Administering Assessments During a Pandemic
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The Centers for Disease Control and Prevention (CDC), a national public health institute in the United States, defines an influenza pandemic as the global outbreak of a new influenza A virus which spreads easily, most of the population has limited or no immunity, and a vaccine might not yet be available. The United States has experienced numerous influenza pandemics throughout its history. Past pandemics include the 1918 Flu Pandemic (H1N1 virus; Spanish Flu), the 1957-1958 Pandemic (H2N2 virus; Asian Flu), the 1968 Pandemic (H3N2 virus), and the 2009 H1N1 Pandemic (Swine Flu). The most recent influenza pandemic is the coronavirus disease 2019 (COVID-19). COVID-19 is a severe acute respiratory syndrome. The most common symptoms include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. More serious symptoms include trouble breathing, persistent pain or pressure in the chest, new confusion, inability to wake or stay awake, and bluish lips or face. Most people experience mild to moderate symptoms and recover without hospitalization. People who are older and have pre-existing medical conditions are at greater risk of serious illness or death. Such conditions can include cancer, diabetes, obesity, pregnancy, asthma, high blood pressure, as well as heart, kidney, liver, and lung diseases. The United States declared COVID-19 a national emergency beginning March 1, 2020. The World Health Organization (WHO) categorized COVID-19 as a pandemic on March 11, 2020. As of April 23, 2021, the total number of COVID-19 deaths in the United States was 566,494.

In 2017 the CDC published *Community Mitigation Guidelines to Prevent Pandemic Influenza* identifying nonpharmaceutical interventions (NPIs) that persons and communities can implement to help limit the spread during an influenza pandemic when a vaccine is not yet available. The three categories of NPIs are personal protective measures, community measures, and environmental measures. Personal protective measures can be further divided into protective measures for everyday use and protective measures reserved for pandemics. Daily personal protective measures include voluntary home isolation (e.g., remain home for at least 24 hours after a fever or symptoms are gone), respiratory etiquette (e.g., cover coughs and sneezes; avoid

touching eyes, nose, and mouth), and hand hygiene (e.g., regular hand washing with soap and water or use of alcohol-based hand sanitizer). Personal protective measures for everyday use are recommended during annual influenza seasons and influenza pandemics. In addition, personal protective measures recommended for pandemics include voluntary home quarantine of exposed household members and wearing a face mask in community settings when ill. Community measures are aimed at reducing exposure and increasing physical space between people. This can be done by temporarily closing schools and workplaces, replacing in-person meetings with teleconferences, and cancelling mass gatherings. Environmental measures focus on the routine cleaning of surface areas and objects that are frequently touched such as desks and door handles. NPIs should be implemented early in a pandemic to reduce the number of overall cases, rate of transmission, peak number of cases and demands on hospitals, and impact on the economy. Indicators that NPIs should continue include increased influenza-related hospitalizations or deaths. Public health authorities, such as the CDC, provide guidance in determining the appropriate NPIs to implement. This may vary among states and localities.

Community measures, such as school closures and dismissals and social distancing in workplaces, may be necessary but are more disruptive to daily life. They create obstacles for service providers to appropriately meet the needs of children. During a school closure, schools are closed and all staff and students remain home while during a school dismissal, schools stay open for staff and students remain home. Internet-based teleschooling allows learning and services to continue. To reduce exposure and increase physical space between people, nationwide school closures began March 12, 2020, and in almost every state in the United States schools remained closed through the end of the 2019-2020 academic school year. Many states began to reopen schools for the 2020-2021 academic school year. Decisions to provide in-person, remote, or hybrid options were left up to school districts and local health departments.

Despite the CDC's *Community Mitigation Guidelines to Prevent Pandemic Influenza,* service providers were still unprepared to navigate this unexpected, new norm. Telehealth has made it possible for services such as counseling and speech therapy to continue despite physical distance constraints. Unfortunately, behavioral, social, and clinical assessment are impacted differently. Limited research is available comparing equivalence of in-person digital administration and remote administration to traditional, in-person administration. However, research is beginning to emerge supporting remote administration as a viable alternative during a

pandemic to allow continuation of care. Wright (2018; 2020) revealed no significant difference between traditional, in-person administration and remote administration of the Woodcock-Johnson IV Cognitive and Achievement Tests and the WISC–V. Additional research is needed.

The following should be considered when administering assessments during a pandemic. Recommendations are based on guidance from organizations such as the American Psychological Association (APA; Wright et al., 2020) and the National Association of School Psychologists (NASP; National Association of School Psychologists, 2020). Similar views are not shared by all national and state level organizations. For example, New Jersey Association of School Psychologists (NJASP) opposes remote administration of cognitive assessments and other diagnostic measures during a pandemic. Regardless, federal, state, or local laws should take precedence.

When determining whether to test during this unprecedent time, the evaluator needs to determine what is in the child's best interest; in some cases, it might be best to pause the assessment while other cases may be time-sensitive or high-priority and therefore necessary to continue (Wright et al., 2020). Evaluators need to ask themselves, what is the goal of the assessment? Is formal testing needed or could decisions be made based on previous evaluations, records, and personal documents? Even under typical circumstances, evaluators should never make decisions and recommendations based solely on a single test score; it should be multimethod. Many factors influence assessment data such as innate factors, background variables, the assessment situation, and test demands.

A pandemic will add additional variables that need to be considered when conducting assessments. Children's behaviors during a pandemic may not be typical for that child. For example, due to a pandemic, children's environmental stressors may increase, their health could be impacted, and the setting and format (e.g., in-person digital, remote) of the assessment may influence how the child responds. In addition to the typical factors, further variables need to be considered when conducting assessments during a pandemic. These variables include the impact of physical distancing on standardized administration procedures and manipulatives and the effect of face coverings on evaluator-child interactions. All assessment data need to be evaluated and integrated to make informed decisions and recommendations.

Regardless of the restrictions in place, evaluators should be sure to administer assessments as close as possible to standardization procedures. However, based on the nature of

subtests, some may be impacted more than others. Verbal subtests that rely on hearing a question read aloud by the evaluator and responding verbally may not be impacted as greatly as nonverbal, performance-based subtests that require the use of manipulatives such as those used on the Block Design from the Wechsler scales. It may not be possible to administer such subtests in a virtual format.

Some tests allow for substitution and proration. For example, the Wechsler Intelligence Scale for Children–Fifth Edition (WISC–V). Seven subtests contribute to the Full Scale Intelligence Quotient (FSIQ) that represents general intellectual ability. Only one substitution is allowed, and the substituted subtest must be for another subtest from the same domain. For example, a Verbal Comprehension subtest may only be substituted for another Verbal Comprehension subtest. Nine subtests are available for substitutions. The manual reports allowable subtest substitutions to obtain the FSIQ. Proration can be used when only one of the seven primary subtests that contribute to the FSIQ is missing. Substitution and proration cannot be used in combination to obtain the FSIQ. Be mindful that substitutions and proration may introduce additional measurement error as the normative FSIQ tables are created using the seven primary subtests that contribute to the FSIQ. If modifications, substitutions, or proration have been made in any way to standardized procedures, evaluators should make note of what has been modified and how this could impact results in reports. Labels such as "estimated" should be used when reporting scores.

In recent years, virtual administration of behavioral, social, and clinical assessments has grown in popularity. Physical distancing constraints of a pandemic emphasized a greater need. Test publishers have begun to offer various service delivery options in addition to the traditional in-person format: in-personal digital administration and remote administration. Clarification in needed to differentiate the two. In-person digital administration is similar to traditional administration however a tablet with an e-stimulus book is used in place of the paper stimulus book during an in-person assessment session. This is not to be confused with remote administration. In remote administration, the evaluator and the child are in separate locations using a videoconferencing platform on their own devices (e.g., desktop computer, laptop, tablet) to view stimuli. During a pandemic, virtual administration offers safer administration options as they allow the evaluator and child to maintain a greater physical distance and reduce the number of physical materials utilized. Both administration options are offered by popular assessment

publishers such as Psychological Assessment Resources (PAR), Inc. and Pearson. PAR, Inc.'s virtual platform, PARiConnect, allows for the remote administration for some assessments.

Virtual administration introduces issues of confidentiality and test security, particularly remote administration. Service providers may need to revisit informed consent to address privacy children have at home. Regardless of the virtual administration format, audio-visual monitoring of test administration is necessary by the evaluator. For remote administration of behavior and personality rating scales, the evaluator must monitor that the child is the one completing the assessment. For in-person and remote administration of performance-based tests, the evaluator must monitor performance and intervene if necessary. Copying and/or sharing test materials (e.g., manuals, protocols, manipulatives) is not a solution to a pandemic unless approved by the test publisher. There are restrictions on e-manuals such as being limited to a single user or device and prohibition of printing. Many publishers have made public statements regarding the use of copyrighted materials during a pandemic.

Background variables that influence virtual assessments include the child's age, culture and ethnicity, and socioeconomic status. For remote administration of assessments, a child must first have access to technology and a stable internet connection. Most platforms require a Windows or Mac computer or an iPad or select Android tablets; smartphones are not recommended. Hardware needed includes speakers, a microphone, a camera, and a specified amount of storage. Brower and software requirements are identified. Some platforms recommend additional accessories such as a stylus and anti-glare screen cover. Performance and accuracy of results are influenced by access to and quality of technology and both the child's and the adult assisting the child's familiarity with technology. Evaluators must become familiar with the virtual platform they choose to utilize (e.g., Google, Zoom, PARiConnect, Q-Interactive) and practice before administering assessments to children.

Although NPIs such as face coverings and physical distancing are meant to help limit the spread of COVID-19, they pose challenges to conducting behavioral, social, and clinical assessments. The CDC recommended wearing face coverings in public on April 3, 2020 but an executive order requiring people to do so was not signed until January 20, 2021. Regardless, many states had mask mandates in place since April 2020. As per the CDC, face masks should completely cover the nose and mouth, areas of the face that are crucial for effective communication. Communication is the process of sharing information, both verbally and non-

verbally. Carbon (2020) found that face masks greatly complicate social interaction as they impact the ability to read different facial expressions. Therefore, both the child and evaluator must rely on other forms of nonverbal communication such as eyes, eyebrows, gestures, and postures. This will most greatly impact building rapport between the child and evaluator and the evaluator's observations of the child in the test sessions and other particular environments (e.g., classroom). Transparent masks are an option. Unfortunately, the CDC does not recommend the use of face shields as a substitute for masks because of a lack of evidence of their effectiveness. Receiving training from Audiologists and Speech-Language Pathologists could be beneficial for evaluators.

In conclusion, virtual administration is a relatively new practice and is outside the boundaries of competence for many evaluators. To ensure children are not denied services, evaluators should obtain relevant education, training, supervision, and consultation or make referrals when necessary. Many publishers offer training opportunities. As new administration formats are introduced, evaluators should always consult the publisher and manual for information regarding the development and recommended use. Evaluators should also remember they are responsible for records whether these are written, automated, or in any other medium (American Psychological Association, 2017).

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