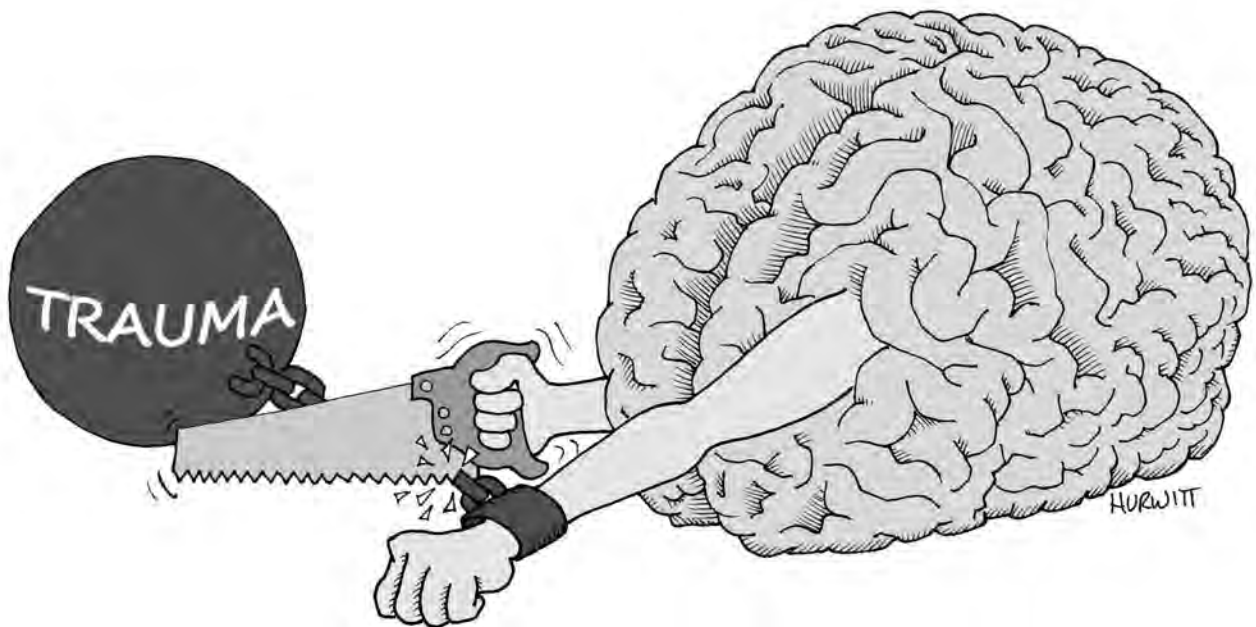


# Child Development, Trauma and the Brain:



## The DYFS Mental Health Screening Program

First Edition

Permission to use given by Robert M. Ring, LSW, MSW; Director, New Jersey Child Welfare Training Academy, 732-448-6318, Robert.Ring@dcf.state.nj.us

# **Child Development, Trauma and the Brain: The DYFS Mental Health Screening Program**

First Edition  
(Revised)

Written and Produced by the  
Rutgers Occupational Training and Educational Consortium  
(OTEC)

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## About This Book

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Children and adolescents involved with the child welfare system have often been exposed to chaotic home environments, the chronic trauma of exposure to neglect and violence, and disruptions caused by removal from home. These experiences can significantly contribute to problems in physical, social and emotional development. Children who have been involved with the child welfare system have a greater than 50 percent chance of developing a significant mental health concern over their lifetime; some studies have indicated that up to 80 percent of children involved in the child welfare system will experience a mental health need.

DCF is committed to strengthening the capacity of frontline staff to identify children with a suspected mental health need and ensure that the appropriate assessment and treatment are received.

The Activities included in this workbook (Child Development, Trauma and the Brain: The DYFS Mental Health Screening Program) focus on trauma as a way of understanding the unique vulnerability of children and adolescents involved with the child welfare system to mental health challenges. It is a resource for:

- Thinking about the physical effects of trauma on children, adolescents and young adults
- Understanding the biological underpinnings of their challenges
- Identifying children with a suspected mental health need.

Participants utilizing this workbook during a training session will learn how to administer the New Jersey Mental Health Screening Tool (MHST) to assist with identifying children who may have mental health need and require further assessment. And DYFS caseworkers will understand what their role and responsibility is in mental health screening.

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## Rutgers OTEC

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Since 2001, the Rutgers Occupational Training and Education Consortium has led a range of workforce development projects supported through federal, state, and foundation sources. With a focus on work environment issues including occupational and environmental health and safety, OTEC develops grant-funded partnerships with employers, unions, and community-based groups. OTEC projects seek to increase the communication and problem-solving skills of individuals and the effectiveness of their organizations.

### **Visit OTEC's Webpage:**

<http://smlr.rutgers.edu/research-and-centers/centers-and-programs/occupational-training-and-education-consortium>

### **Programs and Services**

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# Acknowledgements

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# The Small Group Activity Method

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## Basic Structure

The Small Group Activity Method is based on a series of problem-solving activities. An activity can take from 45 minutes to an hour. Each activity has a common basic structure:

- **Small Group Tasks**
- **Report-Back**
- **Summary**

**1. Small Group Tasks:** The training always begins with groups working together at their tables. Each activity has a task, or set of tasks, for the groups to complete. The task asks that the groups use their experience and the fact sheets to solve problems and make judgements on key issues.

**2. Report-Back:** For each task, the group selects a scribe that takes notes on the small group discussion and reports back to the class as a whole. During the report-back, the scribe informs the entire class as to how his or her group solved the particular problem. The trainer records each scribe's report-back on large pads of paper in front of the class so that everyone can refer to them.

**3. Summary:** Before the discussion drifts too far, the trainer needs to bring it all together during the summary. Here, the trainer highlights the key points of the activity and brings up any problems or points that may have been overlooked during the report-back.

---

### **Three Basic Learning Exchanges**

The Small Group Activity Method is based on the idea that every training is a place where learning is shared. SGAM is a structured procedure that allows and encourages the sharing of information. It is based on three learning exchanges:

- **Participant-to-Participant**
- **Participant-to-Trainer**
- **Trainer-to-Participant**

**Participant-to-Participant:** SGAM makes the Participant-to-Participant exchange a key element of the training. It occurs during the small group task and It will allow case workers to learn from each other.

**Participant-to-Trainer:** Lecture-style training assumes that the trainer knows all the answers. With SGAM trainers have an opportunity to listen and learn from the participants. This is the purpose of the Participant-to-Trainer exchange and it occurs during the report-back.

**Trainer-to-Participant:** This is the trainer's opportunity to clear up any confusion and summarize points they think are key. By waiting until the summary section, trainers reinforce that the learning comes from the group interaction.





## Activity 1: Trauma and Children

### Purpose

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To increase our knowledge and understanding of trauma and its impact on children in out of home placement.

**This activity has one task and it begins on page 2.**



**Task:**

---

In your groups, review the factsheets on pages 4-17 then working together, use the factsheets and your own experience to make a list of key points you would use to inform new resource parents about trauma exposures and children in out of home placement.

**Key Points you would use to inform new resource parents about children in out of home placement and their exposure to trauma:**

1.

2.

3.

4.

5.

6.

7.

8.

# 1. Trauma

By the time most children enter the child welfare system, they have already been exposed to a wide range of painful and distressing experiences. Children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to traumatic events.

A traumatic event is an event that causes overwhelming feelings of terror, horror, or hopelessness. These feelings often occur when a person experiences or witnesses a serious injury, or death. Trauma also results from threats of injury or death, or by experiencing other forms of attack or violation.

Child traumatic stress occurs when exposure to traumatic events overwhelms the child's ability to cope and elicits intense physical and emotional reactions that can be as threatening to the child's sense of physical and psychological safety as the traumatic event itself. These reactions include:

- An overwhelming sense of terror, helplessness, and horror
- Physical sensations such as rapid heart rate, trembling, dizziness, or loss of bladder or bowel control

Sources: Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15*(2), 99–112. De Bellis, M., & Thomas, L. (2003). Biologic findings of post-traumatic stress disorder and child maltreatment. *Current Psychiatry Reports, 5*, 108-117. Watts-English, T., Fortson, B. L., Gibler, N., Hooper, S. R., & De Bellis, M. (2006). The psychobiology of maltreatment in childhood. *Journal of Social Sciences 62*(4) 717-736. U.S. Department of Health and Human Services. (2003). National Survey of Child and Adolescent Well-Being: One year in foster care wave 1 data analysis report. Administration for Children and Families, Office of Planning, Research and Evaluation. (2004b). Children ages 3 to 5 in the child welfare system. NSCAW Research Brief No. 5. Kelley, B. T., Thornberry, T. P., & Smith, C. A. (1997). In the wake of childhood maltreatment. Washington, DC: National Institute of Justice. Johnson, R., Rew, L., & Sternglanz, R. W. (2006). The relationship between childhood sexual abuse and sexual health practices of homeless adolescents. *Adolescence, 41*(162), 221-234. Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association, 286*, 3089-3096. Swan, N. (1998). Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information. *NIDA Notes, 13*(2). Prevent Child Abuse America. (2001). Total estimated cost of child abuse and neglect in the United States.

## The Impact of Child Abuse and Neglect

**Impaired brain development.** Child abuse and neglect have been shown, in some cases, to cause important regions of the brain to fail to grow properly, resulting in impaired development. These alterations in brain maturation have long-term consequences for cognitive, language, and academic abilities as well as problems with emotions and relationships.

**Cognitive difficulties.** The National Survey of Child and Adolescent Well-Being (NSCAW) found that children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement.

**Behavioral problems.** An NSCAW survey of children ages 3 to 5 in foster care found these children displayed clinical or borderline levels of behavioral problems at a rate of more than twice that of the general population.

**Difficulties during adolescence.** Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems. Other studies suggest that abused or neglected children are more likely to engage in sexual risk-taking as they reach adolescence.

**Alcohol and other drug abuse.** Research consistently reflects an increased likelihood that abused and neglected children will smoke cigarettes, abuse alcohol, or take illicit drugs during their lifetime. According to a report from the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children.

**Abusive behavior.** Abusive parents often have experienced abuse during their own childhoods. It is estimated approximately one-third of abused and neglected children will eventually victimize their own children.

## 2. Types of Traumatic Stress

### **Acute Trauma**

A single traumatic event that is limited in time is called an acute trauma. Earthquakes, dog bites, or motor vehicle accidents are all examples of acute trauma. Other examples include:

- School shootings
- Gang-related incidents
- Terrorist attacks
- Natural disasters (e.g., wildfires, floods, hurricanes)
- Serious accidents
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)

Over the course of even a brief acute event, a child may go through a variety of complicated sensations, thoughts, feelings, and physical responses that rapidly shift as the child assesses and reassesses the danger faced and the prospects of safety. As the event unfolds, the child's pounding heart, out-of-control emotions, and other physical reactions are frightening and contribute to his or her sense of being overwhelmed.

### **Chronic Trauma**

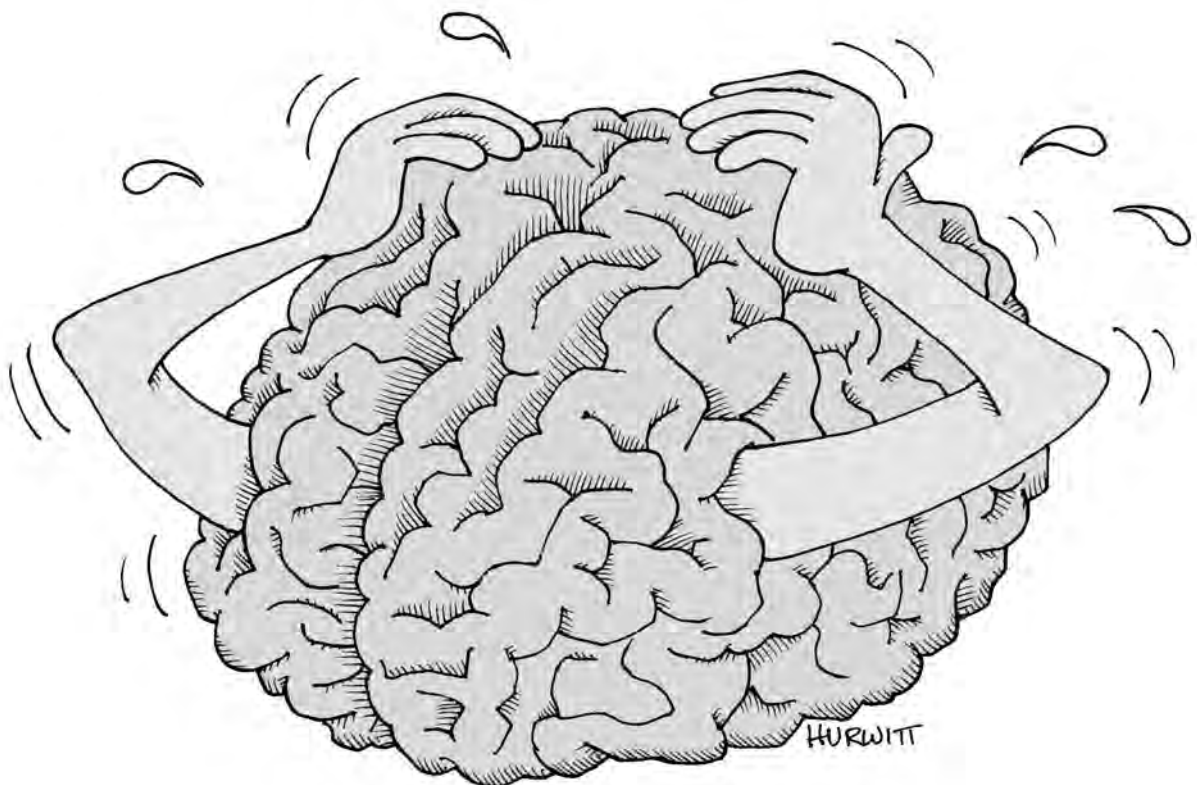
When a child has experienced multiple traumatic events we call it chronic trauma. Chronic trauma may refer to multiple and varied events such as a child who is exposed to domestic violence—or involved in a serious car accident—who then becomes a victim of community violence. Chronic trauma could also result from long-standing physical abuse, community violence or war. It may also include child maltreatment, abuse and neglect.

Neglect is the failure to provide for a child's basic physical, medical, educational, and emotional needs. It can have serious and lifelong consequences. Particularly for very young children who are completely dependent on caregivers for sustenance, experiencing neglect can feel acutely threatening. Neglect often occurs in the context of other maltreatment, such as periods of abandonment and abuse. It is frequently associated with other psychosocial stressors and forms of adversity such as extreme poverty and parental substance abuse.

The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact. A child exposed to a series of traumas may become more overwhelmed by each subsequent event and more convinced that the world is not a safe place. Over time, a child who has felt overwhelmed over and over again may become more sensitive and less able to tolerate ordinary everyday stress.

### **Complex or Developmental Trauma**

Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child’s care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child. Children who have experienced complex trauma have endured multiple interpersonal traumatic events (such as physical or sexual abuse, profound neglect, or community violence) from a very young age (typically younger than age 5).



Source: Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.). (2003). Complex trauma in children and adolescents. National Child Traumatic Stress Network.



### 3. Trauma and Caregiver Breakdown

When trauma is associated with the breakdown or failure of those who should be protecting and nurturing a child, it has profound, complex, and far-reaching effects on nearly every aspect of the child's development and functioning. These children suffer impairment in many of the following areas:

- **Attachment.** Traumatized children may feel that the world is uncertain and unpredictable. Their relationships can be characterized by problems with boundaries as well as distrust and suspiciousness. As a result, traumatized children can become socially isolated and have difficulty relating to and empathizing with others or they may be emotionally indiscriminate.
- **Biology.** Traumatized children may demonstrate biologically based challenges, including problems with movement and sensation, hypersensitivity to physical contact, and insensitivity to pain. They can have problems with coordination, balance, and body tone, as well as unexplained physical symptoms and numerous medical problems (e.g., asthma, skin problems, and autoimmune disorders).
- **Mood regulation.** Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states. They may struggle to communicate their wishes and desires to others.
- **Dissociation.** Some traumatized children experience a feeling of detachment or depersonalization, as if they are observing something happening to them that is unreal. They can also demonstrate amnesia-like states.
- **Behavioral control.** Traumatized children can demonstrate poor impulse control, self-destructive behavior, and aggression towards others. Sleep disturbances and eating disorders can also be manifestations of child traumatic stress.

- **Cognition.** Children exposed to trauma can have problems focusing on and completing tasks in school as well as difficulty planning for and anticipating future events. Some traumatized children demonstrate learning difficulties and problems with language development.
- **Self-concept.** Traumatized children can experience a lack of a continuous, predictable sense of self. They can suffer from disturbances of body image, low self-esteem, shame, and guilt.

### **The Complexity of a Lifetime of Trauma**

Children involved with the child welfare system are likely to have experienced both acute and chronic trauma, in environments characterized by adversity and deprivation, and often without the needed influence of consistent and supportive caregivers. It is important for child welfare workers to recognize the complexity of a child's lifetime trauma history and to not focus solely on the single event that might have prompted a report. **In general, children who have been exposed to repeated stressful events within an environment of abuse and neglect are more vulnerable to experiencing traumatic stress.**

## 4. The Impact of Trauma

The short- and long-term impact of trauma is determined by the nature of the events and the child's response to them. Not every distressing event results in traumatic stress and something that is traumatic for one child may not be traumatic for another. The ultimate impact of a potentially traumatic event depends on several factors including:

- The child's age and developmental stage
- The child's perception of the danger faced
- Whether the child was the victim or a witness
- The child's relationship to the victim or perpetrator
- The child's past experience with trauma
- The adversities the child faces in the aftermath of the trauma
- The presence/availability of adults who can offer help and protection

### Prevalence of Trauma — United States

- Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.
- In 2005, 899,000 children were victims of child maltreatment. Of these:
  - 62.8% experienced neglect
  - 16.6% were physically abused
  - 9.3% were sexually abused
  - 7.1% endured emotional or psychological abuse
  - 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)
- One in four children/adolescents experience at least one potentially traumatic event before the age of 16.
- In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.
- Forty percent (40%) of U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.

Sources: USDHHS. (2007) Child Maltreatment 2005; Washington, DC: US Gov't Printing Office. Costello et al. (2002). *J Traum Stress* ;5(2):99-112. Schwab-Stone et al. (1995). *J Am Acad Child Adolesc Psychiatry*;34 (10):1343-1352. Kilpatrick et al. (2003). US Dept. Of Justice. <http://www.ncjrs.gov/pdffiles1/nij/194972.pdf>.

## 5. Childhood Trauma and PTSD

Children who have experienced chronic or complex trauma frequently are diagnosed with Post Traumatic Stress Disorder (PTSD). According to the American Psychiatric Association, PTSD may be diagnosed in children who have:

- Experienced, witnessed, or been confronted with one or more events that involved real or threatened death or serious injury to the physical integrity of themselves or others
- Responded to these events with intense fear, helplessness, or horror, which may be expressed as disorganized or agitated behavior

The event(s) can be acute with a duration of symptoms less than three months; chronic with a duration of symptoms of three months or more; or with a delayed onset of symptoms of six months or more after the event.

The key symptoms of PTSD include:

- Re-experiencing the traumatic event (e.g. nightmares, intrusive memories)
- Intense psychological or physiological reactions to internal or external cues that symbolize or resemble some aspect of the original trauma
- Avoidance of thoughts, feelings, places, and people associated with the trauma
- Emotional numbing (e.g. detachment, estrangement, loss of interest in activities)
- Increased arousal (e.g. heightened startle response, sleep disorders, irritability)

Source: American Psychiatric Association. (2000), DSM-IV-TR (4th ed.) . Washington DC: APA.

## 6. Traumatic Stress Among Children in CWS

Out of home placement often separates a child from what is familiar and beloved (primary caregivers, family members, friends, home, community, school). In addition, children in the child welfare system typically face many other sources of ongoing stress that can challenge child welfare workers' abilities to intervene. These include:

- Poverty
- Racism and other forms of discrimination
- Separations and frequent moves
- School problems
- Grief and loss
- Refugee or immigrant experiences

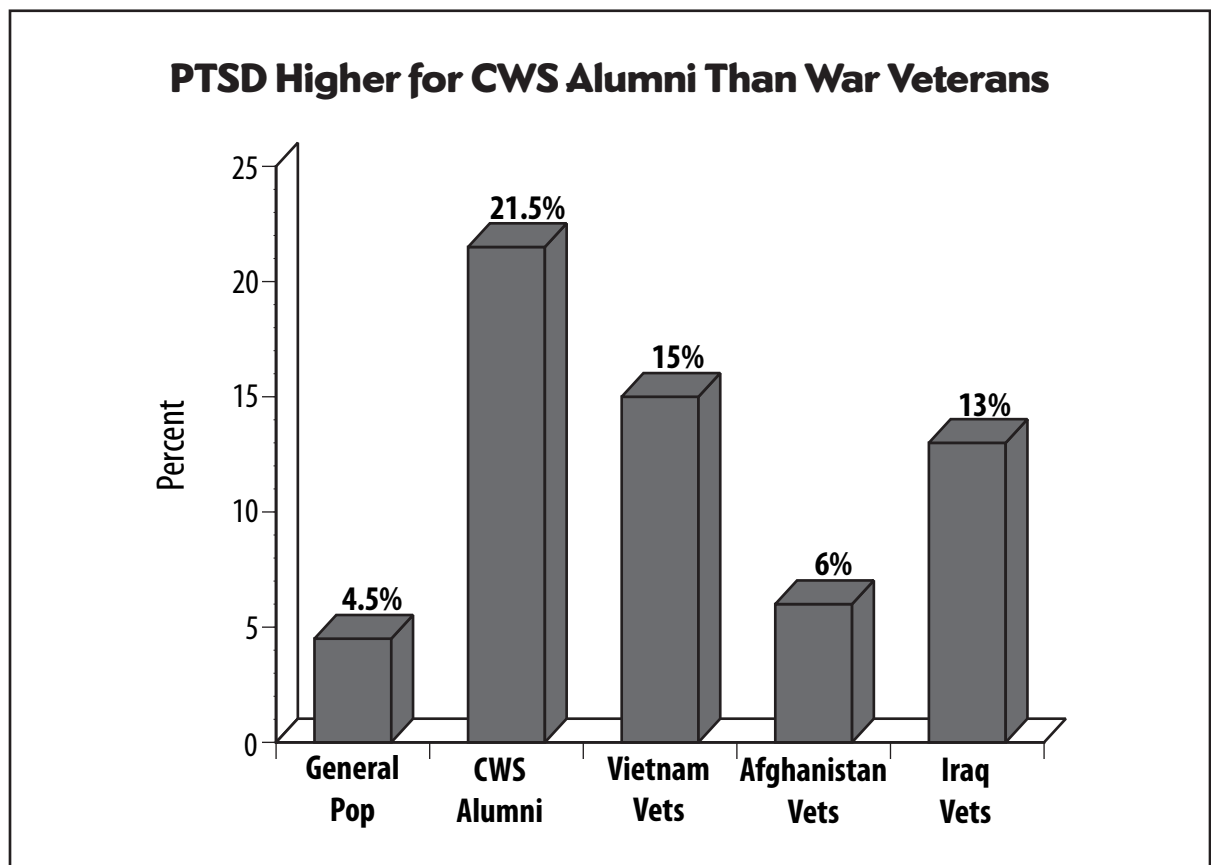
### **PTSD and Children in Out of Home Care**

Significant numbers of children known to the child welfare system are likely to be suffering from child traumatic stress.

- A study of the prevalence of mental health diagnoses in three groups of abused children found that PTSD generally co-occurs with other disorders including depression, anxiety, or oppositional defiant disorder.
- A study of children in foster care revealed that PTSD was diagnosed in 60% of the sexually abused children and in 42% of the physically abused children. They also found that 18% of the foster children who had not experienced either type of abuse had PTSD.

### Foster Care Alumni and PTSD

In 2004, a national study found 4.5% of the general population suffering with PTSD. However, among adult “foster care alumni” the study identified dramatically higher rates of PTSD (21.5%). In fact, the foster care alumni group had higher rates of PTSD than American veterans of war (15% in Vietnam vets, 6% in Afghanistan vets, and 12% to 13% in Iraq vets). The foster care alumni group also had higher rates of major depressive episodes, social phobia, panic disorder, generalized anxiety, addiction, and bulimia.



Sources: Ackerman, P. T., Newton, J. E., McPherson, W. B., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse and Neglect*, 22(8), 759–74. Dubner, A. E., & Motta, R. W. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 67(3), 367–373. Pecora, P. J., Williams, J., Kessler R. C., Downs, A. C., O’Brien, K., Hiripi, E., & Morello, S. (2003)., *Assessing the effects of foster care: Results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs. Revised January 20, 2004. Retrieved December, 2010, from <http://www.casey.org>.

## **7. When Mental Health Needs Are Not Addressed**

In the absence of more positive coping strategies, these disruptions to the child's sense of safety, permanency, and well-being can foster a range of high-risk or destructive coping behaviors including:

- Substance abuse
- Smoking
- Running away
- Eating disorders
- Sexual acting out
- Self-mutilation

Not surprisingly, the experience of childhood trauma is also a known risk factor for many serious adult mental and physical health problems.

## 8. Long-Term Effects of Childhood Trauma

If left untreated, the long-term effects of childhood trauma can be devastating.

- By age 21, nearly 80% of abused children face at least one mental health challenge, including depression, suicide attempts, and eating disorders.
- Adults who experienced multiple adverse childhood experiences, including child maltreatment, are more likely to develop health-risk behaviors such as alcoholism, drug abuse, depression, suicide attempts, smoking, physical inactivity, severe obesity and increased incidence of sexually transmitted diseases.
- The number of adverse childhood experiences showed a graded relationship to the presence of adult diseases including heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

Sources: Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., & Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. Association of State and Territorial Health Officials. (2005). Fact Sheet: Child Maltreatment, Abuse and Neglect. Injury Prevention Policy Fact Sheet. Retrieved May 1, 2007, from <http://www.astho.org/pubs/Childmaltreatmentfactsheet4-05.pdf>.



## 9. What Can We Do?

Among children known to the child welfare system, it is important to recognize that exposure to trauma is the rule, not the exception. As case workers we should:

- Not underestimate the impact of witnessing violence, including witnessing the abuse of a sibling or caregiver.
- Consider that many children bring a lifetime history of trauma, including acute and chronic experiences, in addition to the event that precipitated the most recent report.
- Gather and document psychosocial information regarding all traumas in the child's life. This history has likely had an impact on the child's response to the current events and will be important information for any mental health professional to whom the child is referred for treatment.
- Use the NJ MHST to ensure that our clients are getting a mental health assessment when they are symptomatic.
- **Increase our knowledge and understanding of trauma, child development and how to effectively implement the DYFS Mental Health Screening Program to ensure that the mental health needs of our clients are being met.**

## **Ways for Improving Foster Children's Mental Health**

### **Implement specialized developmental and mental health assessment**

- Create monitoring methods to ensure that needed services are provided

### **Increase access to evidence-based treatments**

- Increase children's mental health insurance coverage
- Provide specialized training to therapists concerning needs of foster children
- Use evidence-based treatments

### **Help maintain placement stability**

- Strengthen initial placement decisions
- Train resource parents in child behavior management
- Provide opportunities for foster children to form positive attachments
- Teach out of home placement children skills for maintaining relationships
- Provide for continuous relationships

### **Increase educational services and experiences**

- Encourage out of home placement youth to obtain a regular diploma
- Provide tutoring
- Decrease the number of school changes
- Ensure that young children have access to quality early childcare and learning experiences

Sources: "Improving the Odds for the Healthy Development of Young Children in Foster Care" (Dicker, Gordon & Knitzer, 2002). Austin, L., "Unlocking Mental Health Services for Youth in Care," Child Welfare League of America, 14, 6-13, 2005.

## Summary

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1. A traumatic event is one that causes overwhelming feelings of terror, horror, or hopelessness. These feelings often occur when a person experiences or witnesses a serious injury, or death. Trauma also results from threats of injury or death, or by experiencing other forms of attack or violation.
2. A single traumatic event that is limited in time is called an acute trauma. When a child has experienced multiple traumatic events we call it chronic trauma. Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child’s care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child.
3. When trauma is associated with the failure of those who should be protecting and nurturing a child, it has profound, complex, and far-reaching effects on nearly every aspect of the child’s development and functioning.
4. The short- and long-term impact of trauma is determined by the nature of the events and the child’s response to them. Not every distressing event results in traumatic stress, and something that is traumatic for one child may not be traumatic for another.
5. Children who have experienced chronic or complex trauma are frequently diagnosed with Post Traumatic Stress Disorder (PTSD).
6. A 2004 study found that 21.5% of adult “foster care alumni” were suffering with PTSD. In fact, the foster care alumni group had higher rates of PTSD than American veterans of war (15% in Vietnam vets, 6% in Afghanistan vets, and 12% to 13% in Iraq vets).
7. The experience of childhood trauma is also a known risk factor for many serious adult mental and physical health problems.

8. If left untreated, the long-term effects of childhood trauma can be devastating. By age 21, nearly 80% of abused children face at least one mental health challenge, including depression, suicide attempts, and eating disorders.
  
9. Among children known to the child welfare system, it is important to recognize that exposure to trauma is the rule, not the exception. As case workers we should increase our knowledge and understanding of trauma, child development and how to effectively implement the DYFS Mental Health Screening Program to ensure that the mental health needs of our clients are being met.



# Evaluation

1. How important is this activity for you and your co-workers?

Please circle one number.

Activity Is Not Important			Activity Is Very Important	
1	2	3	4	5

2. Please put an "X" by the one fact sheet you feel is the most important.

1. Trauma	6. Traumatic Stress Among Children in CWS
2. Types of Traumatic Stress	7. When Mental Health Needs Are Not Addressed
3. Trauma and Caregiver Breakdown	8. Long-Term Effects of Childhood Trauma
4. The Impact of Trauma	9. What Can We Do?
5. Childhood Trauma and PTSD	

3. Which summary point do you feel is most important?

Please circle one number.

Most Important Summary Point				
1.	2.	3.	4.	5.
6.	7.	8.	9.	

4. What would you suggest be done to improve this activity?

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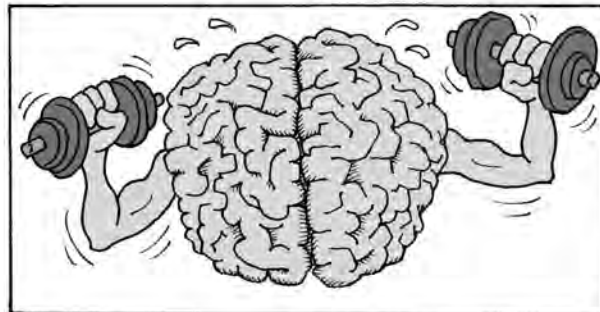
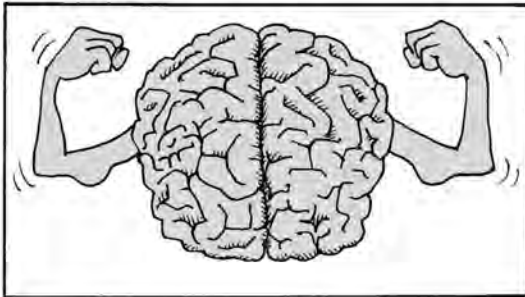
## Activity 2: Trauma and Child Development

### Purpose

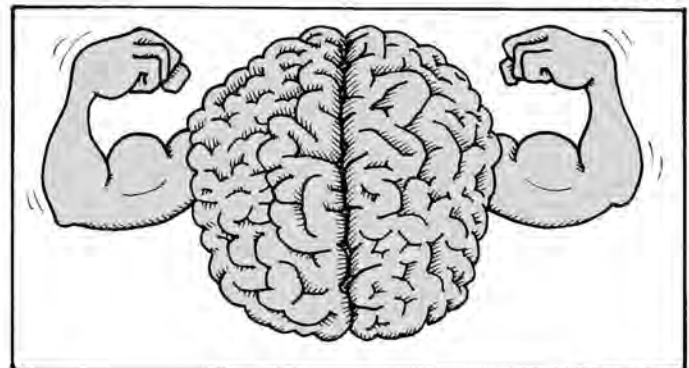
To increase our knowledge and understanding of how untreated trauma can lead to life-long problems and what we can do to recognize and help children overcome trauma.

**This activity has two tasks. Task 1 begins on page 24.**

### Before



### After





## Task 1: How the Brain Develops

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In your groups review the factsheets on pages 26-37, and then based on your experience and the factsheets make a list of points you would use to respond to the statement below. Try to use the fact sheets to back up your responses:

**Statement:**

*I'm not a brain surgeon or Harvard psychologist, but I have worked around kids long enough to know that they are very resilient and seem to be able to bounce back quickly from all kinds of problems including trauma.*

*The brain of a young child is still developing so it doesn't really respond much to positive or negative stimulation. Basically it's a complete package that just needs time to grow!*

*In fact, for children that are less than 3 or 4 years old, trauma really isn't much of a concern—their brains aren't developed enough to know what's going on.*

*That said, when it comes to trauma and young children it's probably better to wait until they are older to see if the exposure has had an impact. If they have issues it's easier to deal with it when they are older and in a better position to tell you what kinds of problems they are having.*

*From a case worker's point of view it's all about making sure that we get them out of the dangerous situations and into safe environments. If we can do that, then mother nature will take care of their brains and they'll be okay.*

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<b>How would you respond?</b>	<b>Fact Sheet #:</b>
1.	
2.	
3.	
4.	
5.	

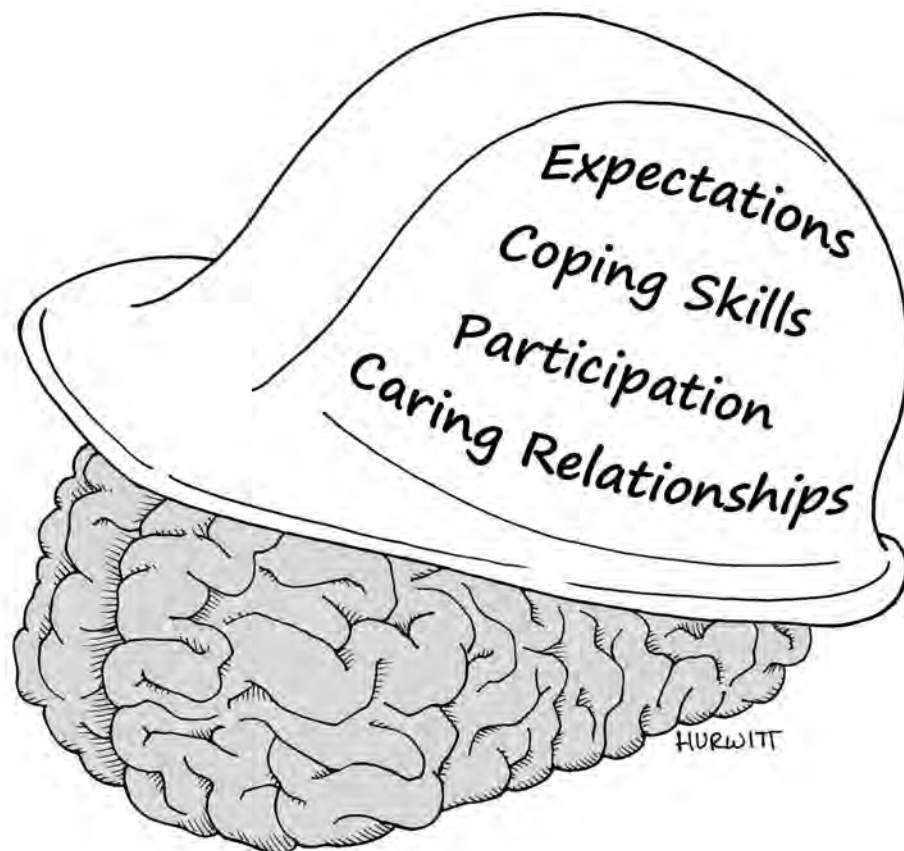
## 1. What About Resilience?

**While there may be personal attributes that contribute to resilience it is not a quality specific to an individual** (“He is a resilient little fellow”). Resilience refers to positive adaptation despite adversity. It is a model that includes risks and protective factors.

### Promoting Resilience

In child welfare case work we promote resilience through the alleviation of risk factors, regular monitoring for and treatment of vulnerability factors, and the provision of environmental protective factors.

A child who has come to the attention of child welfare has been exposed to risk factors that challenge the child’s ability to achieve and maintain well-being. One of the roles of child welfare case practice is to ensure that children have the family and community resources that can serve as protective factors in resilience – a caring adult, appropriate educational



opportunities, a safe concerned caregiver. By screening for mental health need as part of an overall case practice it is possible to identify vulnerability factors early so that they can be addressed early, allowing the child to access the resources that the system has made available.

### **Resilience: Think Adversity, Vulnerability and Protective Factors**

Adversity refers to negative life circumstances that are known to be associated with adjustment difficulties. Risk factors include poverty, chronic exposure to community violence, family chaos, illness, and neglect.

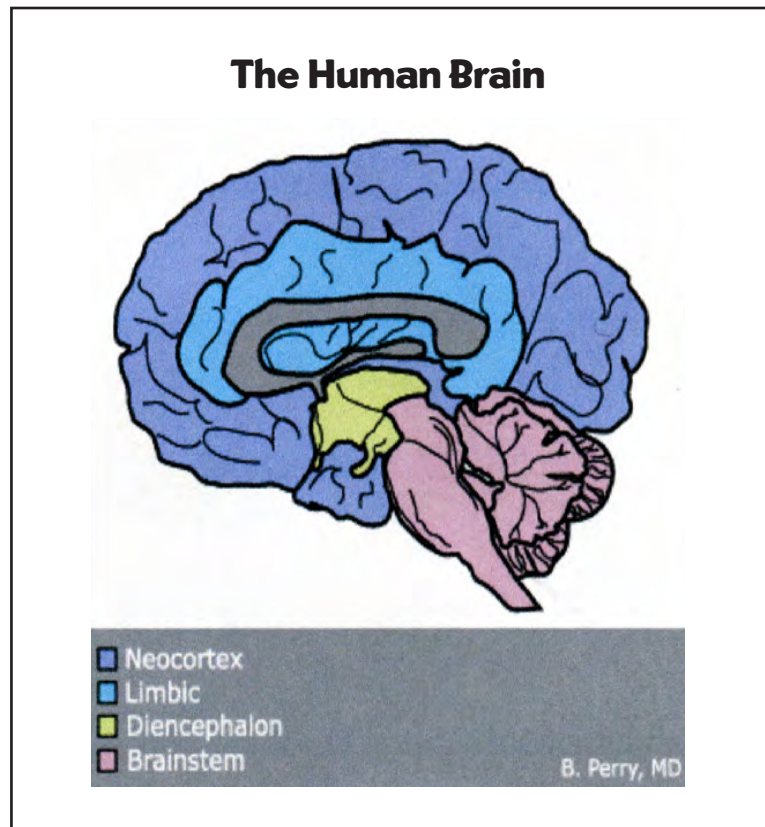
Vulnerability factors are internal factors that may exacerbate the effects of risks – for example, developmental challenges and mental illness may exacerbate the effect of community risk factors for a child.

Protective factors may modify risks in a positive direction, and include coping skills, caring relationships, positive expectations and opportunities for meaningful participation in the environment.

Source: Fraser, M. W., & Terzian, M. A. (2005). Risk and resilience in child development: principles and strategies of practice. In G. P. Mallon & P. M. Hess (Eds.), *Child welfare for the 21st century: A handbook of practices, policies, and programs* (pp. 55-71). New York, NY: Columbia University Press.

## **2. The Brain Develops Sequentially**

The brain is organized so that the basic functions develop first and the most complex functions develop last. The things we do instinctively such as breathing, swallowing, digesting, sleeping, and maintaining our sense of balance are brainstem functions. More complex functions, such as how we control our emotions or abstract thoughts occur in the limbic and neocortex areas of the brain. The limbic area is involved in the processing of emotionally charged memories.



Source: Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, Bruce D. Perry, 2006.

### **3. The Brain Is “Use Dependent”**

While initial development starts soon after conception, the brain continues to grow and develop for years after birth. However, by age 2 a child’s brain weighs 75% of what the adult brain will weigh and it will be almost completely developed by age 5.

As the brain is developing, normal organization of any brain area or capability is “use-dependent.” In other words, if a developing child is spoken to, the neural systems mediating speech and language will receive the sufficient stimulation to organize and function normally. A child who does not hear words will not have this capacity expressed.

#### **Normal Development Requires Timed Patterned Signals**

In fact, all functional capacities in the brain are dependent to some degree upon the presence of appropriately timed, appropriately patterned signals that will specifically stimulate the neural systems that define that function. For example: Normal motor organization requires the opportunity to crawl, stand, cruise, walk, and run. Normal socio-emotional development requires attentive, attuned care giving and a rich array of relational opportunities during development.

#### **Sequential Neurodevelopment**

The table on the next page outlines the sequential development of the brain, along with examples of appropriately matched experiences that help organize and influence the respective parts of the brain that are most actively developing at various stages.

For maltreated children, developmental “age” rarely matches chronological age and as a result the sequential provision of therapeutic experiences should be matched to developmental stage and not chronological age.

## Sequential Neurodevelopment and Therapeutic Activity

<b>Age of Most Active</b>	<b>“Sensitive” Brain Area</b>	<b>Critical Functions Being Organized</b>	<b>Preliminary Developmental Goal</b>	<b>Optimizing Experiences (examples)</b>	<b>Therapeutic and Enrichment Activities (examples)</b>
0–9 Months	Brainstem	<ul style="list-style-type: none"> <li>- Regulation of arousal, sleep and fear states</li> </ul>	<ul style="list-style-type: none"> <li>- State regulation</li> <li>- Primary attachment</li> <li>- Flexible stress response</li> <li>- Resilience</li> </ul>	<ul style="list-style-type: none"> <li>- Rhythmic and patterned sensory input (auditory, tactile, motor)</li> <li>- Attuned, responsive caregiving</li> </ul>	Therapeutic Massage Rhythmic Play -drumming
6 Months–2 Years	Diencephalon	<ul style="list-style-type: none"> <li>- Integration of multiple sensory inputs</li> <li>- Fine Motor control</li> </ul>	<ul style="list-style-type: none"> <li>- Sensory integration</li> <li>- Motor control</li> <li>- Relational flexibility</li> <li>- Attunement</li> </ul>	<ul style="list-style-type: none"> <li>- More complex rhythmic movement</li> <li>- Simple narrative</li> <li>- Emotional and physical warmth</li> </ul>	Music and movement Therapeutic massage
1–4 Years	Limbic	<ul style="list-style-type: none"> <li>- Emotional states</li> <li>- Social language; interpretation of nonverbal information</li> </ul>	<ul style="list-style-type: none"> <li>- Emotional regulation</li> <li>- Empathy</li> <li>- Affiliation</li> <li>- Tolerance</li> </ul>	<ul style="list-style-type: none"> <li>- Complex movement</li> <li>- Narrative</li> <li>- Social experiences</li> </ul>	Play and play therapies - Performing and creative arts and therapies - Parallel play
3–6 Years	Cortex	<ul style="list-style-type: none"> <li>- Abstract cognitive functions</li> <li>- Socioemotional integration</li> </ul>	<ul style="list-style-type: none"> <li>- Abstract reasoning</li> <li>- Creativity</li> <li>- Respect</li> <li>- Moral and spiritual foundations</li> </ul>	<ul style="list-style-type: none"> <li>- Complex conversation</li> <li>- Social interactions</li> <li>- Exploratory play</li> <li>- Solitude, satiety, security</li> </ul>	Storytelling - Drama - Exposure to performing arts - Formal education - Traditional insight-oriented or cognitive-behavioral interventions

Source: Adapted from Bruce D. Perry, *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics*, 2006.

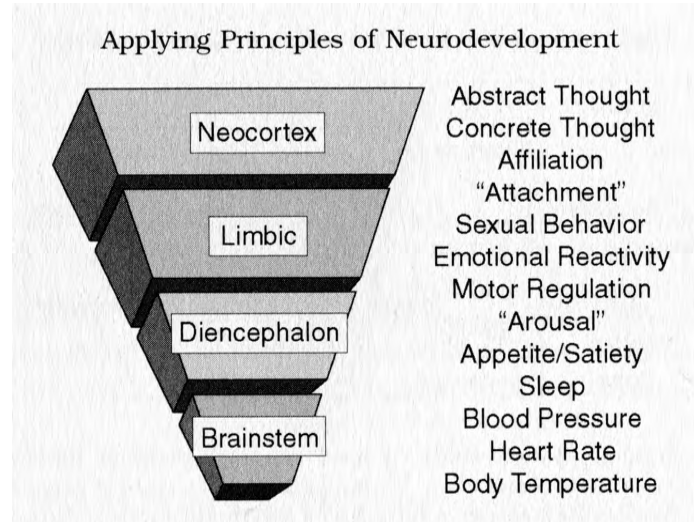


## **4. Dysfunctional Organization of the Brain**

Because a child's brain is use dependent it will develop based on what it is exposed to. It will develop normally when exposed to well patterned, repetitive and appropriately timed experiences. It can also develop abnormally when exposed to repeated chaotic, traumatizing experiences. In other words, when we are exposed to chaos we learn disorganization, when we are exposed to harm we learn fear and these experiences can interfere with normal healthy brain development.

Since different parts of the brain develop at different times, different systems of the brain are particularly vulnerable and sensitive to problems or trauma at different times during a child's development. If the less complex parts of the brain don't develop normally, then the more complex (or higher) levels of the brain are unlikely to develop normally.

## Hierarchy of Brain Function



The human brain is organized from the simple to most complex. The functions (from maintaining body temperature to abstract thought) are mediated in parallel with the areas of the brain noted in the illustration. These areas organize during development and change in the mature brain in a "use dependent" way. The more a certain neural system is activated, the more it will "build in" this neural state—creating an internal representation of the experience corresponding to this neural activation. This use-dependent capacity to make internal representations of the external or internal world is the basis for learning and memory.

Source: Bruce D. Perry, *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics*, 2006.

## 5. The Brain and Messaging

A normal brain works by sending messages through neurons. Neurons are nerve cells—some very long—that carry messages to and from the brain to all parts of the body and connect with other nerve cells through chemicals called neurotransmitters. Individual neurons receive these neurotransmitters and send them onto the next neuron.

### **Use Them Or Lose Them!**

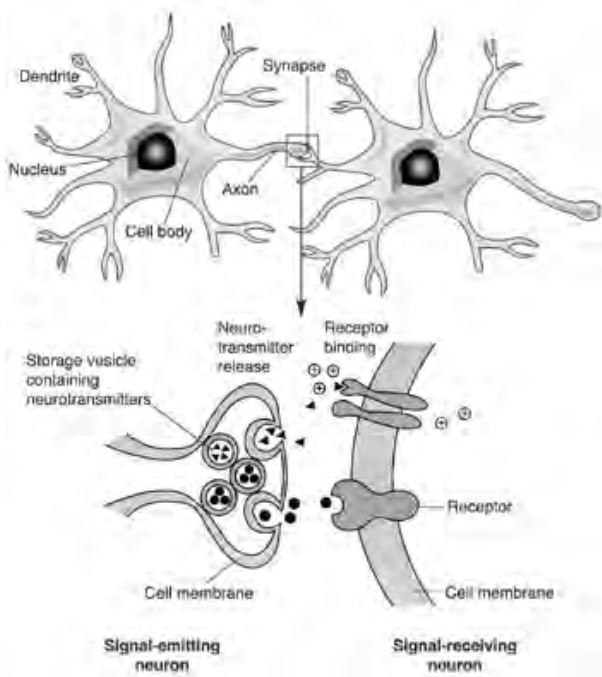
If these neurons don't get used because no messages are coming through, they will decay and die (a process called apoptosis). If they are overused, they become highly sensitized, so that even the smallest reminder of an event activates the same neural pathways as the actual event itself.

**Children who are chronically exposed to trauma may have abnormal neuronal development as the result of no stimulation or the opposite, overstimulation of certain areas of the brain.**

## How Messages Move Inside the Brain

How does the message get from a child's hand (which is touching the hot object) to the brain and then from the brain (saying to remove the hand from the object) back to the hand? The messages are communicated using a long chain of neurons connected by neurotransmitters.

Neurotransmission takes place at special places between neurons called synapses. At the synapse, the distance between two neurons is very short. When the presynaptic neuron releases the chemical message, it needs to travel across the synaptic gap and be received by the (synaptic receptors) on the next neuron. The neurons receive the chemicals on a part of the cell called the dendrite, the message is conveyed to the inner part of the cell, and then sent to the next neuron when the neurotransmitters are released through a part of the cell called the axon. The axon releases the chemical neurotransmitters and the chemical message is received by the dendrites of the next cell. Think of the axons and dendrites as little branches reaching out into the synaptic gap, waiting to send and receive messages. Each neuron can have hundreds of dendrites.



Sources: Robert Sapolsky (2005). "Biology and Human Behavior: The Neurological Origins of Individuality, 2nd edition". The Teaching Company. Eidell Wasserman, Ph.D., *Understanding The Effects of Childhood Trauma On Brain Development in Native American Children*, Tribal Law & Policy Institute, under the Children's Justice Act Training And Technical Assistance Project, 2003.

## 6. Trauma and the Developing Brain

Anything that interferes with normal brain development can actually change how the brain grows. For example, we know that an infant who experiences a blow to the head may never develop the ability to walk or to learn complex tasks. The type of damage is related to where the brain is injured.

Research also indicates that infants and children who suffer emotional trauma or chronic stress during these crucial periods of brain development may also suffer from life-long problems.

Because our brains are interconnected in highly complex ways—meaning they develop sequentially and are “use dependent”—any trauma that occurs while a child’s brain is developing, may lead to abnormal development of many parts of the brain, not just the part that is developing at the time of the trauma.

### **We Can Treat Early Age Victims of Trauma**

Early intervention with high-risk children works. The primary programming implication is that the earlier we can begin to provide appropriate services to children, the more effective we will be and the children’s progress will be more dramatic. Proactive therapeutic interventions are better than reactive ones. It is easier to provide enrichment, therapy and educational services earlier than later. The longer we wait to help these children, the more difficult the therapeutic challenge will be.

It is important to stress that even if interventions occur later, we are still able to make changes if the need is identified and appropriate services are put in place.

Source: Bruce D. Perry, *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics*, 2006.

## **7. The Importance of Early Intervention**

Early intervention with children exposed to trauma may prevent the onset of Post Traumatic Stress Disorder (PTSD) as well as other seriously detrimental outcomes. When the results of trauma are present as externalizing behavior problems, they can threaten the success of child welfare interventions and may result in multiple failed placements and increasingly discouraged, disconnected children.

To ensure the safety and well-being of children receiving child welfare services, and to ensure the success of those services, case workers need to identify and respond, as quickly as possible, to their traumatized child clients.

## **Task 2: Child Development**

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Review the factsheets on pages 40-46, then working together in your groups answer the following questions:

- 1. Can the brain be changed? (Please explain)**
  
- 2. Why is it often more difficult to help children overcome trauma when their brains are in the later stages of development?**
  
- 3. Discuss trauma cases that you have encountered among children in early life, school age and adolescence. Then using one case from each age group, complete the table on the next page. Briefly describe the case, list the symptoms that lead you to suspect that the child was traumatized, the intervention and an update on how much progress the child has made.**

<b>Stage of Development</b>	<b>Brief Description of the Case</b>	<b>Trauma Symptoms</b>	<b>Intervention</b>	<b>Progress</b>
<b>Early Life</b>				
<b>School Age</b>				
<b>Adolescent</b>				



## 8. The Brain Can Be Strengthened and Reorganized

The majority of sequential and use-dependent development of the brain takes place in early childhood. In other words, of all the experiences throughout the life of an individual, the organizing experiences of early childhood have the most powerful and enduring effects on brain organization and functioning! Needless to say a few years of neglect can cause a lifetime of dysfunction and lost potential.

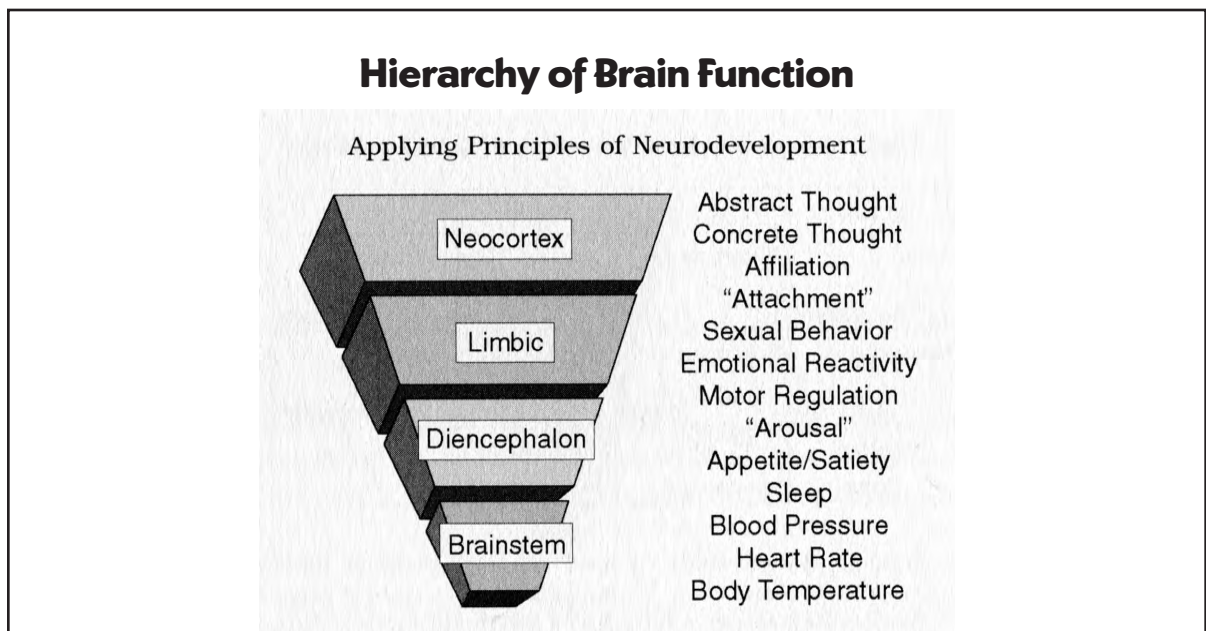
And yet, as discussed in Fact Sheet 9, the brain continues to be capable of change. But it is much easier to reorganize a healthy brain that **has been exposed** to the appropriate sequential and use-dependent development than it is to take a poorly organized brain that **has not been exposed** to appropriate sequential and use-dependent development and reorganize it.

## 9. Brain Flexibility

With the right therapeutic intervention we believe a person is capable of being changed. The human brain is very impressionable (malleable) while it is being organized during development. Even after it is organized the brain is still capable of being influenced, modified, and changed.

However, the ease with which the brain can be modified changes as we grow. The degree of brain flexibility (or as researchers say “plasticity”) is related to two main factors—the stage of development and the area of the brain to be reorganized.

Once an area of the brain is organized, it is much less responsive to the environment. In other words, it is less plastic. After the age of three, it is much more difficult to achieve experience-dependent modifications of brain stem functions. Experience-dependent modifications of the cortex—where network activities such as language development or learning a new phone number occur throughout life—are significantly easier to achieve.



Source: Bruce D. Perry, *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics*, 2006.

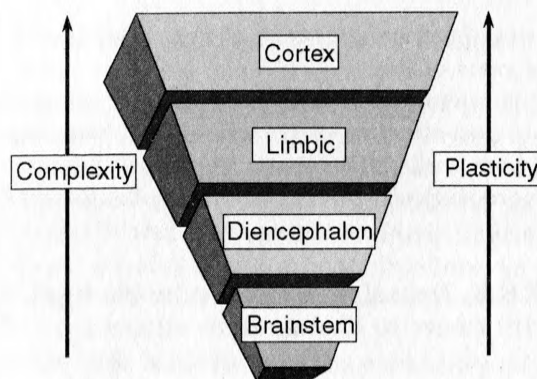
## 10. There Are Limitations

As previously stated, it is difficult to change or reorganize brainstem or diencephalon functions (i.e., “primary functions such as breathing, appetite, heart rate, blood pressure, arousal,” etc) once the brain has organized (generally after the age of three years old). However, we can increase our chances of success by focusing on the upper more complex and flexible cortex and limbic portions of the brain (see the diagram). But in order to focus on the more flexible portions of the brain we may have to address the lower less plastic brainstem and diencephalon. We may utilize medications as part of a treatment plan that allow us to modify emotional dysfunctions (i.e., behaviors) controlled by the brainstem and diencephalon.

### Containing Brainstem Dysfunction Through Medication

Medication use alone does not have an enduring positive impact on children. This is not to say that medications should not be used; medications can be very helpful in containing brainstem dysregulation, enough to allow positive, repetitive healing experiences to take place through other therapeutic activities (e.g., individual cognitive-behavioral therapy).

### Plasticity Across Different Neural Networks or Areas of the Brain



The malleability of specific human brain areas is different. The cortex is the most complex and the most plastic. Some cortex related functions can be modified throughout life with minimal effort... like learning a new phone number. The lower parts of the brain, those mediating core regulatory functions, are not very plastic. And that is probably a good thing because it would be harmful if life-sustaining functions (e.g., breathing), were easily modified by experience once they are organized.

Source: Bruce D. Perry, *Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics*, 2006.

## II. Developmental Trauma

In deepening our understanding of how children at different ages respond to trauma, it is vitally important to consider the experiences and the neurobiology that each child brings to a new traumatic event. Previous experiences, both good or bad, will have a significant impact on how a child deals with a recent trauma.

### **Trauma On an Insecure Foundation**

Children traumatized early in life see the world as a threatening and overwhelming place. Children who develop in a traumatizing environment may experience emotional numbing, dysregulation, or hyperarousal – or a combination of all three. Their neurobiological and psychological development is shaped by the expectation of violence and chaos.

These are experiences that shape the foundation of neurophysiology and psychology, at the brainstem and diencephalon, forming the base of the child's equilibrium. Later events, which might affect emotion (limbic system) and cognition (cortex), are organized based on this insecure foundation.

### **Trauma on a Secure Foundation**

A school aged child at age 8 facing a first trauma – no matter how distressing – brings more secure neurobiology to that trauma than a child who brings a history of repeated trauma and neglect. The child may develop significant changes in neurobiology and psychology going forward. His expectation of a safe, secure, nurturing responsive world may be shaken by this event and he may need to re-organize his brain and behavior in response to that event. But his early development provides a base for his adaptation to this trauma.

Though shaken, this child has a secure foundation to draw upon and is able to use his thoughts (cortex) - and positive interventions and supports in the environment - to organize his emotional and physiological responses.

## 12. How Trauma Impacts Early Life

Trauma early in life, when the brain is developing rapidly, can have serious consequences for the normal development of a child's brain, brain chemistry, and nervous system. These changes can place them at risk for learning difficulties, drug abuse, teen pregnancy, risk taking behavior, and psychiatric and health problems later in life.

In early childhood, trauma can be associated with reduced size of the cortex, the ability of brain hemispheres to connect ("cross-talk"), and the functioning of regions of the brain that govern emotions. These changes can affect IQ and the use of thinking to regulate emotions, and can lead to increased fearfulness and a reduced sense of safety and protection.

### **Early Life Trauma: What to Look For**

In response to trauma, young children may become passive, quiet, and easily alarmed. They can become more generally fearful, especially in regard to separations and new situations.

In circumstances of abuse by parents or caretakers, young children may act confused as to where to find protection and what constitutes a threat. A child may react to very general reminders of traumatic events, like the sounds of another child crying. The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby talk following a traumatic event or traumatic reminder. The preschool child may have very strong startle reactions, night terrors, and aggressive outbursts.

Source: The National Child Traumatic Stress Network, Child Welfare Trauma Training Toolkit – 2nd Edition, [www.NCTSN.org](http://www.NCTSN.org).

## 13. How Trauma Impacts School-Age Years

During school-age years, the brain develops more ability to manage fears, anxieties, and aggression, to sustain attention for learning, to allow for better impulse control, and to manage physical responses to danger that allow children to consider and take protective actions. Trauma that occurs during this period can undermine these developing capacities of the brain and result in major sleep disturbances, new troubles in learning, difficulties in controlling startle reactions, and behavior that alternates between being overly fearful and overly aggressive.

### **School-Age Trauma: What to Look For**

School-age children experience a wider range of unwanted and intrusive thoughts and images. They may think about frightening moments that occurred during their traumatic experiences. They also go over in their minds what could have stopped the event from happening and what could have made it turn out differently. They can have thoughts of revenge that they cannot resolve.

School-age children respond to very concrete reminders (e.g., someone with the same hairstyle as an abuser, or the monkey bars on a playground where a child got shot), and are likely to develop intense, specific new fears that link back to the original danger. They can easily have “fears of recurrence” that result in their avoiding even enjoyable activities they would like to do.

More than any other group, school-age children may shift between shy or withdrawn behavior and unusually aggressive behavior. Normal sleep patterns can be disturbed, and their lack of restful sleep can interfere with daytime concentration and attention.

Source: The National Child Traumatic Stress Network, Child Welfare Trauma Training Toolkit – 2nd Edition, [www.NCTSN.org](http://www.NCTSN.org).

## 14. How Trauma Impacts Adolescence

Throughout adolescence, the maturing brain permits increased understanding about the consequences of behavior; more realistic appraisals of danger and safety; enhanced ability to govern daily behavior to meet longer-term goals; and increased use of abstract thinking for academic learning and problem-solving. When trauma interferes during this stage of brain development, it can result in reckless and risk-taking behavior, in “living for today and not tomorrow,” in underachievement and school failure, and in making bad choices. Because children and adolescents may experience traumatic stress across several developmental stages, they may have a combination of these behaviors.

### **Adolescent Trauma: What to Look For**

Adolescents are particularly challenged by their traumatic stress reactions. They may interpret their reactions as childish or as signs of “going crazy,” being weak, or being different from everyone else. They may be embarrassed by bouts of fear and exaggerated physical responses. They may believe that they are unique in their pain and suffering, resulting in a sense of personal isolation. Adolescents are also very sensitive to the failure of family, school, or community to protect them or to carry out justice. After a traumatic event, they may turn even more to peers to evaluate risks and to support and protect them.

Adolescent behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves and others; or extreme avoidant behavior that can derail their adolescent years. Adolescents may attempt to avoid overwhelming emotions and physical responses through the use of alcohol and drugs. Late night studying, television watching, and partying can mask an underlying sleep disturbance.

Source: The National Child Traumatic Stress Network, Child Welfare Trauma Training Toolkit – 2nd Edition, [www.NCTSN.org](http://www.NCTSN.org).





## Summary

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1. Resilience refers to positive adaptation despite adversity. It is a model that includes risks and protective factors. In child welfare case work we promote resilience through the alleviation of risk factors, regular monitoring for and treatment of vulnerability factors, and the provision of environmental protective factors.
2. The brain is organized so that the basic functions develop first and provide the foundation for the development of later developing more complex functions.
3. While initial development starts soon after conception, the brain continues to grow and develop for years after birth. As the brain is developing, normal organization of any brain area or capability is “use-dependent.” In other words, if a developing child is spoken to, the neural systems mediating speech and language will receive the sufficient stimulation to organize and function normally.
4. Because a child’s brain is use dependent it will develop based on what it is exposed to. It will develop abnormally when exposed to repeated chaotic, traumatizing experiences. In other words, when we are exposed to chaos we learn disorganization, when we are exposed to harm we learn fear and these experiences can interfere with normal healthy brain development.
5. A normal brain works by sending messages through neurons. If neurons are not used because messages are not coming through, the neurons will decay and die (a process called apoptosis). **As a result of inadequate stimulation or the opposite, over stimulation of certain areas of the brain, children who are chronically exposed to trauma may have abnormal neuronal development.**
6. Because our brains are interconnected in highly complex ways—meaning they develop sequentially and are “use dependent”—any trauma that occurs while a child’s brain is developing, may lead to abnormal development of many parts of the brain.
7. Early interventions may prevent the onset of Post Traumatic Stress Disorder (PTSD) as well as other seriously detrimental outcomes. When the results of trauma are present as externalizing behavior problems, they can threaten the success of child welfare interventions and may result in multiple failed placements and increasingly discouraged, disconnected children.

8. The majority of sequential and use-dependent development of the brain takes place in early childhood. A few years of neglect may cause a lifetime of dysfunction and lost potential. It is much easier to reorganize a healthy brain that **has been exposed** to the appropriate sequential and use-dependent development than it is to take a poorly organized brain that **has not been exposed** to appropriate sequential and use-dependent development and reorganize it.
9. Once an area of the brain is organized, it is much less responsive to the environment. After the age of three, it is much more difficult to achieve experience-dependent modifications of brain stem functions. Experience-dependent modifications of the cortex—where network activities such as language development or learning a new phone number occur throughout life—are significantly easier to achieve.
10. Since not all parts of the brain are as plastic (flexible) as others, we focus on the upper more complex and flexible cortex and limbic portions of the brain. However, we may have to contend with the lower less plastic brainstem and diencephalon. We do this through the use of medications that allow us to modify emotional dysfunctions (i.e., behaviors) controlled by brainstem and diencephalon.
11. The experiences and the neurobiology that each child brings to a new traumatic event are important because both good or bad experiences, will have a significant impact on how a child deals with a recent trauma.
12. In response to trauma, young children may become passive, quiet, and easily alarmed. They can become more generally fearful, especially in regard to separations and new situations.
13. School-age children think about frightening moments that occurred during their traumatic experiences. They also go over in their minds what could have stopped the event from happening and what could have made it turn out differently. They can have thoughts of revenge or guilt that they cannot resolve.
14. Adolescents are particularly challenged by their traumatic stress reactions. Their behavior in response to traumatic reminders can go to either of two extremes: reckless behavior that endangers themselves and others; or extreme avoidant behavior that can derail their adolescent years.



# Evaluation

1. How important is this activity for you and your co-workers?

Please circle one number.

Activity Is Not Important			Activity Is Very Important	
1	2	3	4	5

2. Please put an "X" by the one fact sheet you feel is the most important.

1. What About Resilience?	8. The Brain Can be Strengthened and Reorganized
2. The Brain Develops Sequentially	9. Brain Flexibility
3. The Brain is "Use Dependent"	10. There Are Limitations
4. Dysfunctional Organization of the Brain	11. Developmental Trauma
5. The Brain and Messaging	12. How Trauma Impacts Early Life
6. Trauma and the Developing Brain	13. How Trauma Impacts School Age Years
7. The Importance of Early Intervention	14. How Trauma Impacts Adolescence

3. Which summary point do you feel is most important?

Please circle one number.

Most Important Summary Point				
1.	2.	3.	4.	5.
6.	7.	8.	9.	10.
11.	12.	13.	14.	

4. What would you suggest be done to improve this activity?

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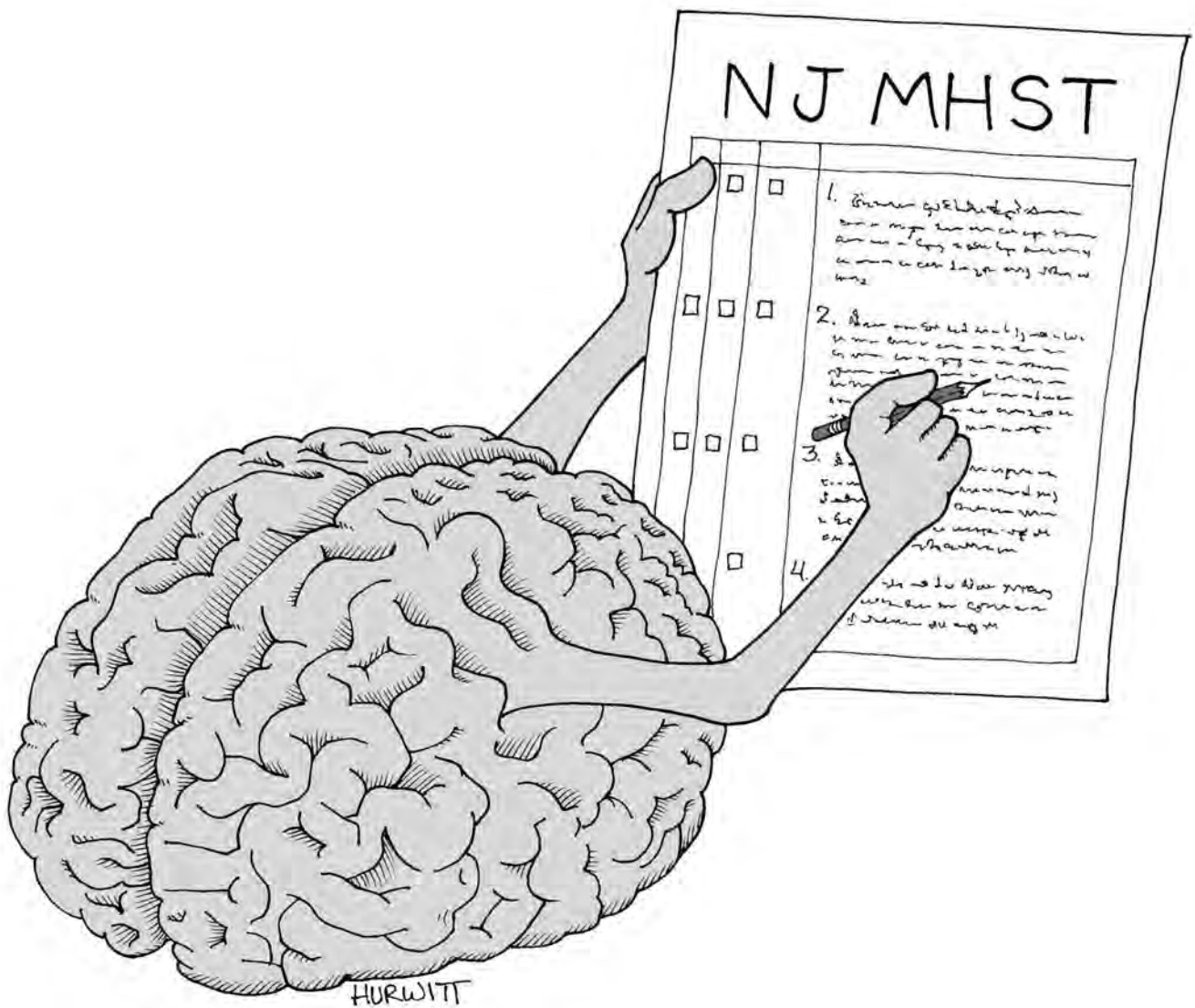


## Activity 3: The NJ Mental Health Screening Tool

### Purpose

To clarify our understanding of what the NJ MHST is and why we need to use it.

**This activity has one task and it begins on page 54.**



## **Task: NJ Mental Health Screening Tool (MHST)**

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Case workers are responsible for child well being. As part of that responsibility, case workers should be able to identify children with a suspected mental health need. Case workers are also responsible for taking appropriate steps to ensure that children with a suspected mental health need receive a mental health assessment and follow up.

The DYFS Mental Health Screening Program can help ensure that children with a suspected mental health need, receive a mental health assessment.

The initial rollout and implementation of the program will generate questions and concerns among DYFS staff. Some of these questions may include:

1. What is a Mental Health Screening Tool?
2. Why do we need a mental health screening program?
3. Is the tool a substitute for doing an assessment?
4. What's the difference between a mental health screen and a mental health assessment?
5. What's the difference between the Nurses PSC-35 and the NJ MHST and why use both tools?
6. Who developed the screening tool?
7. Who is responsible for screening?
8. Who gets screened?
9. How often do we screen?
10. What happens after we complete a screen?

**In your groups, review the factsheets on pages 56-73. Then working together, use the factsheets and your own experience to answer the questions.**

**And if you have addition questions about the NJ MHST program please list them.**



# 1. What Is the New Jersey Mental Health Screening Tool (NJ MHST)?

The NJ MHST is designed to identify children who most urgently need a mental health assessment. This tool may be applied to any child on your

## NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 NJS: Case# \_\_\_\_\_ Person ID# \_\_\_\_\_  
 Casework/supv/contact info \_\_\_\_\_

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	
			<b>Behavior</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Does this child exhibit unusual or uncontrollable behavior?  <b>0 – 18 mos:</b> Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness <b>18 – 36 mos:</b> Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger <b>3 – 5 yrs:</b> Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?  <b>0 – 18 mos:</b> Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems. <b>18 – 36 mos:</b> Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues. <b>3 – 5 yrs:</b> Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?  <i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Placement, Childcare, Education Status</b>  4. Does this child exhibit behaviors that may <b>not</b> allow him/her to remain in his/her current living, preschool and/or childcare situation?  <i>The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>History</b>  5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?  <i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas ,rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.</i>

caseload, including those under DYFS supervision as well as children who are in DYFS out-of-home placements. There are two forms of the instrument: the NJ MHST 0–5 years old; and, NJ MHST 6–Adult.

**Please continue to page 2**

**If you checked any of the above boxes “YES”, child should be referred for assessment. For the young child, a next step will usually include a consult with the child’s pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.**

**If applicable, identify the agency and provider to which the child has been referred:**

\_\_\_\_\_

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(continued)*

# 1. What Is The NJ MHST? (continued)

## NEW JERSEY MENTAL HEALTH SCREENING TOOL (6 YEARS TO ADULT)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 NJS: Case# \_\_\_\_\_ Person ID# \_\_\_\_\_  
 Casework/supv/contact info \_\_\_\_\_

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please indicate the issues under the COMMENTS section on the reverse side of the form.

YES	NO	Unknown	Part 1 - IDENTIFIED RISK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Has this child been a danger to him/herself or to others in the last 90 days?  <i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?  <i>Persistent chaotic, impulsive or disruptive behaviors; daily verbal outburst; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other disciplines, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?  <i>History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (head banging) or vocalizations (e.g. echolalia); smears feces, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?  <i>Either needs immediate evaluation of medication or needs a new prescription.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?  <i>Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?  <i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.</i>

**If you checked any of the above boxes YES, this indicates that the need for Mental Health assessment and/or assistance is urgent.**

**If all the above are either NO or UNKNOWN, please continue on reverse side.**

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

YES	NO	Unknown	Part 2 - RISK ASSESSMENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does the child have problems with social adjustment? <i>Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confirmed due to serious law violations; does not seem to feel guilt after misbehavior, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does this child have problems making and maintaining healthy relationships? <i>Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does this child have problems with personal care? <i>Eats or drinks substances that are not food; regularly enuretic during waking hourse (subject to age of child); extremely poor personal hygiene.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have significant functional impairment? <i>No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Does this child have significant problems managing his/her feelings? <i>Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is this child known to abuse alcohol and/or drugs? <i>Child regularly uses alcohol or drugs.</i>

**If you checked any of the above boxes YES, this indicates child should be referred for a mental health assessment.**

**Please forward the form to:**

(Could be preprinted to have the address of local Mental Health agency.)

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

**Mental Health Follow Up Response**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

- MH Assessment complete; no follow up MH service required.
- MH Assessment complete; MH follow up required.
- Other: \_\_\_\_\_

## 2. Why a Mental Health Screening Program?

### For NJ DYFS Case Workers

Case workers need tools to document the concerns they may have about a child; to clarify why they are concerned about a child; and to make referrals that get children the help they need.

A screening and subsequent assessment for children who enter into out-of-home placement, also assists with documenting problems that were present upon entry into care. An assessment at the start of care can also serve as a baseline to measure the effectiveness of interventions.

### For NJ DYFS Case Workers

National data suggests that most children who come into foster care systems will at some point in their lifetime, require therapeutic intervention and support. For DCF, screening enables us to:

- **Ensure children get services they need when they need them.**  
According to the U.S. Department of Health, as many as 75-80% of children with a need for mental health services do not receive them. A mental health screening program can help ensure that children under DYFS care and supervision receive the services they need when they need them.
- **Strengthen our ability to recognize all children with a suspected mental health need—not just at the time of removal, but over time so that appropriate referrals for an assessment can be made.**

Source: Child Welfare League of America, *National Fact Sheet 2004*, <http://www.cwla.org/advocacy/nationalfactsheet04.htm#notes>

### 3. About the NJ MHST

The NJ MHST is not a substitution for a mental health assessment. The role of the NJ MHST is to provide DYFS with an instrument to better position case workers to identify children with a suspected mental health need and to ensure that no child who may be in need of an assessment goes without one. The ability to recognize a child with suspected mental health needs is an important skill that all DYFS case workers should develop and utilize as part of routine child welfare assessment / case practice.

#### **Child Well Being and Good Case Practice**

While the NJ MHST can play an important role in helping DYFS identify children with a suspected mental health need, the hard work comes later. Ensuring children and families are getting the services they need to address and support mental and behavioral health challenges a child is experiencing is critical to our work in achieving DCF's goal of child well being. It is also good case practice. Engagement with children and families regarding a child's progress in the context of any mental health treatment plan and/or case plan goals, is equally important to achieving optimal child well being.

#### **The NJ Mental Health Screening Tool, and similar tools:**

- May be utilized by professionals who do not have specific expertise in mental health, but who do have contact with children and youth.
- Identify children/youth who have a suspected mental health need or problem
- Are not mental health assessments
- Cannot conclude that a child has a mental health problem
- Are not diagnostic tools

**How is the NJ MHST going to help me with my work?** The tool will help you:

- Document the concerns that you may have about a child
- Clarify why you are concerned about a child
- Make a referral to get a child help

## 4. A Screen Is Not an Assessment or Evaluation

A Screening Tool is an instrument that surveys an individual or a population for the presence of an identifiable physical or mental health need. At the most basic level, a screening tool is a guided thought process aimed at identifying potential challenges to physical and mental health and wellness. Completing a screening tool is about making a point in time determination about whether mental health services are urgently necessary, whether further assessment is warranted or that no further assessment is necessary at this time.

A screening tool involves rational thinking, observation and questioning with consideration about whether any action needs to be taken. A screening is not diagnostic. Therefore, it can be completed by a lay person or a paraprofessional and may even be self-scored (completed by the individual who is being screened).

### **What's Included in a Screening?**

In mental health, a screening tool may simply be a checklist of symptoms or behaviors. A screening tool is intended to be more sensitive than specific because it is more important to identify all people who may have symptoms of a physical or mental health condition than to rule anyone out. The Pediatric Symptom Checklist and the NJ Mental Health Screening Tool (NJ MHST) are examples of screening tools.

There are three possible outcomes that can result from the use of a screen/screening tool:

**1. Positive Screen: Immediate Action Required**

This positive screen result requires immediate response by those planning for and facilitating the care of the screened individual or population. Such a determination indicates that it is necessary to secure immediate access to mental health service and/or treatment. This type of response would occur for example, if the individual was at risk of harming themselves or others (i.e. has attempted suicide, made suicidal gestures, expressed suicidal ideations, is assaultive to others; reckless or puts self in dangerous situations, attempts or has sexually molested other children etc.)

**2. Positive Screen: Complete Referral for Further Assessment**

The distinction between this outcome and the previous one is that the safety of self and/or others is not at risk if further assessment or treatment is not obtained immediately. In this instance the need for further assessment is identified and is not urgent in nature. In such instances the screened individual would go on to receive a mental health assessment.

**3. Negative Screen: No further assessment is needed at this time.**

Good practice indicates that when a negative screen result is obtained, ongoing screening takes place at regular intervals and when significant life changes take place. Examples of significant life change may include, but are not limited to, the following circumstances: change in living situation, change in school, change in medical status, reaching a developmental milestone, loss of a loved one or important relationship etc.



## 5. Assessments

A Mental Health Assessment formally measures and identifies the presence or absence of a mental health need in an individual. Typically a mental health assessment will identify the presence of specific mental health problems and make recommendations for mental health treatments. Mental Health Assessments are completed by a mental health professional such as a Master's level social worker.

### **What's in an Assessment?**

The Mental Health Assessment considers an individual's life experience with attention to the influence of personal history and current circumstance in relation to the following contexts: family, social, educational, employment/vocational, legal/financial, housing, mental health and treatment history, medical, and domestic violence. It also identifies individual strengths and needs and tailors recommendations for types and levels of services needed by the individual. A Mental Health Assessment is designed to be specific and it may recommend additional evaluations are necessary such as IQ testing.

A Mental Health Assessment may follow an accepted framework for assessment, such as a Biopsychosocial Assessment, or it may utilize a formally validated assessment tool such as the Lyons Strengths and Needs Assessment Tool or the Child Behavior Check List or the Strengths and Difficulties Questionnaire (SDQ).

## 6. Evaluations

An Evaluation is a highly specialized form of assessment that provides information about an individual's status in a given sphere. It is completed by a professional with advanced training and expertise in the area of question. For example, only a psychologist has the qualifications to perform a psychological evaluation; only a psychiatrist can perform a psychiatric evaluation.

### **What's in an Evaluation?**

The evaluation provides specific information about the individual's background, history, diagnosis and degree of functioning, as well as a formulation of contributing factors, and specific recommendations responsive to the questions in the evaluation referral.

An evaluation usually includes different components with varying degrees of formalized testing. For example, a psychological evaluation includes individual history, collaborative information from relevant sources, formal testing, an interview, results, summary and recommendations. While some elements of the evaluation may be required in good practice (such as medical history and mental status evaluation in a psychiatric evaluation), other elements will vary with the individual and the purpose of the evaluation. Because the evaluator is the expert, it is up to the evaluator to determine which collaborative information is needed and which testing is essential to develop the evaluation's conclusions. It is expected that when formal testing is part of an evaluation the evaluator adheres to professional standards for validity and reliability.

## **7. How Was the MHST Developed?**

The NJ MHST has been adapted from a MHST that was developed in California and has been used in other states, including Wisconsin and Indiana. The tool was designed to be used by case workers and juvenile justice workers.

The original MHST was developed by a multi-agency workgroup consisting of representatives from county child welfare, juvenile probation, public health and mental health departments, state representatives from the Department of Social Services, Mental Health and the Board of Corrections, and a parent representative. The project was undertaken by the California Institute for Mental Health (CIMH) and funded by a grant from the Zellerbach Family Fund.

## 8. Who Is Responsible for Mental Health Screening?

DCF's child welfare outcomes include child well being. Mental health is a critical part of well being. DCF wants to ensure that DYFS case workers have the capacity and tools to recognize any child with a suspected mental health need and make appropriate referrals and follow up as indicated. DYFS case workers can apply the NJ MHST to any child on their caseload.

The DYFS Child Health Units are charged with supporting child well being for children in DYFS out-of-home placements. The DYFS Child Health Units also play a role in recognizing children with a suspected mental health need as well as working with DYFS staff to make referrals and assist with follow up as indicated.

### More on Children in DYFS Out-of-home Placements

DCF utilizes three avenues of mental health screening for children in DYFS out-of-home placements to facilitate targeted mental health assessments at the time children and youth are experiencing symptoms.

- DYFS Case Workers
- DYFS Child Health Unit Nurse
- Comprehensive Medical Exam providers

<b>Screeners</b>	<b>Tool</b>	<b>Frequency</b>
<b>DYFS Case Worker</b>	NJ MHST	Within 30 days of placement; every 180 days after that and as needed.
<b>DYFS CHU Nurse</b>	Pediatric Symptom Checklist	Within 14 days of placement; every 180 days after that and as needed.
<b>CME Provider</b>	Physician Discretion	At the time of the CME exam.

Details on how and what DYFS Case Workers and CHU Nurses need to document can be found in Activity 4 (pages 79-115) and Attachment A (pages 120-126).

## 9. Who Gets Screened?

Guidelines provided by the American Academy of Child and Adolescent Psychiatry, the Child Welfare League of America and Annie E. Casey Foundation recognize mental health screening programs as a mechanism to identify children in need of mental health assessment.

A robust mental health screening program offers DYFS the benefits of not relying on a point in time evaluation. The program will help ensure that children identified as having a suspected mental health need, throughout their time in placement or while under supervision, receive an appropriate assessment and/or psychiatric evaluation and follow up.

### **How DCF Is Using the NJ MHST**

DCF is using the NJ MHST to facilitate targeted mental health assessments at the time that children and youth are experiencing symptoms. The tool can also be applied on any child under DYFS supervision. That said, there are some notable exceptions.

- The tool is not designed to be applied to children who are already receiving mental or psychiatric services.
  - It is likely that if a child is receiving services already, an assessment or evaluation has already taken place and typically that child would be re-evaluated by the clinician.
  - If there are concerns about a child’s mental health status and the child is already engaged in services, a case conference or other intervention will be necessary to figure out how to support the child/and or the family caring for the child and not a screening tool.

- Also, there are some situations in which a child should be referred directly for a mental health assessment based on what is known about their history. For example a child:
  - Entering placement with mental health histories (not currently in treatment)
  - With a history of physical and sexual abuse (not currently in treatment)
  - Whose primary care taker has a history of mental illness
  - With a history of multiple changes in placement
  - With a history of running away from placements will be referred for a mental health assessment.

## 10. The NJ MHST and the PSC-35

The case worker's New Jersey Mental Health Screening Tool was developed specifically for child welfare workers to assist them with recognizing children with a suspected mental health need. The case worker answers the questions using their skills of observation of the child's current behavior and knowledge of the child's current history available in the record.

### **The PSC-35**

The Pediatric Symptom Checklist (PSC, Y-PSC) is a psychosocial screening tool in the format of a questionnaire designed to aid the Child Health Unit nurses in recognizing children age 2 years and above with suspected cognitive, emotional and behavioral problems (see Attachment A on page 119).

The nurses screen all children within 14 days of entering into DYFS out-of-home placement and then ongoing while in placement every 4-6 months. The PSC questionnaire elicits the parent or youth's report about recent behavior, such as "spends more time alone", "less interested in friends" or "seems to be having less fun." Each question is then rated by the care giver or child based upon how true the item is. The nurse scores the tool and a positive screening tool directs the nurse to seek the assistance of the case worker with scheduling the child for a mental health assessment.

The PSC relies on the caregiver's knowledge of the child's behavior over time and changes in behavior and this information may not be available if the child has just been removed from home.

## 11. Why Use Multiple Tools?

DCF is committed to ensuring that children and youth with mental health need are identified and referred for treatment as soon as possible. Because case workers and CHU RNs see our children and youth at different times and in different settings, we are asking both professionals to assess mental health need. Using different tools increases the likelihood of identifying need and utilizes the different professional expertise of the two sets of screeners.

### **A Robust Mental Health Screening Program**

The DCF Mental Health Screening program is dynamic. It utilizes three different professional groups of screeners, different screening tools, and varying times for screening from first contact throughout a youth's tenure with DCF.

By using three sets of screeners (CME provider, Caseworker, CHU RN), different tools and screening at different times, we are enhancing our ability to identify a youth with mental health need when they become symptomatic. This is further increased by the differences in the tools themselves – the NJ MHST is observational and relies on the caseworker's expertise, the PSC is both observational and behavioral and relies on changes in behavior over time as seen by the RN, Parent, and Youth – which increases the sources of information and types of information used to identify mental health need.

Overall this makes for a robust mental health screening program for DCF.



## 12. Minimum Documentation for DYFS Case Workers

DYFS case workers are required to screen all children entering out of home placement for mental health need within 30 days of entering out of home placement; 180 days thereafter; and, as needed until the permanency plan is met. This is in addition to the screenings provided by the Child Health Unit nurses and community providers.

Mental Health Screening for children in out of home placement is mandatory. The NJ MHST is a guide that may be used to assist DYFS case workers in the screening process. The screening tool will help to ensure that appropriate mental health intervention is initiated as early as possible.

The use of the NJ MHST to engage in screening is not mandatory but meeting each screening interval and documenting the findings in New Jersey Spirit (NJS) is required.

- A case worker may refer a child for a mental health assessment without having completed the NJ MHST. (To document this situation, the caseworker would utilize the value, “Mental Health Screening-Casework” under Medical/Mental Health Type and, “Referral Made” under Medical/Mental Health Activity.)
- A case worker may also find that the child is already engaged in mental health services, so rather than screen the child with the NJ MHST, the caseworker would document the child was screened in the Medical/Mental Health Type using the value, “Mental Health Screening-Casework” and the finding would be that the child is already receiving mental health services under the Medical/Mental Health Activity (Receiving Mental Health Services).
- If the child is not receiving services, and is not referred for a mental health assessment, the case worker **MUST** then use the NJ MHST to engage in a screening for that child and enter their work into NJS. (Medical/Mental Health Type: Mental Health Screening-Casework; Medical/Mental Health Activity: Tool Completed-Referral made or Tool Completed-no Referral made)

*(continued)*

Please note that while the mandatory documentation for mental health screening is required for children in DYFS out of home placements, the NJ MHST was developed for use on any child who may be on your case load. Documentation intervals do not apply to children under supervision but any time a child is screened the outcome should be documented in NJS under the Medical/Mental Health icon.

**New Jersey Spirit (NJS) Fields and Values**

Below are the two fields that case workers are required to complete when engaged in mental health screening of a child. (For the Medical Mental Health Type Cheat Sheet, please see Attachment B on page 129.)

<b>Medical/Mental Health Type</b>	
	Mental Health Screening-Nursing
	Mental Health Screening-Casework
	Mental Health Screening-CME

<b>Medical/Mental Health Activity</b>	
	Tool completed-Referral made
	Tool completed-no Referral made
	Receiving Mental Health Services
	Referral Made
	Less than 2 years old*
* Less then 2 years old is only a Medical/Mental Health Activity option for the Child Health Nurse	

## Summary

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1. The NJ MHST will help you document the concerns that you may have about a child; clarify why you are concerned about a child; and make a referral to get a child help.
2. A Screening Tool is an instrument that surveys an individual or a population for the presence of an identifiable physical or mental health need. A screening tool involves rational thinking, observation and questioning with consideration about whether any action needs to be taken. A screening is not diagnostic. Therefore, it can be completed by a lay person or a paraprofessional and may even be self-scored (completed by the individual who is being screened).
3. A strong mental health screening program for children who enter foster care systems is important because we know that most who experience foster care will at some point in their lifetime, require therapeutic intervention and support. The NJ MHST can assist with identifying children in DYFS out-of-home placements who most urgently need a mental health assessment.
4. A Mental Health Assessment formally measures and identifies the presence or absence of a mental health need in an individual. Typically a mental health assessment will identify the presence of specific mental health problems and make recommendations for mental health treatments. Mental Health Assessments are completed by a mental health professional such as a Master's level social worker.
5. An Evaluation is a highly specialized form of assessment that provides information about an individual's status in a given sphere. It is completed by a professional with advanced training and expertise in the area of question. For example, only a psychologist has the qualifications to perform a psychological evaluation; only a psychiatrist can perform a psychiatric evaluation.
6. The NJ MHST has been adapted from a MHST that was developed in California and has been used in other states, including Wisconsin and Indiana. The tool was designed to be used by case workers and juvenile justice workers.

7. For children in DYFS out-of-home placement, DCF utilizes three avenues of mental health screening to facilitate targeted mental health assessments at the time that children and youth are experiencing symptoms and they include: DYFS Child Health Unit Nurses; Comprehensive Medical Exam providers; and DYFS case workers.
8. The NJ MHST can be applied to any child that a case worker is working with, including children in DYFS out-of-home placements, and children under DYFS supervision.
9. The tool is not designed to be applied to children who are already receiving mental or psychiatric services.
10. The Pediatric Symptom Checklist (PSC, Y-PSC) is a psychosocial screening tool in the format of a questionnaire designed to aid the Child Health Unit nurses in recognizing children age 2 years and above with suspected cognitive, emotional and behavioral problems. The PSC is done in addition to the NJMHST because DCF recognizes the complementary roles and expertise of both the case worker and nurse in identifying children with mental health needs.
11. Using different tools increases the likelihood of identifying need and utilizes the different professional expertise of the two sets of screeners.
12. There are some situations in which a child should be referred directly for a mental health assessment based on what is known about their history or their current status.
13. Mental Health Screening for children in out of home placement is mandatory. The NJ MHST is a guide that may be used to assist DYFS caseworkers in the screening process. Using the NJ MHST as a screen is not mandatory but meeting each screening interval and documenting the findings in New Jersey Spirit (NJS) is required.



# Evaluation

1. How important is this activity for you and your co-workers?

Please circle one number.

Activity Is Not Important			Activity Is Very Important	
1	2	3	4	5

2. Please put an "X" by the one fact sheet you feel is the most important.

1. What Is the NJ MHST?	7. How Was the NJ MHST Developed?
2. Why a NJ Mental Health Screening Program?	8. Who Is Responsible for Mental Health Screening?
3. About the NJ MHST	9. Who Gets Screened?
4. A Screen <u>Is Not</u> an Assessment or Evaluation	10. The NJ MHST and PSC-35
5. Assessments	11. Why Use Multiple Tools?
6. Evaluations	12. Minimum Documentation for DYFS Case Workers

3. Which summary point do you feel is most important?

Please circle one number.

Most Important Summary Point				
1.	2.	3.	4.	5.
6.	7.	8.	9.	10.
11.	12.	13.		

4. What would you suggest be done to improve this activity?

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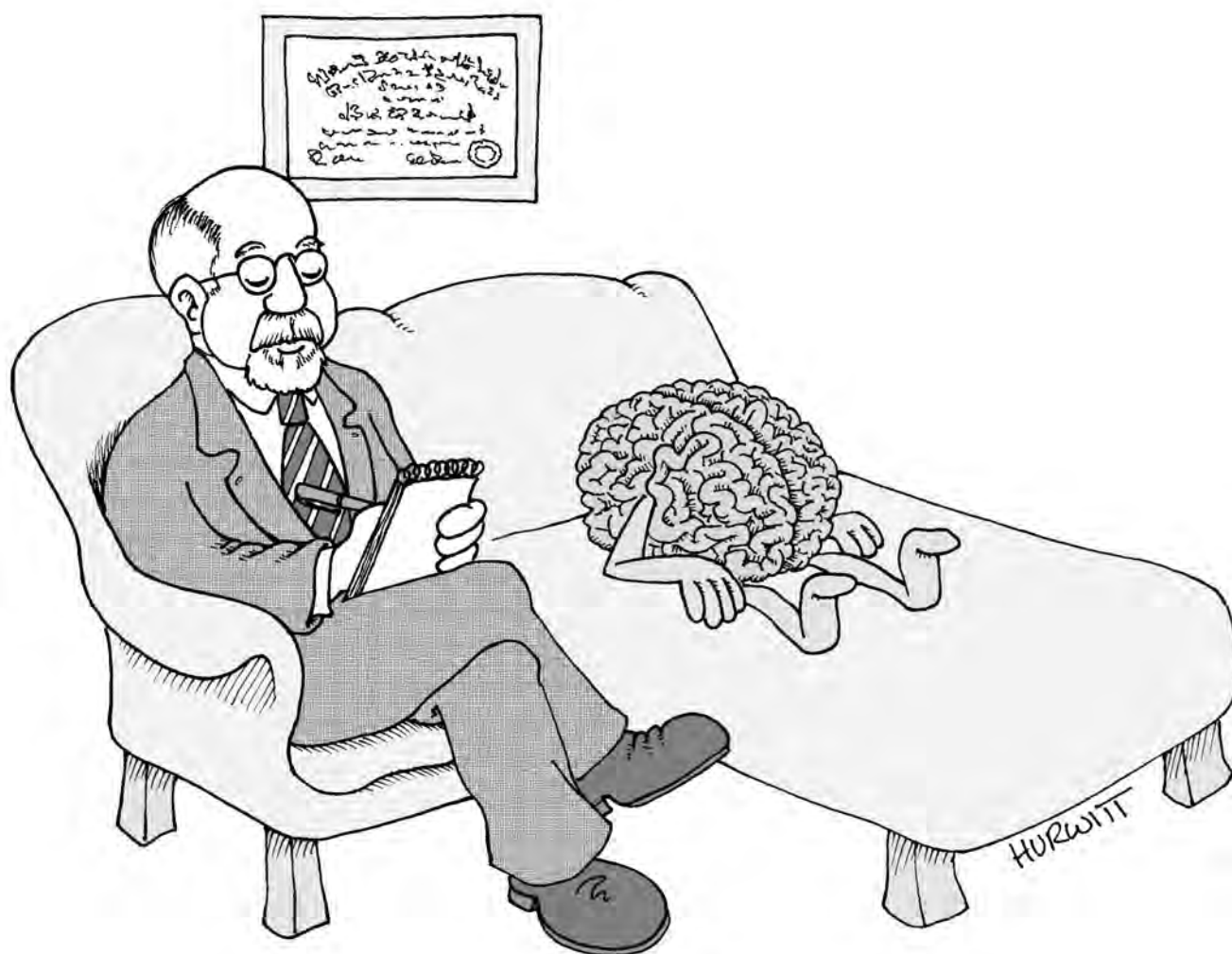


## Activity 4: Case Studies

### Purpose

To improve our critical thinking and problem solving skills and how to use the NJ Mental Health Screening Tool

**This activity has three tasks. Task 1 begins on page 80.**





## Task 1

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**In your groups read the case study below and complete the Notes/Analysis Table on page 81. Then based on the case study, Notes/Analysis Table and the factsheets on pages 83-91, answer questions 1-5 on page 82.**

### **Tommy\***

Four-year-old Tommy was placed in a resource home after police arrested his father for drunken driving and his mother for resisting arrest. Both parents had to be physically restrained before being handcuffed and arrested. Tommy was in the car and witnessed the struggles and arrests.

Extended family members were not available to care for him and that is why he was placed in a resource home. He seems slightly withdrawn and resists soothing or nurturance but he has joined resource family members in petting and playing with their dog. His first few nights were restless, he woke up a few times each night and took about a half-hour to fall back to sleep.

More recently, though still restless, he wakes once a night with or without nightmares, and falls back to sleep more easily. He appears irritable and fatigued during the day. He had a few early episodes of bed-wetting but that ended during the first few weeks of out-of-home placement.

He is in day care three times per week, but is at risk to be excluded, because of several episodes of aggression toward peers, especially girls. He can also be very helpful to others, appears sensitive when they are upset, and attempts to comfort them. He is not interested in books or being read to, but is exploring drawing and painting.

When frustrated, Tommy's demeanor tends to darken, eyes glare, and muscles tense and he breaths heavily. He is likely to attempt to get his way without regard for the feelings or safety of others. On more than one occasion he has ignored verbal limits and fought against physical restraint to the point of exhaustion.

*\*The Tommy Case Study has been edited and revised for this training. It is based on the "Case Vignett-Tommy" as it appears in the Child Welfare Trauma Training Toolkit, March 2008.*

Following visits with his mother, he tends to isolate himself. He does not visit with his father who since the arrest has remained in jail for parole violations. The father has a history of domestic violence. The mother was physically abused as a child.

<b>Notes/Analysis Table</b>	
<b>Data:</b>	<b>Notes/Questions/Analysis</b>
<b>A.</b> Child's trauma history	
<b>B.</b> Child's areas of strength or resilience	
<b>C.</b> Areas of functioning in which child is having difficulty	
<b>D.</b> Other potentially traumatic events, or other experiences with separation, loss, and/or placement disruption	
<b>E.</b> Other information do you need about the child's history	
<b>F.</b> Identify potential areas for assessment, case management and planning next steps	

*(continued)*

## Task 1 (continued)

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### Questions:

1. Does the child exhibit unusual or uncontrollable behavior?  
(See Factsheet 2)

Yes       No       Unknown

2. Does this child seem to be disconnected, depressed, excessively passive or withdrawn? (See Factsheet 3)

Yes       No       Unknown

3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property? (See Factsheet 4)

Yes       No       Unknown

4. Does this child exhibit behaviors that may not allow him/her to remain in his/her current living, preschool and/or childcare situation?  
(See Factsheet 5)

Yes       No       Unknown

5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days? (See Factsheet 6)

Yes       No       Unknown

## 1. Yes (✓) and No (✓) Answers On the NJ MHST

The NJ Mental Health Screening Tool (see Fact Sheets 8 and 20) can be applied to children and youth from the age of 0 to 18 years of age. There are two versions of the NJ Mental Health Screening Tool. You should select the one that is for the child's age:

- NJ MHST 0-5 Years
- NJ MHST 6 Years to Adult

The NJ MHST is a list of behaviors that may be observed in children that may indicate a need for further evaluation.

One "**Yes**" answer on either of the NJ MHST 0-5 or 6-Adult indicates the need for a mental health assessment.

All "**No**" answers indicate there is no current need for a mental health assessment.

All "**Unknown**" answers indicate that there is not enough information to complete the screen at this time and the screen should be repeated.

## 2. Behavior: Unusual or Uncontrollable

( NJ MHST 0-5 YEARS—Question 1: Does the child exhibit unusual or uncontrollable behavior?)

Age	Behavior	Perspective
<b>0-18 months</b>	Crying that is excessive in intensity or duration; persistent arching, “floppiness,” or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness.	Children of this age who are developing normally establish a trust in the caregiver and the environment. They begin to respond to internal and external changes without becoming overwhelmed, and by seeking assistance. They begin to establish day/night rhythmicity. Difficulty with these behaviors represents a possible mental health need.
<b>18-36 months</b>	Any of the behaviors above; extremely destructive disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g., head banging) or self-stimulating behavior (e.g., rocking, masturbation); appears to have an absence of fear or awareness of danger.	Children in this age group are working on developing a sense of self-control and the ability to manage their internal impulses and feelings. When they direct their angry feelings into inconsolable tantrums or hurting themselves or others, they are having difficulty that may represent a mental health need.
<b>3-5 years</b>	Any of the above behaviors; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g., hand washing—becomes distraught if interrupted, etc.); extreme hyperactivity; excessively “accident-prone,” repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g., encopresis, smearing) and aggression (e.g., biting, kicking, property destruction).	As children move into the pre-school years they begin to look beyond their immediate world. If they do not have a secure, safe sense of themselves and their home they can become overwhelmed by anxiety and stimulating experiences. If they have not been treated with care and respect they may treat themselves and others – including animals – harshly. These examples of problems in self-control and self-regulation may indicate a mental health need in a child in this age group.

### 3. Behavior: Disconnected, Depressed, Passive or Withdrawn

(NJ MHST 0-5 YEARS—Question 2: Does this child seem to be disconnected, depressed, excessively passive or withdrawn?)

<b>Age</b>	<b>Behavior</b>	<b>Perspective</b>
<b>0-18 months</b>	Does not vocalize (e.g., “coo”) cry or smile; does not respond to caregiver (e.g., turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g., motion, sound, light, activity, etc.); persistent and excessive feeding problems.	Infants learn about the world through relationship with the primary caregiver. They wake, they coo, they cry and the caregiver responds with similar sounds and care. Newborns orient to the human face preferentially at birth. An infant or toddler who does not have these behaviors may have a mental health need.
<b>18-36 months</b>	Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g., solace, play object attainment); few or no words; fails to respond to verbal cues.	As a normally developing child reaches out to the environment and is responded to with care and concern. The child who has learned that reaching out and exploration provides no response turns inward and expects nothing from the environment. This is a serious indicator of mental health need.
<b>3-5 years</b>	Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g., extremely clumsy); unusual eating patterns (e.g., refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g., no longer talks or is no longer toilet trained).	Children learn these skills through experimentation and experience. The ability to interact with others - and the interest in interacting with others – is fostered through interactions that are positively reinforced. If they do not have the opportunity to learn and practice these skills, they are at risk for mental health problems.

## 4. Behavior: Danger to Self, Other People, Animals or Property

**(NJ MHST 0-5 YEARS—Question 3:** Has this child made statements or acted in ways that present a danger to self, other people, animals or property?)

Including:

- Attempted suicide
- Made suicidal gestures
- Expressed suicidal ideation (thoughts about suicide from fleeting to detailed planning)
- Assaultive to other children or adults
- Reckless and puts self in dangerous situations
- Attempts to or has sexually assaulted other children

### **Young Children Can Think in These Terms**

Children—even children below the age of five—can feel hopeless and actively suicidal. Depressed children may be sad and withdrawn and make hopeless statements, or they may be irritable and lash out aggressively at others.

Children who have been neglected or traumatized may have a limited or narrowed sense of the future and see their life or the life of others as having no value. Sometimes children who have been abused re-create the abusive situation by abusing others in an attempt to “master” the feelings of having been abused.

**Any of these behaviors raises a serious concern that there is a mental health need.**

### **Process and Procedures**

On the NJ MHST 0-5 Years, a “yes” answer to question #3 indicates an urgent need for mental health assessment. It is recommended that an assessment be scheduled to take place no later than five days following the completion of the NJ MHST.

## 5. Placement, Childcare, Education Status: Threatens Child's Ability to Benefit From Stable Environment

(NJ MHST 0-5 YEARS—Question 4: Does this child exhibit behaviors that may not allow him/her to remain in his/her current living, preschool and/or childcare situation?)

The child's behavior and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.

### **Self-Regulation and Adaptation**

A normally developing infant and child learn skills for self-regulation and adaptation to the environment. A child who cannot regulate internal state and emotion, who has not learned to reach for and accept assistance, can have difficulty entering into a family home.

A child who has difficulty managing feelings may be inconsolable or full of rage and will not respond to redirection or reassurance. A child who only knows chaos can have difficulty fitting into a more structured environment. A child who has not experienced a responsive environment may find the experience threatening and intrusive.



## 6. History: Abuse

**(NJ MHST 0-5 YEARS—Question 5:** Has this child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?

Examples of serious abuse include:

- Serious or repeated bruising, especially in unusual areas, broken bones
- Witness torture or sexual abuse
- Witness to murder
- Rarely held or responded to

### **The Impact of Abuse on Developmental Tasks**

The developmental tasks of early childhood may include:

- Learning to trust the environment and the caregiver
- Developing independence and self-regulation
- Engaging in reciprocal social interaction.

A child who is treated in abusive ways does not have the opportunity to develop normally in these ways. Research has demonstrated that children who are neglected have different brain development and are at risk for depression, behavioral and anxiety disorders, including post-traumatic stress disorder. Children who have been exposed to these experiences are at risk and may need mental and behavioral health supports.

## 7. More NJ MHST Process and Procedures

### **Following-up On Answers of “Unknown”**

A child whose screen only indicated answers of “Unknown” should be screened again after two weeks when more information regarding the child is available.

### **What To Do With a Completed NJ MHST?**

A copy of the completed NJ MHST should go into the child’s Case Record and a copy shared with the Child Health Unit.

### **Where Can I Get More Information About the NJ MHST Or What If I Have Questions?**

Please contact the NJ DCF Office of Child Health Services with further questions or concerns.

# 8. The NJ MHST (0-5 Years)

## NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 NJS: Case# \_\_\_\_\_ Person ID# \_\_\_\_\_  
 Casework/supv/contact info \_\_\_\_\_

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Behavior</b></p> <p>1. Does this child exhibit unusual or uncontrollable behavior?</p> <p><b>0 – 18 mos:</b> Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness  <b>18 – 36 mos:</b> Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger  <b>3 – 5 yrs:</b> Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?</p> <p><b>0 – 18 mos:</b> Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems.  <b>18 – 36 mos:</b> Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues.  <b>3 – 5 yrs:</b> Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?</p> <p><i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i></p> <p><b>Placement, Childcare, Education Status</b></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>4. Does this child exhibit behaviors that may <b>not</b> allow him/her to remain in his/her current living, preschool and/or childcare situation?</p> <p><i>The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.</i></p> <p><b>History</b></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?</p> <p><i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.</i></p>

Please continue to page 2

If you checked any of the above boxes “YES”, child should be referred for assessment. For the young child, a next step will usually include a consult with the child’s pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.

If applicable, identify the agency and provider to which the child has been referred:

\_\_\_\_\_

COMMENTS/ADDITIONAL INFORMATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Task 2: Tommy's Update

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**In your groups read the update of Tommy's case and then based on the update and your own experience, develop a strategy for pursuing a case goal of reunification.**

### **Update of Tommy's Case (4 Months Later)**

Tommy is still having difficulty falling asleep and has returned to bed wetting, is irritable during the day, and has become increasingly aggressive with other children in childcare. Tommy's feelings are very intense in foster care.

When frustrated, he has a hot temper and hits, screams, bites, and stomps his feet against the floor, and may hit his head. Other times he cries and cries and can't be consoled, just goes limp. On several occasions he's tried to run away, saying he had to go back home.

In play therapy, Tommy enacts themes of people fighting, police sirens wailing, and police cars speeding to the scene. Sometimes the police cars are caught up in vehicle crashes. Tommy is not interested in continuing the play beyond the fighting and car crashes. There is little interpersonal interaction in his play. He sometimes gives the therapist a vehicle to drive and be crashed into or a doll to fight with, but he remains strongly in control of the play sequence. His therapist has yet to observe him in the day-care setting or at the parent-child visitation center.

The mother is distraught over the separation from Tommy and furious with her husband who she blames for precipitating the foster placement. She is becoming increasingly depressed and is at risk for returning to alcohol or substance abuse. Within visits, she tends to be worried about Tommy or near tears. She often finds fault with the foster parents. After visits with Tommy, she complains at length about her own experience in foster care as a young child and her difficulty arranging transportation to visits, since her dad wrecked her car several months ago after drinking too much at a family reunion.

**Recommended course of action or steps you would take in pursuing a goal of reunification for Tommy:**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

## Task 3: Trina

---

**In your groups read the case study below and complete the Notes/Analysis Table on page 96. Then based on the case study, your own experience, the Notes/Analysis Table and the factsheets on pages 100-112, answer questions 1-6 on page 97 and questions 1-7 on pages 98-99.**

### **Trina\***

Trina is 17 and began shifting back and forth between relatives and foster care when she was five years old. She is the third of five children and has been exposed to parental neglect, drug exposure, death of family members, and multiple moves. At present, Trina spends a lot of time with her sister, who lives in a different foster home. Trina is involved in a number of church activities with her foster mother and sometimes with a former foster family. Trina has a boyfriend who, along with his mother, has been very supportive of Trina.

Trina is articulate and able to express her feelings openly when she feels comfortable. When upset or disappointed, Trina becomes quiet. However, when encouraged to talk about her feelings she is likely to open up. She is sensitive and can cry when frustrated or upset. She is in many ways a typical teenage girl. She enjoys spending time with friends on Facebook and seeing them in person. She loves to laugh and joke. She has an easy smile, is intelligent, and is perceptive about the moods and needs of those around her. Trina is closest to her sister Liana. She is eager to live in the same home with her siblings.

However, there are concerns about Trina's ability to manage her anger. When she gets upset or is provoked, she has a difficult time walking away from the situation. She was suspended from school for fighting three times last year. Two of these incidents occurred while she was defending her sister. Another incident involved a citation from Juvenile Court. Just last week Trina was in an altercation with another student as a result of harsh words exchanged on Facebook.

*\*The Trina Case Study has been edited and revised for this training. It is based on the "Case Vignett-Trina" as it appears in the Child Welfare Trauma Training Toolkit, March 2008.*

Trina moved into her current resource home in 2010. Her sister Bernice has been living in this home alone for a year. There was a period of adjustment when Trina moved into the home. The foster mother worked hard to assure both girls of their place in the family. Once Trina got to know the family better, she adjusted well. She has no behavior problems in the home.

Trina does spend a great deal of time in her sister Liana's foster home, and she probably feels a greater sense of belonging there. She gets along well with her foster parents' young children and helps with household chores. Trina has the ability to attach to others in a very positive manner. She seems quiet at first until she gets to know someone. Trina has always been open and eager to be adopted with her four siblings. Bernice has expressed a desire to be adopted on her own. This was difficult for Trina to hear.

She expresses little hope of finding an adoptive family. She feels that a transfer to a different school setting would help her to manage her anger management problems. On her most recent report card she received good grades, and says that she is trying to improve her behavior and at school. By the end of the school year she will have completed the 10th grade.

*(continued)*



### Task 3: Trina (continued)

<b>Notes/Analysis Table</b>	
<b>Data:</b>	<b>Notes/Questions/Analysis</b>
<b>A.</b> Child's trauma history	
<b>B.</b> Child's areas of strength or resilience	
<b>C.</b> Areas of functioning in which child is having difficulty	
<b>D.</b> Other potentially traumatic events, or other experiences with separation, loss, and/or placement disruption	
<b>E.</b> Other information do you need about the child's history	
<b>F.</b> Identify potential areas for assessment, case management and planning next steps	

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**QUESTIONS (Part 1: Identified Risks)**

1. Has the child been a danger to him/herself or to others in the last 90 days?  
**(See Factsheet 9)**

Yes       No       Unknown

2. Does the child have behaviors that are so difficult that maintaining him/her in current living or educational situation is in jeopardy?  
**(See Factsheet 10)**

Yes       No       Unknown

3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?  
**(See Factsheet 11)**

Yes       No       Unknown

4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill? **(See Factsheet 12)**

Yes       No       Unknown

5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication? **(See Factsheet 13)**

Yes       No       Unknown

6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to severe violent behavior or trauma in the past 90 days? **(See Factsheet 14)**

Yes       No       Unknown

*(continued)*

### Task 3: Trina (continued)

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#### Questions (Part II: Risk Assessment)

1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago.

List: \_\_\_\_\_

Yes       No       Unknown

2. Does the child have problems with social adjustment? **(See Factsheet 15)**

Yes       No       Unknown

3. Does this child have problems making and maintaining healthy relationships? **(See Factsheet 16)**

Yes       No       Unknown

4. Does this child have problems with personal care? **(See Factsheet 17)**

Yes       No       Unknown

5. Does this child have significant functional impairment? **(See Factsheet 18)**

Yes       No       Unknown

**6.** Does this child have significant problems managing his/her feeling?  
**(See Factsheet 19)**

Yes       No       Unknown

**7.** Is this child known to abuse alcohol and/or drugs?

Yes       No       Unknown

## 9. Danger to Self or Others

(NJ MHST 6 YEARS to Adult—Question 1: Has the child been a danger to him/herself or to others in the last 90 days?)

Including:

- Attempted suicide
- Made suicidal gestures
- Expressed suicidal ideation (thoughts about suicide from fleeting to detailed planning)
- Assaultive to other children or adults
- Reckless and puts self in dangerous situations
- Attempts to or has sexually assaulted other children

### **Process and Procedure When Using the 6-Adult Tool**

On the NJ MHST 6 – Adult, a “yes” answer to any of the questions on the front page indicates an “Identified Risk” with a high priority need for mental health assessment. When a “yes” box is checked on the first page, it is recommended that an assessment be scheduled to take place no later than five days following the receipt of the MHST. A “yes” answer to any question under the “Risk Assessment” section on the back of the form indicates the need for a timely mental health assessment referral.

It is the standard of practice that a child who is actively suicidal, homicidal or psychotic be referred directly to the psychiatric emergency room for immediate evaluation.

Circling the behaviors outlined in *Italics* after each question allows the person completing the screening to quickly and easily offer more specific information that will assist in making the referral for the mental health assessment.

## 10. Behavior that Jeopardizes Living or Educational Situation

(NJ MHST 6 YEARS to Adult—Question 2: Does the child have behaviors that are so difficult that maintaining him/her in current living or educational situation is in jeopardy?)

Including:

- Persistent chaotic, impulsive behavior
- Daily verbal outbursts
- Excessive noncompliance
- Constantly challenges the authority of caregiver
- Requires constant direction and supervision in all activities
- Requires total attention of caregiver
- Overly jealous of caregiver's other relationships
- Disruptive levels of activity
- Wanders the house at night
- Excessive truancy
- Fails to respond to limit setting or other disciplines, etc.

## II. Bizarre or Unusual Behavior

(NJ MHST 6 YEARS to Adult—Question 3: Has the child exhibited bizarre or unusual behaviors in the last 90 days?)

Including:

- History or pattern of fire-setting
- Cruelty to animals
- Compulsive or public masturbation
- Appears to hear voices
- Responds to internal stimuli including alcohol or drugs
- Repetitive body motions (head banging) or vocalizations (e.g., echolalia)
- Smears feces, etc.

## 12. Need for Medication

**(NJ MHST 6 YEARS to Adult—Question 4:** Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?)

Including:

- The child needs immediate evaluation of medication or needs a new prescription
- Caretaker is concerned that child needs immediate evaluation for medication
- Child is refusing to take prescribed medication



## 13. Psychiatric History

(NJ MHST 6 YEARS to Adult—Question 5: Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?)

Including:

- Child has a history of psychiatric care, either inpatient or out patient
- Child is taking prescribed psychotropic medication

## 14. Trauma, Abuse, Neglect

(NJ MHST 6 YEARS to Adult—Question 6: Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in the past 90 days?)

Including:

- Subjected to or witnessed serious physical abuse, domestic violence (e.g., cruel restraint, beatings, burns, physical torture, bruising in unusual areas, broken bones, bruising in unusual areas, etc.)
- Subjected to or witnessed torture and/or sexual abuse
- Serious unmet health needs, living arrangements and/or abandonment
- Consistent scapegoating, and/or indifference

## 15. Social Adjustment

(NJ MHST 6 YEARS to Adult Part 2: Risk Assessment—Question 2: Does the child have problems with social adjustment?)

Including:

- Regularly involved in physical fights with other children or adults
- Verbally threatens people
- Damages possessions of self or others
- Runs away
- Regularly lies
- Mute
- Confined due to serious law violations
- Does not seem to feel guilt after misbehavior, etc.

## 16. Healthy Relationships

**(NJ MHST 6 YEARS to Adult Part 2: Risk Assessment—Question 3:**

Does this child have problems with making and maintaining healthy relationships?)

Including:

- Unable to form relationships with peers
- Provokes and victimizes other children
- Gang involvement
- Does not form bond with caregiver, etc.

## 17. Personal Care

**(NJ MHST 6 YEARS to Adult Part 2: Risk Assessment—Question 4: Does this child have problems with personal care?)**

Including:

- Eats or drinks substances that are not food
- Regularly enuretic during waking hours (subject to the age of the child)
- Extremely poor personal hygiene

## 18. Functional Impairment

(NJ MHST 6 YEARS to Adult Part 2: Risk Assessment—Question 5: Does this child have significant functional impairment?)

Including no known history of developmental disorder and:

- Behavior that interferes with ability to learn in school
- Significantly delayed in language
- “Not socialized” and incapable of managing basic age appropriate skills
- Is selectively mute, etc.

## 19. Managing Feelings

**(NJ MHST 6 YEARS to Adult Part 2: Risk Assessment—Question 6: Does this child have significant problems managing his/her feeling?)**

Including:

- Severe temper tantrums
- Screams uncontrollably
- Cries inconsolably
- Significant and regular nightmares
- Withdrawn and uninvolved with others
- Whines or pouts excessively
- Regularly expresses the feelings that others are out to get him/her
- Worries excessively and preoccupied compulsively with minor annoyances
- Regularly expresses feeling worthless or inferior
- Frequently appears sad or depressed
- Constantly restless or overactive, etc.

## 20. The NJ MHST (6 Years to Adult)

### NEW JERSEY MENTAL HEALTH SCREENING TOOL (6 YEARS TO ADULT)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 NJS: Case# \_\_\_\_\_ Person ID# \_\_\_\_\_  
 Casework/supv/contact info \_\_\_\_\_

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please indicate the issues under the COMMENTS section on the reverse side of the form.

YES	NO	Unknown	Part 1 - IDENTIFIED RISK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Has this child been a danger to him/herself or to others in the last 90 days?  <i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?  <i>Persistent chaotic, impulsive or disruptive behaviors; daily verbal outburst; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other disciplines, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?  <i>History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (head banging) or vocalizations (e.g. echolalia); smears feces, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?  <i>Either needs immediate evaluation of medication or needs a new prescription.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?  <i>Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?  <i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.</i>

**If you checked any of the above boxes YES, this indicates that the need for Mental Health assessment and/or assistance is urgent.**

**If all the above are either NO or UNKNOWN, please continue on reverse side.**

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

(continued)



## 20. The NJ MHST (6 Years to Adult) (continued)

YES	NO	Unknown	Part 2 - RISK ASSESSMENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does the child have problems with social adjustment?  <i>Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confirmed due to serious law violations; does not seem to feel guilt after misbehavior, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does this child have problems making and maintaining healthy relationships?  <i>Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does this child have problems with personal care?  <i>Eats or drinks substances that are not food; regularly enuretic during waking hours (subject to age of child); extremely poor personal hygiene.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have significant functional impairment?  <i>No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Does this child have significant problems managing his/her feelings?  <i>Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is this child known to abuse alcohol and/or drugs?  <i>Child regularly uses alcohol or drugs.</i>

**If you checked any of the above boxes YES, this indicates child should be referred for a mental health assessment.**

**Please forward the form to:**

(Could be preprinted to have the address of local Mental Health agency.)

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

### Mental Health Follow Up Response

Name: \_\_\_\_\_ Date: \_\_\_\_\_

MH Assessment complete; no follow up MH service required.

MH Assessment complete; MH follow up required.

Other: \_\_\_\_\_



## Summary

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1. The NJ MHST is a list of behaviors that may be observed in children and youth that may indicate a need for further evaluation.
2. There are two versions of the NJ Mental Health Screening Tool. You should select the one that is for the child's age.
3. What to look for in children ages 0-5 years:
  - unusual or uncontrollable behavior
  - a child who is disconnected, depressed, excessively passive or withdrawn
  - a child who has made statements or acted in ways that present a danger to him/herself, other people, animals or property
  - a child who exhibits behaviors that may not allow him/her to remain in his/her current living, preschool and/or childcare situation?
  - a child that has experienced severe physical or sexual abuse, extreme or chronic neglect, or been exposed to extreme violent behavior or trauma?
4. What to look for in children ages 6-adult:
  - Identified Risks/Urgent Needs**
    - a child who is a danger to him/herself or to others in the last 90 days
    - a child whose behavior is so difficult that maintaining him/her in current living or educational situation is in jeopardy
    - a child who has exhibited bizarre or unusual behaviors in the last 90 days
    - a child who has an immediate need for psychotropic medication consultation and/or prescription refill
    - a child who has a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication
    - a child who has experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to severe violent behavior or trauma in the past 90 days

### **Risk Assessment**

- a child that has a history of the behaviors or experiences listed under the “Identified Risk” section, that occurred more than 90 days ago
- a child having problems with social adjustment
- a child having problems making and maintaining healthy relationships
- a child having problems with personal care
- a child with significant functional impairment
- a child having significant problems managing his/her feelings
- a child known to abuse alcohol and/or drugs



## Evaluation

1. How important is this activity for you and your co-workers?

Please circle one number.

Activity Is Not Important			Activity Is Very Important	
1	2	3	4	5

2. Please put an "X" by the one fact sheet you feel is the most important.

	1. Yes (✓) and No (✓) On the NJ MHST		11. Bizarre or Unusual Behavior
	2. Behavior: Unusual or Uncontrollable		12. Need for Medication
	3. Behavior: Disconnected, Depressed, Passive Withdrawn		13. Psychiatric History
	4. Behavior: Danger to Self, Other People, Animals or Property		14. Trauma, Abuse, Neglect
	5. Placement, Childcare, Education Status: Threatens Child's Ability to Benefit From Stable Environment		15. Social Adjustment
	6. History: Abuse		16. Healthy Relationships
	7. More NJ MHST Process and Procedures		17. Personal Care
	8. The NJ MHST (0-5 Years)		18. Functional Impairment
	9. Danger to Self or Others		19. Managing Feelings
	10. Behavior that Jeopardizes Living or Educational Situation		20. The NJ MHST (6 Years to Adult)

3. Which summary point do you feel is most important?

Please circle one number.

Most Important Summary Point				
1.	2.	3.	4.	

4. What would you suggest be done to improve this activity?

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*Attachment A:*

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## **Attachment A: PSC-35**

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## Child Health Program

### **Instructions for Completing the Pediatric Symptom Checklist (PSC, YPSC)**

#### **Purpose**

The *Pediatric Symptom Checklist* (PSC, Y-PSC) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional and behavioral problems. The PSC obtains the parent's report of the child's behavioral / emotional problems, and the Y-PSC obtains the child's / adolescent's report of their own behavioral / emotional problems. The screening tool helps ensure that appropriate mental health intervention is initiated for a child, as early as possible.

#### **Process for Mental Health Screening and Follow Up**

#### **Screening**

- The screening tool is **administered by the nurse case manager** as part of the initial health assessment for children (age 2 years and up) who are in out-of-home placement as they are opened to health care case management and periodically per protocol, (see Re-Screening), and for children (age 2 years and up) who are living with their biological families, on a case-by-case basis (see Indications).
- The PSC is completed:
  - by the parent (biological / foster) **for all children ages 2 and up**, under the direction of the nurse case manager.
- The Y-PSC (youth self-reporting version) is completed
  - by **children ages 11 years and older**, under the supervision of the nurse case manager, when it is identified that the child / adolescent may be a more reliable reporter of their own behavioral / emotional problems.
- Once completed, the screening tool is scored by the nurse case manager and a score is assigned to the child (see Scoring)

#### **Indications**

##### ***Children in out-of-home placement***

- **All children (age 2 years and older)** who are **entering or currently in out-of-home placement**, **UNLESS** they are currently receiving psychiatric treatment or are scheduled for a CHEC / CME exam that includes a mental health evaluation.
- **Any child with the following history or concerns** should be **directly referred** for further evaluation and **will not need a screening** beforehand.
  - Child with mental health history (not currently in treatment)
  - Child with a history of physical or sexual abuse (not currently in treatment)
  - Child whose primary care taker has a history of mental illness
  - Child with a history of multiple changes in placement
  - Child with a history of running away from placements

##### ***Children in biological homes***

- The screening tool will be used in biological home case consults **when the reason for the referral is to address issues of cognitive, emotional or behavioral problems in a child**, or
- if the **nurse case manager identifies a mental health concern in a child that needs to be assessed**, during the course of a consult.

### **Scoring**

- The screening tool consists of 35 items that describe specific behaviors and emotions.
- **Note: The only section of the form that can be filled in electronically is the identifier section. The scores for each line within the checklist and the total scores must be done by hand. The identifier section should be completed first and then the form printed for actual scoring and signature.**
- A rating is given to each item by the parent / child completing the tool, based on how true each item is, using the following scale:
  - 0 = not true**
  - 1 = somewhat or sometimes true**
  - 2 = very true or often true**
- The total score is then calculated by the nurse case manager, adding together the score for each of the 35 items (add the total scores of all 3 columns to get the final total score).
- Scoring is as follows:
  - When using the screening tool **for children ages 2 to 5 years**, the scores on items 6, 7, 17 and 18 are ignored and the score is based on 31 items. Thus, a score of **24 or higher is considered a positive score** and indicates psychological impairment and the need for referral and further evaluation.
  - When using the screening tool **for children aged 6 years and older**, a **score of 28 or higher is considered a positive score** and indicates psychological impairment and the need for referral and further evaluation.
  - **Items that are left blank are simply ignored.**
  - If **4 or more items are left blank**, the questionnaire is considered **invalid**.
- A positive score suggests a need for referral and further psychological evaluation. (See Referral and Follow-up).

### **Referral and Follow-up**

- As soon as a positive score is known, the nurse case manager communicates this verbally and by email to the DYFS Case Worker and Supervisor, and a case conference is held to discuss referral options and whom to refer child to for further evaluation and treatment. A copy of the scored tool can be given to DYFS and to the referral person / agency.
- When a child is in treatment, the nurse case manager will maintain contact with the treating psychiatrist or facility in order to maintain current information on child's diagnosis, medications, treatment modalities and progress.

### **Re-Screening**

#### ***Children in out-of-home placement***

- After the initial screening, rescreening is **completed every 6 months (or sooner if indicated), on all children in out-of-home placement except those currently receiving mental health treatment.** If a child begins mental health treatment and it is discontinued, then the child will again receive screenings every 6 months as per protocol.

#### ***Children in biological homes***

- After the initial screening, **no automatic rescreening is done.** If the CHU receives another request for nursing assistance in a case where a previous screening tool has been completed *and* the new request is for mental health screening *or* the nurse identifies a mental health concern and the child is not currently receiving psychiatric treatment, then a screening tool is completed and appropriate referral made if indicated.

#### **Psychiatric Emergencies**

- **When a nurse case manager encounters a psychiatric emergency, he / she will call 911, the DYFS Supervisor or the Case Work Supervisor, and the CNC. The psychiatrist treating the child (if child is in treatment) should also be notified. DYFS (or whoever has legal custody) will be responsible for transporting or accompanying the child to the psychiatrist office or psychiatric emergency services for immediate treatment. In no instance will a member of the CHP transport a child to emergency psychiatric treatment.**

#### **Documentation**

- The scored screening tool is filed in the Behavioral Health section of the blue medical chart for children under health care case management or in the nursing case file for any child not under health care case management.
- Any activities, such as screening / re-screening, scoring, communication or correspondence (with DYFS / caregivers / medical and mental health providers), and referral or follow-up, are documented in the **Case Notes**. If addressed during a home visit, any activities can also be documented on the **Pediatric Nursing Report**. Any documentation should then be copied to appropriate DYFS staff and filed in the designated section of the blue medical chart for children under health care case management or in the nursing case file for any child not under health care case management.

Child's Name:	NJ Spirit Case #:
Child's Date of Birth:	NJ Spirit Person #:

**BRIGHT FUTURES  TOOL FOR PROFESSIONALS**

## Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fights with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits the doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____
		Total Column One _____	Total Column Two _____	Total Column Three _____

**TOTAL SCORE** \_\_\_\_\_

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? \_\_\_\_\_


[www.brightfutures.org](http://www.brightfutures.org)

Signature of Nurse Administering PSC \_\_\_\_\_

Date of Screening \_\_\_\_\_

5/7/10

Child's Name:	NJ Spirit Case #:
Child's Date of Birth:	NJ Spirit Person #:

**BRIGHT FUTURES  TOOL FOR PROFESSIONALS**

## Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1	_____	_____	_____
2. Spend more time alone	2	_____	_____	_____
3. Tire easily, little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Have trouble with teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Act as if driven by motor	7	_____	_____	_____
8. Daydream too much	8	_____	_____	_____
9. Distract easily	9	_____	_____	_____
10. Are afraid of new situations	10	_____	_____	_____
11. Feel sad, unhappy	11	_____	_____	_____
12. Are irritable, angry	12	_____	_____	_____
13. Feel hopeless	13	_____	_____	_____
14. Have trouble concentrating	14	_____	_____	_____
15. Less interested in friends	15	_____	_____	_____
16. Fight with other children	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Down on yourself	19	_____	_____	_____
20. Visit doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Have trouble sleeping	21	_____	_____	_____
22. Worry a lot	22	_____	_____	_____
23. Want to be with parent more than before	23	_____	_____	_____
24. Feel that you are bad	24	_____	_____	_____
25. Take unnecessary risks	25	_____	_____	_____
26. Get hurt frequently	26	_____	_____	_____
27. Seem to be having less fun	27	_____	_____	_____
28. Act younger than children your age	28	_____	_____	_____
29. Do not listen to rules	29	_____	_____	_____
30. Do not show feelings	30	_____	_____	_____
31. Do not understand other people's feelings	31	_____	_____	_____
32. Tease others	32	_____	_____	_____
33. Blame others for your troubles	33	_____	_____	_____
34. Take things that do not belong to you	34	_____	_____	_____
35. Refuse to share	35	_____	_____	_____
		Total Column One _____	Total Column Two _____	Total Column Three _____
		TOTAL SCORE _____		

Signature of Nurse Administering PSC \_\_\_\_\_

Date of Screening \_\_\_\_\_

Child's Name:	NJ Spirit Case #:
Child's Date of Birth:	NJ Spirit Person #:

**Lista de Síntomas Pediátricos (Pediatric Symptom Checklist Youth Report Y-PSC)**

Favor de marcar debajo de cada título lo más adecuado para usted:	NUNCA (0)	ALGUNAS VECES (1)	FRECUENTEMENTE (2)
1. Se queja de dolores y malestares -----	1. _____	_____	_____
2. Pasa mucho más tiempo a solas-----	2. _____	_____	_____
3. Se cansa fácilmente, tiene poca energía -----	3. _____	_____	_____
4. Es inquieto(a), incapaz de sentarse tranquilo(a)-----	4. _____	_____	_____
5. Tiene problemas con un(a) maestro(a)-----	5. _____	_____	_____
6. Está menos interesado(a) en la escuela -----	6. _____	_____	_____
7. Es muy activo(a), tiene mucha energía-----	7. _____	_____	_____
8. Sueña despierto demasiado-----	8. _____	_____	_____
9. Se distrae fácilmente-----	9. _____	_____	_____
10. Temeroso(a) de nuevas situaciones-----	10. _____	_____	_____
11. Se siente triste, infeliz -----	11. _____	_____	_____
12. Está irritable, enojado(a)-----	12. _____	_____	_____
13. Se siente sin esperanzas-----	13. _____	_____	_____
14. Tiene problemas para concentrarse-----	14. _____	_____	_____
15. Menos interesado(a) en amistades-----	15. _____	_____	_____
16. Pelea con otros niños-----	16. _____	_____	_____
17. Se ausenta de la escuela-----	17. _____	_____	_____
18. Está empeorando sus notas escolares-----	18. _____	_____	_____
19. Se siente mal de sí mismo(a)-----	19. _____	_____	_____
20. Visita al doctor y el doctor no le encuentra nada malo	20. _____	_____	_____
21. Tiene problemas para dormir-----	21. _____	_____	_____
22. Se preocupa mucho-----	22. _____	_____	_____
23. Quiere estar con usted más que antes-----	23. _____	_____	_____
24. Cree que él/ella es malo(a)-----	24. _____	_____	_____
25. Toma riesgos innecesarios-----	25. _____	_____	_____
26. Se lastima frecuentemente-----	26. _____	_____	_____
27. Parece divertirse menos -----	27. _____	_____	_____
28. Actúa más chico que niños de su propia edad -----	28. _____	_____	_____
29. No obedece las reglas -----	29. _____	_____	_____
30. No demuestra sus sentimientos -----	30. _____	_____	_____
31. No comprende los sentimientos de otros -----	31. _____	_____	_____
32. Molesta o se burla de otros -----	32. _____	_____	_____
33. Culpa a otros por sus problemas -----	33. _____	_____	_____
34. Toma cosas que no le pertenecen -----	34. _____	_____	_____
35. Se niega a compartir -----	35. _____	_____	_____
Total Columna Uno _____	Total Columna Dos _____	Total Columna Tres _____	
Total Column One _____	Total Column Two _____	Total Column Three _____	
<b>RESULTADO TOTAL _____</b>			
<b>TOTAL RESULTS _____</b>			

*M.S. Jellinek and J. M. Murphy, Massachusetts General Hospital*  
Spanish PSC Gouverneur Revision 2-7-03

\_\_\_\_\_  
Signature of Nurse Administering PSC

\_\_\_\_\_  
Date of Screening

5/7/10

Child's Name:	NJ Spirit Case #:
Child's Date of Birth:	NJ Spirit Person #:

**Lista de Síntomas Pediátricos (Pediatric Symptom Checklist –PSC)**

La salud física y emocional son importantes para cada niño. Los padres son los primeros que notan un problema de la conducta emocional o del aprendizaje de su hijo(a). Ud. puede ayudar a su hijo(a) a obtener el mejor cuidado de su doctor por medio de contestar estas preguntas. Favor de indicar cual frase describe a su hijo(a)

Indique cual síntoma mejor describe a su hijo/a:	NUNCA (0)	ALGUNAS VECES (1)	FRECUENTEMENTE (2)
1. Se queja de dolores y malestares -----	1. _____	_____	_____
2. Pasa mucho más tiempo a solas-----	2. _____	_____	_____
3. Se cansa fácilmente, tiene poca energía -----	3. _____	_____	_____
4. Es inquieto(a), incapaz de sentarse tranquilo(a)-----	4. _____	_____	_____
5. Tiene problemas con un(a) maestro(a) -----	5. _____	_____	_____
6. Está menos interesado(a) en la escuela -----	6. _____	_____	_____
7. Es muy activo(a), tiene mucha energía-----	7. _____	_____	_____
8. Sueña despierto demasiado-----	8. _____	_____	_____
9. Se distrae fácilmente-----	9. _____	_____	_____
10. Temeroso(a) de nuevas situaciones-----	10. _____	_____	_____
11. Se siente triste, infeliz -----	11. _____	_____	_____
12. Está irritable, enojado(a)-----	12. _____	_____	_____
13. Se siente sin esperanzas-----	13. _____	_____	_____
14. Tiene problemas para concentrarse-----	14. _____	_____	_____
15. Menos interesado(a) en amistades-----	15. _____	_____	_____
16. Pelea con otros niños-----	16. _____	_____	_____
17. Se ausenta de la escuela-----	17. _____	_____	_____
18. Está empeorando sus notas escolares-----	18. _____	_____	_____
19. Se siente mal de sí mismo(a)-----	19. _____	_____	_____
20. Visita al doctor y el doctor no le encuentra nada malo	20. _____	_____	_____
21. Tiene problemas para dormir-----	21. _____	_____	_____
22. Se preocupa mucho-----	22. _____	_____	_____
23. Quiere estar con usted más que antes-----	23. _____	_____	_____
24. Cree que él/ella es malo(a)-----	24. _____	_____	_____
25. Toma riesgos innecesarios-----	25. _____	_____	_____
26. Se lastima frecuentemente-----	26. _____	_____	_____
27. Parece divertirse menos -----	27. _____	_____	_____
28. Actúa más chico que niños de su propia edad -----	28. _____	_____	_____
29. No obedece las reglas -----	29. _____	_____	_____
30. No demuestra sus sentimientos -----	30. _____	_____	_____
31. No comprende los sentimientos de otros -----	31. _____	_____	_____
32. Molesta o se burla de otros -----	32. _____	_____	_____
33. Culpa a otros por sus problemas -----	33. _____	_____	_____
34. Toma cosas que no le pertenecen -----	34. _____	_____	_____
35. Se niega a compartir -----	35. _____	_____	_____

Total Columna Uno \_\_\_\_\_ Total Columna Dos \_\_\_\_\_ Total Columna Tres \_\_\_\_\_  
 Total Column One \_\_\_\_\_ Total Column Two \_\_\_\_\_ Total Column Three \_\_\_\_\_

**RESULTADO TOTAL** \_\_\_\_\_  
**TOTAL RESULTS** \_\_\_\_\_

¿Tiene su hijo(a) algún problema emocional o del comportamiento para el cual necesita ayuda? ( ) No ( ) Sí  
 ¿Hay algunos servicios que Ud. desearía que su hijo(a) recibiese para estos problemas? ( ) No ( ) Sí  
 ¿Si contesta sí, cuáles servicios? \_\_\_\_\_

*M.S. Jellinek and J. M. Murphy, Massachusetts General Hospital  
 Spanish PSC Gouverneur Revision 2-7-03*

\_\_\_\_\_  
**Signature of Nurse Administering PSC**

\_\_\_\_\_  
**Date of Screening**

5/7/10





*Attachment B:*

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# **Attachment B: New Jersey Spirit Cheat Sheet**

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## Medical Mental Health Type Cheat Sheet

The screenshot displays the NJSPiRiT desktop interface within a Windows Internet Explorer browser window. The interface is titled "SCOTT RYAN's Desktop (Central Office 2)" and includes a navigation menu with options like "Create", "Maintain", "Utilities", "Specialized Search", and "Help". The main content area is divided into "Messages and Links" and "Cases". The "Cases" section shows a list of cases, with the "Medical/Mental Health" section highlighted by a red circle. This section includes a "Medical Profile" link for a child named "Chik, Test".

**Messages and Links:**

- NJ SPiRiT HELP DESK  
1-866-733-2208  
Email: njspirithelpdesk@dcf.state.nj.us  
The NJS Help Desk is available during normal business hours 9:00AM to 5:00PM Monday through Friday. On-call service is available after hours, weekends and holidays until 1:00AM.
- eCATS SUPPORT HELP DESK  
1-877-382-8718, ext. 7898  
Email: ecatsupport@dcf.state.nj.us
- [CaseLoad Report](#)
- [NJ SPiRiT December 2011 Newsletter](#)
- [Microsoft Home Use Program](#)
- [SafeMeasures Link](#)
- [Documenting Contact Notes in NJS for SafeMeasures](#)
- [Documenting Family Team Meetings in NJS](#)
- [DCF Portal Password Change](#)
- [NJ SPiRiT Knowledge Web](#)
- [How On 1 Guides and Other Support Materials](#)
- [NJS Cheat Sheets](#)
- [How to Close Out an Adoption/KLG case w/Subsidy 01-11-2010](#)
- [Rate Tables 01/2010: Resource Family, Relative Care, KLG, and Sub Adopt](#)
- [Contracted Services Resource Director](#)
- [DHS 2011 Service Dictionary - Complete](#)
- [DHS 2011 Service Dictionary - Quick Reference Guide](#)
- [DYFS Substitute Care Director includes NJS Resource ID#s](#)
- [DYFS Online Policy Manual](#)
- [NJS User Guide and Definitions](#)
- [NJS Form Instructions](#)
- [DYFS Catchment Listing](#)
- [Assignment Designees - Intake Units \(7/17/2007\)](#)
- [Assignment Designees - Resource Family Units \(7/17/2007\)](#)
- [DCF 26-90 Court Report](#)
- [DCF 26-90 Court Report Cheat Sheet](#)
- [Family Agreement Form - \(Form 22-45\)](#)
- [Spanish-Family Agreement Form - \(Form 22-45\)](#)
- [Family Team Meeting Notes & Agreement Form - \(Form 22-46\)](#)
- [Spanish-Family Team Meeting Notes & Agreement Form - \(Form 22-46\)](#)
- [Training Academy Website](#)
- [NJS Web-Based Training](#)
- [Life Book Pages - November 2009](#)

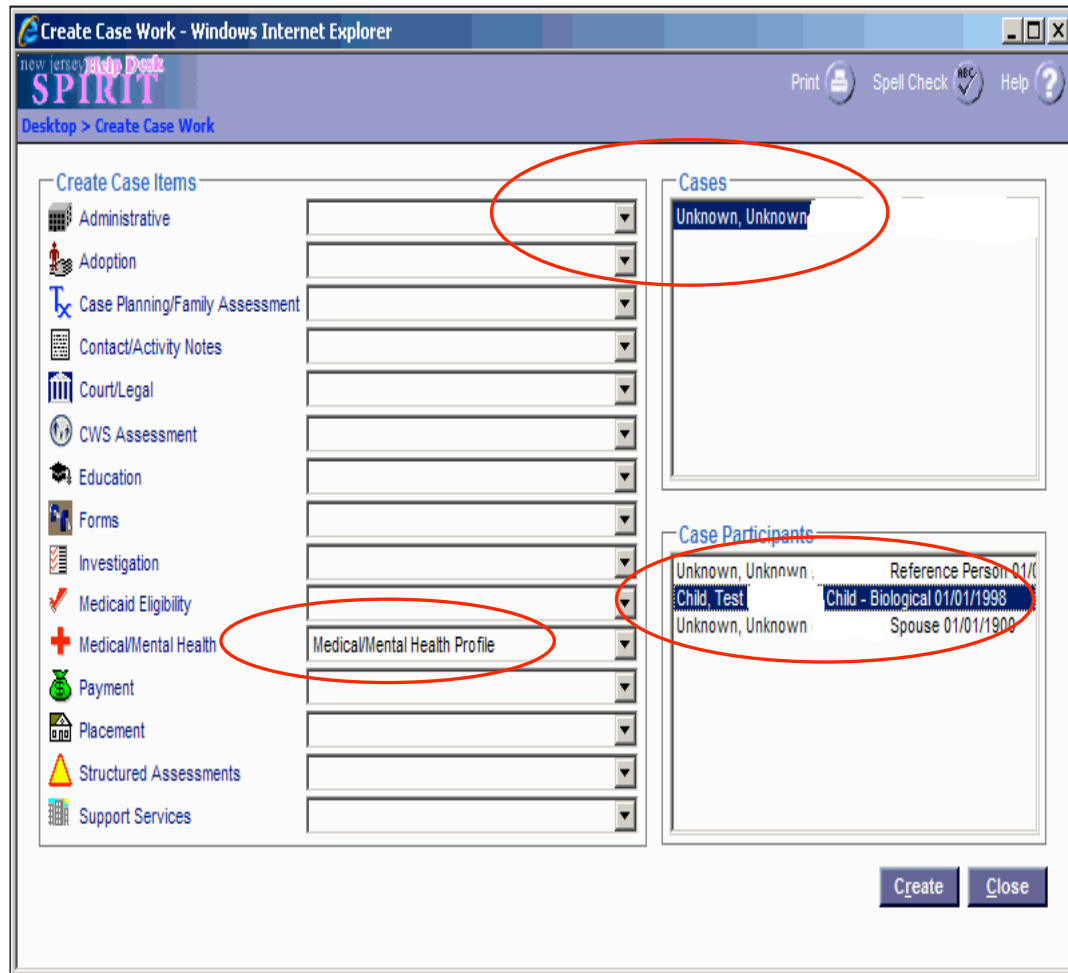
**Cases:**

- Unknown, Unknown | [Actions](#)
- CPS-Family 11/22/2011 In-Home 1334 Morris Street Gloucester City, NJ 08030 BYRNE, GARY CAMDEN SOUTH LO
- [Assignment](#)
- [Contact/Activity Notes](#)
- [Income/Eligibility](#)
- [Intakes](#)
- [Investigation](#)
- [Medical/Mental Health](#)
- [Medical Profile](#) 12/20/2011 [Chik, Test](#)
- [Resources](#)
- [Workers](#)
- [Approvals](#)
- [Intakes](#)

The "Medical Profile" link is circled in red in the original image.

### Step 1:

- ➔ From the NJS Desktop >Click the Case expando
- ➔ Click Medical/Mental Health expando and click Medical Profile hyperlink for child you wish to update.



- Step 2:** (If the child does not already have a medical record created)
- ➔ Click “Create, Case Work”.
  - ➔ From the Medical/Mental Health drop down select Medical/Mental Health Profile and Select the Case and the Child and Click Create

The screenshot shows a web browser window titled "Medical Mental Health - Windows Internet Explorer". The page has a purple header with the "SPRIT" logo and navigation links like "Print", "Spell Check", and "Help". Below the header, there's a breadcrumb trail: "Desktop > Create Case Work > Medical Mental Health".

The main content area is divided into several sections:

- General Information:** Fields for Name (Child, Test), Person ID, Race, Gender, Date of Birth, and Primary Worker.
- Medical Profile:** A tabbed interface with options for Medical Profile, Mental Health Profile, Providers, Medications, Medical History, Characteristics, Disability Or Risk Factors, and Health Plan.
- Identifiers:** Fields for SSN, Medicaid Number, SSI Number, Behavioral Health Case Number, and Behavioral Health Authorization Number (with a yellow highlight and text "Enter a number ###").
- Birth History:** Fields for Name of Birth Hospital, Location, Child Birth Weight (lb/kg), Child Birth Height (in/cm), Child Head Circumference (in/cm), Full Term (Yes/No/Unknown), Gestational Age, Newborn Hearing Screen (Pass/Fail/Unknown), Prenatal Care (Yes/No/Unknown), and Drug/Alcohol Exposed (Yes/No/Unknown). There are also text boxes for describing drug/alcohol use and other significant birth history.
- Health History:** Fields for Hospitalization (Yes/No/Unknown) and History of injuries/illness/significant childhood diseases (Yes/No/Unknown), both with text boxes for descriptions.

At the bottom, there is an "Options:" dropdown menu, a "Go" button, and "Save" and "Close" buttons.

➔ The Medical Mental Health Window will open.

Medical Mental Health - Windows Internet Explorer

SPiRiT

Desktop > Create Case Work > Medical Mental Health

General Information

Name: Child, Test      Person ID:      Race:

Gender      Date of Birth:      Primary Worker:

Medical Profile    Mental Health Profile    Providers    Medications    **Medical History**    Characteristics    Disability Or Risk Factors    Health Plan

Treatment History

Insert

Options:    Go    Save    Close

**Step 3:**

- ➔ Select the Medical History tab
- ➔ Click insert button at bottom right to open a new treatment history record.

Medical Mental Health - Windows Internet Explorer

SPiRiT

Print Spell Check Help

Desktop > Create Case Work > Medical Mental Health

General Information

Name: Child, Test Person ID: Race:

Gender: Date of Birth: Primary Worker:

Medical Profile Mental Health Profile Providers Medications **Medical History** Characteristics Disability Or Risk Factors Health Plan

Treatment History

NUSPirit Resource Provider: Search Other Provider:

Service Dates: First: 00/00/0000 Last: 00/00/0000

Medical/Mental Health Type: Medical/Mental Health Activity:

Procedure

Diagnosis

Consult/Recommendation/Other

Insert

ptions: Save Close

**Step 4:**  
Enter the **Service Date** in the "**First**" Date Field.

Medical Mental Health - Windows Internet Explorer

Desktop > Create Case Work > Medical Mental Health

General Information

Name: Child, Test      Person ID:      Race:

Gender:      Date of Birth:      Primary Worker:

Medical Profile    Mental Health Profile    Providers    Medications    Medical History    **Characteristics**    Disability Or Risk Factors    Health Plan

Treatment History

NUSPRIT Resource Provider:  Search      Other Provider:

Service Dates: First: 12/30/2011      Last: 00/00/0000

Medical/Mental Health Type:       Medical/Mental Health Activity:

Procedure

- Comprehensive Medical Exam CME
- EPSTD Exam
- Follow Up to CME
- Follow Up to EPSTD
- Health Related

Diagnosis

- Immunizations Record Review
- Mental Health Assessment
- Mental Health Screening- Casework
- Mental Health Screening- CME

Consult/Recommendation

- Mental Health Screening- Nursing
- Mental Health Treatment Services
- Substance Abuse Treatment

Insert

Options:             

**Step 5:**  
From the Medical/Mental Health Type drop down list, select "**Mental Health Screening - Casework**".



The screenshot shows a web browser window titled "Medical Mental Health - Windows Internet Explorer". The page header includes the "SPIRIT" logo and navigation links like "Print", "Spell Check", and "Help". The main content area is divided into several sections:

- General Information:** Fields for Name (Child, Test), Person ID, Race, Gender, Date of Birth, and Primary Worker.
- Navigation Tabs:** Medical Profile, Mental Health Profile, Providers, Medications, Medical History (selected), Characteristics, Disability Or Risk Factors, Health Plan.
- Treatment History:** A section with a search bar for "NLSPIRIT Resource Provider" and "Other Provider", and "Service Dates" (First: 12/30/2011, Last: 00/00/0000). It includes a dropdown for "Medical/Mental Health Type" (set to "Mental Health Screening- Casework") and another dropdown for "Medical/Mental Health Activity" which is currently open, showing options: "Less Than 2 Years Old", "Receiving Mental Health Services", "Referral Made", "Tool Completed-No Referral Made", and "Tool Completed-Referral Made".
- Procedure, Diagnosis, and Consult/Recommendation/Other:** Three large text input fields for detailed notes.
- Buttons:** "Insert", "Save", and "Close" buttons are visible at the bottom.

**Step 6:**

- ➔ Select the appropriate Medical/Mental Health Activity from the drop down list
- ➔ If any comments, enter in Consult/Recommendation/Other text field

**Step 7:**

The Worker needs to enter his/her name in the **Other Provider** box.

- ➔ Click Save and Close to return to the desktop, or insert to enter another treatment history record.

**Note:** Please remember to click Save after entering each record.

## NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 NJS: Case# \_\_\_\_\_ Person ID# \_\_\_\_\_  
 Casework/supv/contact info \_\_\_\_\_

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	
			<p><b><u>Behavior</u></b></p> <p>1. Does this child exhibit unusual or uncontrollable behavior?</p> <p><b>0 – 18 mos:</b> Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness  <b>18 – 36 mos:</b> Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger  <b>3 – 5 yrs:</b> Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)</p> <p>2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?</p> <p><b>0 – 18 mos:</b> Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems.  <b>18 – 36 mos:</b> Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues.  <b>3 – 5 yrs:</b> Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).</p> <p>3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?</p> <p style="padding-left: 40px;"><i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i></p> <p><b><u>Placement, Childcare, Education Status</u></b></p> <p>4. Does this child exhibit behaviors that may <b>not</b> allow him/her to remain in his/her current living, preschool and/or childcare situation?</p> <p style="padding-left: 40px;"><i>The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.</i></p> <p><b><u>History</u></b></p> <p>5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?</p> <p style="padding-left: 40px;"><i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas ,rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.</i></p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Please continue to page 2**

**If you checked any of the above boxes “YES”, child should be referred for assessment. For the young child, a next step will usually include a consult with the child’s pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.**

**If applicable, identify the agency and provider to which the child has been referred:**

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**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

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## NEW JERSEY MENTAL HEALTH SCREENING TOOL (6 YEARS TO ADULT)

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**NJS: Case#** \_\_\_\_\_ **Person ID#** \_\_\_\_\_  
**Casework/supv/contact info** \_\_\_\_\_

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please indicate the issues under the COMMENTS section on the reverse side of the form.

YES	NO	Unknown	Part 1 - IDENTIFIED RISK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Has this child been a danger to him/herself or to others in the last 90 days?  <i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?  <i>Persistent chaotic, impulsive or disruptive behaviors; daily verbal outburst; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other disciplines, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?  <i>History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (head banging) or vocalizations (e.g. echolalia); smears feces, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?  <i>Either needs immediate evaluation of medication or needs a new prescription.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?  <i>Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?  <i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.</i>

**If you checked any of the above boxes YES, this indicates that the need for Mental Health assessment and/or assistance is urgent.**

**If all the above are either NO or UNKNOWN, please continue on reverse side.**

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

YES	NO	Unknown	Part 2 - RISK ASSESSMENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does the child have problems with social adjustment?  <i>Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confirmed due to serious law violations; does not seem to feel guilt after misbehavior, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does this child have problems making and maintaining healthy relationships?  <i>Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does this child have problems with personal care?  <i>Eats or drinks substances that are not food; regularly enuretic during waking hours (subject to age of child); extremely poor personal hygiene.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have significant functional impairment?  <i>No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Does this child have significant problems managing his/her feelings?  <i>Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is this child known to abuse alcohol and/or drugs?  <i>Child regularly uses alcohol or drugs.</i>

**If you checked any of the above boxes YES, this indicates child should be referred for a mental health assessment.**

**Please forward the form to:**

(Could be preprinted to have the address of local Mental Health agency.)

**COMMENTS/ADDITIONAL INFORMATION:** \_\_\_\_\_

### Mental Health Follow Up Response

Name: \_\_\_\_\_ Date: \_\_\_\_\_

MH Assessment complete; no follow up MH service required.

MH Assessment complete; MH follow up required.

Other: \_\_\_\_\_