

Identifying Fetal Alcohol Spectrum Disorder and psychiatric comorbidity for children and youth in care: A community approach to diagnosis and treatment

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ABSTRACT

Background: Several challenges exist when making a diagnosis of Fetal Alcohol Spectrum Disorder (FASD) and identifying co-morbid psychiatric illness, particularly for children and youth accessing child welfare services. Here, we describe an integrated three-phase approach to the identification of FASD and psychiatric comorbidity for children and youth in care, consisting of: (1) completion of a standardized neurobehavioral screening tool by a child protection worker (CPW); (2) assessment by a pediatrician, including facial measurements and; (3) integration of findings in a psychiatric assessment.

Main Findings: The majority of participants (14/18, 78%) of youth who were suspected by a CPW and pediatrician of a diagnosis of FASD using the screening tool were determined to have met criteria. A diagnosis was made in all cases where there was confirmed history of prenatal exposure and a majority of these youth were found to have sentinel facial features of FASD. Psychiatric comorbidity was diagnosed and treatment recommendations made for all children and youth referred.

Conclusions: This study supports the utility of an integrated community approach to diagnosing and treating comorbid psychiatric disorders in FASD by employing existing child protection and physician services in a community setting. Based on these preliminary findings, we encourage that youth who access formal care systems be screened for FASD by their CPW and are provided with appropriate pediatric and psychiatric assessments to clarify the diagnosis, while also identifying comorbid psychiatric illness to target appropriate interventions.

1. Introduction

Prenatal alcohol exposure leads to a range of lifelong adverse effects, including growth deficits, characteristic facial features, as well as functional and/or structural brain damage. These effects are collectively referred to as Fetal Alcohol Spectrum Disorder (FASD) and

represent the leading cause of developmental and cognitive disabilities among children and youth (hereafter referred to as youth) in the Western world (Popova et al., 2016). Not all children exposed to alcohol in the intrauterine environment may experience these effects, and FASD as a diagnostic entity upon which to focus assessments and interventions has been subject to ethical debate (Helgesson et al., 2018).

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Studies have documented multiple common cognitive deficits, including impulsivity, deficits in attention, poor abstract thinking, excessive friendliness and poor adaptive functioning [for review, see Mattson, Bernes & Doyle (2019)]. These challenges can last a lifetime and place an enormous burden on families, healthcare and judicial systems, with FASD-associated societal costs in Canada estimated at over \$344 million annually amongst those up to 21 years of age (Popova, Lange, Burd, & Rehm, 2014).

Utilizing active case ascertainment, recent Canadian findings of the prevalence of FASD among elementary school students range from 2 to 3% (Popova et al., 2019) with previous estimates of approximately 4% in the general population (Flannigan, Unsworth, & Harding, 2018). Data from the Canadian province of Manitoba and the Northern Plains Nations indicate FASD is 13 times more prevalent amongst youth in care, and youth with FASD were 64 times more likely to be removed from their homes (Gough & Fuchs, 2008). Youth with FASD also undertook more changes in their home placements through foster care systems, which, in the context of poor adaptive functioning, make such transitions particularly difficult (Popova et al., 2014). Youth placed in care are typically exposed to higher rates of childhood trauma and unstable family dynamics/structure, further impacting their mental health outcomes and potential development of co-morbid psychiatric illness (Chasnoff, Wells, & King, 2015; Chasnoff, Wells, Telford, Schmidt, & Messer, 2010; Lange, Shield, Rehm, & Popova, 2013; Popova et al., 2016).

As such, several studies have identified a high incidence of psychiatric comorbidity in individuals with FASD (see Weyrauch, Schwartz, Hart, Klug, & Burd, 2017). In a sample of 156 American youth with FASD, Chasnoff et al. (2015) found that 94% had a co-occurring mental health diagnosis, with 67% having two or more mental health diagnoses. Among these diagnoses, Attention Deficit Hyperactivity Disorder (ADHD) occurred most frequently, with rates up to 15 times higher than the general population (Lange, Rehm, Anagnostou, & Popova, 2018). Externalizing disorders, such as Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), as well as Autism Spectrum Disorder have also been found to occur at higher rates in youth with FASD (Greenbaum, Stevens, Nash, Koren, & Rovet, 2009; Lange et al., 2018; O'Connor et al., 2002; Streissguth, Barr, Kogan, & Bookstein, 1996; Streissguth et al., 2004). Post-natal adversity, including placement in foster care and multiple home transitions, have been identified as significant predictors in the development of externalizing behavioral disorders (Rodriguez et al., 2009; Staroselsky et al., 2009). Internalizing disorders, such as depression and anxiety, also occur to a higher degree in these youth and are subject to inherent diagnostic challenges (Pei, Job, Kully-Martens, & Rasmussen, 2011).

There has been limited research regarding the incidence of FASD in youth who engage with formal care systems, and their related psychiatric co-morbidities. In a systematic review of the literature, Weyrauch et al. (2017) identified only one study that reported psychiatric comorbidity findings exclusively in youth who accessed child welfare systems. In this study, Chasnoff et al. (2015) outlined the critical need for a multidisciplinary assessment for high risk youth in care who were referred for general behavior problems and later evaluated for FASD and psychiatric concerns.

To this end, there are several challenges associated with making a diagnosis of FASD. In many circumstances, it is difficult to confirm maternal alcohol consumption on history, particularly in a situation where custody of a child may be involved. This has informed the different classes of FASD diagnoses suggested by Cook et al. (2016), which are utilized in Canada and elsewhere: FASD with or without sentinel facial features, with or without confirmed maternal exposure. FASD remains an umbrella term now encapsulating previous diagnostic entities including partial FASD and alcohol related neural deficits. Furthermore, a lack of understanding and comfort expressed by health care providers in their knowledge of FASD, diagnostic procedures, and/or treatment recommendations have also been highlighted as barriers to

identifying FASD in youth by pediatricians (Gahagan et al., 2006; Rojmahamngkol, Cheema-Hasan, & Weitzman, 2015). In addition, limited evidence-based processes and screening tools to facilitate multidisciplinary assessments for FASD in community settings impedes the ability to complete evaluations with children who may have FASD, but whose needs have been undetected (Lange, Rovet, Rehm, & Popova, 2017).

Beginning in late 2016, the Children's Aid Society of Toronto (CAST), Canada, began offering a multidisciplinary assessment service for youth in care who were referred for general psychiatric assessment by a pediatrician. This model of care was implemented in response to a lack of access to specialized diagnostic teams for youth in care suspected of prenatal alcohol exposure. The assessment procedure was expanded to include input from child protection workers (CPW) in querying cases of FASD in collaboration with the CAST pediatrician. Furthermore, Complex Case Reviews and other resources were employed to operationalize a consistent method to screen for FASD within this care model. Finally, priority was placed on psychiatric co-morbidity assessment and treatment planning as these youth progressed through formal care systems.

The objective of the current study was to describe our three-phase multidisciplinary approach to diagnosing FASD for youth in care through CAST services. This approach consisted of: 1) completion of a standardized neurobehavioral screen by a (CPW); 2) pediatric assessment of those screening positive, including facial measurements, and; 3) integration of findings through a full psychiatric assessment. Here, we summarize preliminary demographic information, psychiatric comorbidity, medication considerations and treatment strategies that were provided to youth seen at CAST, their caregivers and CPW. Our hope was to provide a framework for this integrated practice so that it can be applied in communities and jurisdictions with youth with FASD who are engaged in the child welfare system.

2. Methods

2.1. Research protocol

A retrospective chart review was completed of data collected at CAST medical clinic, Toronto, Canada, between March 2016 to November 2017. The initial sample included all youth who were previously or currently in the care of CAST. All study procedures were approved by the Research Ethics Board of CAST and the research was conducted in accordance with the Helsinki Declaration.

Initial inclusion criteria for chart review were all of clients who were referred for neuropsychiatric assessment to the primary author during the study period. All youth were involved in child welfare services, had been referred by their pediatrician and had been screened using the NST by their CPS. Charts were further refined to include only those where there was a positive NST screen and where consent was obtained for study inclusion. Consent was obtained directly from the youth or the appropriate substitute decision maker (adoptive/foster parents or caseworkers) if the participant was deemed incapable of providing consent. Consent was obtained retrospectively for inclusion in the study. The nature of the work was explained as well as the right to refuse participation. CPW's, caregivers and participants were invited to ask questions about the study prior to signing any consent forms. Exclusion criteria were absence of consent and individuals who were over the age of 18 at the time of assessment.

2.2. Phase 1: Neurobehavioral screen

The Neurobehavioral Screening Tool (NST) [adapted from Nash, Koren, and Rovet (2011)] was utilized to initially screen youth coming into care at CAST and was completed by the CPW (refer to Appendix A). CPW's are generally masters level social workers and received training in the completion of the NST. Items included questions pertaining to

oppositional behaviors, impulsivity and hyperactivity. This standardized tool has been validated previously with a sensitivity of 86% and specificity of 82% for identifying youth with FASD (Nash et al., 2011). LaFrance et al. (2014) demonstrated that the NST yielded 62.5% sensitivity for participants with FASD and 50% for prenatal alcohol exposure (PAE). Specificity values were 100%, with no typically developing control participants scoring positive. Within the FASD group there was also a trend for higher sensitivity among adolescents aged 12 to 17 (70.8%) compared with children aged 6 to 11 years (54.2%).

2.3. Phase 2: Pediatric assessment

Youth screening positive on the NST were referred for assessment by a pediatrician at CAST to determine if a diagnosis of FASD was possible. Measurements for sentinel facial features were completed as per the 2015 Canadian Guidelines (Cook et al., 2016). This included scoring of palpebral fissure length (greater than two standard deviations below the mean or less than the third percentile), as well as smoothness of philtrum and thinness of upper lip utilizing the five-point scale of the Washington Lip-Philtrum Guide (Astley & Clarren, 2000). History of exposure to alcohol during pregnancy was determined by review of CAST records, direct maternal verification, alcohol related diagnosis or treatment during pregnancy, results of urine and meconium testing for alcohol at birth, and/or removal of the child by CAST due to maternal alcohol abuse or heavy drinking during pregnancy.

2.4. Phase 3: Psychiatric assessment

Those youth queried for a diagnosis of FASD through the NST and pediatrician review were then referred for fulsome psychiatric assessment by the primary author to provide final diagnostic impressions. Each interview began in the presence of biological and/or foster parents, as well as the participants' assigned CPW and was structured to allow for confidential portions to be completed with the participant alone. Identifying information, past psychiatric history, including previous psychiatric diagnoses, engagement with other therapeutic services (i.e. counseling, occupational therapy, speech-language pathology, etc.), past medical history, current and past pharmacological therapy, allergies, forensic and substance use history, as well as a thorough assessment of the child's social and developmental history were all obtained. Presenting mental health concerns were investigated. Further demographic and background information was gathered from CAST reports and developmental records completed by the CPW. Previous psychological reports were also reviewed.

The above information was integrated with available physical examination and psychological test results (including IQ scores from previous assessments and psychoeducational reports to diagnose learning disabilities) to generate a final diagnostic impression regarding the presence or absence of FASD (see Fig. 1). Four diagnoses were possible, as per the 2015 Canadian guidelines: (1) FASD with sentinel facial features (criteria must be met for all three sentinel facial features); (2) FASD without sentinel facial features (anything less than three facial features); (3) at risk for neurodevelopmental disorder and FASD associated with prenatal alcohol exposure, and; (4) no diagnosis. Using DSM-V criteria (American Psychiatric Association, 2013), the psychiatric opinion also provided impressions regarding: (1) the presence or absence of psychiatric comorbidities; (2) central nervous system (CNS) impairment, and; (3) treatment recommendations inclusive of psychopharmaceutical and psychotherapeutic interventions, as well as sociobehavioral and environmental considerations. Impressions regarding CNS impairment were also supplemented by integrating information available from previous psychological assessments, as well as documented developmental histories and CAST records.

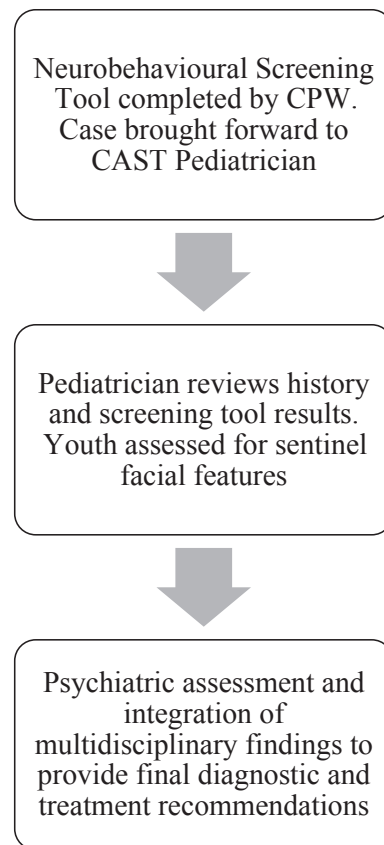


Fig. 1. Chart depicting three-phase assessment approach. CPW = child protection worker. CAST = Children's Aid Society of Toronto.

2.5. Data collection and analysis

Data were extracted from the participant's clinic files and were entered into a database using Microsoft Excel 2017. Participant names and any identifying information were removed to protect anonymity. Demographic and descriptive data were collated and interpreted using SPSS version 21.0.

3. Results

In total, 106 children were referred to the primary author for psychiatric assessments over the study period, all of whom had been screened by their CPW using the NST. Of these, 23 clients screened positively on the NST to determine if they met criteria for FASD. There were no children who scored a positive NST that were not assessed. Further data regarding the number of children who were screened with the NST was not available at the time of this publication. Informed consent was obtained from 18 (78%) youth to be included in the study. As outlined in Table 1, the average age was 9.22 ± 3.75 years, with a range of 3 to 15 years. Nine were between the age of 3 and 8 (early childhood), three were between the age of 9 and 11 (middle childhood) and six were above the age of 12 (adolescent). There were 9 males and 8 females, with one 13-year-old participant who was transitioning from male to female.

Of the 18 clients who were referred for suspected FASD, 14 were diagnosed with FASD, yielding a positive predictive value of 78%. Confirmed prenatal alcohol exposure was present in 13/18 (72%) participants, all of whom were diagnosed with FASD. Ten of those who were diagnosed had findings on physical examination of facial features meeting criteria for FASD with sentinel facial features versus four who did not, as per measurements taken by the referring pediatrician. The average intelligence quotient (IQ) in the group diagnosed with FASD

Table 1
Demographic and psychiatric comorbidity data.

	n = 18
Mean age in years (SD)	9.22(± 3.75)
● Maximum age	15
● Minimum age	3
Gender	
● Male	9(50%)
● Female	8(44%)
● Transgender	1(6%)
Confirmed PEA	13(72%)
FASD diagnoses	14(78%)
● Confirmed PEA and sentinel facial features	9
● Confirmed PEA without facial features, but CNS impairment	4
● Unknown PEA with sentinel facial features and CNS impairment	1
IQ*	
● FASD Group (n = 14)	70(± 10.3)
● No Diagnosis (n = 4)	83.5(± 4.95)
Comorbidities	
● ADHD	10(56%)
● Learning Disabilities	4(22%)
● Tic Disorder	3(17%)
● Conduct Disorder	3(17%)
● Oppositional Defiant Disorder	2(11%)
● Intellectual Disability	2(11%)
● Major Depressive Disorder	2(11%)
● Substance Use Disorder	1(6%)
● Adjustment Disorder	1(6%)
● Speech or Language Disorder	1(6%)
Number of Comorbidities by Youth	
● 0	3(17%)
● 1	8(44%)
● 2	6(33%)
● 3	1(6%)
Guardianship	
● Biological parents	0
● Foster parents	14(78%)
● Group home	3(17%)
● Adoptive parents	1(5%)
Number of environmental changes	
● 1	3(17%)
● 2	8(44%)
● 3	4(22%)
● > 3	3(17%)
Number of foster homes	
● 0	3(17%)
● 1	10(56%)
● 2	4(22%)
● 3	1(6%)
Medications at time of assessment	
● None	9(50%)
● Melatonin	7(39%)
● Stimulant	5(28%)
● Stimulant + Other	5(28%)
● Alpha-agonist	1(6%)
● Norepinephrine Reuptake Inhibitor	1(6%)
● Antipsychotic	1(6%)
Psychological assessment received previously	13(72%)

Note: ADHD = Attention Deficit Hyperactivity Disorder, FASD = Fetal Alcohol Spectrum Disorder, PEA = Prenatal Exposure to Alcohol

*Full psychoeducational testing was only available for 2 participants.

was 70 ± 10.3, and 83.5 ± 4.95 in the group of children who were not diagnosed (n = 4). All those who were diagnosed with FASD were determined to have met cognitive impairment in three or more the neurodevelopment domains as defined by Cook et al. (2016).

All children had at least one other psychiatric comorbidity, as determined by criteria of the Diagnostics Statistical Manual version V. The three most common psychiatric comorbidities diagnosed in those with FASD were attention deficit hyperactivity disorder (ADHD) (9/14, 64%), tic disorder (4/14, 28%) and learning disability (2/14, 14%). Within the group of children who did not meet criteria for FASD, one participant had oppositional defiance disorder (ODD), one presented

Table 2
Treatment recommendations and considerations post-psychiatric assessment.

Treatment recommendation	n = 18
Medications	
● No Changes	7(39%)
● Add New Medication	7(39%)
● Add Stimulant	3(17%)
● Lower Dose of Current Medication	1(6%)
● Increase Dose of Current Medication	2(11%)
Psychotherapeutic intervention	
● CBT	6(33%)
● Behavioral Therapy	8(44%)
● Animal Therapy	4(22%)
● Play Therapy	8(44%)
● Speech-Language Pathology	4(22%)
● Combination of CBT/Behavioral/Play/Animal	10(56%)
Social intervention	
● No changes	7(39%)
● Recreational Therapy	8(44%)
● Nonspecific Group Therapy	3(17%)
Psychoeducational intervention	
● Assessment for new IEP	4(22%)
● Continue current IEP	8(44%)
Placement considerations	
● Co-parenting with Family Placement	1(6%)
● High Parent:Child Ratio	1(6%)
● Intense Supervision	2(11%)
● Visitations with Biological Mother	1(6%)

with comorbid Post Traumatic Stress Disorder (PTSD) and conduct disorder (CD), one had ADHD, and the other presented with a history of major depressive disorder.

With respect to treatment, medication changes were recommended in 10/14 (71%) of the children diagnosed with FASD and in one child who was not diagnosed with FASD (refer to Tables 2 and 3). Psychotherapeutic interventions were recommended in all 18 participants who were assessed, while sociobehavioral interventions were recommended in 6/14 (43%) of the participants diagnosed with FASD and in all four of the children who were not diagnosed. Placement considerations were made in 6/14 (43%) of cases of children diagnosed with FASD and in none of the cases of children who were not diagnosed.

Note: CBT = Cognitive behavioral therapy, IEP = individualized educational plan.

4. Discussion

This study describes a multidisciplinary three-phase approach to the assessment of youth in care queried for a diagnosis of FASD by their CPW. To address a common challenge of limited access to specialized diagnostic teams, the current care model tied together pre-existing services offered by a community children’s welfare agency to help facilitate the process of FASD diagnosis and treatment. Similar processes may be applied in other sectors involving youth who have accessed a child welfare system. Our findings reveal that 78% of youth who were suspected by a CPW and pediatrician of a diagnosis of FASD using the NST were determined to have met criteria. A diagnosis was made in all cases where there was confirmed history of prenatal exposure and a majority of these youth were found to have sentinel facial features of

Table 3
Treatment recommendations in the FASD versus no diagnosis group.

Treatment recommendations	FASD (n = 14)	No diagnosis (n = 4)
Medication changes	7(50%)	1(25%)
Psychotherapeutic intervention	14(100%)	4(100%)
Social intervention	6(43%)	4(100%)
Placement considerations	6(43%)	0
Psychoeducational testing	10(71%)	2(50%)

FASD.

The current approach for diagnostic assessment enabled more timely diagnosis of FASD as well as identification and treatment recommendations for psychiatric co-morbidity in youth with FASD. The NST had a positive predictive value of 78%, supporting the use of this tool as an efficient method to screen for youth who may meet criteria for a diagnosis of FASD. Further assessment by a pediatrician provided the necessary information to integrate findings for a final diagnostic impression. This highlights the importance of a collaborative care model in the diagnosis and assessment of youth queried for FASD.

Psychiatric comorbidity was present in all youth referred for consideration of an FASD diagnosis and resulted in further psychiatric treatment recommendations. In keeping with findings from other studies, the most common comorbidity found in the current study was ADHD [see [Burd \(2016\)](#) for review]. Surprisingly, however, the majority of youth diagnosed with FASD did not meet criteria for ODD or CD, despite previous reports of increased prevalence of these externalizing disorders in youth with FASD [see [Lange et al. \(2018\)](#) for review].

Learning disorders were diagnosed in only four participants within our sample, two of whom were diagnosed with FASD. This is despite significant evidence that learning disabilities are often comorbid with FASD ([Burd, 2016](#)). Fulsome psychoeducational testing was only available for two participants, which limited our ability to confirm this diagnosis in most cases. Given the propensity for comorbidity of learning disorders in youth with FASD, formal psychoeducational testing is important to complete, but is not required to make a diagnosis of FASD. Regardless, in 71% of cases of youth diagnosed with FASD, recommendations for further psychoeducational testing and suggestions for augmenting individualized educational plans (IEP) were made through a psychiatric assessment.

In addition, half of the youth referred for psychiatric assessment were started on psychotropic medications by their pediatrician prior to referral. Further recommendations for changes to medications were made in half of youth diagnosed with FASD and in one of the youth who was not diagnosed with FASD. This exemplifies the benefit of incorporating psychiatric assessment in the diagnostic process for youth who are queried for FASD; suggestions for changes in medication regimen are possible.

Further recommendations regarding placement were only made in youth who were diagnosed with FASD versus those who were not. This may relate to the increased challenges that these youth face in relation to their social settings and adaptations to changes in their milieu ([Lange et al., 2013](#); [Popova et al., 2014](#)). Children with FASD are much more prone to environmental stressors and likely require more support in their care environments. Notably, the majority of children referred had undertaken more than one environmental change and had been placed in one or more foster homes. Independent of diagnosis, all youth referred were offered psychotherapeutic and/or social interventions. This is indicative of the importance of early diagnosis and intervention for these youth.

4.1. Limitations

Several limitations to this study should be noted. Our small sample size limited statistical comparison between the group of children diagnosed with FASD and those who did not receive a diagnosis. Although it is possible that age may be related to the number or type of comorbidities present in our current study, our sample size restricts any

definitive conclusions. The pattern of age distribution in our sample, however, fits with data from large-scale surveillance studies in the United States suggesting an average age of diagnosis of FASD occurring at 4 years, with a range of birth to 7.8 years ([Moberg et al., 2014](#)). This analysis would be meaningful to conduct in future research to better clarify specific age-related needs of youth with FASD who access the child welfare system. In addition, only those children who were referred by their pediatrician were considered for diagnosis of FASD. This followed the completion of the NST by the CPW assigned to each child. It is possible that youth with more subtle presentations were not scored on the screening tool and may have been missed; initial screening alone should not be relied upon solely to enable further diagnostic query. Lastly, neuropsychological assessments were not completed in the majority of the youth seen at through the CAST services. As such, full assessments of CNS impairment were subsequently not made through our services for the majority of participants. However, the psychiatric assessment and integration of information available through CAST records, developmental records completed by the CPW and previously available psychological reports that were reviewed for each participant were sufficient to ascertain CNS impairment in most cases in order to make FASD diagnoses in a more timely manner.

5. Conclusions

Overall, the current study supports the value of an integrated community assessment approach that achieves more timely diagnosis and treatment of youth in care who are queried for a diagnosis of FASD. Screening by CPWs facilitated this process. The majority of children who were referred by the pediatrician for further psychiatric assessment went on to receive a diagnosis of FASD, supporting the efficiency of this approach to screening for FASD. Psychiatric assessments were effectively utilized in conjunction with pediatric and CPW assessments to confirm a diagnosis. Comprehensive psychiatric treatment recommendations including medication and psychotherapeutic interventions, as well as sociobehavioral and environmental recommendations can optimize outcomes for these youth. Based on these preliminary findings, we encourage that youth who access formal care systems be screened for FASD by their CPW and are provided with appropriate pediatric and psychiatric assessments to clarify the diagnosis, while also identifying comorbid psychiatric illness to target appropriate interventions.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Neurobehavioural screening tool

Neurobehavioural Screening Tool

NAME: _____

DATE OF BIRTH: _____

Have you or any adult involved in the care of this child/youth

1. Has this child/youth been seen or accused of or thought to have acted too young for his or her age? <i>Place a check in all columns if “YES” was endorsed</i>	YES	NO
2. Has this child/youth been seen or accused of or is thought to be disobedient at home? <i>Place a check in columns “A” and “C” if “YES” was endorsed</i>	YES	NO
3. Has this child/youth been seen or accused of or is thought to lie or cheat? 4. Has this child/youth been seen or accused of or is thought to lack guilt after misbehaving? <i>Place a check in columns “A” and “C” for each “YES” endorsed</i>	YES YES	NO NO
5. Has this child/youth been seen or accused of or thought to have difficulty concentrating, and can't pay attention for long? 6. Has this child/youth been seen or accused of or is thought to act impulsively and without thinking? 7. Has this child/youth been seen or accused of or is thought to have difficulty sitting still is restless or hyperactive? <i>Place a check in column “A” for each “YES” endorsed</i>	YES YES YES	NO NO NO
8. Has this child/youth been seen or accused of or is thought to display acts of cruelty, bullying or meanness to others? 9. Has this child/youth been seen or accused of or is thought to steal items from home? 10. Has this child/youth been seen or accused of or is thought to steal items from outside of the home? <i>Place a check in column “B” for each “YES” endorsed.</i>	YES YES YES	NO NO NO

A	B	C	D
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