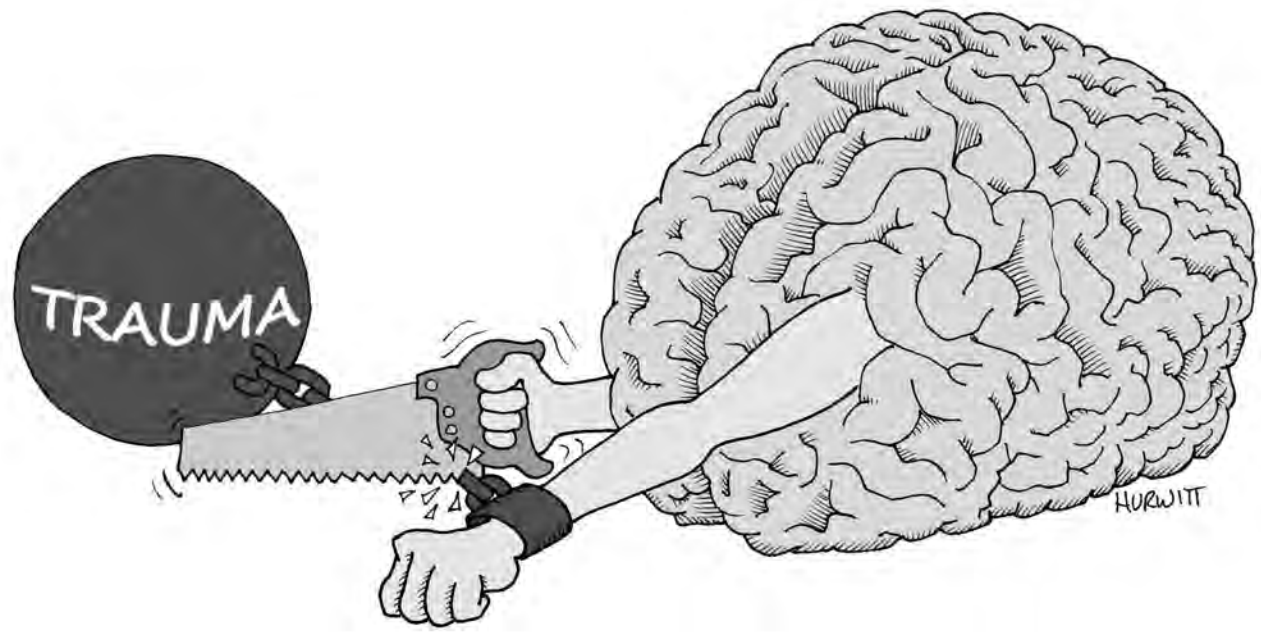
# Child Development, Trauma and the Brain:




# The DYFS Mental Health Screening Program

## Trainer Guide

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 NJ Mental Health Screening Program (Trainer Guide)

First Edition

Written by the
Rutgers Occupational Training and Educational Consortium
(OTEC)
Produced by the
Institute for Families-Rutgers School of Social Work

Funding for the Child Development, Trauma and the Brain: The DYFS NJ Mental Health Screening Tool Program was provided by the New Jersey Department of Children and Families (NJ DCF)

# Table of Contents

# About This Book

Children and adolescents involved with the child welfare system have often been exposed to chaotic home environments, 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 then 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.

# Rutgers OTEC

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

For information about OTEC's programs and services, contact:

Occupational Training and Education Consortium
The Labor Education Center
Rutgers, The State University of New Jersey
50 Labor Center Way
New Brunswick, NJ 08901-8553
Phone: (732) 932-6926

### OTEC Staff

Michele Ochsner, Co-Director
Carmen Martino, Co-Director
Debbie McNeill, Program Coordinator

### Illustrations

Mark Hurwitt

# Acknowledgements

***Child Development, Trauma and the Brain: The DYFS NJ Mental Health Screening Tool Program*** was developed with the support and guidence of our Curriculum Advisory Team (CAT). CAT members reviewed factsheets, offered suggestions for improving tasks and provided technical assistance through each draft of the workbook.

## CAT Members

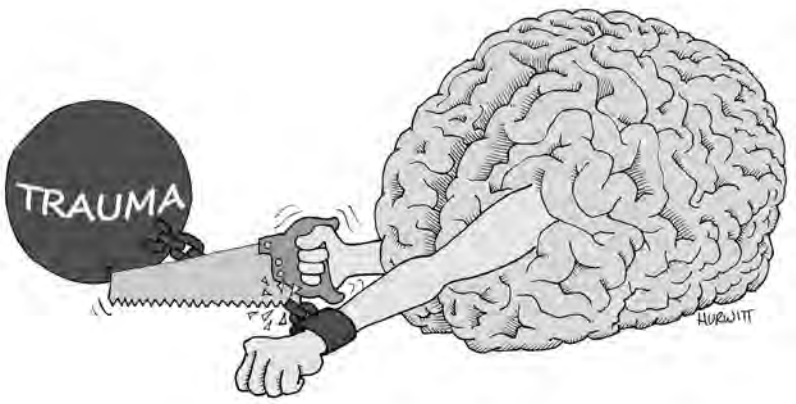
Ernestine Counts, DYFS, Supervising Family Service Specialist II
Dale Mooney, DYFS, Family Services Specialist II
Andrea Stokes, DYFS, Supervising Family Service Specialist II
Ryan Spinelli, DYFS, Family service Specialist I
Karen Hicks, Monmouth Cares, Clinical Consultant to DYFS
Gail Howell, DYFS, Supervising Family Service Specialist I
Jim Daly, DYFS, Supervising Family Service Specialist II
Stephen Melnykevich, DYFS, Family Serve Specialist II
Sandra McDonnell, DYFS, Monmouth/Ocean Area Office Team Leader
Mindy Kolczynski, DYFS, Supervising Family Services Specialist I
Philip Wilensky, DYFS, Family Service Specialist II
Meghan Clemente, DYFS, Family Service Specialist I
Courtney Devine, DYFS, Family Service Specialist II
Jennifer Dietrich, DYFS, Family Service Specialist II
Teniquwa Sutherland, DYFS, Family Service Specialist I
Angela Olewunne, DYFS, Family Service Specialist I
Christine D'Andrea, DYFS, Family Service Specialist II
April Hinton, DYFS, Family Service Specialist II
Brendan Kunzman, DYFS, Family Service Specialist II
Tara Mathis, DYFS, Family Service Specialist II
Dawn Graham, DYFS, Family Services Specialist II
Michele Schwartz, DCF OCHS, County Service Specialist
Debra Lancaster, DCF OCHS, Director

## CAT Member and Project Advisor

Dr. Mary Beirne, DCF Chief Child/Adolescent Psychiatrist

# Trainer Guide: Course Overview

## Course Description




This course will help case workers identify children in the child welfare system who may have mental health needs. Special emphasis is placed on the importance of using the New Jersey Mental Health Screening Tool (NJMHST) to get children the help they need as soon as possible.

However, beyond the tool itself, the course will focus on trauma— the most common mental health challenge among foster care children. Through a close examination of trauma the course enhances case worker understanding of the unique vulnerabilities of the children and adolescents under our care and supervision. Specifically, the course provides case workers with an opportunity to think not only about the physical effects of trauma but also to understand the biological underpinnings of the challenges faced by children and adolescents in the system.

## Course Objectives

- To increase case worker knowledge and understanding of trauma and its devastating long-term impact on children in foster care when left untreated;

- To increase case worker knowledge and understanding of how the brain develops and organizes itself; how trauma affects brain development; and how the brain can be strengthened and reorganized to overcome trauma.

- To increase case worker knowledge and understanding of what the NJ MHST is, why we need to use it, and how it will be used.

- To strengthen case worker critical thinking, group problem solving and communication skills.

## Course Design

The course does not rely upon power point presentations or lectures. It is a participatory training that requires case workers to use their work experience as the foundation for expanding and enhancing their knowledge and understanding of trauma and how to use the NJ MHST. In addition to learning technical information and the procedures for using the tool, we want to encourage case workers to use their experience, ask questions and most importantly to learn from each other in the process.

Each module or activity relies on the Small Group Activity Method (SGAM).
**SGAM activities have a common basic structure:**

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

**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.

**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 report-back on large pads of paper in front of the class so that everyone can refer to them.

**Summary:** Before the discussion drifts too far, the trainer brings the activity 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.

*(continued)*

## Course Design (continued)

**SGAM relies on three learning exchanges:**

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

**Participant-to-Participant:** The Participant-to-Participant exchange is 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:** The Participant-to-Trainer exchange gives trainers an opportunity to listen and learn from the participants. 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.

# Trainer Guide: Before You Begin!

### Room Set Up

Before the day gets started, set up the room for small groups. Be sure to number the tables so you can more easily take report backs from each group.

### Introductions

To assist you with understanding who is in the room and to ensure that participants know who is in the room, it is important to do introductions. Ask participants to share their name, current role in DYFS, years of experience, and what other work they have done during their tenure. Be sure to introduce yourself!

### Training Methodology

It might be helpful to let participants know that today's training will be different. Let them know that the day will rely largely on their experience and the information in the workbook. The course does not rely upon power point presentations or lectures.

Because the training methodology depends on case worker participation, it is important that you communicate your enthusiasm about the NJ MHST and the training. This is an vital DCF initiative, and one that will have a direct positive influence on the children and famlies we serve!

Encourage participants to read the About this Workbook and/or highlight parts of that section for them in your introduction.

### Thank the Participants

As part of your introduction to the day, be sure to thank participants for being present. And do the same at the end of the day.

If there are questions about the NJ MHST or the curriculum that you don't know the answer to, let the participant know that you will get back to them with the answer and/or redirect them to contact the DCF Office of Child Health Services.

# Trainer Guide: Activity Instructions

## ACTIVITY 1: TRAUMA AND CHILDREN

**Objectives:**
To increase case worker knowledge and understanding of trauma and its devastating long-term impact on children in foster care when left untreated.

To improve critical thinking, group problem solving and communication skills.


**Resources:**
Workbooks (for each participant) Flip chart paper, masking tape, and markers.

**Time:**
60 minutes

**Context:**
Dr. Beirne—*One of the most amazing things I ever learned is that psychiatric illness is physical – we know that people who have ADHD may be hyper or that people who are depressed may be tired, but it's not just symptoms. The basis for psychiatric illness – where it really is – is biological: in our brains.*

*We will talk more in the second activity about how things actually change in our brains but this activity is focused on the impact that outside events can have on our physiology. Our brains are use-dependent and we will talk more about that as well in the second activity.*

*But here we need to understand that if something bad happens to you – an accident, a betrayal, an injury, witnessing something horrifying – that event is carved into your brain cells. It is part of your memory, part of your experience, part of what you expect from the world and part of how you know the world is.*

*If you have had a traumatic experience, a researcher could stimulate that specific portion of your brain where the event is stored in your memory with a chemical or with a probe and you would re-experience the entire event as if it were happening live while you were just sitting there in the researcher's room.*

*So when a child has a traumatic experience it is recorded in the child's brain. However, since a child is a growing organism, the trauma is an early experience and it influences all of the experiences that come after it. All of the experiences that come after it!*

*If you have reached out to comfort a traumatized child, you might have found your kind touch to be met with an exaggerated startle, as if the child had expected a blow rather than a kindness. Why? Because an unexpected gentle touch may trigger a response that was learned following unexpected blows or intrusive acts. Any new experience that is similar in some way to the traumatic event can trigger a re-experience of the traumatic event – just like the researcher's probe. The child can re-experience all of the feelings of being traumatized in what may seem to others to be a minor or neutral or even positive situation.*

*Even more important, when a child has an early traumatic experience it changes the child's expectations: so the child goes into new experiences expecting danger, pain, betrayal, horror. This leaves the child with an on-going sense of arousal, anxiety, defensiveness and "waiting for the other shoe to drop."*

*(continued)*

## ACTIVITY 1: TRAUMA AND CHILDREN (continued)

### Context (continued):

*On the positive side, however, good experiences also influence the child's development. A relationship with a positive adult, a teacher or a coach, a new family, a therapist can all contribute to different expectations over time. This leads to resilience.*

*For children each year builds on the year before. It is important to intervene early because the child can begin to form current experiences based on more balanced experiences.*

### Instructions:

**Introduce the Activity**

- Ask the participants to turn to **page 1**, **Activity 1: Trauma and Children.**
- Read the **Purpose** statement.
- Read the instructions for completing the **Task** and assign someone from each group to take notes (ask for volunteers).
- Check with each group and make sure they understand the Task and what they are being asked to do.
- Check back with each group periodically to see how they are doing.

**Take Report Backs From Each Group**

- Ask the note taker for Group One to report back on one of the key points (**not all, just one**) they would use to inform new resource parents about children in foster care and their exposure to trauma.
- Record Group One's answer on the flip chart paper in front of the room.
- Then go to Group Two and ask their note taker to report back on one of the key points (**again not all, just one**) they would use to inform new resource parents about children in foster care and their exposure to trauma.

- Continue the procedure of taking one response from each group until they run out of responses. Then ask the entire class if anyone has any more points they would like to make. If there are more responses take them and record them on the flip chart paper.

**Conclude the Report Backs**

- Ask the participants if they have any more questions or comments about the Task and/or the Activity.
- Take any questions or comments (you do not have to record the information on the flip chart).

**Summarize the Activity**

- Tell all participants to go to the Summary and then read one or two of the points you think are the most important.
- Try to focus on points that were not raised or points that might need further clarification.

**Complete the Evaluation**

- Ask the participants to turn to page 21 and complete the Evaluation.
- Read all four questions out loud (just the questions, no need to read the possible choices for questions 2 and 3) and make sure that everyone understands how to complete the evaluation.
- Collect the Evaluations.

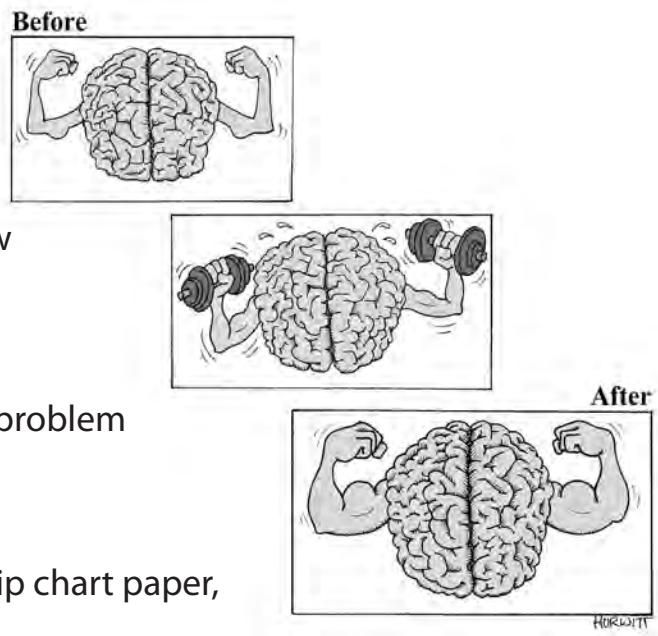
**Transition Statement for Activity 2**

- *After our break we will be working on Activity 2: Trauma and Child Development and we will be taking a closer look at trauma and how it impacts the brain and can lead to life-long problems when left untreated.*

## ACTIVITY 2: TRAUMA AND CHILD DEVELOPMENT

### Objectives:

To increase case worker knowledge and understanding of how the brain develops and organizes itself; how trauma affects brain development; and how the brain can be strengthened and reorganized to overcome trauma.




To improve critical thinking, group problem solving and communication skills.

### Resources:

Workbooks (for each participant) Flip chart paper, masking tape, and markers.

### Time:

90 minutes

### Context:

Dr. Beirne—*For this activity and throughout the course of the day's training, one of the most salient points to keep in mind is that the ways in which infants and young children experience the world has a direct impact on their brain development. In other words, because our brains develop sequentially and are use dependent (see the fact sheets for more information on this subject), early events and/or experiences, both good and bad, can have a dramatic affect on brain development.*

*For example, a newborn's hearing is tested before the baby leaves the hospital. If there is a problem, follow-up tests are done. If hearing loss is confirmed, the baby is fitted with hearing aids so that she will learn to hear, understand and produce speech properly. If she grows up to school age with undetected hearing problems, her speech will be impaired because that's the way she has heard language.*

*An early intervention solves the hearing impairment for an infant and so it is the same with children who are exposed to emotional or physical trauma during the crucial periods of brain development. If the trauma is addressed through early proactive interventions, then a positive outcome—a child who grows up with high hopes and expectations—is more likely. However, if the trauma is not addressed, the brain will develop abnormally. The wiring in the brain will be faulty and the outcome—a child with grave doubts about himself and the world around him—is just as likely.*

*Early interventions are the key to success and that's what makes the training and the caseworker's use of the NJ MHST so important!*

## Instructions:

### Introduce the Activity

- Ask the participants to turn to **page 23, Activity 2: Trauma and Child Development.**
- Read the **Purpose** statement.
- Read the instructions for completing **Task 1** and read the statement.
- Assign someone new from each group to take notes (ask for more volunteers).
- Emphasize that groups should try to back up their responses with a supporting factsheet.
- Check with each group and make sure they understand the Task 1 instructions and what they are being asked to do.
- Check back with each group periodically to see how they are doing.
- Groups should have at least one response for each of the five paragraphs in the statement.

*(continued)*

## ACTIVITY 2: TRAUMA AND CHILD DEVELOPMENT (continued)

### Instructions (continued):

**Take Report Backs From Each Group**

- Read the first paragraph from the statement then ask the note taker for Group Two how they responded and what factsheet they used.
- Record Group Two's answer on the flip chart paper in front of the room.
- Then ask all participants if they had any other responses to the first paragraph of the statement.
- Record any other answers on the flip chart paper in front of the room.
- Read the second paragraph, ask Group Three how they responded and continue repeating the above same steps for each paragraph in the statement.

**Conclude the Report Backs for Task 1**

- Ask the participants if they have any more comments about the statement.
- Take any questions or comments (you do not have to record the information on the flip chart).

**Transition Statement Between Task 1 and Task 2**

- *Having discussed how the brain develops, we will now turn our attention to how trauma impacts the brain at different stages of development and the symptoms we need to be looking for among children we suspect or know have been exposed to trauma.*

**Introduce Task 2**

- Ask the participants to turn to page 38 and read the instructions for completing **Task 2**.
- Assign someone new from each group to take notes (ask for more volunteers).
- Hand out one sheet of flip chart paper and markers to each group and tell them that they should record their answers to **Question 3** on the flip chart paper using the Question 3 table on page 39 as a guide.

- Inform the participants that during the report back each group will bring their Question 3 flip chart responses to the front of the room and explain one of the cases they have identified.
- Check with each group and make sure they understand the Task 2 instructions and what they are being asked to do.
- Check back with each group periodically to see how they are doing.

**Take Report Backs From Each Group**

- Read **Question 1** then ask the note taker from Group Three how they answered the question.
- Record Group Three's answer on the flip chart paper in front of the room.
- Then ask all participants if they had any other responses to the first question.
- Record any other answers on the flip chart paper in front of the room.
- Read **Question 2** and ask Group Four how they responded and continue repeating the above same steps for Question 2.
- Ask for a Group to bring their flip chart response to **Question 3** up to the front of the room and ask the scribe or Group spokesperson to discuss one of the trauma cases they identified. The explanation should include all the aspects noted in the top row of the table (e.g., Stage of Development, Brief Description of the Case, Trauma Symptoms, Intervention, and Progress Made).
- Give each Group the opportunity to bring their flip chart to the front of the room and present one of their cases.
- After each presentation ask the class if anyone has any questions or comments.
- Thank the Group for their contribution (clap and encourage others to do the same).

*(continued)*

## ACTIVITY 2: TRAUMA AND CHILD DEVELOPMENT (continued)

### Instructions (continued):

**Conclude the Report Backs for Task 2**

- Ask the participants if they have any more comments about Task 2 or the Activity.
- Take any questions or comments (you do not have to record the information on the flip chart)

**Summarize the Activity**

- Ask participants to go to the Summary and then read one or two of the points you think are the most important.
- Try to focus on points that were not raised or points that might need further clarification.

**Complete the Evaluation**

- Ask the participants to complete the Evaluation.
- Collect the Evaluations.

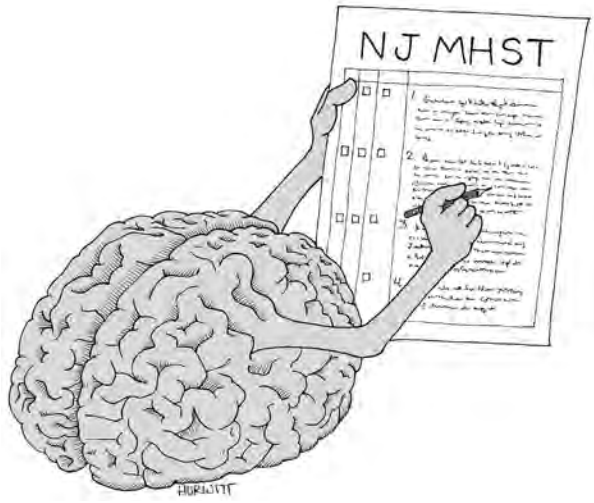
**Transition Statement for Activity 3:**

- *After our break we will be working on Activity 3: The NJ Mental Health Screening Tool. We will use this time to make sure that everyone understands what the tool is, why we are using it, and how it will be used in the field*.

## ACTIVITY 3: THE NJ MENTAL HEALTH SCREENING TOOL

### Objectives:

To increase case worker knowledge and clarify their understanding of what the NJ MHST is and why they need to use it.




To improve case worker critical thinking, group problem solving and communication skills.

### Resources:

Workbooks (for each participant)
Flip chart paper, masking tape, and markers.

### Time:

60 minutes

### Context:

Dr. Beirne— *We know that case workers refer children for mental health assessments and follow up treatment as part of their work. But until now, DYFS has not had a systematic way of capturing this information and has lacked a consistent "safeguard" for ensuring that children who are not already engaged in mental and behavioral health treatment, are screened on an on-going basis for a suspected mental health need.*

*Activity 3 is about the NJ MHST. Case workers use it if a child is not already engaged in mental and behavioral health treatment and is not already referred for an assessment. If the child is engaged in mental and behavioral health treatment (and presumably then has had mental health assessments and on going evaluation), case workers are still required to document that they have thought about this.*

*(continued)*

## ACTIVITY 3: THE NJ MENTAL HEALTH SCREENING TOOL (continued)

*For example, if you are the caseworker, and have a child who is in a residential treatment center receiving psychiatric care, you are still responsible for "screening" the child, but would not apply the NJ MHST (we know they have a mental health need and are being treated for it). You would document in NJ SPIRIT that the child is already receiving mental health services (see Activity 3, Fact Sheet 12).*

*The top three issues likely to be raised during the reportbacks and discussions of Activity 3 include:*

- *"Liability"--what if caseworker fails to identify a mental health need? (We are more liable if we do nothing!)*
- *"Duplication"--child health unit nurses and caseworkers are both required to do screenings for children in out of home placement—isn't that a waste of time and what if we get different results?*
- *What am I accountable for?*

*In most cases, it is anticipated that if one participant raises these types of issues, another will address them and this is ideal. If that fails to happen or you can not elicit an appropriate response from participants to address these concerns, you will have to step in. You can remind them that they are not being asked to be experts, and it only takes one yes to refer a child for an assessment. We would anticipate that at times, the nursing tool and the worker tool will differ in terms of results. That's part of the point of having multiple parties engaged in screenings with different lenses.*

## Instructions:

### Introduce the Activity

- Ask the participants to turn to **page 53, Activity 3: The NJ Mental Health Screening Tool.**
- Read the **Purpose** statement.
- Read the instructions for completing the **Task** and read each question out loud.
- Assign someone new from each group to take notes (ask for more volunteers).
- Emphasize that groups should try to back up their responses with a supporting factsheet.
- Check with each group and make sure they understand the Task instructions and what they are being asked to do
- Check back with each group periodically to see how they are doing (**Note:** If the participants ask about specific questions about the tool itself, inform them that in the last Activity (Activity 4: Case Studies) they will have an opportunity to go over all aspects of using the tool including a review and explanation for every question.)

### Taking the Report Back

- Read **Question 1** then ask the note taker from Group Four how they answered the question.
- Record Group Four's answer on the flip chart paper in front of the room
- Then ask all participants if they had any other responses to Question 1.
- Record any other answers on the flip chart paper in front of the room.
- Read **Question 2**, ask Group One how they responded and continue repeating the above steps for Questions 2 through 10.

### Conclude the Report Backs for the Task

- Ask the participants if they have any more comments or questions about the Task or the Activity.
- Take any questions or comments (you do not have to record the information on the flip chart).

*(continued)*

## ACTIVITY 3: THE NJ MENTAL HEALTH SCREENING TOOL (continued)

### Instructions (continued):

**Summarize the Activity**

- Ask the participants to go to the Summary and then read one or two of the points you think are the most important.
- Try to focus on points that were not raised or points that might need further clarification.

**Complete the Evaluation**

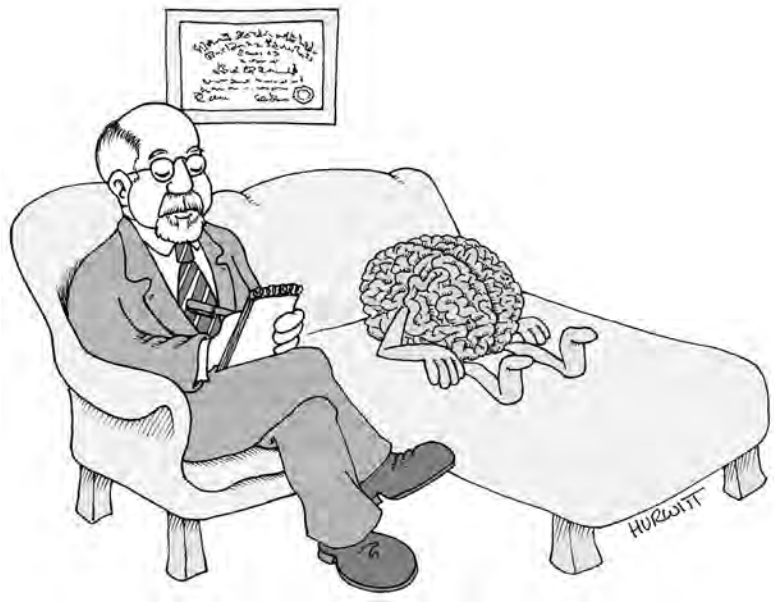
- Ask the participants to complete the Evaluation.
- Collect the Evaluations.

**Transition Statement for Activity 4: Case Studies**

- *After our break we will be working on Activity 4: Case Studies. We will use this time to make sure that everyone understands how to use the tool.*

## ACTIVITY 4: CASE STUDIES

**Objectives:**
To increase case worker knowledge and understanding of how to use the NJ MHST.



To improve case worker critical thinking, group problem solving and communication skills.

**Resources:**
Workbooks (for each participant) Flip chart paper, masking tape, and markers.

**Time:**
90 minutes

**Context:**
Dr. Beirne—*In this activity case workers have the opportunity to work on using the MHST with case studies. It will give them a chance to practice using the tool and at the same time sharpen their critical thinking and problem solving skills.*

*In tasks 1 and 3 the participants will complete the NJ MHST for two children: Tommy, a pre-school age boy, and Trina, a teenager. In addition, follow-up case information is provided in Task 2 for Tommy. It will encourage further discussion and provide case workers with an opportunity to integrate case practice skills into managing cases where mental and behavioral health needs have already been identified.*

*(continued)*

## ACTIVITY 4: CASE STUDIES (continued)

### Context (continued):

*In fact, in Task 2 our Tommy is already receiving mental health services so he doesn't need a screening but don't point this out to participants, wait see if they pick up on it. Again, you want to keep in mind that the goal here is to sharpen case practice skills and get case workers thinking about next steps. At the end of the day, we want them to understand that while the tool can get a child to an assessment, in many ways, the hard work comes later!*

*You will also notice that some of the case study information is ambiguous and training participants may not agree on what is important. They may want to discuss their differences. This is an important part of the process, because there is not always a clear right or wrong answer. This provides an opportunity for you to remind and reassure everyone that for both the 0-5 and 6-Adult screenings it only takes one "yes" answer to indicate that a further assessment is required.*

*In both case studies we are looking at children who will qualify for an assessment because "yes" answers in both cases will have already been checked and that really is the only thing that matters.*

*So, even in situations in which experienced case workers might not agree on analysis and interpretation of one or more pieces of data, children who give indications of possible mental health need will be referred for follow-up assessment.*

### Instructions:

**Introduce the Activity**

- Ask the participants to turn to **page 79, Activity 4: Case Studies.**
- Read the **Purpose** statement.
- Read the instructions for completing **Task 1** and read the case study out loud.
- Assign someone new from each group to take notes (ask for more volunteers).

- Emphasize that before completing questions 1-5 on page 82, groups should complete the Notes and Analysis Table on page 81. (**Note:** The questions listed on page 82 are the exact same questions that appear on the MHST (0-5 Years))
- Also, inform the groups that for each of the five questions there is a corresponding factsheet that provides more details. Participants should review each factsheet before answering the questions.
- Check with each group and make sure they understand the Task instructions and what they are being asked to do.
- Check back with each group periodically to see how they are doing.

**Taking the Report Back**

- Read question 1 then ask the note taker from Group one how they answered the question (**Note:** You don't have to record the answers on the flip chart paper)
- Then ask all participants if they agree or have any other comments for question 1.
- Read the second question, ask Group Two how they responded and continue repeating the above same steps for questions 2 through 5.
- (**Note:** In some situations groups may have different interpretations or points of view as to how the questions should be answered. When this occurs have them go back to their Notes and Analysis to back up their points. And at the appropriate time stress that while there may be differences of opinion on one or more of the questions, the child in question will still get an assessment and that is what is important.)

*(continued)*

## ACTIVITY 4: CASE STUDIES (continued)

### Instructions (continued):

**Conclude the Report Backs for Task 1**

- Ask the participants if they have any more comments or questions about Task 1.
- Take any questions or comments (you do not have to record the information on the flip chart)

**Transition Statement Between Task 1 and Task 2**

- *Now lets take another look Tommy's case a few months later...*

**Introduce Task 2 (Note: Depending upon time, Task 2 is optional)**

- Ask the participants to turn to **page 92, Task 2: Tommy's Update.**
- Read the instructions for completing Task 2.
- Assign someone new from each group to take notes (ask for more volunteers).
- Hand out one sheet of flip chart paper and markers to each group and tell them to record their recommended step by step process of reunification for Tommy and his mom.
- Inform them that during the report back each group will have an opportunity to bring their recommendations to the front of the room and explain them to the class.
- Check with each group and make sure they understand the Task 2 instructions and what they are being asked to do.
- Check back with each group periodically to see how they are doing.

**Take Report Backs From Each Group**

- Ask the note taker from Group Three to bring their recommendations to the front of the room and explain the steps his/her group recommends with the goal of reunification for Tommy and his mom.

- Then ask all participants if they have any questions and/or comments about the recommendation.
- Give each Group the opportunity to bring their flip chart to the front of the room and present their recommendations.
- After each presentation ask the class if anyone has any questions or comments.
- Thank the Group for their contribution (clap and encourage others to do the same).

**Conclude the Report Backs for Task 2**

- Ask the participants if they have any more comments regarding Task 2
- Take any questions or comments (you do not have to record the information on the flip chart)

**Transition Statement Between Task 2 and Task 3**

- *We have one more case study to analyze and it will give us an opportunity to complete an MHST 6 to Adult form. Please turn to page 94.*

**Introduce Task 3**

- Read the instructions for completing Task 3 and read the case study out loud.
- Assign someone new from each group to take notes (ask for more volunteers)

*(continued)*

## ACTIVITY 4: CASE STUDIES (continued)

### Instructions (continued):

**Introduce Task 3 (continued)**

- Emphasize that before completing questions including Part I: Identified Risks and Part II: Risk Assessment they should complete the Notes and Analysis Table. (Note: the questions are the same as they appear on the MHST (6 Years to Adult.)
- Also, inform the groups that for each of the questions there is a corresponding factsheet that provides more details. Participants should review each factsheet before answering the questions.
- Check with each group and make sure they understand the Task instructions and what they are being asked to do.
- Check back with each group periodically to see how they are doing

**Taking the Report Back**

- Read question 1 then ask the note taker from Group One how they answered the question (Note: You don't have to record the answers on the flip chart paper)
- Then ask all participants if they agree or have any other comments for question 1.
- Read the second question, ask Group Two how they responded and continue repeating the above same steps for the remaining questions on Part I and all of Part II.

- (**Note:** In some situations groups may have different interpretations or points of view as to how the questions should be answered. When this occurs have them go back to their Notes and Analysis to back up their points. And at the appropriate time stress that while there may be differences of opinion on one or more of the questions, the child in question will still get an assessment and that is what is important.)

**Conclude the Report Backs for Task 3**

- Ask the participants if they have any more comments or questions about Task 3.
- Take any questions or comments (you do not have to record the information on the flip chart).

**Summarize the Activity**

- Tell all participants to go to the Summary and then read one or two of the points you think are the most important.
- Try to focus on points that were not raised or points that might need further clarification.

**Complete the Evaluation**

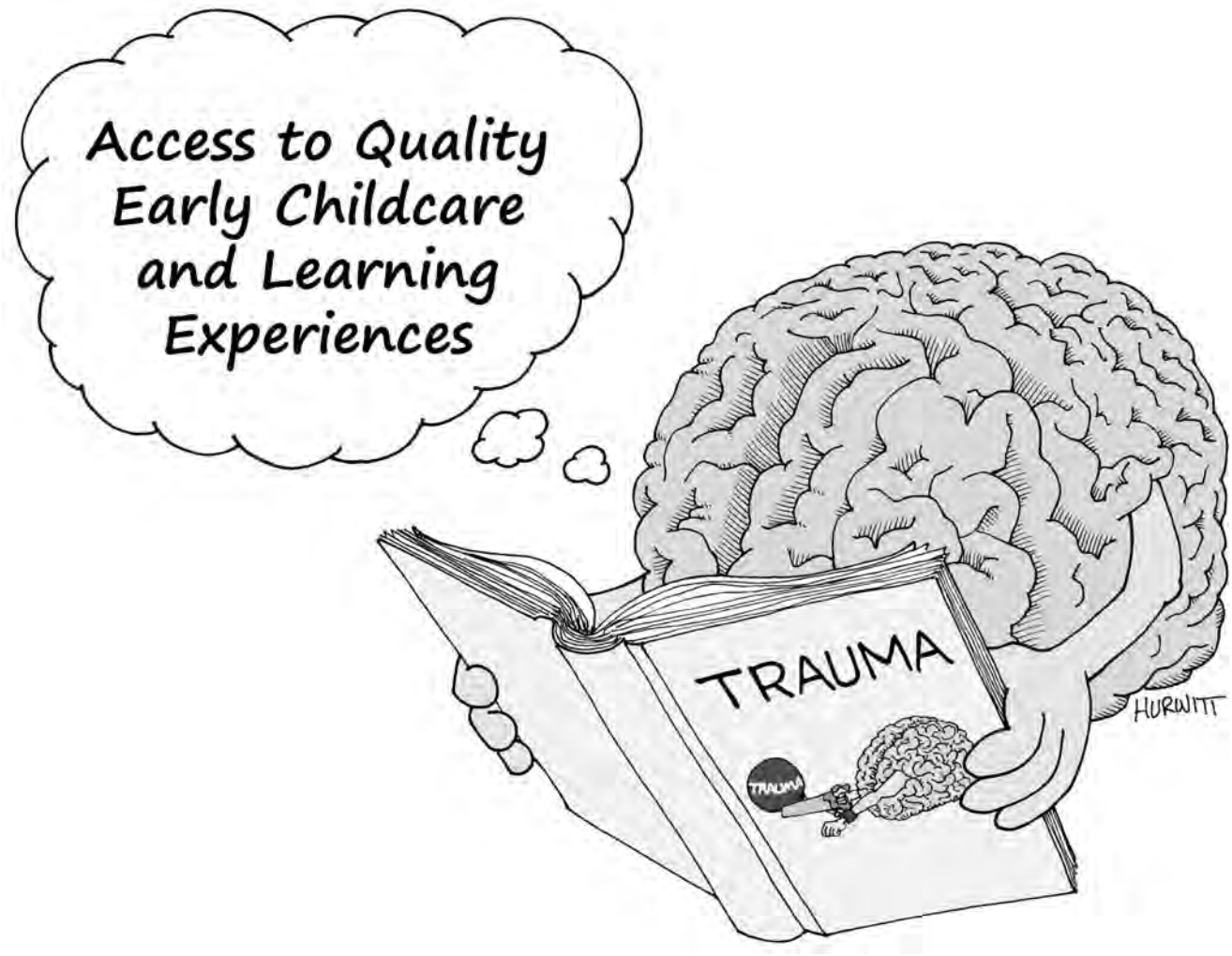
- Ask the participants to complete the Evaluation
- Collect the Evaluations

# Activity 1: Trauma and Children

## Purpose

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 Repots, 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

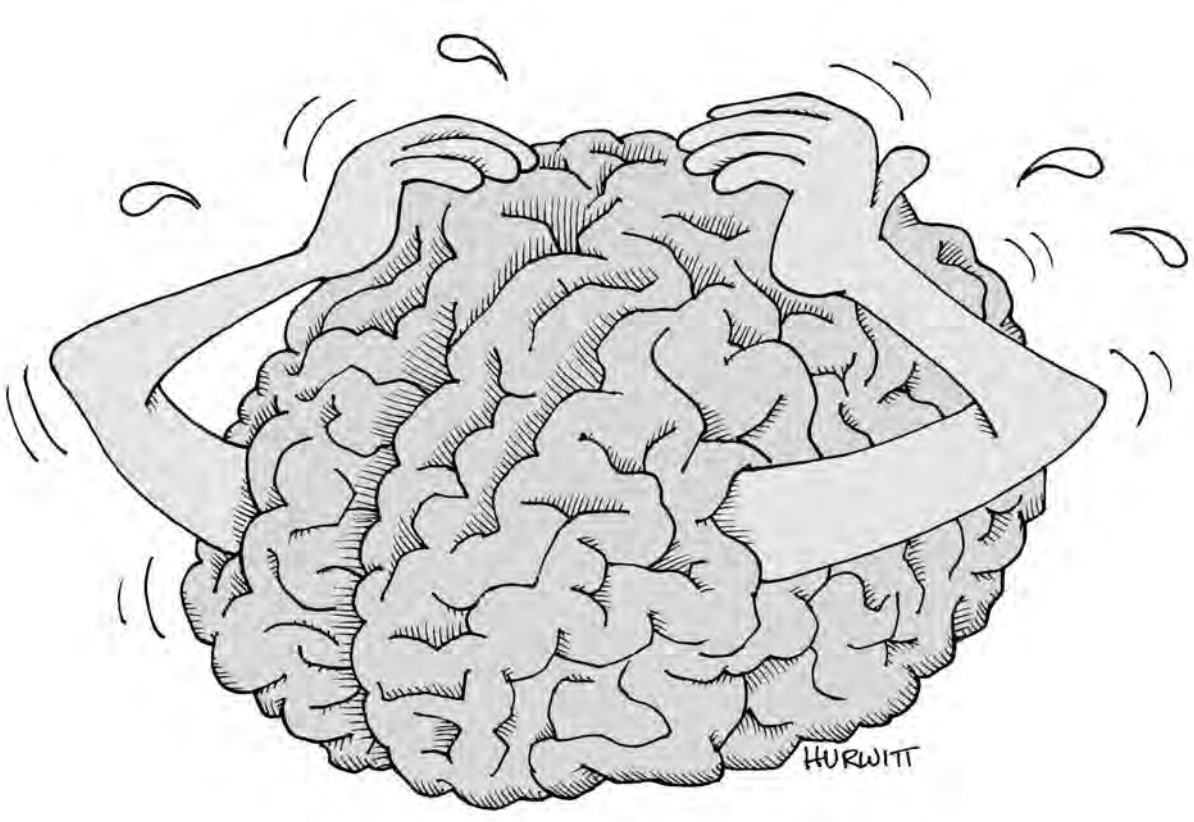
When a child has experienced multiple traumatic events we call it chronic trauma. Chronic trauma may refer to multiple and varied events such as a child who is exposed to domestic violence—or involved in a serious car accident—who then becomes a victim of community violence. Chronic trauma could also 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.**

Source: Child Welfare Trauma Training Toolkit: Trainer's Guide—1st Edition, March 2008

# 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

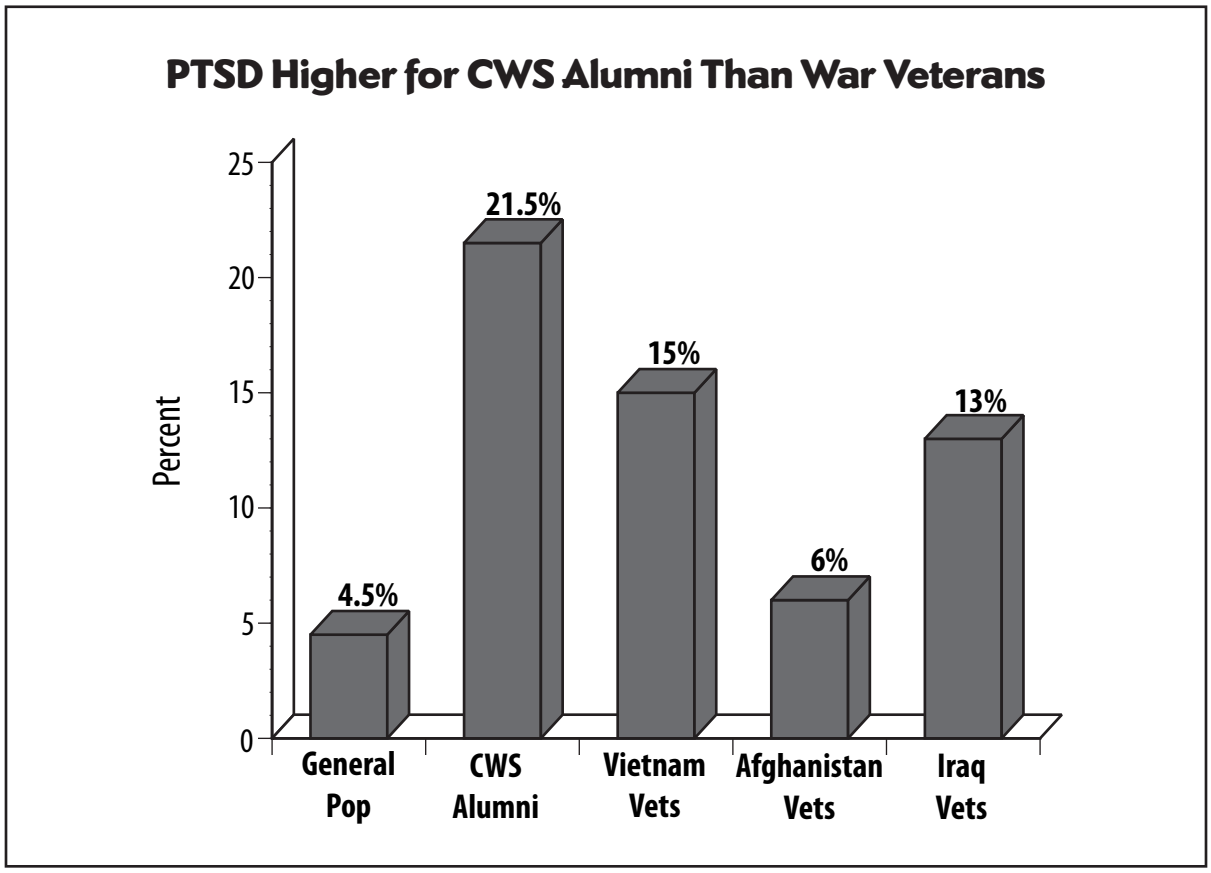
Significant numbers of children known to the child welfare system are likely to be suffering from child traumatic stress.

- 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

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. | |

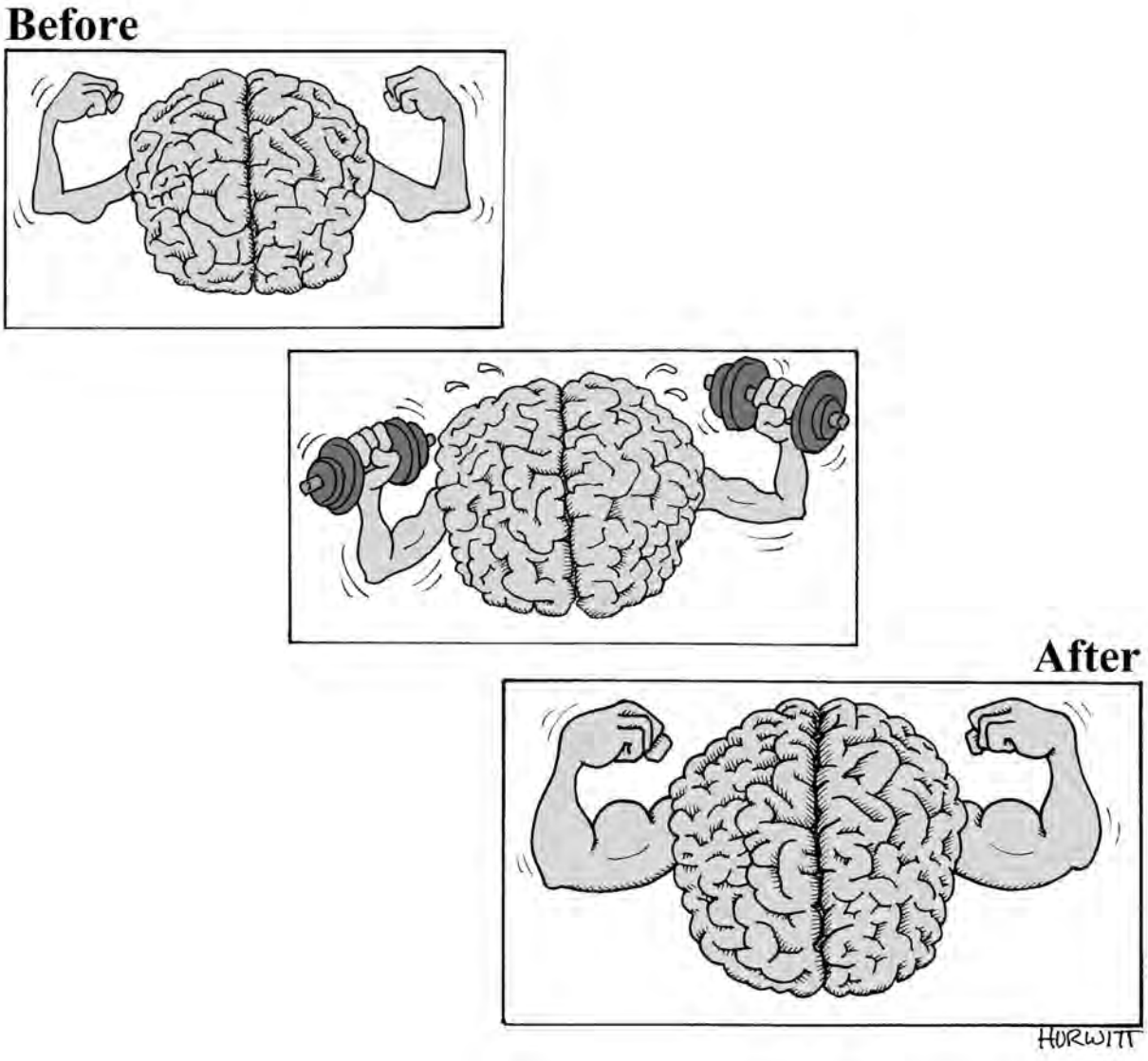
4. What would you suggest be done to improve this activity?

# 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.**



## Task 1: How the Brain Develops

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.*

| How would you respond? | Fact Sheet #: |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |

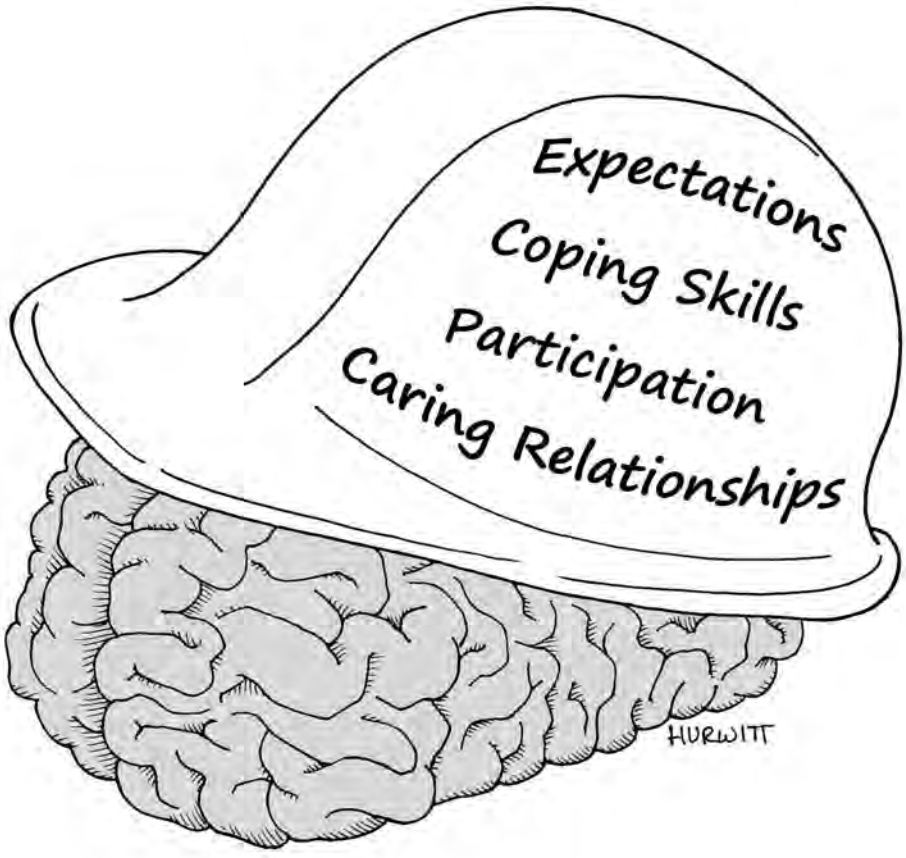
# 1. What About Resilience?

**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.

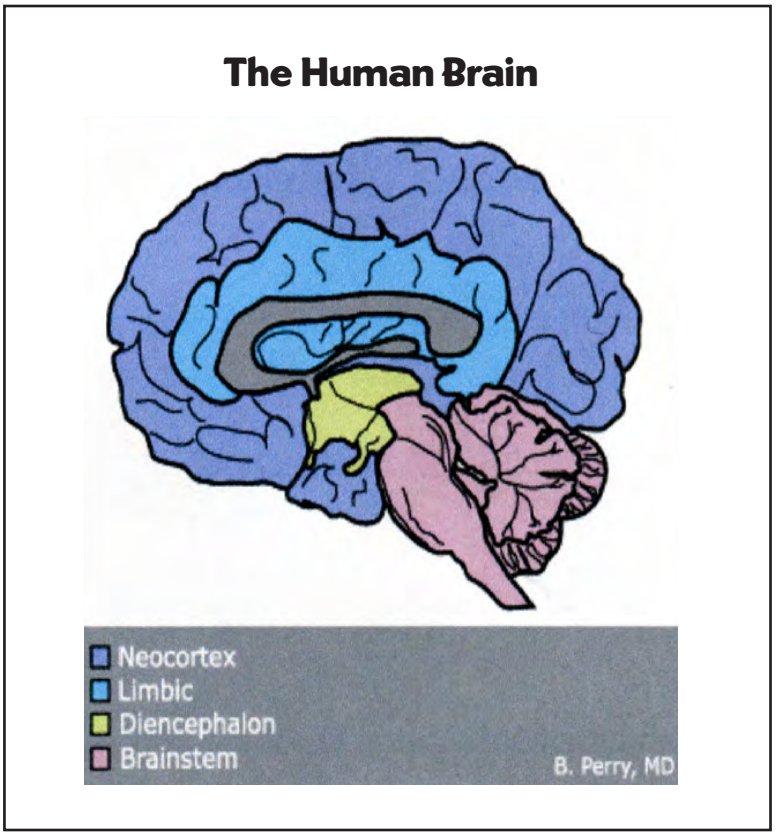
Vulnerability factors are internal factors that may exacerbate the effects of risks – for example, developmental challenges and mental illness may exacerbate the effect of community risk factors for a child.

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

| Age of Most Active | "Sensitive" Brain Area | Critical Functions Being Organized | Preliminary Developmental Goal | Optimizing Experiences (examples) | Therapeutic and Enrichment Activities (examples) |
|---|---|---|---|---|---|
| 0–9 Months | Brainstem | - Regulation of arousal, sleep and fear states | - State regulation<br>- Primary attachment<br>- Flexible stress response<br>- Resilience | - Rhythmic and patterned sensory input (auditory, tactile, motor)<br>- Attuned, responsive caregiving | Theraputic Massage<br>Rhythmic Play<br>-drumming |
| 6 Months–2 Years | Diencephalon | - Integration of multiple sensory inputs<br>- Fine Motor control | - Sensory integration<br>- Motor control<br>- Relational flexibility<br>- Attunement | - More complex rhythmic movement<br>- Simple narrative<br>- Emotional and physical warmth | Music and movement<br>Therapeutic massage |
| 1–4 Years | Limbic | - Emotional states<br>- Social language; interpretation of nonverbal information | - Emotional regulation<br>- Empathy<br>- Affiliation<br>- Tolerance | - Complex movement<br>- Narrative<br>- Social experiences | Play and play therapies<br>- Performing and creative arts and therapies<br>- Parallel play |
| 3–6 Years | Cortes | - Abstract cognitive functions<br>- Socioemotional integration | - Abstract reasoning<br>- Creativity<br>- Respect<br>- Moral and spiritual foundations | - Complex conversation<br>- Social interactions<br>- Exploratory play<br>- Solitude, satiety, security | Storytelling<br>- Drama<br>- Exposure to performing arts<br>- Formal education<br>- Traditional insight-oriented or cognitive-behavioral interventions |

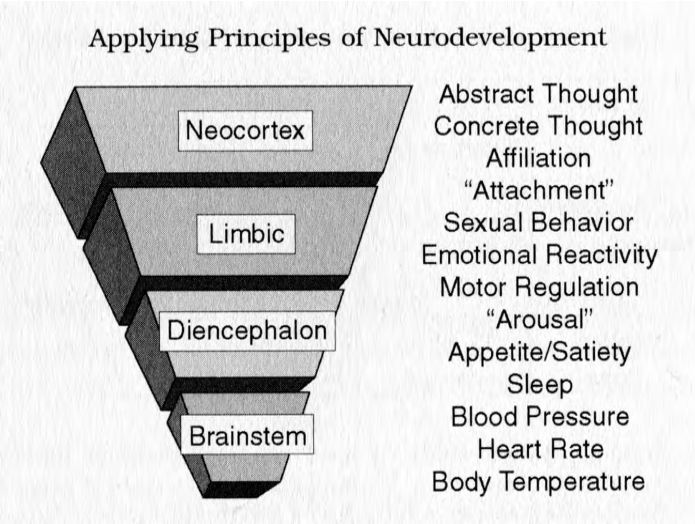
Source: Adapted from Bruce D. Perry, A*pplying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics,* 2006.

# 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.

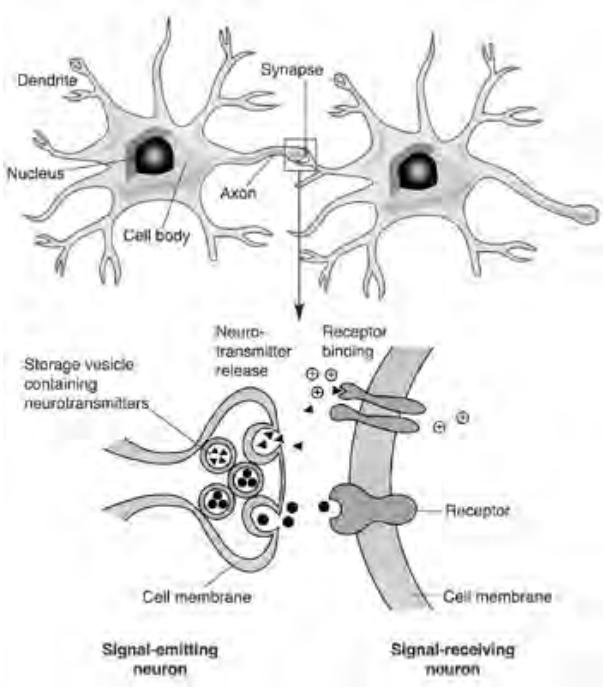
### Use Them Or Lose Them!

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 hundred 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, A*pplying 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

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.**

| Stage of Development | Brief Description of the Case | Trauma Symptoms | Intervention | Progress |
|---|---|---|---|---|
| **Early Life** | | | | |
| **School Age** | | | | |
| **Adolescent** | | | | |

# 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.

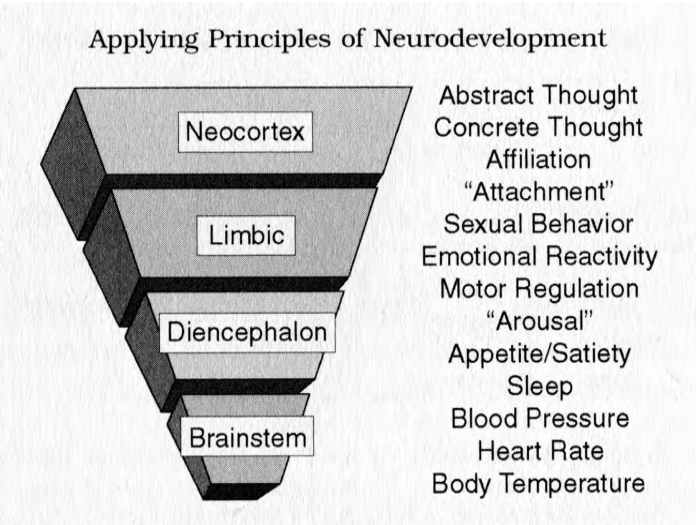
# 9. Brain Flexibility

With the right theraputic 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 througout life—are significantly easier to achieve.

## Hierarchy of Brain Function




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

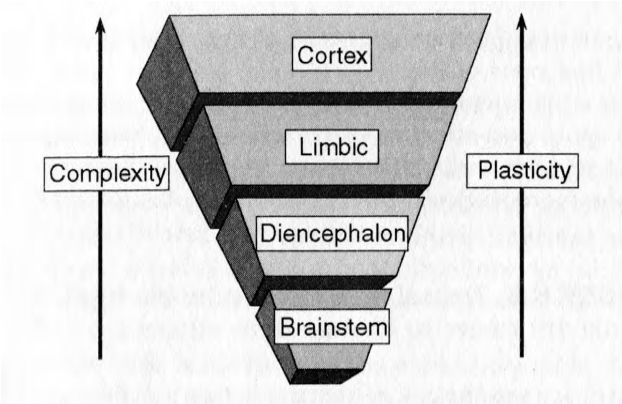
# 10. There Are Limitations

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, A*pplying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children, The Neurosequential Model of Therapeutics,* 2006.

# 11. 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 drawn 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.

# 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.

# 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.

# Summary

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 developming 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 througout 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 Flexibillity |
| | 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. | |

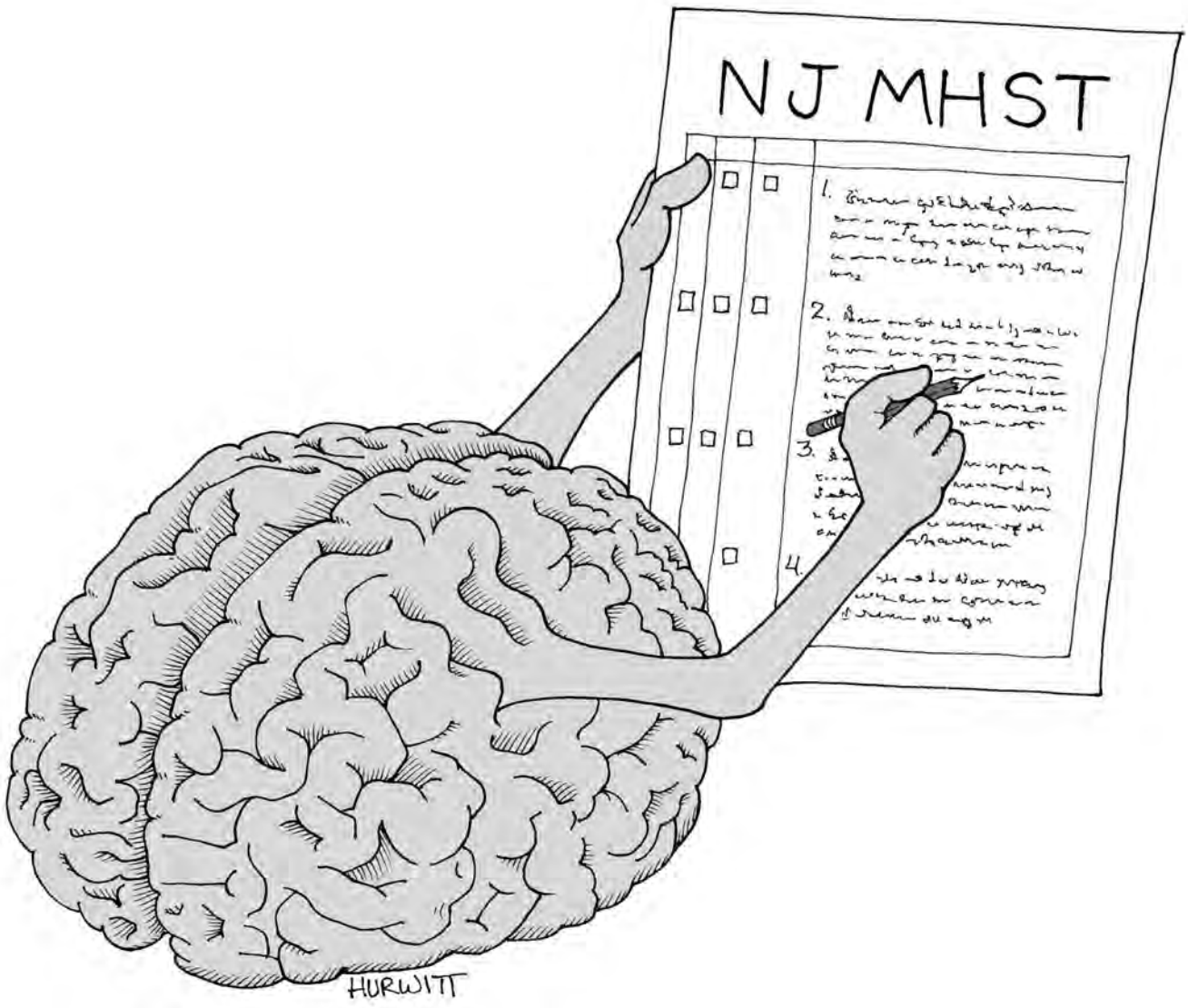
4. What would you suggest be done to improve this activity?

# 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)

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 | |
|---|---|---|---|
| | | | **Behavior** |
| ☐ | ☐ | ☐ | 1. Does this child exhibit unusual or uncontrollable behavior?<br><br>**0 – 18 mos**: 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<br>**18 – 36 mos**: 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<br>**3 – 5 yrs**: 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) |
| ☐ | ☐ | ☐ | 2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?<br><br>**0 – 18 mos**: 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.<br>**18 – 36 mos**: 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.<br>**3 – 5 yrs**: 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). |
| ☐ | ☐ | ☐ | 3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?<br><br>*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.* |
| | | | **Placement, Childcare, Education Status** |
| ☐ | ☐ | ☐ | 4. Does this child exhibit behaviors that may **not** allow him/her to remain in his/her current living, preschool and/or childcare situation?<br><br>*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.* |
| | | | **History** |
| ☐ | ☐ | ☐ | 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?<br><br>*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.* |

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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | 1. Has this child been a danger to him/herself or to others in the last 90 days?<br>*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.* |
| ☐ | ☐ | ☐ | 2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?<br>*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.* |
| ☐ | ☐ | ☐ | 3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?<br>*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.* |
| ☐ | ☐ | ☐ | 4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?<br>*Either needs immediate evaluation of medication or needs a new prescription.* |
| ☐ | ☐ | ☐ | 5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?<br>*Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.* |
| ☐ | ☐ | ☐ | 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?<br>*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.* |

**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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | 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: _____ |
| ☐ | ☐ | ☐ | 2. Does the child have problems with social adjustment?<br>*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.* |
| ☐ | ☐ | ☐ | 3. Does this child have problems making and maintaining healthy relationships?<br>*Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.* |
| ☐ | ☐ | ☐ | 4. Does this child have problems with personal care?<br>*Eats or drinks substances that are not food; regularly enuretic during waking hourse (subject to age of child); extremely poor personal hygiene.* |
| ☐ | ☐ | ☐ | 5. Does this child have significant functional impairment?<br>*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.* |
| ☐ | ☐ | ☐ | 6. Does this child have significant problems managing his/her feelings?<br>*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.* |
| ☐ | ☐ | ☐ | 7. Is this child known to abuse alcohol and/or drugs?<br>*Child regularly uses alcohol or drugs.* |

**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 neeed 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

| Screener | Tool | Frequency |
|---|---|---|
| **DYFS Case Worker** | NJ MHST | Within 30 days of placement; every 180 days after that and as needed. |
| **DYFS CHU Nurse** | Pediactric Symptom Checklist | Within 14 days of placement; every 180 days after that and as needed. |
| **CME Provider** | 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 clinican.
  - 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 then 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.)

| | Medical/Mental Health Type |
|---|---|
| | Mental Health Screening-Nursing |
| | Mental Health Screening-Casework |
| | Mental Health Screening-CME |

| | Medical/Mental Health Activity |
|---|---|
| | Tool completed-Referral made |
| | Tool completed-no Referral made |
| | Receiving Mental Health Services |
| | Referral Made |
| | Less than 2 years old* |

# Summary

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 Is Not 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. | | | |

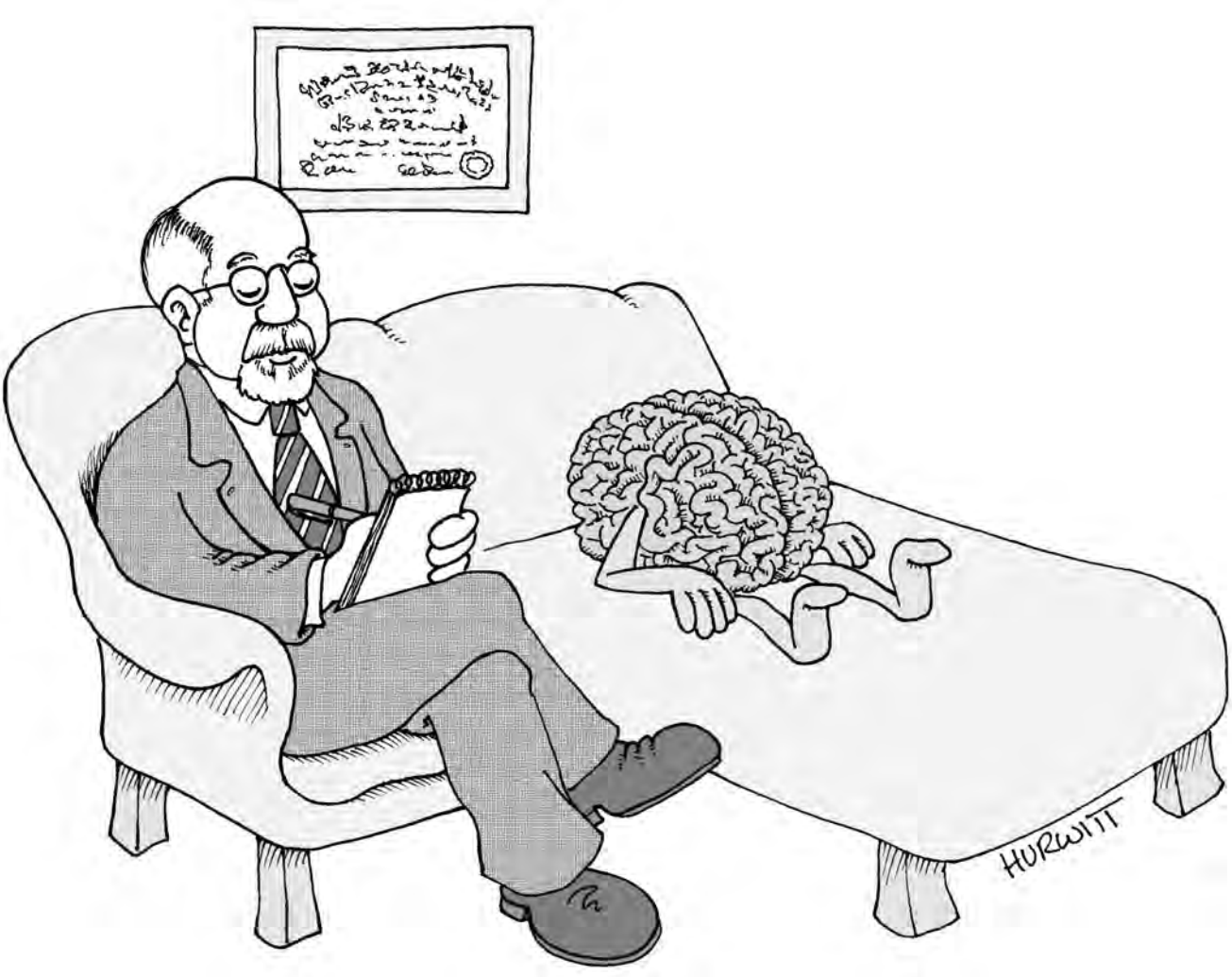
4. What would you suggest be done to improve this activity?

# 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

**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.

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

*(continued)*

## Task 1 (continued)

### 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, series 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 |
|---|---|---|
| **0-18 months** | 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. |
| **18-36 months** | 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. |
| **3-5 years** | 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 the 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?)

| Age | Behavior | Perspective |
|---|---|---|
| **0-18 months** | 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. |
| **18-36 months** | 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. |
| **3-5 years** | 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 | |
|---|---|---|---|
| | | | **Behavior** |
| ☐ | ☐ | ☐ | 1. Does this child exhibit unusual or uncontrollable behavior?<br><br>**0 – 18 mos**: 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<br>**18 – 36 mos**: 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<br>**3 – 5 yrs**: 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) |
| ☐ | ☐ | ☐ | 2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?<br><br>**0 – 18 mos**: 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.<br>**18 – 36 mos**: 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.<br>**3 – 5 yrs**: 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). |
| ☐ | ☐ | ☐ | 3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?<br><br>*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.* |
| | | | **Placement, Childcare, Education Status** |
| ☐ | ☐ | ☐ | 4. Does this child exhibit behaviors that may **not** allow him/her to remain in his/her current living, preschool and/or childcare situation?<br><br>*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.* |
| | | | **History** |
| ☐ | ☐ | ☐ | 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?<br><br>*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.* |

**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

**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)

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

## 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)

### 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 know 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.

# 11. 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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | 1. Has this child been a danger to him/herself or to others in the last 90 days?<br>*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.* |
| ☐ | ☐ | ☐ | 2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy?<br>*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.* |
| ☐ | ☐ | ☐ | 3. Has the child exhibited bizarre or unusual behaviors in the last 90 days?<br>*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.* |
| ☐ | ☐ | ☐ | 4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill?<br>*Either needs immediate evaluation of medication or needs a new prescription.* |
| ☐ | ☐ | ☐ | 5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication?<br>*Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.* |
| ☐ | ☐ | ☐ | 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?<br>*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.* |

**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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | 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: _____ |
| ☐ | ☐ | ☐ | 2. Does the child have problems with social adjustment?<br>*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.* |
| ☐ | ☐ | ☐ | 3. Does this child have problems making and maintaining healthy relationships?<br>*Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.* |
| ☐ | ☐ | ☐ | 4. Does this child have problems with personal care?<br>*Eats or drinks substances that are not food; regularly enuretic during waking hourse (subject to age of child); extremely poor personal hygiene.* |
| ☐ | ☐ | ☐ | 5. Does this child have significant functional impairment?<br>*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.* |
| ☐ | ☐ | ☐ | 6. Does this child have significant problems managing his/her feelings?<br>*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.* |
| ☐ | ☐ | ☐ | 7. Is this child known to abuse alcohol and/or drugs?<br>*Child regularly uses alcohol or drugs.* |

**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

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?