misdiagnosis or overlooked symptoms.
Presently, Pediatrics providers are encouraged to carry out a variety of mental health and behavioral health screenings beginning as early as the first year of life. So what we have here is a list of all of the the different mental health and behavioral health screenings and the timing of them.
So at the 6:12, 24 and 36 month visits, pediatricians are encouraged to check in on mental and behavioral health, including the mental and behavioral health of parents.
And then we know that autism screenings are recommended at the 18 and 24 month visits specifically.
After age 3, mental and behavioral health screenings are recommended annually, and then after age 8, anxiety specific screenings are recommended annually, and after age 12, depression and suicide specific screenings are recommended annually.
By definition, screenings are not diagnostic. They let us know when additional information and investigation is needed, but they don't necessarily give us a

diagnostic conclusion. So as you all are collecting this information through screenings.
What are we expected to do with a positive screen? And there there's quite a few options. One would be to continue to provide psychiatric medication management for for kids as appropriate. But sometimes you might find that a child's symptoms are beyond the scope.
Your own practice and you might be thinking who who do I refer these children to? So I wanted to quickly cover some of the mental health care providers that you might consider making a referral to and helping distinguish between what the roles of these providers are. This is a question that.
That I get very often, especially from the families I work with, needing help understanding what the difference between the role of a psychologist, A psychiatrist and a master's level counselor or therapist is. So we'll start with clinical psychologist, which is my role.
Individuals who are clinical psychologists have completed either a PhD or a PsyD, which means that they have more of a focus on research, and it's a there's a pretty heavy emphasis on research, particularly for those with PhDs.
Plus, they've got advanced clinical training and have licenses licenses as a psychologist. So clinical psychologists, in addition to conducting research, typically do psychological assessments, which is the focus of of our discussion today, as well as the content experts.
And psychotherapy. And I wanted to make a note that neuropsychologists are kind of a subspecialty within psychology, and these are folks who've received an extra year of clinical training with an emphasis on assessment and brain-based conditions. So you'll hear me refer to them in a little bit, but I just want to make that clear that not all clinical psychologists are neuropsychologists, but all psychologists can conduct assessment. So the the next most common question I get is about psychiatrists, as you all are probably aware.
Psychiatrists are folks who have completed medical school, advanced clinical training, and have a medical license. They receive some training in therapy these days. It used to be a much bigger part of the field, but now it's becoming more and more rare to find psychiatrists who offer psychotherapy in addition to medication management. feature of a psychiatrist is they're the experts in psychiatric medication management and they have prescribing authority, unlike psychologists. And so these might be the folks that you refer to if you think that a child could benefit from focused care in

terms of medication management.
And then last but not least, we've got our master's level counselors and therapists. These are folks who've completed a master's degree in a mental health related field, and there's a variety of them. I've listed a few of the most common. There's counseling, social work and marriage and family therapy. These are are ones that. Commonly do psychotherapy and these folks can help. They're they're really great at doing psychotherapy. They've got pretty thorough training in that and they are, especially for social workers, are really skilled at connecting families to community resources.
So as you can see, there's a good bit of overlap. All of these fields can technically do psychotherapy, but we really think about their the master's level therapists and clinical psychologists as being the our go to folks for for psychotherapy.
For a thorough, for a thorough psychological assessment, you'll go to a psychologist, and for medication management, you'll go to a psychiatrist. OK, So what do I mean by psychological assessment? Psychological assessment is the process wherein a psychologist evaluates mental and behavior.
Behavioral health, and it may include psychological testing. The evaluation is used to answer questions from patients, their families, and their healthcare providers. And the main thing to know is that a psychological evaluation is considered comprehensive and diagnostic.
Why would you want to do a psychological assessment? The primary reason is to provide diagnostic clarification related to developmental, emotional, and behavioral concerns. But it can also help us evaluate the severity of symptoms. Perhaps we know that a child has a certain diagnosis, but we want to understand better.
How severe are their present symptoms? This might be one good way to do it.
Another reason to do this is to inform treatment plans and recommendations. Having a nice comprehensive look at the child's current functioning can help provide these tailored recommendations for their care.
Another common reason why families specifically look for a psychological assessment is to help determine if there's anything that the child needs at school. So providing those educational recommendations becomes a big purpose.
It can also help caregivers and youth understand the own individual strengths and weaknesses of of the child. This can be kind of an unintended consequence. Sometimes it's not always the reason why folks present, but it is a big part of of what we're looking for in a psychological assessment.

Identifying where a child is really doing well and what areas they might need assistance with. And then last but but definitely not least, we've got allowing access to specialized treatments and services. So this can of course be SSI and SSDI as well as special education services sometimes and.
Specifically treatments treatment wise, we know that applied behavioral analysis for children with autism, a lot of times documentation of evaluation of some kind is required. These these are some of the primary reasons why you might.
Choose to make a referral for an evaluation.
So as a broad overview of the components of a psychological assessment, once the referral is received, the data collection begins. Then once data collection is complete, then there's a discussion of the findings with family.
And then a report is created and distributed to the the primary stakeholders. So that's the the big zoom out of of what it looks like. Let's talk about the sources of data. Overall psychological evaluations rely upon a multi-method data collection process.
So I'm not making a diagnosis based on one measure alone. I'm always incorporating multiple sources of data in order to inform my diagnostic decision-making. So these are all the the kind of categories of data that I'm collecting.
I'm always starting with an interview with the caregiver. This might be specifically focused on a particular diagnosis and and.

Jennifer Talley, LMSW 12:40
There's no audio on this. Like I've got I'm having a job.

Andrews, Ellen M 12:43
In the instance of children who have a specific referral for an autism diagnosis, it might be very targeted towards autism symptoms, but it could also be very broad. So that is always my starting place and it helps guide the rest of the.
evaluation and the decisions I make in that context.
Then we've got the interview that I do with youth. Once children get to be about 7 or 8 years old, I can interview them and get their perspective on their own experiences of certain symptoms and and their environment. I also might use.
Structured interview like a specific measure of obsessive compulsive disorder called the CY box or the structured interview for psychosis risk syndromes. If there's a concern for psychosis depending on the age of the child and the symptoms that are.

Being explored, I might have a caregiver present, but I always like to try to talk with the child independently of the parent so that they can feel more comfortable. Same goes with caregivers. I always want to have an opportunity to talk with parents without the child in the room, so that way they can feel comfortable opening up. be sharing things that might come across as critical about the child without them being there.
And then I'm often using a variety of standardized questionnaires. These can be, again, very broad. I use some questionnaires that are 200 to 300 questions and get give a lot of information about a wide variety of behaviors.
And emotional experiences. But I can also give very focused questionnaires about specific symptoms of trauma, anxiety, depression, things of that nature. And I am always for children who are old enough who can read and can complete these, I'm giving them.
to both the children themselves and the caregivers. And sometimes I give the same measure to both so I can compare their perspectives of the the same situations.
Review of records is pretty much always a part of my evaluation. This can be in both medical records of course, as well as academic records, and I'll talk a little bit towards the end about the academic records that can be informative.
I am always, as often as I can, getting information from an outside collateral source, so someone who's outside of the household who can give me information about the child's behavior, generally in a public setting. So this is most often teachers.
But as lately I've been seeing many, many children who have who are being homeschooled or doing virtual school online, which poses a challenge to getting that information. So sometimes I'm also hearing from, you know, youth group leaders or coaches or people.
People who are outside of the family, but maybe not in the classroom. I I really like to hear from teachers because they have such a nice sample. They're they they see so many kids, they are able to identify behaviors that really stand out from other kids. Whereas caregivers, sometimes they might over pathologize or under pathologize their child's behavior. So it's nice to have that outside source. And this is particularly critical when I'm making a diagnosis of ADHD, which we'll talk about.
This is what most people think about when they think about a psychological evaluation or testing. I use standardized performance-based tests, which means that the child is there in person with me, usually in a one-on-one setting, and I am measuring their performance on specific things.

In real time and some of the domains that I'm able to measure with these tests are listed here. So the big one is cognitive performance or IQ, language skills, motor coordination skills, visual perception.
Academic knowledge is is often measured with these tests. Memory, social communication through observation on interactive tests, which I'll mention in a little bit as well. And then executive functioning and emotional functioning. And by emotional functioning I when I say.
Performance based test. I am often thinking about things that are a little bit more open-ended than a questionnaire. So rather than asking, you know, have you been feeling sad or down lately? I might have a child. I give a child a picture and I have them tell me a story based on the picture and see what themes come about.
That can be really helpful for younger kids, especially who might not have the language to describe their own emotional experiences, but can tell me stories or or make give me information from those more open-ended sources of of data.
And then I'm also constantly looking out for behavioral observation. So is the child cooperative? Are they polite? Are they withdrawn? How much, you know, are they putting into the to the evaluation? It's it's a really big component of.
The evaluation itself.
All right, so when is the right time to refer for a psychological assessment? You might consider referring for an assessment when there are concerns or unanswered questions about the child's emotional, behavioral, intellectual, or academic functioning.
And I'll give a few specific instances in which a referral might be warranted. The first, of course, is if the family asks for a referral, they've done their homework, they have questions that that they want answered, and it makes sense to to refer in that instance, of course. So that's that's cut and dry.
Usually, if the patient has suspected symptoms of autism, has never been diagnosed or needs re-evaluation to access their applied behavioral analysis services, that might be a good time to to make a referral. Psychologists aren't the only ones who are experts in this.
Of course, developmental behavioral pediatricians are really good at this as well, but psychologists with the proper, you know, experience do this all the time.
If there are questions or concerns for the patient's learning or acquisition of independent daily living skills, and I really want to drive this one home because I think a lot of times you all might be the providers who catch this the earliest. So if

you're noticing that a child is approaching 8910 and mom is saying I have to come. I constantly watch them. I have to help them dress or bathe. I am. They're not able to follow safety rules at home. That might be an indicator that there are some concerns for that child's learning. They're not able to take in those daily living skills that we would expect them to.
To at their age and there might be an intellectual concern that we need to identify or something else going on. But I think that sometimes parents are not aware of how unusual that is at different age levels and as providers you might have more insight about that and might be able to encourage them to.
To get this evaluated, I've been seeing here at UT a lot of families who are. I'm currently working mostly with adolescents right now and I've been getting a lot of referrals where children have this kind of concern and they're maybe 12/13/14 and have never.
Received a diagnosis of an intellectual disability before, and we know that the earlier we can identify it, the the more time the family has to pursue services and work towards potential guardianship if needed for adulthood.
OK, if the patient's followed by a mental health professional but their symptoms persist. So let's say you've got a patient who you know has a mental health concern and they've been followed by a psychiatrist or a therapist and they've been working with them for 2-3.
four years and their their symptoms don't seem to be getting better, then it might be time to consider an assessment to see if there's anything that hasn't been considered yet that might be contributing to their present picture.
If the family or if the patient has received a provisional diagnosis in the past and a clarification is needed, it might be a good time. So maybe you notice in the chart or from from parent report that you know people have mentioned that they might have something like OCD because they've got these repetitive behaviors.
That might be a good time to say, hey, let's figure this out, let's do go for a psychological assessment. And then last but not least, if the patient demonstrates a variety of psychiatric symptoms and the the differential diagnostic picture appears complex. So if.
Here.
Sometimes from providers and the term whack-a-mole, we're looking at this question and as soon as we address that, then another symptom pops up and as soon as we address that, another symptom pops up. When we're noticing that where

there's a lot going on and we're not really sure what's at the core of it, that's often a good time to consider a more comprehensive assessment rather.
And going symptom by symptom.
OK. I also wanted to make a note about patients who are experiencing a mental health crisis. This typically looks like active suicidal ideation, but can also be other things, homicidal ideation for example. And I just really want to emphasize and I I'm sure that you all are aware of this, but we always.
We just want to refer for crisis intervention first. We wouldn't want to refer a child who's in an active crisis for an assessment. And the reason for that is that typically to have a psychological assessment, there are quite long wait lists and when a child is in an active mental health crisis.
They need attention immediately. So the the options for that are emergency rooms, psychiatric inpatient facilities, partial hospitalization programs, day treatment programs, these places where kids can have more eyes on them every day to ensure their safety and help get them to a stable.
Place Here at UT Health, we have a clinic called the Transitional Care Clinic that offers a living room service. This is available for adolescents and adults, and the purpose of this is to help prevent.
Patients are having to go to an inpatient facility. It's when patients can come to our clinic and be seen by somebody within the hour, get some attention and care to be stabilized and potentially determine if a higher level of care is needed. So I encourage you to consider.
This if you happen to encounter a patient who is in an active crisis, I also want to mention that we know that evaluation results are not going to be very accurate if a child is in a period of crisis. What we measure might not really be informative about or predictive of how they do.
Later. So just keep that in mind. We want them to be in a more stable place when we're doing an evaluation, OK.
So here are some common referral questions and concerns. By far the most common referral questions I've been getting here have been ADHD and autism spectrum disorder, but other common ones that you might consider and that psychologists routinely evaluate for behavioral concerns.
Especially for younger kids, emotional concerns. So this might be anything along the lines of anxiety, depression, OCD. I would even potentially put psychosis in this category. So that's that's of course our bread and butter.

Intellectual functioning is a big one, and psychologists are really the folks to go to to do a measure of intellectual functioning. If a child has concerns for learning disabilities or academic underachievement, that is.
A common reason why families might come to see me, but I will kind of put a caveat that generally schools are able to do academic assessments and identify those learning disabilities. But it really varies from school district to school district. Some are, you know, really great about.
Identifying these and some are less great. So just keeping in mind that a lot of times schools have more information than I would have at my disposal and they are are really good at at capturing those learning disabilities specifically the specific ones like dyslexia.
For example, and then personality features is something that people ask me about pretty often, especially for adolescents. I would not make a diagnosis of a personality disorder for an adolescent or a younger child because personality, we think of personality.
being fluid through, you know, early adulthood. Personalities can change, but there might be some information that's informative about a child's picture, and there are some things we can look at in terms of personality that can can be informative.
And then lastly, I think about environmental factors. So these might be exposure to traumatic events, current stressors. It can also include family functioning. Sometimes, you know, we have an identified patient who's who's struggling in some way and the more that I get to know them, the more.
I see that maybe the whole family is struggling. It's not specific to that child and we need some family-based interventions. So that's that's another reason why patients present to to see me. And then these are a few things that neuropsychologists tend to specialize in.
So seizures and epilepsy, head trauma, stroke and brain-based illnesses. This is really where neuropsychologists come into play and have a lot of expertise. That said, I have, you know, seen quite a few patients who have seizures and epilepsy, but really when it comes to head trauma and those brain.
Based illnesses, neuropsychologists are are really great and their lens is a little different. They're really focused on the functioning of the brain itself and I would say clinical psychologists on average are looking more at.
The whole picture and more focus on the emotional presentation, but that's that's a very generalized statement there.

OK, so I wanted to talk through kind of the timeline of when I start considering certain diagnoses or certain domains to evaluate based on the child's age. So as you can imagine, we can't measure everything for every child based on.
Our diagnostic criteria for particular diagnosis and just the abilities of a child. So for toddlers, for example, from, you know, ages 12 to 24 months, they might not have enough language for us to be able to really truly evaluate lots many different things. So the focus when I'm.
Working with children in this age group is always going to be on developmental delays and autism. Once they get to be preschool age, we can start looking at emotional and behavioral concerns as as they are around more people, they're exposed to new environments.
Some of these things can come about.
Then, in addition to the those diagnoses that we can address for toddlers and preschoolers, when children get to be school-aged, we can look at, we can start looking into intellectual disabilities.
ADHD and learning disabilities, where these are generally not things that we're able to look at for for children younger than age 5, and particularly for IQ when it comes to an intellectual disability.
IQ was thought to be pretty stable by the time a child is 6 or 7 years old. And by that I mean if I measure a 7 year old's IQ with a reliable measure and they've, you know, really put in good effort into that that test, I would expect.
Expect that that their performance and the score that I get will be pretty consistent with their performance on an IQ test when they're 24 years old. We really don't see much change in IQ. IQ is thought to be something that's pretty stable.
But it can be very hard to measure when children are below age 6. There are tests for it, but it's not necessarily predictive all of the time for how that child will will perform later in life.
And then when children get to be this pre-adolescent adolescent age, one of the things that I see a lot in my clinic are new diagnoses of autism level one. So these are those very mild symptoms of autism, what we used to capture with the diagnosis of Asperger's syndrome.
These are kids who maybe they were able to kind of get along. They didn't have very big behavioral problems. Maybe they had some sensory sensitivities or some repetitive behaviors, but they weren't that disruptive and socially they could kind of. Kind of scoot by and then once they get into middle school, the social demands

increase. Kids are using more sarcasm. They are, you know, doing more interpersonal interactions in in a lot of ways and.
Some of these, sometimes that's when we start to see social differences become more apparent. So a lot of times you might see that kids with autism at this level might not receive their diagnosis until they're, you know.
About middle school age.
Again, this is the time when I might start considering evaluating personality features, and then in this age group I'm often starting to see re-evaluations for the first time. Maybe they were evaluated when they were five and they need to be evaluated again to access certain services or to plan.
And for their transition to adulthood and potential guardianship in some instances.
OK, so let's talk about testing batteries. People tend to be kind of interested in the the batteries that I give. And I think the important thing to take away from this presentation is that batteries can vary widely based on the referral question, the age of the child.
The availability of that's idea and the child's abilities. So I don't have a set battery of tests that I'm getting every time. A lot of times I'm making decisions as I go. I'll have a list of tests that I'm planning to give and questionnaires I'm planning to give.
And then something I learn or behavioral observations I make throughout the day make me decide, oh, I'm going to add in this test. So it's a constantly evolving process where the information I'm getting as I go helps inform.
What other questions arise and what data I decide to collect. But I will say that there are three main components that I'm always going to include in an evaluation for children really of of any age. One is that measure intellectual functioning.
That's going to be, even if they're little, it's going to be informative to how they're doing at that time. But definitely once they're, you know, six and older, this is going to really tell us a lot about how they are interacting in their environment.
Then we've got the measures of adaptive functioning or daily living skills. I can measure this in a couple ways. One is through a an interview with parents that I score, and then another is through a standardized report measure completed by parents.
And this tells me how the child is doing in their real life and how are they? How are their abilities comparing to other children their age? And then lastly, that emotional measuring emotional behavioral function is always going to be a part of my evaluation, so.

This is generally those questionnaires about mood and anxiety and behavior and it kind of. I'll do this regardless of the referral question. Even if it's a pretty straightforward autism evaluation, I always want to make sure we're we're covering our bases and and.
Not overlooking some kind of emotional or behavioral concern.
OK, so to illustrate the differences between batteries I might use, I thought it might be helpful to take a look at what I would consider for an ADHD battery and and what I would consider for an autism battery. So I'll walk us through the ADHD battery 1st and then we'll compare that to autism.
So if a child, if there's a question about ADHD, the first thing to know is that they don't need a full psychological evaluation. I think a lot of people think that that it's necessary, but it's really not. This is something that pediatricians are very skilled at in terms of incorporating.
Feedback from parents and teachers. That's really all we need. And the reason for that is because there's not a specific test for ADHD and we're really not good at capturing ADHD symptoms on tests there. Like I mentioned before, there are some executive functioning measures that we have, but what we're finding more and more is that.
Those measures are not predictive of how kids are doing in terms of their executive functioning skills in the real world settings. So what that means is I'm always relying on collateral report from those outside sources in order to make this diagnosis.
Where an evaluation can be helpful for ADHD is ruling out other possible causes of inattention or behavioral regulation difficulties. So if we have, I generally try to say like I will accept a referral for a complex ADHD question where providers.
And parents are like, well, is it is it anxiety? Or is there perhaps depression? Or is there something else? Autism versus ADHD? If there's kind of that complex differential, that might be a good time for an ADHD evaluation. Otherwise, a comprehensive look is not always needed.
For autism, by contrast, I'm really basing my evaluation on my observations. So I'm incorporating the developmental history that parents give me and what I get from record review, but I really am.
Basing my diagnosis in large part upon my observations made in my interactions with the child. And I do this through some observation based tests where they're standardized procedures for.
Pulling in the child's social skills. So I'm doing things like playing with them or

interviewing them, or having them tell me a creative story in these open-ended ways and seeing how they react. And this will.
This is how I decide this kind of diagnosis in addition to that developmental history. So for the batteries themselves, for ADHD and autism, I'm going to do an interview with the parent, of course, but for autism, it's going to be more developmentally focused, particularly on their early life.
Ages 2345, that's going to be very informative to me, especially if I'm working with an adolescent. Then I'm for both. I'll be doing that measure of adaptive functioning and a cognitive measure and then.
For ADHD, I'll have the parents do parent report measures and I'll include a measure of executive functioning to see their perception of their executive functioning skills in the home environment. And then for autism, I'll have them do a specific questionnaire of social communication skills.
And then for ADHD, I'm really going to rely on those parent reported or excuse me, the teacher reported measures of behavior, whereas autism, I'm going to rely on that observation-based test. So you might hear about the ADOS 2 or the CARS 2. Those are some observation-based tests I might use.
And then for both on include standardized questionnaires of mood, OK.
So there are a few other specific details that might be helpful to to be aware of. One is that in order to preserve the integrity of a test and make sure that it's not getting out into the public, the details of most psychological tests cannot be shared broadly. So I I'm not able to share specific.
Questions or the raw data for tests. And the reason for this is that if we if people start having access to this information, a they could make their own version of the test. So it's a copyright issue, but B people could start preparing for the test in advance. Studying, right? Like you might study for an SAT, you could study for your psychological evaluation, and then we're not measuring the same thing that was measured by the the normed sample that I'm comparing the children to. And so it's really important and that's why I'm not sharing any examples of questions today for that reason.
Another is that in general, psychological testing can pretty much take place only about once a year. This is because repeating tests too quickly can result in artificially inflated scores or improved performance on tests as the patient has the opportunity to learn the test. There might be some examples.
Some examples where some exceptions rather where it can be helpful for patients to

have a couple tests a year. One is after a particular procedure, neuropsychologist might do tests quickly in succession, but another might.
It might be if the child really wasn't able to engage in that first test for behavioral reasons, they were maybe dysregulated, they couldn't really complete the testing, then it's OK to to do another evaluation. So just keeping that in mind as you consider referrals.
OK, so the last part about a psychological evaluation, the last component is the feedback, visit and recommendations. So this is the appointment. Usually for me, I do it as a separate appointment. You might find psychologists who do it the same day as.
The testing itself, there's different ways to do it, but the the bottom line is that every psychological evaluation should include some discussion of the evaluation results with the families, and this is to make sure that they understand the diagnoses, that their questions can be answered, and that the.
The recommendations can be understood, and so when I'm making recommendations after an evaluation, I'm really thinking about these core domains, home, life and parenting. Are there any things that can be changed at home? Maybe adding more structure, maybe changing the way?
Parents are having more special time with parents. For example, if a child seems to be in need of that, that's one thing I might recommend. I'm always considering the school and academic environment, which I'll talk about next, but the thing to know is that.
The schools might read my recommendations. They don't have to abide by them, but it's something I think can be helpful to have it in writing that these are things that a psychologist has recommended for for their school performance and and that can help the parent better advocate for what?
The child needs.
I'm always making recommendations about social and emotional health. So this might be including more behavioral activation, and that means, you know, having the child do more activities. Or it might be even removing activities. If the child is extremely busy, we might say, hey, let's let's, you know, pare it down so that.
The child has more time to play or or, you know, have downtime. It might also include things like a social skills group or opportunities, more social clubs that the child can participate in and then.
Health and well-being. This is where I might be saying, hey, I think you should go see

a neurologist or I think that we need to go see a sleep specialist. I'm always considering sleep. It's a big part of functioning for kids, and I might even make some sleep hygiene recommendations as well.
And then lastly, I'm always trying to connect families to community resources that might be helpful. So this for for caregivers who are grandparents, this might be connecting them to a group of of other grandparents who are primary caregivers, or it might be helping families with a child with autism connect to other.
Families or community resources for children with autism. This is generally how I tend to think about the recommendations I make. And I will say I try not to overwhelm families with the recommendations. I really try to give my most pressing recommendations and if a child family presents as being pretty.
Overwhelmed or and and it was almost a feat for them to even make it to the evaluation with me, I might give them fewer recommendations. So that way there's an increased chance that they actually follow through on those key recommendations. Like I consider it kind of picking my battles, right? What? What is the most important thing that I want them to take away from the evaluation and and. Focusing on that.
OK, so I want to touch on school-based evaluations because I think this is something you might encounter with your patients and I think it's something that's very confusing. School evaluations can be really similar to outpatient psychological evaluations, but there are some key differences and my goal in sharing this is that you'll be.
They're better able to decide when an outpatient assessment is needed and help guide families who have confusion about this. So you all might be aware about the Individuals with Disabilities Education Act or IDEA. This is the law that makes available a free and appropriate public education to children in the United States and.
Ensure special education and related services for those kids. The key thing to note is that an identified disability must adversely affect a child's performance in school. So this is where there might be a discrepancy between my clinical diagnosis or your clinical diagnosis and what the school is recognizing as a.
Disability. So perhaps what I've seen in the past is I've seen children who have a autism spectrum disorder diagnosis for me, autism level one, but they're doing really well academically. It's more about their social performance.
That's that's causing a problem. I've seen where schools will not give children special

education services in that instance because their academic performance isn't being impacted. So just keep in mind that that is one way in which schools have a different lens from us clinically and why, you know, teachers might say, hey.
The school said that they don't have this diagnosis, but you're telling me they do. How do we, you know, reconcile that? And the the main explanation is that academic impact. So I I've listed here the 13 different idea group categories.
For.
Or disability. The main thing to know is that most of the mental health diagnoses fall under this category of emotional disturbance. So this is where you might find, you know, generalized anxiety disorder or OCD or major depressive disorder might fall in this category.
Other health impairment is where children with ADHD tend to be placed. So the other ones I think are a little bit more straightforward, but just having that information can be helpful. And I will say that children can have multiple designations, so you can be a child with autism.
Or have a designation of autism as well as intellectual disability as well as emotional disturbance. You can have multiple listed.
OK. So this is just a comparison of what a medical evaluation or clinical, you know, diagnosis might look like versus a school-based evaluation. We're basing our clinical and medical diagnoses on the DSM 5 or the ICD 10 criteria.
Whereas the school is using their IDEA eligibility categories, so they're not looking at our clinical criteria. One downside about our clinical evaluations and diagnoses is that they cost money and or they might require insurance coverage, whereas the school.
Evaluations are free, so if parents have any hesitation about doing it, helping them understand that their evaluations are free can be helpful, and it might be something that's accessible to families who can't otherwise afford a comprehensive clinical evaluation.
Um.
And clinical and medical evaluations are going to be what is necessary to allow for the insurance coverage of therapeutic intervention sometimes and allow for access to support services like SSI, SSDI. So just keeping in mind that a school-based evaluation is generally not, it's not going to be sufficient for the family to give. Those services sharing, you know that evaluation won't be enough for an insurance provider. The insurance provider is going to want to see a medical provider giving

these diagnosis and then the converse is true as well. So if I provide a clinical diagnosis, that's not going to be sufficient for the school to.
Make special education services available for their students through an IEP or a 504 plan. So they have to do their own evaluation to make those determinations. All right, it's important to know that caregivers can specifically request an evaluation for their children through their school district by making a formal.
Written request. The schools similar to me are going to use a variety of assessment tools that they're actually required to do so, and no single measure can be the sole criterion for a determination. The last thing I wanted to highlight is that caregivers can share documentation from medical reports for.
Reviewed during the evaluation. So if you are providing some information that you think the school should know, I would definitely highlight that to parents and make sure that they know, hey take this to the school. They have to, you know, review it as part of the school-based evaluation.
OK. So in closing, I wanted to share a few resources before we move into questions. Within our own psychiatry department, we've got the clinic that I'm housed in. It's called the NOW Clinic. We serve ages 11 all the way up through adulthood. We have, you know.
Patients who are considered geriatric in our clinic and we have grant funding available. So that means patients we're we're considered a rapid access clinic, which means that patients should be able to come see us quickly without being on too long of a wait list and they don't necessarily have to pay anything at all.
So keep that in mind for families who need services but maybe don't have the financial resources to to go out in the community and find them. Our clinic offers medication management, individual psychotherapy, group therapies and family therapy. And we also have me doing a psychological assessments for youth. Unfortunately, right now we don't.
Have anyone doing psychological assessments for adults. We do have another clinic in the same building as me upstairs. It's called the We Care Clinic and it serves younger, a younger population and again they have no cost services. They're a training clinic, so they're all licensed professional counselor associates earning their hours towards.
Full licensure and they have therapy and parenting support, family therapy. So this can be great for kids who have behavioral concerns who are younger. They have what's called PCIT or parent child interaction therapy, which is a great intervention.

And then Clarity Child Guidance Center is where many of our psychiatry providers are and they also have other services there, but they're those are not affiliated with UTSA. And then I mentioned the Transitional Care Clinics living room service.
I hope that you all are aware about CPAN. This is the real-time access to a network of mental health experts where you can call this number and receive a peer consultation by phone with a psychiatrist. So if you're managing medications for a child and you have a question, we.
This is a great way to to get that consultation for free and but the purpose is we know that there's such a need for psychiatry services for youth. There's a a really a a lack of child psychiatrists and this is one way that they're trying to kind of close that gap in treatment.
But I wanted to just mention that they've got some awesome things on their website that might be useful to you about mental health, and they also offer CNEs.
This is a calm is a free online training that you can can can participate in for lethal means safety. So that means locking up dangerous items for youth to prevent suicide. Awesome program, really great and it's free.
And then lastly, if you have a family that feels like their educational needs are not being met for their child, they might benefit from working with an educational advocate. And the TEAM project is one that I've found that's free, where children from zero to 26 can get support in understanding disabilities.
Disabilities and their rights under the the laws of IDEA. All right. I know I was going quick there at the end, but I would love to hear your questions and any thoughts and answer anything that y'all have. So thank you so much.

Ranch, Daniel 53:46
Doctor Anders, thank you for that outstanding presentation. Open up for questions. You can unmute your mic and ask or place in the chat. And we have a question from Doctor Janet Williams. Go ahead please, Doctor William.

Williams, Janet F (Dr.) 53:59
Hey, great job, Doctor Andrews. I've got all kinds of questions. First of all, I wanted to know why or or what's the speed at which a patient could be evaluated?

Andrews, Ellen M 54:04
I.

Williams, Janet F (Dr.) 54:18
For suspected autism at at your clinic, meaning is there a large wait list or whatever and but why would someone send a patient to your clinic or your your colleagues clinics and not?
A developmental pediatrician.

Andrews, Ellen M 54:40
That's a really great question. So right now the timeline, my schedule is pretty full through February. So it's a couple months, but not outrageous. And generally once I'm able to see a patient for an intake, I can schedule their testing right away. So it's not as though the.
It's a drawn out process. Once they see me, we can do it pretty quick. There's a lot of overlap between what a developmental pediatrician can do and what I could do for autism. I think that in a lot of ways we work hand in hand. That's the the post doctoral.
Fellowship I did was working side by side with those providers and one benefit of seeing a developmental pediatrician is they could follow them over time. But I think the benefit of seeing a psychologist is having a more comprehensive look at the mental health concerns. So if you have.

Williams, Janet F (Dr.) 55:34
Really.

Andrews, Ellen M 55:36
A patient with more complex symptoms of other things, anxiety, depression. It might be nice to do kind of a one and done evaluation of everything at once with me. And I think that in my clinic I tend to work more with adolescents.

Williams, Janet F (Dr.) 55:51
Hello.

Andrews, Ellen M 55:52
And I think developmental pediatricians often tend to work, do evaluations for the first time with the younger kids, the toddlers.

Williams, Janet F (Dr.) 55:58
Right.
Right.
OK, great. I have a second question, but I'll let other people go first.

Andrews, Ellen M 56:05
OK, great to see you.

Ranch, Daniel 56:07
You can go ahead and ask Doctor Williams.

Williams, Janet F (Dr.) 56:09
Oh, so are is anyone there using a I like Cognoa or some of the programs out there for autism?

Andrews, Ellen M 56:24
To my knowledge, no one in our clinic is using a a program like that yet. Yeah, you're welcome. Thank you.

Williams, Janet F (Dr.) 56:29
Yeah. OK. Thank you. Thank you so much.

Ranch, Daniel 56:34
Doctor Wu asked if you could share some of the resources that you had at the end of your presentation. And that was the same thing I was going to ask too, because I want to know physically where your clinic is, because I will be sending all of my teenage kidney transplant patients to you.

Williams, Janet F (Dr.) 56:48
Sydney.

Andrews, Ellen M 56:50
Alright.

Ranch, Daniel 56:50
But yeah, maybe if you could share those resources with me and then I'll be happy to have our team distribute to the department.

Andrews, Ellen M 56:57
Yes, I'd be happy to share those. Absolutely. And just so you know, the clinic, the our mental health and Wellness clinic is in the Medical Center off of Eckert Rd. off off Babcock. So we're not far from main campus, but you know, we are a little removed, but it's nice because we're all in the same building.
building. The majority of the psychiatry department is here in this building.

Ranch, Daniel 57:20
And do you happen to have any satellite sites or plans for the future to have other remote clinics since our patients obviously are coming from all around the city?

Andrews, Ellen M 57:30
Yeah. To my knowledge, we don't have any yet and I have not heard of any plans for that yet. We've just moved into this building within the last 2 1/2 years. So I think that plans for expansion are probably a little early, but we'll see.

Williams, Janet F (Dr.) 57:48
And are all types of coverage taken? The Medicare? Medicaid. Yeah. OK. And all insurance. Thank you.

Andrews, Ellen M 57:52
Yes.
Yeah, exactly. All insurance plus the grant. Exactly.

Ranch, Daniel 58:02
While we're waiting for additional questions to potentially pop up, I had one. So the population I deal with is kidney transplant and one of the biggest issues actually both our kidney transplant recipients and before the transplant when they're on dialysis is medication adherence. And I wonder what approach or tools you might have for those patients.

Andrews, Ellen M 58:22

That's a great question. I think that's something that therapists often help families with is helping to problem solve. You know, the barriers to medication adherence. There's a lot of different reasons why children might not take medications. I just. Saw a patient yesterday who didn't like the texture and taste of pills or liquid medication, so her psychiatrist had to get creative and think of alternatives. But I think that helping the psychiatry team be aware and the therapist if the patient is working with one can be helpful to just kind of problem solve some.
Those questions.

Ranch, Daniel 59:05

Thank you. And we have a question from Dr. Brooks and then Dr. Lopez.

Brooks, Edward G 59:09

Hi, I'm an immunologist and we're getting more and more referrals for neuropsychiatric autoimmune conditions like PANDAS is sort of the classic one. And there's specific neuropsychiatric testing can help support that diagnosis, particularly if we're trying to get them approved for IVIG therapy.

Andrews, Ellen M 59:20

Yeah.
Hmm.

Brooks, Edward G 59:29

Is there expertise in your group in in these groups of disorders?

Andrews, Ellen M 59:35

To my knowledge, there is not. I have seen patients with PANDAS, but it hasn't been the primary reason for referral. But this is an area I mentioned neuropsychologists earlier. They are growing in this direction. More and more people are specializing in neuroimmunology.
As as a kind of sub focus within neuropsychology, right now we don't have a dedicated pediatric neuropsychologist in our hospital. We have one lifespan

neuropsychologist to my knowledge who works with adults and children.
But we don't have that yet, and I think it's there's a critical need for it.

Brooks, Edward G 1:00:17
Well, I can supply you with lots of referrals.

Andrews, Ellen M 1:00:19
OK, terrific. I'll take them.

Brooks, Edward G 1:00:23
Doctor Lopez.

Lopez, Cynthia 1:00:26
Hi, good morning. Thanks for the talk. I was just wondering, do you have or do you offer dialectical behavior therapy? And if so, I guess for in general for most of your psychotherapy, since you're a free service, is there a limit, like a time limit or number of sessions?
Um.

Andrews, Ellen M 1:00:47
That's a great question. Yes, we have dialectical behavior therapy. It's a terrific program we've got here for adolescents. We have a multi-family format, which I love. It means that they are in group learning DBT skills with alongside their parents so their parent can help support their youth.
Use of skills outside of the therapeutic setting and it's really a wonderful program.
For those who aren't familiar, dialectical behavioral therapy is a therapy aimed at at supporting individuals who have chronic suicidality or non-suicidal self-injury and so the.
This is a fabulous program and it's very rare to to have such a good program in a in a clinic like ours because it is such a costly program. Patients who don't have any insurance can be seen by us in that DBT group for six months on our grant.
So it's really, really great. And then if they have the means to pay for longer, they can stay longer.
Thank you for that question.

1:01:57
Thank you.

Ranch, Daniel 1:01:59
All right. Well, it is just past 8:30, so thank you again, Doctor Andrews, for a fantastic session. I'm sure more of our teammates will be reaching out to you for your expertise. As a reminder, the Grand Rounds participation code is in the chat box. Also, please complete the post Grand Rounds assessment. The feedback really helps our.

Andrews, Ellen M 1:02:09
Absolutely.

Ranch, Daniel 1:02:19
Speakers and our program. Otherwise, thank you again, Doctor Andrews, and everybody have a great rest of your day.

Andrews, Ellen M 1:02:26
Thank you all.

Sheila Reifle stopped transcription