PENNSYLVANIA
Child Welfare Training Program

The Pennsylvania Enhancing Assessments Toolkit

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The 2008 Child and Family Service Review (CFSR) indicated that Pennsylvania needed to improve the caseworkers' abilities to assess and understand the underlying issues in a family. Reviewers found that in 55% of the cases reviewed, the needs of children, parents and foster parents were not adequately assessed. Similar results were found in the 2002 CFSR as well. The assessment of children, youth and families was identified as an area needing improvement. In response to this area of needed improvement, Pennsylvania, through the Program Improvement Plan (PIP), created the Enhancing Assessments PIP workgroup.

This workgroup began to meet in August 2009, and began to examine casework practice related to assessing children, youth, adults and families. The ability to adequately assess needs, and to ensure that those assessments continue throughout the life of the case, directly affects the likelihood of providing appropriate services related to the identified underlying issues. Assessment is an ongoing process that happens throughout the life of a case; not just during the intake/investigation/assessment phase of the case. This can be a daunting task for any helping professional so the workgroup focused on developing a toolkit that would provide users with easy to use tools to support their assessments of children, youth and families.

One of the first steps the workgroup took was to conduct a survey to gather information about screening/assessment tools that are currently used, and to identify gaps in practice areas not covered with existing tools. They then utilized this information in

creating the Toolkit itself. This Toolkit includes the Matrix, revised Compendium of Rapid Assessment Tools, and Peer-to-Peer Discussion Guide. This workgroup consisted of staff from County Children and Youth Agencies, program offices of both at the Department of Public Welfare and Pennsylvania Department of Education, Family Centers and the Pennsylvania Child Welfare Training Program.

The Enhancing Assessments Toolkit is designed to provoke critical thinking amongst caseworkers. It is not meant to replace supervision, nor is it inclusive of all family situations and circumstances. What it does is provide workers and supervisors a tool to help them apply critical thinking skills as they explore the possible underlying causes of a family's concern(s). The Toolkit provides users with the english versions of the tools. Given the variety of languages spoken, please access the internet for additional translations. Workers should follow their county's policies and practices regarding referrals to outside providers.

I. Introduction for Caseworkers

A comprehensive family assessment in child welfare encompasses a great deal of information to be gathered and analyzed. This assessment process begins from the first contact a caseworker has with a family and continues throughout the life of the case. Caseworkers are not only responsible for identifying all risk and safety factors, but also need to assess family strengths, areas of concerns, and protective capacities. Often, this assessment process also involves reports and/or evaluations from other professionals as well. One of the most important aspects to any family assessment is the family's involvement in the assessment process, and where they are in the Stages of Change Model (Prochaska, J.O., and DiClemente, C.C. 1984).

With all the information needed in order to complete such a family assessment, caseworkers may simply narrow the focus of their assessment on the issue/concern that necessitated the initial referral to the agency rather than addressing the underlying issues within the family. This Toolkit is designed to aid caseworkers in identifying and addressing underlying issues within a family in order to provide the most appropriate services to strengthen/empower families while maintaining the child(ren) safely in the home or enabling the child(ren) to successfully return home.

Matrix

As a caseworker, one of your most valuable skills is that of critical thinking. The Matrix is designed in order to enhance and/or improve the skill of critical thinking in caseworkers. In fact, the development of the Matrix was guided by feedback from

caseworkers! Caseworkers can utilize the Matrix to critically examine a case on their own, rather than having to wait for supervision or rely on supervision alone. The Matrix does not replace the need for supervision, but rather enables caseworkers to demonstrate how they are able to apply their critical thinking skills on their own. This tool provides a list of observations that are typical of those that caseworkers encounter with families in the field. With each observation there follows a list of possible underlying issues that may be the cause of the manifestation of the observation/behavior.

For example, the problem of truancy with a child/youth is often explained within the context that the child/youth does not like school. However, as many caseworkers have learned, the problem of truancy may actually be a result of a variety of different underlying issues some of which are listed in the Matrix. While comprehensive, this list of underlying issues is not meant to be all-inclusive and there could certainly be other possible underlying issues to explain the observations. Caseworkers may use this tool in the field, prior to/after a home visit or in supervision.

Caseworkers may find it helpful to use the Matrix tool throughout their on-going assessment process with the family to assist in identifying or ruling out possible underlying issues and use the information in creating, evaluating, and revising Family Service Plans. Caseworkers are strongly encouraged to use this tool with those cases that have remained stagnant for some time, such as those cases where the families have made little or no progress with the current services and Family Service Plan that

are in place. The Matrix also provides a link to various screening/assessment tools that are contained in the Collection of Screening Tools.

Collection of Screening Tools

The Collection of Screening Tools offers a number of screening tools available to caseworkers that supplement the Pennsylvania Child Welfare System mandated tools such as the Risk Assessment, In-Home Safety Assessment, Educational Assessment, Out-of-Home Safety Assessment and Ages & Stages Questionnaires® (ASQ™). Some of these tools may simply be questions that can be asked while visiting with a family and documented in a structured case note. Other tools can be given to parents to complete while the caseworker is meeting with the child(ren) privately, and vice-versa. These tools provided can assist caseworkers in two different ways in the assessment process.

1. First, the tools can help identify or rule out possible underlying issues in a family. These tools are free, and are easily accessible by caseworkers.
2. Secondly, the tools can be used to help engage family members in the assessment process and in recognizing that certain issues within the family are areas of concern that should be addressed in family service planning.

Peer-to-Peer Facilitated Discussion Guide

The last item in the Toolkit is the Peer-to-Peer Facilitated Discussion Guide. While many agencies may already have some type of peer case review/discussion as part of their case review process, this peer-to-peer discussion guide provides suggestions for the types of questions that should be asked during a discussion in order to elicit critical

thinking, improve engagement with family, revise case goals, and determine the need for additional services. The discussion is really meant to be more than a simple case review. While the topics of a typical case review are certainly discussed, this guide is intended to help the caseworker get to the underlying issues in a family so that appropriate goals can be set that will lead to safe case closure.

Similar to the purpose of the Matrix, this tool attempts to enhance the critical thinking skills of the caseworker by utilizing the strengths and knowledge of other caseworkers. As a caseworker, you may often ask another caseworker for help or feedback on a case. While this is often an informal discussion, the use of this tool in the peer-to-peer review will allow for a more structured and focused discussion. As a result, your supervisor or agency may decide to develop a more formal process or identify certain peers who they would recommend to be part of this facilitated discussion.

Summary

This Toolkit provides caseworkers several aids to assist in the difficult task of implementing a comprehensive family assessment. While the use of this Toolkit is not mandated, we hope that you will take the time to review it, and decide to make good use of it. In utilizing the Toolkit, you are likely to improve your critical thinking skills, become more independent in analyzing the case, and improve your ability to assess families by being able to identify the underlying issues within the family. Addressing these underlying issues will not only enable children to remain or return successfully to their homes, but also reduce the length of time a family is involved in your agency. The benefit of the toolkit will be for you and the families with whom you work. Together, you

will be able to determine the appropriate goals and link the family with the necessary services that will address the root causes of the issues of concern that made the family known to Child Welfare.

II. Introduction for Supervisors

Child welfare supervisors often supervise a unit of caseworkers who are at various stages in their professional development. These caseworkers often have a variety of different work experiences, levels/types of education, length of tenure at the agency, strengths/needs, and personal experiences, which require supervisors to use a number of different approaches in supervising a diverse group. Providing supervision to caseworkers includes reviewing cases while also helping caseworkers to improve their skills, thereby assisting them in becoming more independent and accurate in making family assessments.

One of the most important skills to help develop in caseworkers is that of critical thinking. This Toolkit was designed to aid supervisors in developing and enhancing caseworkers' critical thinking skills as it applies to family assessments. Developing critical thinking skills in caseworkers will likely lead to more accurate family assessments and targeted, effective family service planning. The development of these skills also results in supervision that is more productive by engaging the caseworker in the decision-making process. As a supervisor, you are constantly aware of and reminded about the importance of outcomes. In ensuring that the caseworkers you supervise are effectively addressing the underlying issues within a family through service planning, you will undoubtedly improve outcomes by keeping more children safely in their homes, re-unifying children with their families sooner and preventing children from entering and/or re-entering into care.

Matrix

The Matrix is a tool that caseworkers can use themselves, but it can also be a valuable tool to use during supervision. This tool provides a list of observations that are typical of those that caseworkers encounter with families in the field. Each observation is followed by a list of possible underlying issues that may be the cause of the manifestation of the observation/behavior. Please note that this tool is not all-inclusive, and that additional observations/underlying issues may exist.

Within the Matrix is a link to a screening tool that a caseworker can utilize. During supervision, you can apply the Matrix to review specific cases to help foster the critical thinking skills of a caseworker. Using the Matrix to improve the critical thinking skills can be done using a variety of teaching techniques such as one-to-one teaching and brainstorming. Consistently using the Matrix in supervision is likely to lead to caseworkers using the Matrix on their own to better assess the case and apply critical thinking skills. In time, caseworkers will likely complete family assessments more accurately, become more independent, and rely less on the supervisor to guide them through the assessment process. This could also provide the supervisor with more time to make use of opportunities to enhance the caseworkers' professional development.

Collection of Screening Tools

The Collection of Screening Tools offers a number of screening/assessment tools that supplement Pennsylvania Child Welfare mandated tools such as the Risk Assessment, In-Home Safety Assessment, Educational Assessment, Out-of-Home Safety

Assessment and Ages & Stages Questionnaires® (ASQ™). Some of these tools may simply be questions that can be asked while engaging with the family and documented in a structured case note. Other tools can be given to parents to complete while the caseworker is meeting with the child(ren) privately and vice-versa. The tools that are provided can assist caseworkers in two different ways in their assessment process.

1. First, the tools can help identify or rule out possible underlying issues in a family. These tools are free and therefore are easily accessible by the caseworkers.
2. Secondly, the tools can be used to help engage family members in the assessment process and in recognizing that certain issues within their family are areas of concern that should be addressed in family service planning.

Supervisors often instruct caseworkers on how to manage the completion of their paperwork, which at times can make a caseworker feel overwhelmed. The screening/assessment tools provided in this toolkit are quick and easy and require minimal, if any, training to utilize. Supervisors will be directly responsible for encouraging their caseworkers to use these tools in their day-to-day practice. In presenting these tools to caseworkers, supervisors can explain how such tools can make caseworkers' jobs much easier. They can do this by pointing out how the screening tools can identify underlying issues earlier in the life of the case, which will lead to improved service planning, that will best remedy the issues in the home and lead to a more timely safe case closure. As a supervisor, you play an integral role in enhancing family assessments and in promoting this toolkit with caseworkers.

Peer-to-Peer Facilitated Discussion Guide

The last item in the Toolkit is the Peer-to-Peer Facilitated Discussion Guide. With the many time demands place on a supervisor, it is beneficial to have at your disposal a tool that helps develop the critical thinking skills of the caseworkers you supervise. While many agencies may already have some type of peer case review/discussion in place, this peer-to-peer discussion guide provides suggestions to the type of questions that should be asked during a discussion in order to elicit critical thinking, improve engagement with family, revise case goals, and determine the need for additional services. The discussion is really meant to be more than a simple case review. While the topics of a typical case review are certainly discussed, the guide is intended to help the caseworker get to the underlying issues in a family so that appropriate goals can be set that will lead to safe case closure.

Similar to the purpose of the Matrix, this tool attempts to enhance the critical thinking skills of the caseworker utilizing the strengths and knowledge of other caseworkers. This guide is designed to be used in a more formalized setting rather than the many informal discussions that caseworkers often have from day to day. As such, if your agency does not have a formalized peer-to-peer discussion process in place, you might want to identify certain caseworkers with cases that would benefit from this type of discussion. It would also be advantageous to identify experience/knowledgeable caseworkers within your agency that caseworkers may seek out to participate in a discussion. In supervision, the caseworker can later process what insight they have gained from the peer-to-peer discussion.

Summary

This Toolkit provides supervisors a great opportunity to help improve upon the family assessments capabilities of the caseworkers they supervise, while also aiding in their professional development. Developing caseworkers' critical thinking skills leads to them becoming more knowledgeable and independent. This in turn provides you more time to perform quality supervision with them and to complete all your other responsibilities. While the use of the Toolkit is optional to caseworkers, we strongly encourage supervisors to promote the benefits that come from its use and application.

As a supervisor, you play the most vital role in the professional development of a caseworker. By teaching them how to address the underlying issues in a family, they will be able to provide the right services that will strengthen, empower, and preserve the families we serve.

III. Introduction for Community Partners

Children, youth and families are part of a larger community system that must join together to support a healthy environment for everyone to live, grow, and learn. Through this partnership, many resources and much support is provided to individuals and families in crisis. It is only through this team work that positive changes occur. Some critical community partners for families involved in the child welfare system include Family Centers, community centers, clubs, religious groups, schools, day care centers, mental health providers, and many more.

This Toolkit is designed to provide resources and tools for community service providers to assist in identifying and addressing underlying issues within a family in order to provide or connect families to the most appropriate services to meet their unique needs. A comprehensive family assessment encompasses a great deal of information to be gathered and analyzed and when done proactively can prevent future struggles. The assessment process begins from the first contact a service provider/home visitor/teacher has with a family and continues throughout the life of the family's involvement with services. Assessments include identifying family strengths, areas of concerns, and protective capacities. Often, this assessment process also involves reports and/or evaluations from other professionals. Sometimes families are involved with county child welfare, juvenile probation, or the criminal justice system and community service providers at the same time. It is imperative that services are collaborative in order for the child, youth, and family to achieve success. One of the most important aspects to any family assessment is the family's involvement in the assessment process, and where they are in the Stages of Change Model (Prochaska,

J.O., and DiClemente, C.C. 1984). If an individual or family has acknowledged that there are issues that need to be addressed, they are on their way to making positive changes.

With all the information needed in order to complete such a family assessment, it can be difficult to know where to start. Some providers may want to focus their assessment on the issue/concern that necessitated the initial referral to the agency rather than addressing the underlying issues within the family. However, this narrow focus often overlooks the reasons why a family is experiencing difficulties. And it is often why families continue to cycle through services again and again. By trying to get to the underlying issues of substance abuse or unhygienic homes, providers can support families to work on their underlying issues so that they can break these cycles. The resources provided in this Toolkit will help community providers identifying and addressing underlying issues.

Matrix

The Matrix is designed to enhance and/or improve critical thinking skills. In fact, the development of the Matrix was guided by feedback from Family Center staff, child welfare professionals, and many community partners. The Matrix does not replace the need for supervision or formal assessments, but provides a structure to demonstrate how critical thinking skills are applied toward factual decision making. This tool provides a list of observations that are typical of those encountered with families. After each

observation there is a list of possible underlying issues that that may be the cause of the manifestation of the observation/behavior.

For example, the problem of a “dirty home” is often explained within the context that the family is lazy or lacks proper cleaning skills. However, as many home visitors have learned, the problem of hoarding/unhygienic environments may actually be a result of a variety of different underlying issues like mental health or drug and alcohol abuse. The matrix section of the toolkit offers workers a quick tool to help identify underlying issues. While comprehensive, this list of underlying issues is not meant to be all-inclusive, and there could certainly be other possible underlying issues to explain the observations. Observations should always include a discussion with the family and gathering of corroborating information so that the assessment is comprehensive and helpful.

Home visitors and service providers may use the Matrix tool in the field, prior to/after a home visit/office meeting or in supervision. The Matrix tool may also be used throughout the on-going assessment process with the family to assist in identifying or ruling out possible underlying issues, and to use the information in creating, evaluating, and revising family service plans. The use of the tool with families that have remained stagnant for some time, such as those cases where the families have made little or no progress with the current services, is strongly encouraged as the lack of progress may be rooted in a lack of understanding of the underlying issues. The Matrix also provides a link to various easily accessible and free screening/assessment tools that are contained in the Collection of Screening Tools.

Collection of Screening Tools

The Collection of Screening Tools offers a number of screening/assessment tools available to supplement required tools your organization may already be completing such as the Ages & Stages Questionnaires® (ASQ™). Some of the Screening Tools may simply be questions that can be asked while visiting with a family and included in case documentation. Other tools can be given to parents or the child to complete before, during or after a visit. The tools provided can assist in two different ways in the assessment process.

1. First, the tools can help identify or rule out possible underlying issues in a family. These tools are free and are easily accessible.
2. Secondly, the tools can be used to help engage family members in the assessment process and in recognizing that certain issues within the family are areas of concern that should be addressed in family service planning and delivery.

Peer-to-Peer Facilitated Discussion Guide

The last item in the Toolkit is the Peer-to-Peer Facilitated Discussion Guide. While many agencies may already have some type of peer case review/discussion as part of their family review process, this peer-to-peer discussion guide provides suggestions to the types of questions that should be asked during a discussion in order to elicit critical thinking, improve engagement with the family, revise case goals, and determine the need for additional services. The discussion is really meant to be more than a simple case review. While the topics of your typical case review are certainly discussed, this

guide is intended to help get to the underlying issues in a family so that appropriate goals can be set that will lead to safe case closure and better outcomes for the family.

Similar to the purpose of the Matrix, this tool attempts to enhance critical thinking skills by utilizing the strengths and knowledge of others. The use of this tool in the peer-to-peer review process allows for a more structured discussion and focus than informal conversations. As a result of using the peer to peer review process, your supervisor or agency may decide to develop a more formal process or identify certain peers for whom they would recommend to be part of this facilitated discussion.

Summary

This Toolkit provides several aids to completing a comprehensive family assessment. While the use of this Toolkit is not mandated, we hope that you will take the time to review it, and decide to make good use of it. In utilizing the Toolkit, you are likely to improve your critical thinking skills, improve your ability to assess families by being able to identify the underlying issues, and impact sustainable changes for children, youth and families.

IV. Workers Experiences Assessing Families

Tips for Using Screening Tools

The screening/assessment tools provided in the toolkit are meant to enhance caseworkers' abilities to assess a family's needs. These tools are not intended to replace caseworkers' knowledge, experience, supervision, and training in the field of child welfare. In using these tools in the field caseworkers may be surprised with the results that they yield. The tools may help in identifying an underlying issue or in some cases, there may be unexpected revelations. Regardless of the type of results the tools provide another source of information for workers to use in their on-going family assessment process.

When Tools Contradict What is Known

There may be occasions when caseworkers use the screening/assessment tools where the results will contradict other sources of information gathered in the on-going assessment process. One of the simplest examples of this is the use of drug and alcohol screening tools at the intake/investigation level. When families first come into contact with the child welfare system, they are at times apprehensive to provide complete and accurate information about themselves and the family. If a caseworker gets a report of a caregiver abusing substances and the screening tool does not indicate a need for a more comprehensive drug and alcohol assessment, a caseworker should not simply ignore the original allegation of substance abuse. The caseworker can continue to assess the family member in that area through a random drug screen, reviews of criminal history and/or treatment history, and interviews with other family

members. If the other information gathered would indicate a need for drug and alcohol assessment, then a caseworker can look at the screening tool to provide some insight as to what stage the caregiver is in regarding the Stages of Change Model (Prochaska, J.O., and DiClemente, C.C. 1984).

When a screening/assessment tool contradicts what is already known about a family member, it may also provide a caseworker an opportunity to critically examine the current family assessment. An example of this actually occurred during the development of the toolkit. A caseworker decided to use the Edinburgh Postnatal Depression Scale (post-partum depression scale) with a mother who was previously diagnosed with Post-Partum Depression after the birth of her second child. Three weeks after giving birth to her third child the caseworker administered the scale; the caseworker believed that the mother was depressed again. However, this time the scale indicated that the mother was in no way suffering from Post-Partum Depression. Rather than simply dismissing the results of the scale, the caseworker considered the possibility that there were other reasons to explain the mother's mental health concerns. The caseworker then re-focused their engagement skills with the mother, who later disclosed that she remained in an emotionally and physically abusive relationship with her ex-boyfriend. The mother, who was engaged to another man, was afraid to disclose this information to anyone out of fear that her fiancé would find out. While the caseworker had spoken with the mother in the past about her current relationship, there were no disclosures of any domestic violence. It is possible that one of the domestic

violence screening/assessment tools, if it had been used, could have identified this as an underlying issue several months earlier.

Family Engagement and Using the Tools

The success of the screening/assessment tools relies heavily on a caseworker's engagement skills, rather than reducing the need to engage the family. Caseworkers need to consider that families might not have felt comfortable with disclosing information at the intake/investigation level of a case, and may feel more comfortable as the work with the family has progressed. In this sense, a caseworker should not dismiss re-using a tool with a family member even though the tool yielded no significant results when it was first used at the intake/investigation. Caregivers who at first felt as though they are being "investigated" for child abuse may, through their work with the caseworker, be more open to disclose concerns in a screening/assessment tool than they were previously.

Engagement also plays an important role in discussing the results of the tools with the family members. Caseworkers should expect that family members will want to know the results of the tools and should be prepared to discuss them with the family, including how it may be applied in regard to service planning. The processes of engaging and assessing families are both on-going processes and workers need to recognize that they occur simultaneously when a family is involved in the child welfare system.

Examples

The following are two stories that actually occurred in the field. One story demonstrates how the screening/assessment tools helped to identify and prioritize the issues of concern in what appeared to be a rather complex case. The other is an example of what could possibly happen when a caseworker merely focuses on the presenting issues of a family, instead of focusing on the underlying issues. We encourage both caseworkers and supervisors to read the stories to provide some insight of how the screening/assessment tools can be a valuable source of information in the assessment process.

The following story is an actual CYS case. For confidentiality reasons, the names of the family members have been changed.

The Jones family was opened for services after an unfounded CPS investigation for sexual abuse. Child, Derrick, was 15 when he and his family were temporarily staying with the Rios family for the weekend while the Jones' home was getting repairs done. While staying with the Rios family, Derrick raped 12 year-old Maria Rios and was charged criminally. His mother, Theresa Jones, did not believe that Derrick committed any crime and got into a physical altercation with Maria's mother and was later charged with assault. Children and Youth Services conducted a sexual

Caseworker POV

The new caseworker was confused and upset that this case was even opened for services because it appeared to be purely Juvenile Probation's responsibility. The caseworker simply focused the FSP on the clearly indentified issues because that is why the case was opened. Those issues were already being addressed by other agencies so the caseworker felt there was little for CYS to do.

abuse investigation, but unfounded the case because it was determined that Derrick did not meet the criteria of a perpetrator. The case however was opened for services because the mother tested positive for marijuana, had the pending assault charge, and was unable to get Derrick to go to sex offender treatment.

When the new ongoing caseworker was assigned the case, the caseworker went to the home and met with mother, Derrick, and his younger sibling, Christian, who was 9. When discussing goals for the Family Services Plan, the caseworker agreed to put in place a paid provider to get Derrick to his sex offender treatment. Mother also explained that she will be given Accelerated Rehabilitative Disposition (ARD) for 12 months for her assault charge and she would have to go to counseling and do drug tests for Adult Probation. Since Christian appeared to be very attached to his mother and was doing well in the home, the goals of the FSP mirrored the requirements of both the Juvenile and Adult Probation Offices for the family.

After a couple of months of unsuccessfully trying to get Derrick to attend sex offender treatment, he was eventually placed in a

Caseworker POV

The caseworker tried to get the supervisor to immediately close the case, but the supervisor wanted to know how the younger child was doing in the home. Rather than addressing or talking about Christian's truancy issue with the mother, the caseworker knew that he could get Christian to attend school regularly and close the case as planned.

The caseworker tried to get the supervisor to immediately close the case, but the supervisor wanted to know how the younger child was doing in the home. Rather than addressing or talking about Christian's truancy issue with the mother, the caseworker knew that he could get Christian to attend school regularly and close the case as planned.

detention facility for not attending treatment and for taking a box cutter to school. Since Derrick was placed at the detention facility and the mother was under the supervision of APO, the caseworker planned to close the case immediately, until the attendance records for Christian were received. In the first two months, Christian had a very high number of unexcused absences at school. The caseworker, knowing how attached Christian was to his mother and brother, explained to Christian that unless he wanted to be removed from the home like his brother, then he would have to go to school. For the next month, Christian went to school every day on time and the caseworker closed the case.

Four years passed by and the caseworker was walking through the lobby of his agency and noticed a mother sitting there with a young man, who appeared to be Christian. The caseworker asked the mother why she was at the agency. The mother said that they were here for dependency court because Christian refuses to go to school. The mother said that Christian had 60 unexcused absences last year and has yet to go to a single day of school this year. The mother also said that she is depressed and is again using marijuana daily. The mother said that everyone has tried everything with Christian, but nothing is working. The mother said that Christian is running the streets, and will likely be put in placement today, unless he runs away before the hearing. Mother said she is at a loss of what to do and she now

Caseworker POV

The caseworker felt very bad and guilty after seeing that the family was again involved with CYS. The caseworker wished that CYS engaged the Jones family then as they engage families today. The Caseworker felt that CYS could have done so many things differently with the family then, so that Christian would not be likely going into placement now.

has to focus on her 3-year-old son, Eric. The caseworker said he was sorry to hear the news and wished mother and Christian the best.

The following story is an actual CYS case. For confidentiality reasons, the names of the family members have been changed.

In late September the county caseworker received a numbered Childline CPS report on child, Kimberly "Kim" Schaeffer, a 16 year-old female. Kim was the alleged victim of Emotional Abuse. Her father, Jeff Schaeffer, is listed as the perpetrator. The referral source was a psychiatric hospital, where Kim was recently admitted. During her intake at the hospital, Kim alleged that there was on-going domestic violence in the home between her mother, Susan Schaeffer, and her father. Kim also alleged that her father consistently made derogatory and degrading comments towards her, often while he was drinking, which led to her suicidal ideation and past suicide attempts. Since Kim's hospital was located in another county, the caseworker asked that the county's CYS agency conduct a courtesy interview with Kim, which resulted in Kim making the same allegations against her father that she did at the intake.

While Kim remained hospitalized, the caseworker went to the home and met with the parents. The caseworker went over the Alleged Perpetrator letter and reviewed the allegations with the

Caseworker POV

Since drugs and alcohol are often underlying issues, caseworker uses the MAST & DAST screens for all families when a new report is received.

Caseworker decided not to discuss or utilize the domestic violence screen at this time because father was present in the home.

parents. Both parents immediately denied that there was any domestic violence occurring in the home and that the father was emotionally abusive towards Kim. Mother explained that she had separated and divorced the father about four years ago because she felt that he was “abusive” towards her then 17 year-old son. Mother stated that Jeff has changed over the years, which led to the two of them getting back together in June of this year. Father explained that he is a truck driver and is typically away from the home five to six days out of the week. Father admitted the need to rebuild his relationship with his daughter, but denied verbally degrading his daughter. Father explained that when he returned to the home in June, Kim was not happy because she had been doing what she wanted all the time and her mother allowed her to get away with everything. Father went on to say that when he is home that Kim typically goes across the street to be with Rodger, a 33 year old intellectually disabled man who lives with his mother. Caseworker had mother and father complete the MAST & DAST (drug and alcohol screening tools). In discussing a plan for Kim’s discharge from the hospital, her father stated that he would be out on the road when she is discharged so that the caseworker could continue the assessment while father is away.

Caseworker POV

Caseworker chose to use the SDQ due to the mental health concerns of the child. The CEDV was chosen to assess the level of domestic violence in the home that child previously disclosed. With father out of the home the caseworker felt it was now safe to use the WAST with mother. The SDQ was used in order to get a mother’s perspective on the child’s behaviors.

The screening/assessment tools were of great value to the caseworker due to the quality of the interview with the child.

Upon Kim's discharge from the hospital, the caseworker went to the home to meet with the mother and Kim. The caseworker first met with the mother and child together to explain the reasons for the visit and what the caseworker wanted to accomplish. The caseworker then asked Kim to complete the Strength and Difficulties Questionnaire (SDQ) and the Child Exposure to Domestic Violence (CEDV) assessment while the caseworker and the mother met in private. The caseworker then met with the mother and utilized the Woman Abuse Screening Tool (WAST). After talking with the mother, the caseworker asked the mother to complete the parent version of the SDQ while the caseworker met with Kim in private. When the caseworker met with Kim, the caseworker found it difficult to interview her. Kim had returned home on a number of psychiatric medications that appeared to severely affect her alertness and ability to focus. Kim typically would only respond to questions with "yes, no, or I don't know." Before leaving the caseworker met with mother and Kim again and talked about the importance of following up with a psychiatrist immediately to ensure that Kim was on the right medication.

Caseworker POV

The scoring for the CEDV, WAST, MAST, DAST, and SDQ's took caseworker 20 minutes.

Caseworker wanted to focus part of his interview with child on her social interactions at school, not only because of the screens/assessments, but also because child was admitted to the psychiatric hospital from school. Caseworker began to get a clearer picture of what was occurring in the family. The father's return to home has caused some conflict in the home, but the child has a great deal more issues with her peers, and was unable to communicate with her parents. Child also was no longer able to "get away" with as many things in the home now that her father had returned.
Issues of parenting surrounded two areas, mother and father had different parenting styles, and both parents needed education on how to better parent a child with mental health issues.

Prior to supervision, the caseworker reviewed both of the SDQ's, the CEDV, the MAST & DAST screens, and the information gathered from using the WAST. On the CEDV, Kim scored the highest on the Community Exposure subscale. The CEDV also showed that most of the parents' verbal arguments were about or involved Kim. The WAST indicated that mother reported no signs of domestic violence occurring in the home. The SDQ's yielded some interesting results that led to the caseworker to realize that they had a number of follow-up questions for Kim. The SDQ's clearly indicated that Kim was in need of mental health services but what most intrigued the caseworker was that both mother and Kim scored Kim abnormally high on both the Emotional Symptoms Score and Peer Problems Score. The drug and alcohol screens on the parents yielded no need for any further assessment on the mother, but did indicate that the father needed to be further assessed. In supervision, the caseworker discussed the results with the supervisor and they agreed that the caseworker should meet with Kim again and have a focused discussion about her relationships with peers at home and at school.

The caseworker then met with Kim at school where she continued to appear to be struggling with the effects of her new medications. Caseworker talked at length with Kim about her peers at home and at school. Over the course of the conversation, Kim eventually broke down and began to cry. Kim expressed a great deal of frustration with how the girls at her school had been treating her. Kim talked about how much she had tried to fit in, but nothing seemed to work for her. Kim also admitted to telling these girls at school that she had been having sex with Rodger, because she thought that would

impress them but they only made fun of her even more. Kim said that she couldn't tell the teachers at school because that would only make the problem worse. Kim also said that she wants to marry Rodger in order to live on her own and not have to deal with all these painful things. Kim also recanted what she had said about her father that led to the original referral. Kim said that there was a time in her life that her father was like what she had alleged, but that was over fours years ago.

The caseworker later met with the family to discuss what they had learned from the assessment of the family case. The caseworker informed the family that though the report was going to be unfounded, the family was going to be opened for services. The caseworker explained that the areas of concern were in regards to the child's mental health, parenting, the father's alcohol use, and parent-child conflict. The caseworker explained that the agency and the family would work together in developing a plan to address the issues in the family, and would access various community resources. The caseworker then further explained the reasons why the family was being opened for services. The caseworker showed the mother the results of the SDQ. The caseworker showed how the mother scored the child very high on having behavioral problems, while Kim scored herself very low. The caseworker pointed out that this often means that a parent is not addressing a child's behaviors. The mother admitted that she does not address the

Caseworker POV

The caseworker decided that showing the results of the SDQ to the mother was very important because it led to the mother's acknowledgement of an area needing improvement needed in her parenting. This also led to the father's disclosure that provides more insight into the family dynamics. Caseworker would put in a paid provider immediately to address the parenting and communication issues but planned to remove the provider once appropriate home-based mental health services were in place.

child's behaviors because she is afraid of how Kim reacts when she is confronted. The father explained that he is the one who typically holds the child accountable for her behaviors, which was a big change for Kim when he returned to the home. The caseworker asked mother if she felt her parenting would be a goal she wanted to work on. The mother said that it was, and the caseworker stated that they would help by putting in place a paid provider to address this area of her parenting.

The parents also felt as though Kim's mental health was not being properly addressed and they had concerns about the medication prescribed for her. The caseworker discussed a partial hospitalization program as a resource for Kim and her family to address their immediate concerns. The caseworker explained that the Partial Hospitalization program could assure that she is on the right medication and link the family with some home-based services such as Family Based Services or Multi-Systemic Therapy. The caseworker also explained it was important for the parents to request an evaluation for an Individualized Educational Plan (IEP) for Emotional Support for Kim that could be put in place for her return to school. The caseworker, with Kim's permission, went over the CEDV tool with the family. The caseworker explained how an IEP could assist Kim in the school setting by appropriately addressing the

Caseworker POV

It also appeared to the caseworker that Kim was overly medicated at this time and felt that the Partial Hospitalization program would serve several purposes such as addressing the medication, implementation of an IEP, and home-based therapeutic services. Caseworker decided to show the results of the screening tools helped in engaging the family in recognizing areas of concern. The results showed an "un-biased" source from the family's perspective as the results were based on their responses.

Since the caseworker only worked with the family on the intake level for less than 60 days they did not have the time to do a comprehensive family assessment. The assessment that was completed better prepared the family and the next caseworker in identifying the underlying issues so that FSP goals and objectives would truly address the areas of concern.

stressors that led to her hospitalization. The family agreed to the therapeutic and educational goals for Kim and agreed that the mental health providers coming to the home would be of great benefit to the family. The caseworker then went over the alcohol screen with the father. The father denied that there was an issue with his alcohol use but agreed to call his insurance company and schedule an evaluation.

The caseworker then explained how the case would be assigned to an ongoing caseworker who would work with the family to write down the details of their plan. The caseworker explained that the family would be asked to identify their strengths that will be drawn from in order to achieve the goals of the Family Service Plan. The caseworker also talked about Family Group Decision Making as another way of creating a Family Service Plan. The caseworker thanked the family for their cooperation and encouraged them to follow through with the plan that they create in order to strengthen and empower their family.

V. The Matrix

The Matrix is a tool that caseworkers can use themselves, but it can also be a valuable tool to use during supervision. This tool provides a list of observations that are typical of those that caseworkers encounter with families in the field. After each observation there follows a list of possible underlying issues that may be the cause of the manifestation of the observation/behavior. Next to most of the underlying issues will be a link to a screening/assessment tool that workers can utilize in order to assist them in identifying the underlying issue. There are three different versions of the Matrix with the longer version having a link to a screening tool and the shorter version enabling caseworkers to take the Matrix with them when they are out in the field.

The Matrix is designed in order to enhance and/or improve caseworkers' critical thinking skills. Caseworkers can utilize the Matrix to critically examine a case on their own, rather than having to wait for supervision or rely on supervision alone. The Matrix does not replace the need for supervision, but rather enables caseworkers to demonstrate how they are able to apply their critical thinking skills on their own. Caseworkers may find it helpful to use the Matrix tool throughout their on-going assessment process with the family to assist in identifying or ruling out possible underlying issues, and use the information in creating, evaluating, and revising Family Service Plans.

During supervision, supervisors can apply the Matrix to review specific cases to help foster the critical thinking skills of a caseworker. Using the Matrix to improve the critical thinking skills can be done with a variety of teaching techniques such as one-to-one

teaching and brainstorming. Consistently using the Matrix in supervision is likely to lead to caseworkers using the Matrix on their own to better assess the family and apply critical thinking skills. In time, caseworkers will likely complete family assessments more accurately, become more independent, and rely less on the supervisor to guide them through the assessment process.

There are several versions of the Matrix included in Pennsylvania's Enhancing Assessments Toolkit. Multiple versions were developed so that various learning styles could be accommodated and a specific in-field edition was also developed as a quick reference guide.

- Version 1 is designed to be used within the electronic version of the toolkit. It will link users directly to the appropriate section of the toolkit. Not every item has a link to a screening tool; users may wish to consult the Pennsylvania Safety Assessment and Mangement Process Manual.

- Version 2 is designed for workers to print out and carry with them in the field. It is a quick reference or cheat sheet.

- Version 3 is also designed for workers to print our and carry with them in the field. It is a quick reference or cheat sheet. It contains the same information as versions 1and 2, but is formatted differently.

Underlying Issues Matrix 1	
This chart is not all encompassing, nor is it meant to capture all underlying issues or observations warranting follow-up. This chart is to be used as a tool with supervisors and caseworkers to stimulate dialogue and enhanced thinking to better our ability to identify and address the underlying issues our families face.	
Observation/Presenting Concerns	**Possible Underlying Issues**
Atypical fidgeting, squirming, and/or out of the ordinary behavior	Custody issues
	Domestic violence
	Drug/alcohol
	Lack of acceptance/unready for change
	Low/limited cognitive abilities (adult/child)
	Mental health (adult/child)
	Physical health needs
	Religious/cultural practices
Child is not up to date on immunizations	Domestic violence
	Drug/alcohol
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of parenting skills/knowledge
	Language/literacy barriers
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Medical care continuity issue
	Mental health (adult/child)
	Religious/cultural practices
	Unemployment/under employment
	Unreported physical/sexual abuse
Chronic runaway	Attachment issues
	Bullying
	Criminal/delinquent activity
	Custody issues
	Domestic violence
	Drug/alcohol
	Educational needs not being met
	Emotional abuse
	Family/household dynamics
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of parenting skills/knowledge
	Language/literacy barriers
	Low neighborhood attachment and community disorganization
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Religious/cultural practices

Observation/Presenting Concerns	Possible Underlying Issues
	Teen pregnancy
	Unreported physical/sexual abuse
	Unstable housing
Compliance with caseworker meetings	Domestic violence
	Drug/alcohol
	Emotional abuse
	Employment schedule conflicts
	Family/household dynamics
	Lack of acceptance/unready for change
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of childcare
	Language/literacy barriers
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Religious/cultural practices
	Unreported physical/sexual abuse
Compliance with treatment	Attachment issues
	Custody issues
	Domestic violence
	Drug/alcohol
	Employment schedule conflicts
	Lack of acceptance/unready for change
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of childcare
	Lack of parenting skills/knowledge
	Language/literacy barriers
	Low/limited cognitive abilities (adult/child)
	Mental health (adult/child)
	Physical health needs
	Relationship/rapport with provider (gender, values, etc.)
	Religious/cultural practices
Family conflict/arguments/reported physical/sexual abuse	Attachment issues
	Criminal/delinquent activity
	Domestic violence
	Drug/alcohol
	Emotional abuse
	Family/household dynamics
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)

Observation/Presenting Concerns	Possible Underlying Issues
	Previous abuse of adult as child
	Unreported physical/sexual abuse
Home environment concerns (i.e. animal neglect, broken furniture, broken windows, holes in walls, leaking roof, etc.)	Domestic violence
	Drug/alcohol
	Emotional abuse
	Family/household dynamics
	Lack of basic housekeeping knowledge/skills
	Lack of community resources/awareness of resources
	Lack of parenting skills/knowledge
	Lack of social supports
	Low neighborhood attachment and community disorganization
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Mental health (adult/child)
	Physical abuse
	Physical health needs
	Sexual abuse
	Sibling conflict
	Unemployment/under employment
	Unreported physical/sexual abuse
	Unstable housing
Inappropriate clothing for season	Custody issues
	Domestic violence
	Drug/alcohol
	Emotional abuse
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of parenting skills/knowledge
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Mental health (adult/child)
	Physical abuse
	Sexual abuse
	Unreported physical/sexual abuse
Lack of supervision of children	Custody issues
	Drug/alcohol
	Emotional abuse
	Family/household dynamics
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of childcare
	Lack of parenting skills/knowledge
	Lack of social supports

Observation/Presenting Concerns	Possible Underlying Issues
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Mental health (adult/child)
	Physical abuse/unreported physical abuse
	Physical health needs
	Religious/cultural practices
	Sexual abuse
Little/limited food in home/failure to thrive/malnourishment	Drug/alcohol
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of knowledge of child development/nutritional needs
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
Parentified child	Domestic violence
	Drug/alcohol
	Lack of parenting skills/knowledge
	Lack of social supports
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Religious/cultural practices
	Sexual abuse
Personal hygiene	Drug/alcohol
	Emotional abuse
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Reported physical/sexual abuse
	Unreported physical/sexual abuse
Transiency/homelessness	Criminal/credit history
	Criminal/delinquent activity
	Custody issues
	Domestic violence
	Drug/alcohol
	Emotional abuse
	Family/household dynamics
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of parenting skills/knowledge

Observation/Presenting Concerns	Possible Underlying Issues
	Lack of social supports
	Language/literacy barriers
	Low neighborhood attachment and community disorganization
	Low/limited cognitive abilities (adult/child)
	Low/limited resource management skills
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Religious/cultural practices
	Unemployment/under employment
	Unreported physical/sexual abuse
Truancy	Attachment issues
	Bullying
	Criminal/delinquent activity
	Custody issues
	Domestic violence
	Drug/alcohol
	Educational needs not being met
	Emotional abuse
	Family/household dynamics
	Lack of basic necessities - food, clothing, transportation, housing, etc.
	Lack of parenting skills/knowledge
	Language/literacy barriers
	Low neighborhood attachment and community disorganization
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Proximity to school
	Religious/cultural practices
	Unreported physical/sexual abuse
	Unstable housing
Typical developmental milestones not being met	Attachment issues
	Drug/alcohol
	Emotional abuse
	Exposure to toxic environmental substances
	Lack of parenting skills/knowledge
	Low/limited cognitive abilities (adult/child)
	Maltreatment/neglect
	Mental health (adult/child)
	Physical health needs
	Religious/cultural practices
	Reported physical/sexual abuse

Observation/Presenting Concerns	Possible Underlying Issues
	Sexual abuse
	Unreported physical/sexual abuse

Underlying Issues Matrix 2

This chart is not all encompassing, nor is it meant to capture all underlying issues or observations warranting followup. This chart is to be used as a tool with supervisors and caseworkers to stimulate dialogue and enhanced thinking to better our ability to identify and address the underlying issues our families face.

Observations/Presenting Concerns

Atypical fidgeting, squirming, and/or out of the ordinary behavior	Child is not up to date on immunizations	Chronic runaway	Compliance with caseworker meetings	Compliance with treatment	Family conflict/arguments/reported physical/sexual abuse	Home environment concerns (i.e. animal neglect, broken furniture, broken windows, holes in the walls, leaking roof, etc.)	Inappropriate clothing for season	Lack of supervision of children	Little/limited food in home/failure to thrive/malnourishment	Parentified child	Personal hygiene	Transiency/homelessness	Truancy	Typical developmental milestones not being met	**Possible Underlying Issues**
		X		X	X								X	X	Attachment issues
		X											X		Bullying
												X			Criminal/credit history
		X			X							X	X		Criminal/delinquent activity
X		X		X			X	X				X	X		Custody issues
X	X	X	X	X	X	X	X			X		X	X		Domestic violence
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Drug/alcohol
		X											X		Educational needs not being met
		X	X		X	X	X	X			X	X	X	X	Emotional abuse
			X	X											Employment schedule conflicts
														X	Exposure to toxic environmental substances
		X	X		X	X		X				X	X		Family/household dynamics
X			X	X											Lack of acceptance/unready for change
						X									Lack of basic housekeeping knowledge/skills
	X	X	X	X	X		X	X	X		X	X	X		Lack of basic necessities - food, clothing, transportation, housing, etc.
			X	X				X							Lack of childcare
						X									Lack of community resources/awareness of resources
									X						Lack of knowledge of child development/nutritional needs
	X	X		X		X	X	X		X		X	X	X	Lack of parenting skills/knowledge
						X		X		X		X			Lack of social supports
	X	X	X	X								X	X		Language/literacy barriers
		X				X						X	X		Low neighborhood attachment and community disorganization
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Low/limited cognitive abilities (adult/child)
	X					X	X	X	X			X			Low/limited resource management skills
	X	X	X		X	X	X	X	X	X	X	X	X	X	Maltreatment/neglect
	X														Medical care continuity issue
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Mental health (adult/child)
						X	X	X						X	Physical abuse
X		X	X	X		X		X	X		X	X	X	X	Physical health needs
					X										Previous abuse of adult as child
													X		Proximity to school
				X											Relationship/rapport with provider (gender, values, etc.)
X	X	X	X	X				X		X		X	X	X	Religious/cultural practices
											X			X	Reported physical/sexual abuse
						X	X	X		X					Sexual abuse
						X									Sibling conflict
		X													Teen pregnancy
	X					X						X			Unemployment/under employment
	X	X	X		X	X	X	X			X	X	X	X	Unreported physical/sexual abuse
		X				X							X		Unstable housing

Underlying Issues Matrix 3

Possible Underlying Issues

This chart is not all encompassing, nor is it meant to capture all underlying issues or observations warranting followup. This chart is to be used as a tool with supervisors and caseworkers to stimulate dialogue and enhanced thinking to better our ability to identify and address the underlying issues our families face.

Observations/Presenting Concerns	Attachment issues	Bullying	Criminal/credit history	Criminal/delinquent activity	Custody issues	Domestic violence	Drug/alcohol	Educational needs not being met	Emotional abuse	Employment schedule conflicts	Exposure to toxic environmental substances	Family/household dynamics	Lack of acceptance/unready for change	Lack of basic housekeeping knowledge/skills	Lack of basic necessities - food, clothing, transportation, housing, etc.	Lack of childcare	Lack of community resources/awareness of resources	Lack of knowledge of child development/nutritional needs	Lack of parenting skills/knowledge	Lack of social supports	Language/literacy barriers	Low neighborhood attachment and community disorganization	Low/limited cognitive abilities (adult/child)	Maltreatment/neglect	Medical care continuity issue	Mental health (adult/child)	Physical abuse	Physical health needs	Previous abuse of adult as child	Proximity to school	Relationship/rapport with provider (gender, values, etc.)	Religious/cultural practices	Reported physical/sexual abuse	Sexual abuse	Sibling conflict	Teen pregnancy	Unemployment/under employment	Unreported physical/sexual abuse	Unstable housing
Atypical fidgeting, squirming, and/or out of the ordinary behavior					X	X	X						X										X				X		X				X						
Child is not up to date on immunizations						X	X								X				X		X		X	X	X	X	X						X				X	X	
Chronic runaway	X	X		X	X	X	X	X	X			X			X				X		X	X	X		X		X		X				X			X	X	X
Compliance with caseworker meetings						X	X		X	X		X	X		X	X					X		X		X		X		X				X				X		
Compliance with treatment	X				X	X	X			X			X		X	X			X		X		X				X		X			X	X						
Family conflict/arguments/reported physical/sexual abuse	X			X		X	X		X			X			X						X		X		X		X			X							X	
Home environment concerns (i.e. holes in walls, broken furniture, broken windows, leaking roof, etc.)						X	X		X			X		X			X		X	X		X	X	X	X		X	X	X				X	X		X	X	X
Inappropriate clothing for season					X	X	X		X						X				X				X	X	X		X	X						X				X	
Lack of supervision of children					X		X		X			X			X	X			X	X			X	X	X		X	X	X				X		X			X	
Little/limited food in home/failure to thrive/malnourishment							X								X			X					X	X	X		X		X										
Parentified child						X	X												X	X			X		X		X						X		X				
Personal hygiene							X		X						X								X		X		X		X					X	X			X	
Transiency/homelessness			X	X	X	X	X		X			X			X				X	X	X	X	X	X	X		X		X				X			X	X	
Truancy	X	X		X	X	X	X	X	X			X			X				X		X	X	X		X		X		X		X		X			X	X	X
Typical developmental milestones not being met	X						X		X		X								X				X		X		X		X				X	X				X	

VI. Mental Health

As children and youth caseworkers, we encounter families and their members struggling to function successfully in their environment. In addition to financial, medical, and social challenges, the clients you serve may also be working to overcome mental health disorders. The American Psychiatric Association (2000) defines a mental health disorder as "a clinically significant behavior or psychological syndrome or pattern that occurs in an individual and that is associated with present distress… or disability…" (p. xxxi). While various statistics note the prevalence of specific disorders in our country, the Substance Abuse and Mental Health Services Administrations (SAMSHA) reports that approximately 10.6 million Americans were in need of mental health services in 2009 (About the Agency (SAMHSA), 2012). A knowledge base regarding this issue empowers us to be more effective caseworkers in supporting both our clients' safety and overall wellness. This section will discuss the manner in which diagnoses are developed by professionals, how to proceed when a client's ongoing behavior presents concerns, resources available to support the caseworker during assessment and referral, as well as the role and integration of recovery concepts.

As a caseworker, you will not be asked or expected to play the role of diagnostician. However, it is beneficial to be informed regarding the relationship between problems we can observe and treatment that clinicians can provide. Since 1952, the American Psychiatric Association has been responsible for the publication for the Diagnostic and Statistics Manual of Mental Disorders. Generally known as the DSM, it is now in its fourth edition with text revisions (abbreviated DSM-IV-TR). This comprehensive text

presents the treatment and insurance field standard diagnostic criteria for mental health disorders (American Psychiatric Association, 2000). Note that these criteria are most often utilized for the purposes of directing treatment planning and coordination of payment with insurance companies; it is not intended for use in labeling a person or the struggles he or she is working to overcome.

The DSM-IV-TR breaks down a diagnosis into five "axes." Axis I encompasses "clinical disorders and other conditions that may be the focus of clinical attention" (American Psychiatric Association, 2000). This can include the following:

> Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Intellectual Disabilities, which is diagnosed on Axis II); Delirium, Dementia, and Amnestic and Other Cognitive Disorders; Mental Disorders due to a General Medical Condition; Substance-Related Disorders, Schizophrenia and Other Psychotic Disorders; Mood Disorders; Anxiety Disorders; Somatoform Disorders; Factitious Disorders, Dissociative Disorders, Sexual and Gender Identity Disorders, Eating Disorders, Sleep Disorders; Impulse-Control Disorders Not Elsewhere Classified; Adjustment Disorders; Other Conditions That May Be a Focus of Clinical Attention (p.28)

Axis II encompasses intellectual disabilities and personality disorders. The American Psychiatric Associate (2000) notes that personality disorders include, "as an enduring pattern of inner experience and behavior that deviates markedly from the expectation of

the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning or impulse control." (p.686). Axis II diagnoses can include the following:

> Paranoid Personality Disorder; Schizoid Personality Disorder; Schizotypal Personality Disorder; Antisocial Personality Disorder; Borderline Personality Disorder; Histrionic Personality Disorder; Narcissistic Personality Disorder; Avoidant Personality Disorder; Dependent Personality Disorder; Obsessive-Compulsive Personality Disorder; Personality Disorder Not Otherwise Specified. (p.29)

Axis III encompasses general medical conditions. This can include medical conditions that have developed and been treated, chronic conditions, conditions or complications related to birth, and allergies. These can encompass all systems of the body. Axis IV is used to identify the factors and circumstances in a person's environment that can impact the outcomes of treatment for a mental health disorder. This is the area in which the issues that we are involved with supporting a resolution to are identified. These can include the following:

> Problems with primary support group; Problems related to the social environment; Educational problems; Occupational problems; Housing problems; Economic problems; Problems with access to health care services; Problems related to interaction with the legal system/ crime; Other psychosocial and environmental problems. (p.32).

Axis V is used for the diagnostician's overall assessment of the person's level of functioning. This is done using a scale that scores a Global Assessment of Funtioning (GAF). This is a scale from 1 to 100, with 1 marking a complete inability to function safely and 100 marking completely successful functioning. The GAF score provides the opportunity to give a quantitative value to qualitative symptoms. There are guidelines for developing the most appropriate score, but the scale must be individualized, as the American Psychiatric Association (2000) notes that "impairment of functioning due to physical (or environmental) limitations," (p.34) should not impact the score.

Your role in supporting children, youth, and their families will not include diagnosing or assessing mental health disorders; however, it is beneficial to become familiar with the language of clinicians who may be treating your clients. As aforementioned, there are limitations to the current DSM-IV-TR. McQuaide (1999) notes the lack of an opportunity for a diagnostician to highlight a client's strengths (McQuaide, 1999). Likewise, there is no category is which to list a client's self-identified goals or natural supports, which can be key components in overcoming challenges. In the years since the current publication, much has been learned in the field of mental health disorders, and the next edition of the text seeks to reflect this (American Psychiatric Association, 2010)

Despite the lack of responsibility to provide diagnosis or treatment, it is likely that you might still find yourself wondering, "Could this person have a mental health disorder?" The Mayo Clinic (2011) commented on the confusion that can arise in trying to distinguish normal behaviors and feelings from problematic symptoms. The spectrum of

symptoms that compose the previously discussed criteria in the DSM-IV-TR affect a person's thoughts, behaviors, and feelings. These can be observed through self-reflection (for example, a child noticing that he feels sad) or outside observation (for example, a caseworker noticing that a child seldom smiles). Observable symptoms that may warrant further evaluation can include, but are not limited to:

> Marked change in personality, eating, or sleeping patterns; Inability to cope with problems or daily activities; Strange or grandiose ideas; Excessive anxiety; Prolonged depression or apathy; Thinking or talking about suicide; Substance abuse; Extreme mood swings or excessive anger, hostility or violent behavior. (Staff, 2011)

An appropriate approach to the question of whether further assessment is necessary is to examine or have a conversation about how these symptoms are affecting or interfering in a client's day-to-day ability to function successfully. For example, as a caseworker you might have concerns about a mother's possible symptoms of depression. Your first step might be to review if this is affects her ability to follow a goal plan or to provide appropriate care for her children. If you find this is the case, it would be beneficial to discuss a referral for a more thorough evaluation. Another example is that a caseworker is informed that there have been complaints from a teacher that a child is hyperactive in school. The child has been failing several classes and is danger of repeating the same grade level next year. Again, a more formal evaluation would be indicated. A person's primary care (family) physician or pediatrician is typically the

starting point for an evaluation for treatment. If there is a situation in which due to his or her behaviors, a person is at risk of harming him or herself, or others, the evaluation can be conducted in conjunction with your community's crisis resources.

There is a broad spectrum of resources available to support treatment of mental health disorders. There are two main levels of care through which clients will access treatment, inpatient and out-patient, but there is a wide variety of resources that offer different amount of supports to each. Each service has admission criteria that directs the appropriateness and dictates the funding for each service. Inpatient treatment is the most restrictive level of care, and takes place in a hospital or a facility that is licensed similarly. Within this treatment approach are short term acute-care units, longer-term extended acute care units, and in limited numbers in Pennsylvania the long term state hospitals. A residential treatment facility is a long-term placement for children and adolescents under the age of eighteen who do not need to remain in the hospital but who could benefit from additional structured treatment prior to returning to residence in the community. Out-patient treatment can include partial hospitalization day programs, out-patient therapy, case-management services, and medication management with a psychiatrist or nurse practitioner. "Out-patient" therapy can include individual or group therapies, as well as community based services such as Family Based Mental Health Services, High Fidelity Wraparound Services, Behavioral Health Rehabilitative Services (include Therapeutic Support Staff, Mobile Therapists, and Behavioral Specialist Consultants). The National Institute of Mental Health (2009) recommends that the health care professional treating the client (child, youth, or adult)

will assess the client's needs and strengths and refer him or her for the most appropriate treatment available in the community (National Institute of Mental Health, 2009).

Within the framework of discussion on treatment options, it is necessary to review the potential inclusion of medication as part of a treatment regimen. Medication can be prescribed as part of a treatment regimen by a medical doctor (MD or DO) or a medical professional such as a physician's assistant or nurse practitioner. For adults as well as children and youth, different classes of psychotropic medication can be used to regulate the brain chemistry (such as neurotransmitters) and affect behaviors and mood (National Institute of Mental Health, 2009).

INSTRUCTIONS FOR USE

Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up.

INSTRUCTIONS FOR SCORING

The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

HOW TO INTERPRET THE PSC OR Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site: http://psc.partners.org.

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Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191–197.

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Pediatric Symptom Checklist (PSC)

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

Please mark under the heading that best describes your child:

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

Total score _____

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

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

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

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

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

INSTRUCTION MANUAL
Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures

BACKGROUND

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders.[1] Patients first completed a one-page 27-item screener and, for those disorders for which they screened positive, were asked additional questions by the clinician using a structured interview guide. However, this 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis. This proved to be a barrier to use given the competing demands in busy clinical practice settings.

Therefore, in two large studies enrolling 6000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics), a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.[2,3] In the past decade, the PHQ in general and the PHQ-9 depression scale in particular [4-6] have gained increasing use in both research and practice. The original PRIME-MD is now largely of historical interest and seldom used except in a few types of research studies.
Given the popularity of the PHQ-9 for assessing and monitoring depression severity, a new 7-item anxiety scale using a response set similar to the PHQ-9 was initially developed to diagnose generalized anxiety disorder (hence its name, the GAD-7) and validated in 2740 primary care patients.[7] Though originally developed to diagnose generalized anxiety disorder, the GAD-7 also proved to have good sensitivity and specificity as a screener for panic, social anxiety, and post-traumatic stress disorder.[8] Finally, the PHQ-15 was derived from the original PHQ studies and is increasingly used to assess somatic symptom severity and the potential presence of somatization and somatoform disorders.[9]

Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ. Also, alternative or abbreviated versions of the PHQ-9 and GAD-7 are sometimes used in certain screening or research settings [10-14]
Although the PHQ was originally developed to detect five disorders, the depression, anxiety, and somatoform modules (in that order) have turned out to be the most popular.[10] Also, most primary care patients with depressive or anxiety disorders present with somatic complaints and co-occurrence of somatic, anxiety, and depressive symptoms (the *SAD* triad) is exceptionally common. This is the rationale behind the PHQ-SADS screener.[15] The most commonly used versions of the PHQ scales are summarized in **Table 1, page 3**.

CODING AND SCORING

The full PHQ, Brief PHQ, and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM-IV disorders. The diagnostic algorithm for the PHQ modules are included in footers at the bottom of each page of the PHQ, and also reiterated in **Table 2, page 4**. The other measures are principally used to derive severity scores (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity; PHQ-15 for somatic symptom severity) or as ultra-brief screeners (PHQ-2, GAD-2, PHQ-4). An example in which the PHQ depression module can be used as both a diagnostic module as well as a depression severity score (PHQ-9 score) is shown in **Table 3, page 5.**

Over time, the severity scores have been a particularly popular use of the measures, and are now used much more commonly than the provisional diagnoses. For example, cutpoints of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the PHQ-9, GAD-7, and PHQ-15 respectively. Also, a cutpoint of 10 or greater is considered a "yellow flag" on all 3 measures (i.e., drawing attention to a possible clinically significant condition), while a cutpoint of 15 is a "red flag" on all 3 measures (i.e., targeting individuals in whom active treatment is probably warranted). For the ultra-brief measures (PHQ-2 and GAD-2), a score of 3 or greater should prompt administration of the full PHQ-9 and/or GAD-7, as well as a clinical interview to determine whether a mental disorder is present.

The final question on the PHQ (and some of its abbreviated versions) asks the patients to report "how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

A particularly important question is how to assess suicide risk in individuals who answer positively to the 9th question of the PHQ-9. A four-item screener has been developed that may assist in positive responses to this 9th question [16], although a final decision about the actual risk of self-harm requires a clinical interview.

Table 1. Versions: Patient Health Questionnaire (PHQ) Family of Measures

Measure	Description	Scoring	References
Core			
PRIME-MD	Predecessor of PHQ, now mainly of historical interest.	Combined self-administered patient screener with clinician follow-up questions.	1
PHQ	Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.	Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.	2, 3
PHQ-9	Depression scale from PHQ.	Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.	1, 4, 5, 6, 10
GAD-7	Anxiety measure developed after PHQ but incorporated into PHQ-SADS.	Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.	7, 8, 10
PHQ-15	Somatic symptom scale from PHQ.	Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.	9, 10
PHQ-SADS	PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.	See scoring for these scales above.	10
Variants			
Brief PHQ	PHQ-9 and panic measures from original PHQ plus items on stressors and women's health.	See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.	3
PHQ-A	Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.	Diagnostic scoring described in manual, available upon request.	11
PHQ-2	First 2 items of PHQ-9. Ultra-brief depression screener.	Two items scored 0 to 3 (total score of 0-6)	10, 12
GAD-2	First 2 items of GAD-7. Ultra-brief anxiety screener.	Two items scored 0 to 3 (total score of 0-6)	8, 10, 12
PHQ-4	PHQ-2 and GAD-2.	See PHQ-2 and GAD-2 above.	10, 12, 13
PHQ-8	All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies.	Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.	5, 10, 14

Table 2. Diagnostic Algorithms for the PHQ

Page 1

Somatoform Disorder if at least 3 of #1a-m bother the patient "a lot" and lack an adequate biological explanation.

Major Depressive Syndrome if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) .

Other Depressive Syndrome if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Note**:** the diagnoses of Major Depressive Disorder and Other Depressive Disorder requires ruling out normal *bereavement (mild symptoms, duration less than 2 months***)**, a history of a *manic* episode (Bipolar Disord and a *physical disorder, medication or other drug* as the biological cause of the depressive symptoms.

Page 2

Panic Syndrome if #3a-d are all 'YES' and 4 or more of #4a-k are 'YES'.

Other Anxiety Syndrome if #5a and answers to three or more of #5b-g are "More than half the days".

Note**:** The diagnoses of Panic Disorder and Other Anxiety Disorder require ruling out a *physical disorder***,** *medication or other drug* as the biological cause of the anxiety symptoms.

Page 3

Bulimia Nervosa if #6a,b, and c and #8 are 'YES';

Binge Eating Disorder the same but #8 is either 'NO' or left blank.

Alcohol abuse if any of #10a-e are "YES".

Additional Clinical Considerations. After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- *Have current symptoms been triggered by psychosocial **stressor(s**)?*
- *What is the **duration** of the current disturbance and has the patient received any **treatment** for it?*
- *To what extent are the patient's symptoms i**mpairing** his or her usual work and activities?*
- *Is there a **history** of similar episodes, and were they **treated**?*
- *Is there a **family history** of similar conditions?*

Table 3. Example of PHQ Depression Module for both Diagnostic and Severity Purposes

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month.

2. Over the last 2 weeks, how often have you been bothered by any of the following:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	(0)	(1)	(2)	(3)
a. Little interest or pleasure in doing things?……..	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?……..…	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☒	☐
d. Feeling tired or having little energy?.....……...…..	☐	☐	☐	☒
e. Poor appetite or overeating?.....…….….	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?……..	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television? ……..	☐	☐	☐	☒
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?.....……..	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way? …….	☐	☒	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) . Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Major Depressive Disorder Diagnosis. The criteria for Major Depressive Syndrome are met since she checked #2a "nearly every day" and five of items #2a to i were checked "more than half the days" or "nearly every day". Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case, the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

USE OF SOME SCREENERS AS SEVERITY AND OUTCOME MEASURES

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case (see table 3, page 5), the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed. The **PHQ-8** is scored just like the PHQ-9 and its total score ranges from 0 to 24. Cutpoints on the PHQ-8 are identical to the PHQ-9.

GAD-7 Anxiety Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutpoints for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cutpoint for further evaluation is a score of 10 or greater.

PHQ-2 and GAD-2 Severity. These consist of the first two items of the PHQ-9 and GAD-7 respectively, and constitute the two core DSM-IV items for major depressive disorder and generalized anxiety disorder, respectively. Each ranges from a score of 0 to 6. The operating characteristics of these ultra-brief measures are quite good; the recommended cutpoints for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the **PHQ-4** a 4-item screening measure which ranges from a score of 0 to 12, and serves as a good measure of "caseness" (i.e., the higher the score, the more likely there is an underlying depressive or anxiety disorder). In particular, the PHQ-2 and GAD-2 subscores of the PHQ-4 provide separate depressive and anxiety scores, and can be used as screeners for depression and anxiety.

PHQ-15 Somatic Symptom Severity. This is calculated by assigning scores of 0, 1, and 2 to the response categories of "not at all", "bothered a little", and "bothered a lot", for the 13 somatic symptoms of the PHQ (items 1a-1m). Also, 2 items from the depression module (sleep and tired) are scored 0 ("not at all"), 1 ("several days") or 2 ("more than half the days" or "nearly every day"). Thus, a PHQ-15 score can be derived from page 1 of the PHQ, or from separate administration of the PHQ-15 scale or the PHQ-SADS. PHQ-15 scores of 5, 10, and 15 represent cutpoints for low, medium, and high somatic symptom severity, respectively.

Sensitivity to Change for Monitoring Treatment Outcomes. A particularly important use of a measure is its responsiveness to changes of condition severity over time. This is well-established for the PHQ-9 which is increasingly used as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response).[6,10] An example of how different PHQ-9 severity levels might guide treatment is shown in **Table 4, page 7**. There is preliminary evidence that the PHQ-15 may be responsive to changes as individuals with somatoform disorders or high somatization are treated.[10] The GAD-7 has demonstrated change as a secondary anxiety outcome in several depression trials, but has not yet been studied as a primary outcome in anxiety trials. Also, since there is more diagnostic splitting for anxiety than for depressive disorders, it remains to be determined whether a single anxiety measure can suffice as an outcome measure. It is likely the GAD-7 will be useful but not yet certain it will be sufficient.

Psychometrics. The psychometrics of the PHQ and its component scales are described in the validation articles for specific measures (see Selected References on page 9) and are summarized in a review article on the PHQ-9, GAD-7, and PHQ-15.[10]

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521

TRANSLATIONS

There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com). The abbreviated versions of these measures – PHQ-8, PHQ-2, GAD-2, and PHQ-4 – can simply be derived from the translations by selecting the relevant items (see Table 1, page 3). The PHQ-15 can also be simply derived by selecting the 13 somatic items (1a-1m), plus the *sleep* and *tired* items (2c and 2c) from the PHQ translations.

Many of the translations have been developed by the MAPI Research Institute using an internationally accepted translation methodology. Thus, most of the translations are linguistically valid. However, unlike the English versions of the PHQ and GAD-7, few of the translations have been psychometrically validated against an independent structured psychiatric interview.

If a translation is not available for a language you are interested in using, and you have the interest and resources to develop a linguistically valid translation, please send an e-mail to questions@phqscreeners.com for instructions on how to proceed. One requirement is that we are provided a copy of the final translation as well as a description of the translation methodology.

WEBSITE

Copies of the PHQ family of measures, including the GAD-7, are available at the website:

www.phqscreeners.com

Also, translations, a bibliography, an instruction manual, and other information is provided on this website.

QUESTIONS NOT ADDRESSED IN THIS INSTRUCTION DOCUMENT

For further questions, please send an e-mail to questions@phqscreeners.com

QUESTIONS REGARDING DEVELOPMENT, ACKNOWLEDGMENTS AND USE

The PHQ family of measures (see Table 1, page 3), including abbreviated and alternative versions as well as the GAD-7, were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

All of the measures included in Table 1 are in the public domain. No permission is required to reproduce, translate, display or distribute.

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Brief Patient Health Questionnaire™ (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name_____ Age_____ Sex: ☐ Female ☐ Male Today's Date_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	NO	**YES**
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐

If you checked "NO", go to question #3.

b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1a-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a-i are at least "More than half the days" (count #1i if present at all).Pan Syn if all of #2a-e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	**NO**	**YES**
	☐	☐

6. What is the most stressful thing in your life right now? _____

_____

7. Are you taking any medicine for anxiety, depression or stress?	**NO**	**YES**
	☐	☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged**	☐ **No periods because pregnant or recently gave birth**	☐ **Periods have become irregular or changed in frequency, duration or amount**	☐ **No periods for at least a year**	☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive**

	NO (or does not apply)	**YES**
a. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability, anger or mood swings	☐	☐
b. If YES: Do these problems go away by the end of your period?	☐	☐
c. Have you given birth within the last 6 months?	☐	☐
d. Have you had a miscarriage within the last 6 months?	☐	☐
e. Are you having difficulty getting pregnant?	☐	☐

PHQ-4				
Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Guidelines for Using the Mental Health Screening Form III

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's **entire life history**; therefore all questions begin with the phrase "Have you **ever**..."

The **preferred** mode of administration is for staff members to read each item to the respondent and get their "yes" and "no" responses. Then, **after** completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "**When** did this problem first develop?"; "**How long** did it last?"; "Did the problem develop **before**, **during**, or **after** you started using substances?"; and, "**What** was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients for them to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the client read the MHSF-II instructions and question number one to the staff member monitoring this process. If the client can not read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a client or s/he reads the questions and responds on his/her own, the completed MHSF-III **should be carefully reviewed** by a staff member to determine how best to use the information. It is strongly recommended that a **qualified mental health specialist** be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "**Total Score**" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, **questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories**: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Post-Traumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; 12Q Eating Disorders (Anorexia, Bulimia); Q13 Manic Episode; Q14 Panic Disorder; Q15 Obsessive-Compulsive Disorder; Q16 Pathological Gambling; Q17 Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above cited questions was investigated by having four mental health specialists independently "select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories." All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does **not**, by itself, insure that a mental health problems exists at this time. A "yes" response raises only the **possibility** of a **current** problem, which is why a consult with a mental health specialist is strongly recommended.

J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A.

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever ...."

1) Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

YES NO

2) Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

3) Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO

4) Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

YES NO

5) Have you ever heard voices no one else could hear or seen objects or things which others could not see?

YES NO

6) a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO

b) Did you ever attempt to kill yourself? YES NO

7) Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?

YES NO

8) Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

YES NO

9) Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? YES NO

OVER

10) Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO

11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.
YES NO

16) 1.Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17) Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
YES NO

Print Client's Name: _____ Program to which client will be assigned: _____

Name of Admissions Counselor:_____ Date: _____

Reviewer's Comments: _____

_____

_____

Total Score: _____ (each yes = 1 pt.)

Strengths And Difficulties Questionnaire.

The Strengths And Difficulties Questionnaire (SDQ), which was referred to in the story previously, is a brief, behavioral screening tool for 3-16 year olds. It can be completed by the youth and there is also caregiver and helping professional versions of the SDQ. The SDQ evaluates the following:

1. Emotional Symptoms
2. Conduct Problems
3. Hyperactivity/Inattention
4. Peer Relationship Problems
5. Prosocial Behavior

This tool is available free and there is a variety of SDQ formats and in various languages. This tool can be found on the internet at the following web address: http://www.sdqinfo.org/a0.html

VII. Substance Abuse

In the United States, substance abuse rates have remained relatively constant for the last 10 years. In a study conducted by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2010), it was estimated that when evaluating past month use, about 22.6 million, or 8.9% of Americans over 12 years old used some form of illicit drug.

When examining the issue within the confines of public child welfare it becomes more difficult to generate a reliable statistic to illustrate prevalence. The National Center on Substance Abuse and Child Welfare (2010) cites six factors contributing to this difficulty:

- The population studied (e.g., in-home versus out-of-home cases, urban versus nonurban, and foster care versus those being investigated for allegations of abuse or neglect);
- The definition of the substance use disorder (any use versus criteria of substance abuse or dependency);
- The method used to determine substance involvement (e.g., risk assessment measures, prospective assessment tools, or retrospective case reviews);
- Whether the substance use is a primary or secondary contributing factor in the child welfare case;

- Which program area families are participating in (e.g., family preservation services when children have remained in the home versus adoption services when parental rights have been terminated); and
- The method of analysis being use.

Despite the obvious difficulties in obtaining reliable data about this population, numerous studies have been conducted in attempt to gain some perspective. Very few studies have been conducted to determine the prevalence of substance abuse amongst families whose children have not been removed. In a 2006 study, Barth, Gibbons and Guo found that about 11.1% of families surveyed had some problem with substance dependence. These findings were somewhat lower than expected, as they are not grossly different from the rates found in the general population. The study however measured only dependence, not overall use.

When the focus turns to children who are living in out-of-home care, the rates increase dramatically. Some studies have been conducted (DHHS, 2005; McNichol & Tash, 2001) and by evaluating the findings of these studies, we can estimate that between 40% and 80% of children living in out-of-home care have caregivers who struggle with substance abuse. While range is obviously broad, it does illuminate the disparity of use between the general population and those involved with the child welfare system.

While statistics about prevalence can be difficult to interpret, we are well aware of the negative and sometimes catastrophic outcome for children exposed to substance

abusing caregivers. Numerous studies have been conducted on this topic. The results of these studies tell us that children with substance abusing caregivers are more likely to:

- Experience child abuse and neglect (DeBellis et al., 2002; Dube et al., 2001; Hanson et al., 2006);
- Have attachment problems as infants (Tay, 2005); and
- May have less of an opportunity to live in structured homes, have positive role models and have appropriate socialization opportunities (Hornberger, 2008).

Child welfare professionals are regularly faced with the challenge of identifying and providing services to clients who abuse substances. Barth et. al (2006) highlighted the problem by noting that substance use among child welfare clients is often undetected or wrongly detected. This notion should serve as a motivator for child welfare professionals to gain basic competency in the assessment of substance abuse with their clients.

While competency is a good place to start, child welfare professionals may experience difficulty in other areas of service provision such as:

- Lack of funding;
- Lack of access to services for their clients;
- Lack of training opportunities; and
- Lack of cross-systems collaboration.

Cross-systems collaboration is a key component to working with clients who abuse or are addicted to substances. When searching for answers to problems that are in reality, too broad to compartmentalize, child welfare caseworkers must avoid collaboration efforts that involve making assumptions about other disciplines that are without foundation.

Research (Vulliamy & Sullivan, 2000) has recommended a pragmatic approach to bridging the gaps between child welfare and other disciplines. Formal and informal cross training, facilitated discussion and information sharing, when possible, will help to clarify roles and confidentiality requirements.

Engagement

An essential component to successful screening of clients with possible substance abuse problems is engagement. Some methods currently employed in child welfare practice to enhance engagement efforts and understand client progress were originally developed within the arena of substance abuse treatment.

The core components of Motivational Interviewing (Miller & Rollnick, 2002) are useful when engaging and screening clients for possible substance abuse. The components are:

- **Open-ended questions**
    - Those statements that client's cannot answer with a "yes," "no" or "six times in the last week." An open-ended question is designed to

encourage a full, meaningful answer using the subject's own knowledge and/or feelings. They allow the client to create the momentum for forward movement. These types of questions allow us to help our clients explore opportunities for, and possibilities of change.

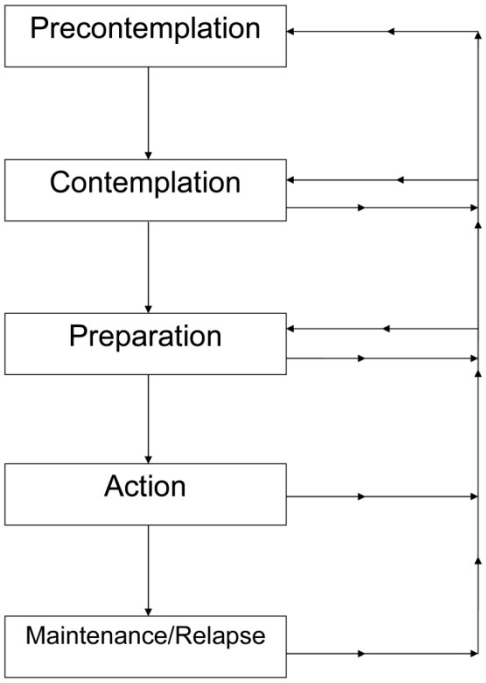
- **Affirmations**
    - These highlight areas of strength in the client. Most of the time, problems faced by our clients are not brand new. Since we know that relapse is an unfortunate step of recovery, most of our substance-addicted clients have tried to quit in the past and failed. For clients suffering from addictions, affirmations can be a rare event. However, they must be congruent and authentic. If the client thinks you are insincere, then rapport can be damaged rather than built.
- **Reflective Listening**
    - Remember that our clients are self-experts. They can tell us what has worked and what has not. By listening carefully, we gain an abundance of important information. By demonstrating that we are listening carefully, clients will begin to trust us and see that we want to join them in efforts to achieve safety for their children and personal wellness.
- **Summaries**
    - Specialized forms of reflective listening. By pausing from time to time to restate or clarify, the client will see that you are listening and have an active interest in what they are saying. Summaries have the ability to

draw relevant information from long narratives. They are also reliable methods of concluding inactive topics and transitioning to new ones.

Once clients are engaged in the helping process, it is helpful to follow the work of Prochaska and DiClemente (1983). The Stages of Change Model (figure 1) is helpful to both client and professional as they work to gain an understanding of the process of substance abuse and addiction recovery.

Figure 1

The Stages of Change Model



The Stages of Change Model is divided into five distinct phases.

In the **precontemplation** stage, clients will not be thinking seriously about changing. During this stage, they are usually not interested in any kind of help. People in this stage tend to defend their current bad habit(s) and do not feel it is a problem.

They may be defensive in the face of your efforts to help them. They do not focus their attention on quitting and tend not to discuss their bad habits with others. In this stage, people do not yet see themselves as having a problem.

While clients in this stage seem argumentative, in denial, or even hopeless, resist the urge to try to "convince" them to change, as this will produce greater resistance. Some examples of questions you can ask a client in **precontemplation** are:

- What would have to happen for you to know this is a problem?
- What warning signs would let you know this is a problem?
- Have you ever tried to change in the past?

In the **contemplation** stage, clients will be more aware of the consequences of their substance abuse and they may spend time thinking about their problem.

Although they are able to consider the possibility of changing, they tend to be hesitant about it. In this stage, people weigh the pros and cons of quitting or modifying their behavior. Although they think about the negative aspects of their substance abuse and

the positives associated with giving it up (or reducing), they may doubt that the long-term benefits associated with quitting will outweigh the short-term costs.

Clients experiencing this stage are beginning to see things differently. This can be a crucial time for them. Along with thoughts of change, feelings of guilt, shame, hopelessness and desperation are common. This is the point at which you begin discussing potential support systems that are in place or could be in place.

This stage has no determined timeframe. It can last a day, a week or a lifetime.

People in this stage may be open to receiving information about their substance abuse, and could be more likely to use recommended services.

Some examples of questions you may ask in that stage are:

- What were the reasons for not changing before?"
- "What would keep you from changing at this time?"
- "What are the barriers today that keep you from change?"
    - "What might help you with that aspect?"
- "What has helped in the past?"
- "What would help you at this time?

In the **preparation** stage, people have made a commitment to make a change. Their impetus for changing is reflected by statements like:

- “I have to do something about this, this is serious.”
- “Something has to change. What can I do?”

Questions like these may be viewed as the client doing personal research. These are to be seen as major steps and they should be fostered as such.

Sometimes, clients in the preparation stage experiment with different options of change. They may decide to cut back, use a different drug or “test the waters” at support groups. While these types of behavioral modifications are not exactly what we desire, they are steps in the right direction. Because our clients are experts on themselves, we sometimes have to allow them to test their own hypotheses.

Some ways we can support our clients in this stage are:

- Praising decisions to modify behavior;
- Identify and assist in overcoming barriers to change; and
- Assisting your client in identifying social supports.

Sometimes, clients may try to skip this stage. This can be dangerous because they may not understand what it is going to take to make a major lifestyle change.

The stage where clients believe they have the ability to change their behavior is called **action.** During this stage, clients are actively taking steps to address their addiction.

This tends to be the shortest of all the stages. This is a stage when people must depend on their own willpower. That means it could be a period of 6 months or as little as a few moments. This stage produces the greatest risk for relapse. Clients who arrive at the **action** stage generally need as much support as possible. The time spent in the other stages should involve gathering and implementing as many supports as possible so the client can rely on them during their **action** stage.

During this phase, clients will constantly review their commitments to themselves and to their supports. The development of plans to deal with stressors or triggers, and the use of short-term rewards help to bolster motivation. Clients will generally be open to support and help during this time.

As a caseworker, during this stage you may do any or all of the following to support your client in the **action** stage:

- Offer encouragement and support;
- Acknowledge the uncomfortable aspects of withdrawal; and
- Reinforce the importance of remaining in recovery for themselves and for their children.

During the **maintenance** stage, clients must avoid, consistently and successfully, temptations to return to substance abuse. **Triggers** are those situations, people, places

and things that remind, tempt or cause persons with addictions to either contemplate returning to drug abuse or actually **relapse.**

These clients will remain conscious that what they are motivated to achieve is personally worthwhile and meaningful. They are generally tolerant of themselves and understand that it will take time to let go of old behavior patterns and learn new ones until they become standard practice. Even though they may have thoughts of returning to their old bad habits, they resist the enticement and remain resolute. **Maintenance** usually occurs after 6 months of **action.**

During this time, caseworkers should help their clients identify drug-free sources of pleasure, support lifestyle changes and affirm the client's determination and self-efficacy. All of these strategies are aimed at **relapse** prevention

It is common to hear the phrase, "**Relapse** is part of recovery." Since most persons with addictions are aware of this, it sometimes becomes an excuse to return to old habits once they are in the maintenance stage. Sobriety is a difficult lifestyle for a person with an addiction. Issues related to relapse can be effectively addressed by reframing the situation for your client.

If your client relapses, use the situation as an opportunity to evaluate the triggers that caused the relapse. Encourage your client to reassess motivational barriers, plan

stronger coping mechanisms and then move back into the model at whatever stage is necessary, with the exception of moving directly to **action** without **contemplation**.

Some strategies that may be helpful for caseworkers when their clients **relapse** are:

- Examine what can be or has been learned from the relapse;
- Express concern about the relapse;
- Highlight the positive characteristics of the client's efforts to seek sobriety; and
- Support the client's self-efficacy so recovery seems possible.

Being competent and comfortable working from this model will also enhance the caseworker's ability to communicate and collaborate with medical professionals and substance abuse treatment professionals.

Screening Tools

Utilizing formal screening methods will enhance the child welfare professional's ability to serve their clients through informed decision-making and critical thinking. Becoming familiar with Motivational Interviewing strategies and the Stages of Change Model can open doors to engaging clients in a manner that makes the screening process less static and more comfortable for the professional and client alike.

This toolkit has been developed to provide some screening tools that may aid the child welfare professional in making assessments, making critical decisions, formulating family service plans, and developing child permanency plans.

For the purposes of this toolkit, we have included three tools for use in screening your clients for possible substance abuse problems. These screening tools are the Michigan Alcohol Screening Test (MAST), the Drug Abuse Screening Test (DAST) and the CRAFFT, a tool for screening adolescents for alcohol abuse. All of the tools are provided to guide your practice and decision making process. It is important to remember that these screening tools are **non-diagnostic** and do not replace the services provided by qualified drug and alcohol professionals.

The Michigan Alcohol Screening Test (MAST), developed in 1971, was created "…to provide a consistent, quantifiable, structured interview instrument to detect alcoholism…" (Selzer, 1971, p. 89). It is considered one of the most accurate alcohol screening tests available. It consists of 25 questions about a person's alcohol consumption tendencies, history and behaviors. It is brief and can be self-completed or done with the assistance of a professional if unbiased assistance is needed.

The Drug Abuse Screening Tool (DAST) "…was designed to provide a brief instrument for clinical screening and treatment evaluation research. The 28 self-report items tap various consequences that are combined in a total DAST score to yield a *quantitative* index of problems related to drug misuse." (Gavin, Ross and Skinner, 1989, p. 363) Like the MAST, this screening tool can be completed by the client or if literacy assistance is needed, the professional can assist the client. If this is the case, the professional must remain unbiased and allow the client to answer all of the questions.

The CRAFFT is a tool for screening adolescents under age 21 for alcohol abuse. It has proven to be a very effective and accurate tool. This tool consists of a series of six questions designed to determine if the adolescent is abusing alcohol. The results of the screen are designed to be indicative of the need for a longer conversation about alcohol use and the possibility for professional evaluation. The CRAFFT acronym stands for key words within each of the questions. They are:

- C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
- A - Do you ever use alcohol/drugs while you are by yourself, ALONE?
- F - Do you ever FORGET things you did while using alcohol or drugs?
- F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
- T - Have you gotten into TROUBLE while you were using alcohol or drugs?

Conclusion

We hope the information provided here, and the subsequent screening tools will help you and your colleagues to make informed decisions and to conduct thorough assessments of your clients aimed at determining how your client's struggles are manifested. The issue of substance abuse within the context of child welfare is very complicated and is generally multi-faceted. These tools are to serve as guides in the

casework process and as potential bridges to more effective cross-systems collaboration.

NCADD

NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE
OF THE SAN FERNANDO VALLEY

6640 Van Nuys Blvd., Suite C
Van Nuys, CA 91405-4617
818-997-0414
FAX 818-997-0851
www.ncadd-sfv.org

Michigan Alcohol Screening Test

NOTE: This test can be downloaded in PDF format, but Adobe Acrobat is required.

The MAST Test is a simple, self scoring test that helps assess if you have a drinking problem. Please answer YES or NO to the following questions:

MICHIGAN ALCOHOLISM SCREENING TEST (MAST)

			YES	NO	Points
	0.	Do you enjoy drinking now and then?	☐	☐	
*	1.	Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)	☐	☐	(2)
	2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	☐	☐	(2)
	3.	Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	☐	☐	(1)
*	4.	Can you stop drinking without a struggle after one or two drinks?	☐	☐	(2)
	5.	Do you ever feel guilty about your drinking?	☐	☐	(1)
*	6.	Do friends or relatives think you are a normal drinker?	☐	☐	(2)
*	7.	Are you able to stop drinking when you want to?	☐	☐	(2)
	8.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐	☐	(5)
	9.	Have you gotten into physical fights when drinking?	☐	☐	(1)
	10.	Has you drinking ever created problems between you and your wife, husband, a parent, or other relative?	☐	☐	(2)
	11.	Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	☐	☐	(2)
	12.	Have you ever lost friends because of your drinking?	☐	☐	(2)
	13.	Have you ever gotten into trouble at work or school because of drinking?	☐	☐	(2)
	14.	Have you ever lost a job because of drinking?	☐	☐	(2)
	15.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	☐	☐	(2)
	16.	Do you drink before noon fairly often?	☐	☐	(1)
	17.	Have you ever been told you have liver trouble? Cirrhosis?	☐	☐	(2)
**	18.	After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there?	☐	☐	(2)
	19.	Have you ever gone to anyone for help about your drinking?	☐	☐	(5)
	20.	Have you ever been in a hospital because of drinking?	☐	☐	(5)

21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization? ☐ ☐ (2)

22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem? ☐ ☐ (2)

*** 23. Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If YES, How many times? ☐) ☐ ☐ (2)

*** 24. Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (If YES, How many times? ☐) ☐ ☐ (2)

* Alcoholic response is negative

** 5 points for Delirium Tremens

*** 2 points for each arrest

SCORING

Add up the points for every question you answered with YES, for Q23 and Q24 multiply the number of times by points ☐

0 - 3	No apparent problem
4	Early or middle problem drinker
5 or more	Problem drinker (Alcoholic)

Programs using the above scoring system find it very sensitive at the five point level an it tends to find more people alcoholic than anticipated. However, it is a screening test and should be sensitive at its lower levels.

References

Selzer, M.L., The Michigan Alcoholism Screening Test (MAST): The Quest for a New Diagnostic Instrument. American Journal of Psychiatry, 3:176-181, 1971.

Selzer, M.L., Vinokur, A., and van Rooijen, L., Self-Administered Short Version of the Michigan Alcoholism Screening Test (SMAST). Journal of Studies on Alcohol, 36:117-126, 1975

Name: _____

DAST (Drug Abuse Screening Test)

Date: _____

Instructions: Circle either yes or no to the right of the question to indicate your answer.

1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Do you abuse drugs on a continuous basis?	Yes	No
7.	Do you try to limit your drug use to certain situations?	Yes	No
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
9.	Do you ever feel bad about your drug abuse?	Yes	No
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
11.	Do your friends or relatives know or suspect you abuse drugs?	Yes	No
12.	Has drug abuse ever created problems between you and your spouse?	Yes	No
13.	Has any family member ever sought help for problems related to your drug use?	Yes	No
14.	Have you ever lost friends because of your use of drugs?	Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?	Yes	No
16.	Have you ever been in trouble at work because of drug abuse?	Yes	No
17.	Have you ever lost a job because of drug abuse?	Yes	No
18.	Have you gotten into fights when under the influence of drugs?	Yes	No
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	Yes	No
20.	Have you ever been arrested for driving while under the influence of drugs?	Yes	No
21.	Have you engaged in illegal activities to obtain drugs?	Yes	No
22.	Have you ever been arrested for possession of illegal drugs?	Yes	No
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	No
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	Yes	No
25.	Have you ever gone to anyone for help for a drug problem?	Yes	No
26.	Have you ever been in hospital for medical problems related to your drug use?	Yes	No
27.	Have you ever been involved in a treatment program specifically related to drug use?	Yes	No
28.	Have you been treated as an outpatient for problems related to drug abuse?	Yes	No

Name _____

CRAFFT

Date _____

Instructions: Place an X on the line to indicate your response.

	yes	no
1. Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?	____	____
2. Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	____	____
3. Do you ever use alcohol or drugs while you are by yourself Alone?	____	____
4. Do you ever forget things you did while using alcohol or drugs?	____	____
5. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	____	____
6. Have you ever gotten into trouble while you were using alcohol or drugs?	____	____

VIII. Suicide

As caseworkers supporting children, adolescents, and their families, the safety of those we serve is of paramount concern. The risks our clients encounter, however, are not limited to those persons and circumstances around them. Published statistics vary, but research would indicate that attempted and completed suicide is on the rise. According to the National Institute of Mental Health, the third leading cause of death for the age group of 15 to 24 year olds was suicide. Additionally, it has been found that while more females than males attempt suicide, more males complete it.

As caseworkers coordinating services for children and adolescents, we have the unique opportunity to make an impact on this trend. The National Youth Violence Prevention Resource Center reported that 80% of those teenagers who commit suicide in fact attempt to seek support. It is pivotal that we be aware of what a potential suicide risk looks like, and how to handle this in a safe manner.

This ToolKit includes the Suicide Assessment Five-step Evaluation and Triage (SAFE-T) protocol as a resource to do this. The SAFE-T provides a five-part guideline for a caseworker to review with a client after a contact. It can be used if any of the risk factors listed in the first step are present. Review of the tool will provide the guideline subjects to be reviewed with clients, including risk factors, protective factors, a suicide inquiry, assessment of risk, and documentation. As in all case-work, documentation and notification of the appropriate authorities is vital.

As in any conversation or evaluation, rote questioning will not support your client in feeling safe to disclose information. Therefore, it will be necessary to familiarize yourself with the risk factors noted in step one, and proceed with further assessment if any are present. For example, if a child talks about having “nothing to live for,” after removal from his or her parents’ home, this would be a reflection of both a Key Symptom and a Stressor noted in step one. Bullying is another issue that is a rising trigger for children and teens attempting suicide. Likewise, awareness of not only our client’s current status but their history as well (such as past attempts noted in Suicidal Behavior) will help us to be vigilant in our assessment and prevention efforts.

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1.800.273.TALK (8255)

www.sprc.org

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE

1.800.273.TALK (8255)

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
  Co-morbidity and *recent onset of illness increase risk*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
- **Family history:** of suicide, attempts or Axis 1 psychiatric disorders requiring hospitalization
- **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
- **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- **Plan:** timing, location, lethality, availability, preparatory acts
- **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

** For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition*
** Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- **Assessment** of risk level is based on clinical judgment, after completing steps 1-3
- **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

IX. Domestic Violence

In the field of child welfare, the issue of domestic violence is a concern that is all too familiar to the families that we encounter. Domestic violence is often the reason why a family is referred to the county agency or is apparent upon the caseworker's initial home visit. When domestic violence is immediately identified, caseworkers have agency protocols in place to make the proper assessment and referrals for treatment. There are, however, occasions where domestic violence is not so easily identified. As suggested in the Matrix, domestic violence can be an underlying issue that results in the manifestation of a variety of observations and behaviors that caseworkers encounter with families. The screening tools in this section of the toolkit are provided in order to help caseworkers identify the issue of domestic violence within a family. It is important to note that these screening tools, like most screening tools in the toolkit, are **used to identify issues** and **not to rule out** the issue of domestic violence within a family. Depending on the nature and severity of the abuse, an individual may never be willing to disclose the domestic violence in the home, whether in-person or on a screening tool. That is why it is important for caseworkers to continue to assess family relationships throughout the family's involvement with the agency.

Use of Screening Tools

The decision to use the screening tools to identify possible domestic violence is not a difficult one. As part of the Safety Assessment & Management Process (SAMP), caseworkers should be assessing for possible domestic violence with every family that they encounter. This assessment should not be limited to parents/caregiver, but should

extend to all individuals in the home or those who come into constant contact with the family. Caseworkers can use simple questions such as:

- Have the police ever been called to the home?
- Is anyone in the home verbally or physically threatening anyone else in the home?
- Are you or another family member afraid of anyone involved in your life?
- Tell me about your relationship with your partner.
- Has anyone in the home been verbally or physically assaulted by someone else in the home or by a person that they are in a relationship with?

These are just some examples of basic questions that can be asked in order to use one of the screening tools or immediately refer a family member to a domestic violence provider/evaluator. These questions could be posed as "standard questions" that all caseworkers ask of every family that they encounter. Caseworkers should also have ongoing discussions with their families about the nature of their relationships with each other and with their partners. The domestic violence screening tools can and should be used with families where other issues appear to be the predominate concerns within the family. For example, in families where the apparent concern is mental health or substance abuse, caseworkers may find using these screening tools extremely helpful because domestic violence may be the underlying issue that exacerbates the issues of mental health and substance abuse. These tools can also be used with families where the caseworker continues to have concerns or observes behaviors within a family but

has yet been able to identify the underlying issue causing the concerns. After the decision has been made to use the screening tools, caseworkers need to be aware of how to best approach the family member with the tool.

The Adult Victim

The toolkit contains a variety of screening tools for the adult victim such as The Hurt, Insult, and Scream Scale (HITS) and The Woman Abuse Screening Tool. When administering any of the domestic violence screening tools, caseworkers must always be aware of the safety concerns of the child(ren), the alleged victim, and themselves. When administering the screening tools with the alleged victim, it is important that the victim feels comfortable and safe. At a minimum, the alleged perpetrator should be out of the room and unable to hear the conversation taking place. If domestic violence has occurred, a caseworker would want to administer the screening tools when the perpetrator of domestic violence is outside the home or the caseworker is able to meet with the victim in private at the office. Some of the screening tools may be self-administered, in which case the alleged victim can complete the screening tool while the caseworker is meeting with other family members. The alleged victim would then put it in a sealed envelope, and give it to the caseworker prior to the caseworker leaving the home. Caseworkers must try their best to assure the alleged victim that their responses to the screening tool will not be disclosed to the perpetrator and that the results will be used to determine if there is a need for a more complete assessment by a domestic violence professional.

The Perpetrator

While the toolkit does not contain a specific screening tool for perpetrators, there are some ways that a caseworker can screen for domestic violence. When doing so, caseworkers must again be mindful of the safety of all the parties involved. Caseworker approaches to screening perpetrators will often be determined by the reasons why they are screening for domestic violence at the given time. If a family was referred to the agency because of an allegation of domestic violence, a caseworker may use direct questions with the perpetrator such as:

- Have you used or threatened to use physical force with your partner?
- Caseworker can use the statement “all couples fight” to approach the topic and then ask if their fights have ever gotten physical.
- Tell me about your relationship with your partner.
- How are the decisions made in your home?
- Who are your partner’s friends and family? Do they speak to them often?
- Have you ever yelled, screamed, or called your partner names?
- Are there any weapons in the home?
- Has anyone ever gotten hurt during an argument?

These direct questions are appropriate when the perpetrator has already been made aware of the allegations that led to the agency involvement. Other questions may be typical of those you ask as part of the Safety Assessment and Management Process (SAMP):

- Could you describe the nature of your relationship with your partner?
- What are the good and bad things about your partner?
- Is there one thing that your partner does that constantly upsets you?
- What do you do when you disagree with your partner?
- What does it look like when you get angry with your partner?
- Have you ever yelled, screamed, or called your partner names?
- Have you ever threatened your partner?
- Who handles the money in your family?

Another option for caseworkers to screen for domestic violence with perpetrators is the use of what appears to be standard non-threatening questions about domestic violence that are asked of everyone. These types of questions are typically the safest way to screen a perpetrator. This can be done as seen below:

- Have you ever pushed, kicked, shoved, or hit your partner?
- Has your partner ever pushed, kicked, shoved, or hit you?
- Have you ever verbally threatened your partner?
- Has your partner ever verbally threatened you?
- Have you ever told your partner you were going to kill/hurt yourself?
- Has your partner ever told you that he/she was going to kill/hurt himself/herself?

(Washington State Department of Social and Health Services, Children's Administration, 2010).

The Child(ren)

Assuring the safety of the children is the number one responsibility of caseworkers. Caseworkers should constantly be screening for issues of domestic violence throughout the life of the case in order to assure the children's safety. Caseworkers can use similar questions to those listed below to assess if there are any domestic violence concerns:

- Do they (parents and/or adults in the home) yell at each other, call each other bad names, or threaten each other?
- Does anyone break or smash things when they get angry? Who?
- Do they (parents and/or adults in the home) hit one another? What do they hit with?
- Have the police ever come to your home? Why?
- Have you ever been hit or hurt when mom and dad (or girlfriend or boyfriend) is fighting?
- Are you afraid to be at home? To leave home?
- Has either your mom or dad hurt your pet?
- Do you think its okay to hit when you are angry? When is it okay to hit someone?
- Have you ever called the police when your parents are fighting?
- Where are you when parents/caregivers/adults are fighting in the home?

Similar to the techniques recommended with the victim, screening for domestic violence should ideally be done when and where the child(ren) feel the most safe and

comfortable. Talking with the child(ren) at school or in the home when the perpetrator is not home are typically appropriate times. To the best of the caseworker's ability, he/she should try to re-assure the child(ren) that their disclosures would not be shared with the perpetrator. This toolkit does provide one screening tool for children called the Child Exposure to Domestic Violence (CEDV) tool. If caseworkers are having a difficult time engaging children to communicate any/all concerns, some children might find it more comfortable in using the CEDV to express their concerns. The CEDV contains several subscales that help provide some insight as to where violence is occurring, how often, and the severity of the violence.

After Using the Screening Tools

Caseworkers should try their best to score the results of any screening tool as soon as possible. When domestic violence is disclosed, caseworkers and their supervisors have the responsibility of assuring the safety of the vulnerable family members. Typically, any disclosure of domestic violence would require a new Safety Assessment and discussion with the caseworker supervisor as per the SAMP. Such a discussion would provide some idea of the severity and risk of domestic violence that affects the safety of the child(ren) in the home. A plan may be created for the caseworker to make the proper referrals for the family members, assess the protective capabilities of the caregivers, determine whether a safety plan needs to be implemented and determine the best way to discuss the issue of domestic violence with the family. Remember, any disclosure of domestic violence in the home may actually place family members at greater risk.

Documentation

This toolkit is designed to be a helpful resource for caseworkers and not an addition to the paperwork demands already placed on them. It is, however, important to document in the file the use of any domestic violence screening tool you may use. If a caseworker uses some of the questions discussed earlier, they can simply document family members' response in the appropriate section of their structured case notes. If the tool itself is used, documentation should again be made in the structured case note, and the tool should be filed in the appropriate section of the case file. Any administered screening tool that indicates a need for a referral for a more comprehensive assessment should be mentioned in the appropriate category of the Safety Assessment.

Woman Abuse Screening Tool (WAST)

1. In general, how would you describe your relationship?

☐ A lot of tension

☐ Some tension

☐ No tension

2. Do you and your partner work out arguments with:

☐ Great difficulty?

☐ Some difficulty?

☐ No difficulty?

3. Do arguments ever result in you feeling down or bad about yourse1f?

☐ Often

☐ Sometimes

☐ Never

4. Do arguments ever result in hitting, kicking or pushing?

☐ Often

☐ Sometimes

☐ Never

5. Do you ever feel frightened by what your partner says or does?

☐ Often

☐ Sometimes

☐ Never

6. Has your partner ever abused you physically?

☐ Often

☐ Sometimes

☐ Never

7. Has your partner ever abused you emotionally?

☐ Often

☐ Sometimes

☐ Never

8. Has your partner ever abused you sexually?

☐ Often

☐ Sometimes

☐ Never

To score this instrument, the responses are assigned a number. For the first question, “a lot of tension” gets a score of 1 and the other 2 get a 0. For the second question, “great difficulty” gets a score of 1 and the other 2 get 0. For the remaining questions, “often” gets a score of 1, “sometimes” gets a score of 2, and “never” gets a score of 3.

Brown JB, Lent B, Schmidt G, Sas G. Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. Journal of Family Practice. 2000; 49(10):896-903

"HITS" A domestic violence screening tool for use in the community

HITS Tool for Intimate Partner Violence Screening: Please read each of the following activities and fill in circle that best indicates the frequency with which you partner acts in the way depicted.

How often does your partner?	Never	Rarely	Sometimes	Fairly often	Frequently
1. Physically hurt you	O	O	O	O	O
2. Insult or talk down to you	O	O	O	O	O
3. Threaten you with harm	O	O	O	O	O
4. Scream or curse at you	O	O	O	O	O
	1	2	3	4	5

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score of greater than 10 is considered positive.

Clinical Research and Methods
(Fam Med 1998;30(7):508-12.)

HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting

Kevin M. Sherin, MD, MPH; James M. Sinacore, PhD; Xiao-Qiang Li, MD; Robert E. Zitter, PhD; Amer Shakil, MD

Background and Objectives: Domestic violence is an important problem that is often not recognized by physicians. We designed a short instrument for domestic violence screening that could be easily remembered and administered by family physicians.

Methods: In phase one of the study, 160 adult female family practice office patients living with a partner for at least 12 months completed two questionnaires. One questionnaire was the verbal and physical aggression items of the Conflict Tactics Scale (CTS). The other was a new four-item questionnaire that asked respondents how often their partner physically Hurt, Insulted, Threatened with harm, and Screamed at them. These four items make the acronym HITS. In phase two, 99 women, who were self-identified victims of domestic violence, completed the HITS.

Results: For phase one, Cronbach's alpha was .80 for the HITS scale. The correlation of HITS and CTS scores was .85. For phase two, the mean HITS scores for office patients and abuse victims were 6.13 and 15.15, respectively. Optimal data analysis revealed that a cut score of 10.5 on the HITS reliably differentiated respondents in the two groups. Using this cut score, 91% of patients and 96% of abuse victims were accurately classified.

Conclusions: The HITS scale showed good internal consistency and concurrent validity with the CTS verbal and physical aggression items. The HITS scale also showed good construct validity in its ability to differentiate family practice patients from abuse victims. The HITS scale is promising as a domestic violence screening mnemonic for family practice physicians and residents.

HITS- A violence screening tool for domestic violence and intimate partner violence

History of early HITS tool development and research at UIC-Christ Hospital Residency in Illinois

Academic projects were developed at the UIC-Christ Family Practice Residency in 1996-2002 most notably including the development of a new domestic violence screening tool known as HITS. The tool was developed by the then UIC-Christ Family Practice Residency Program director, Kevin Sherin MD, MPH,. The original research with the HITS instrument involved: Dr's Zitter, Sinacore, Li and Shakil and validated the tool in several populations including the Family Practice Center population and domestic violence shelter populations. The UIC –Christ FPR website then stated that " The problem of domestic violence is foremost in the minds of many patients, and it is often unrecognized by health providers. Drs. Sherin, Zitter, Bardwell, Li, Shakil and Shannon are all involved in the series of "HITS" research phases. "HITS" is a four-item instrument used to screen for domestic violence. Please see "HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting," Family Medicine, July-August 1998, pp. 508-512. Recently HITS Phase III was completed, and Phase IV is in the planning phase" .(The above history is from the UIC-Christ FPR website below: http://www.uic.edu/orgs/uiccfp/research.htm#History)

The original HITS research is found on the Family Medicine Journal Website
http://www.stfm.org/fmhub/fm1998/julaug98/abstrac9.html

Other researchers using HITS

HITS is used globally now in China, Saudi Arabia, the Middle East, Africa, Europe, and South and North America. It has been validated for women in Spanish, and partner violence with males. In the US, the HITS tool is used or has been recommended by Kaiser Permanente Group of Northern California, The New Jersey Hospital Association, the Alaska Department of Health and Human Services, Parkland Hospital in Dallas, the Department of OB GYN at USF in Tampa, the CDC, and others. It has been translated into multiple languages including Mandarin Chinese and Arabic. Below are some of the US published researchers who are working with the HITS tool.

Dr Amer Shakil has continued the HITS research program in Texas at Texas Southwestern health center at Dallas. Dr. Shakil has validated the HITS tool in Males, and is now working on a Pediatric Version Of HITS.

Link for Male HITS study at STFM site

http://www.stfm.org/fmhub/fm2005/abstracts.cfm?xmlFileName=fammedvol37issue3.xml#Amer193

Dr. Ping Hsin-Chen at the University of Medicine and Denistry of New Jersey has validated the HITS tool in Spanish populations.

Abstract:
http://fampra.oxfordjournals.org/cgi/content/abstract/cmi075?ijkey=FkbUiqUfEZzA9YT&keytype=ref

http://www.femalepatient.com/html/arc/sig/screening/articles/029_04_039.asp

Recent internet search yielded the following links with information about the HITS tool:

http://apha.confex.com/apha/128am/techprogram/paper_14805.htm

Validation of the HITS Domestic Violence Screening Tool With Males [New Window]
A four-item HITS (Hurt-Insult-Threaten-Scream) screening tool is one of. those instruments. ... applicable screening tool like HITS is established, fu- ...
http://www.stfm.org/fmhub/fm2005/March/Amer193.pdf [Preview This Site]

Family Medicine Journal Volume 37 Issue 3 March 2005 Abstracts [New Window]
Validation of the HITS Domestic Violence Screening Tool With Males ... A four-item HITS (Hurt-Insult-Threaten-Scream) screening tool is one of those ...
http://www.stfm.org/fmhub/fm2005/abstracts.cfm?xmlFileName=fammedvol37issue3.xml [Preview This Site]

Development of an Intimate Partner Violence Screening Tool: The ... [New Window]
Conclusion: HITS shows promise of being a rapid screening tool for intimate partner violence screening. Further studies in other populations are warranted. ...
http://apha.confex.com/apha/128am/techprogram/paper_14805.htm [Preview This Site]

Brief Screening Tools [New Window]
... in the Emergency Department" JAMA 1997; 277: 1357-1361. HITS Screening Tool. Have any of the following occurred to you by a partner? H. HURT physically? ...
http://www.ucdmc.ucdavis.edu/medtrng/domain/pdfs/Brief_Screening_Tools.pdf [Preview This Site]

HITS: a short domestic violence screening tool for use in a family ... [New Window]
BACKGROUND AND OBJECTIVES: Domestic violence is an important problem that is often not recognized by...
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9669164&dopt=Abstract

Screening for domestic violence in a predominantly Hispanic ... [New Window]
The utility of validated screening tools to detect abuse in diverse populations ... Reliability and validity of HITS were compared with the ISA-P and WAST. ...

http://fampra.oxfordjournals.org/cgi/content/abstract/22/6/617 [Preview This Site]

Screening for domestic violence in a predominantly Hispanic ... [New Window]
English HITS was effective as a screening tool for domestic violence (P < 0.001). ... Given that no other screening tools will be used before HITS in actual ...

http://fampra.oxfordjournals.org/cgi/content/full/22/6/617 [Preview This Site]
Domestic Violence [New Window]
HITS is a screening tool that is designed for outpatient clinical settings and consists of four questions based on the acronym for Hurt, Insult, Threaten, ...

http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijapa/vol4n1/violence.xml [Preview This Site]

Domestic Violence Nursing Policies [New Window]
Total Hits - 5280 | Hits Today - 3413, View Ratings | Add Your Rating. Domestic Violence Screening Tools for Health Care Professionals Adobe pdf format ...

http://www.4nursingmanagers.com/Policies/rn/asp/ID.27/pt/ViewInCat.htm [Preview This Site]
.
Femalepatient.com [New Window]
The Hurt, Insult, Threat, Scream (HITS) screening tool was designed as a ... HITS: A short domestic violence screening tool for use in a family practice ...

http://www.femalepatient.com/html/arc/sig/screening/articles/029_04_039.asp [Preview This Site]
More Sponsored Links About This
Appendix 3. Screening Instruments [New Window]
Domestic Violence Screening Tool58. Have you ever been threatened, hit, punched, slapped, or injured by a husband, boyfriend, or significant other you had ...

http://www.ahrq.gov/clinic/3rduspstf/famviolence/fvrevapp3.htm [Preview This Site]

Journal of Family Practice: Domestic violence: screening made ... [New Window]
New screening tools are briefer and more efficient than earlier devices. The HITS Scale (38) (Hurt, Insult, Threaten, Scream; Table 2) is a practical 4-item ...
http://www.findarticles.com/p/articles/mi_m0689/is_7_52/ai_106026459

Women's Experiences with Battering (WEB) SCALE

Developed by Paige Hall Smith, University of North Carolina at Greensboro

---

Here are 10 statements that other women have used to describe their lives with their partners. Please read each statement and circle the answer that best describes how much you agree or disagree with each. Answer the questions thinking about your current (or your most recent) partner.

Item	**Strongly** agree	**Somewhat agree**	**Agree a little** l	**Disagree a little**	**Somewhat disagree**	**Strongly disagree**
1. He makes me feel unsafe even in my own home.	1	2	3	4	5	6
2. I feel ashamed of the things he does to me.	1	2	3	4	5	6
3. I try not to rock the boat because I am afraid of what he might do.	1	2	3	4	5	6
4. I feel like I am programmed to react a certain way to him.	1	2	3	4	5	6
5. I feel like he keeps me prisoner.	1	2	3	4	5	6
6. He makes me feel like I have no control over my life, no power, no protection.	1	2	3	4	5	6
7. I hide the truth from others because I am afraid not to.	1	2	3	4	5	6
8. I feel owned and controlled by him.	1	2	3	4	5	6
9. He can scare me without laying a hand on me.	1	2	3	4	5	6
10. He has a look that goes straight through me and terrifies me.	1	2	3	4	5	6

To score:

1.Reverse score the items [so that 1=6, 2=5, 3=4, 4=3, 5=2, and 6=1].

2. Sum.

3. The range is from 10 – 60 so that higher scores mean higher psychological vulnerability (i.e. more battered).

4. If you want to dichotomize the scores, the women who score < = 19 are not battered; women who score 20+ are battered.

Citations

1. **Smith, P.H.**, Earp, J.A., and DeVellis, R. (1995). Measuring battering: development of the Women's Experience with Battering (WEB) Scale. Women's Health: Research on Gender, Behavior, and Policy, 1(4), 273-288.
2. **Smith, P.H.**, Smith, J.B. and Earp, J.A. (1999). Beyond the measurement trap: a reconstructed conceptualization and measurement of battering. Psychology of Women Quarterly, 23: 179-195.

Children's Exposure to Domestic Violence Scale
User Manual

Authors of this manual include:
Jeffrey L. Edleson
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Narae Shin

 Support for this project was provided by the Minnesota Agriculture Experiment Station project MIN 55-019, the Burt and Nan Galaway Fellowship Fund, and Title IV-E Child Welfare Training funds. Correspondence should be sent to Professor Jeffrey L. Edleson, MINCAVA, University of Minnesota School of Social Work, 105 Peters Hall, 1404 Gortner Avenue, St. Paul, MN 55108 or via email to <jedleson@umn.edu>.

The project website is located at http://www.mincava.umn.edu/cedv.

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Forward

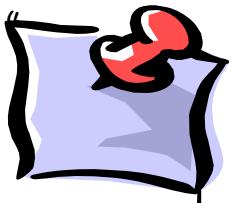
"But how do you assess children's exposure?"

This is the question I am most often asked by practitioners and researchers as I travel around North America and beyond to speak about children's exposure to domestic violence. Ironically, I have often found myself without a useful answer. Thus the CEDV was born when I decided I should do something about it and try to help provide a concrete response to this question.

Several years ago, with generous support from the Minnesota Agriculture Experiment Station (they are interested in families too!), the Burt and Nan Galaway Fellowship Endowment and Title IV-E Child Welfare Training funds, my students and I set out to develop a measure to help fill the clear gap in assessment of children exposed to domestic violence. First we set out to understand the issues requiring assessment and what measures existed that might be useful in this domain. The result of this search was a review article recently published in *Children and Youth Services Review* (Edleson et al., 2007) that served as the basis for Chapter 1 in this *Manual*. Next, we set out to develop a measure and test its reliability and validity. The CEDV is the result and its development is documented in a paper currently under editorial review at a scholarly journal (Edleson, Shin & Johnson, 2007). This newer paper is the basis for Chapters 2 and 3 of this *Manual*.

Our work continues with the launch of the online version of the CEDV and a supporting website where this *Manual* and other materials are available. You can find all of this information and any updates at http://www.mincava.umn.edu/cedv. Our desire is to make the CEDV freely available to support your work and hope you will support our work by providing us with feedback on the CEDV. We also hope you find this *Manual* useful and that many children and their families will directly benefit from your improved assessments.

Jeffrey L. Edleson, Ph.D.
St. Paul, Minnesota
June 2007



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Chapter 1: Assessing Child Exposure*

Child exposure to adult domestic violence has increasingly become a concern for both practitioners and researchers. For example, new research in child welfare systems has revealed that large proportions of children under protective supervision are exposed to adult domestic violence but that screening and investigation of the violence is often inadequate (English, Edleson & Herrick, 2005; Hazen, Connelly, Kelleher, Landsverk & Barth, 2004). Juvenile and family courts struggle to understand and assess the significance of child exposure when making decisions concerning custody and visitation (Jaffe, Lemon & Poisson, 2003; Kernic, Monary-Ernsdorff, Koepsell & Holt, 2005). Law enforcement leaders have questioned their own responses to children who are present when police respond to adult domestic assault reports (International Association of Chiefs of Police, 1997). And, finally, battered women's shelters and other domestic violence prevention programs have increasingly recognized and expanded their responses to the needs of children in the families they serve (Saathoff & Stoffel, 1999).

Professionals working in these programs have little guidance and few tools to carefully assess exposed children so that they can target new policies and practices to best serve them. As a result, several investigators have developed instruments to measure the impact of exposure. For example, Graham-Bermann (1996) developed the *Family Worries Scale*, and Grych and colleagues (Grych, Seid, & Fincham, 1992) developed the *Children's Perception of Interparental Conflict Scale*. These instruments measure the emotional and behavioral consequences of a child's exposure to adult domestic violence, but do not give information about the child's actual exposure experiences.

There are no existing measures of a child's exposure to adult domestic violence that both adequately measure it and have been subjected to rigorous psychometric testing. Hamby and Finkelhor (2001) examined a large number of assessment tools for use in monitoring child victimization but very few of these instruments were designed to monitor childhood exposure to adult domestic violence. Their review reveals that researchers and clinicians have most often adapted the adult version of the widely used Conflict Tactics Scales (Straus, 1979; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) to assess children's levels of exposure. These adaptations vary greatly and leave the field with no standard method of measuring prevalence or individual incidents of exposure (Jouriles, McDonald, Norwood, & Ezell, 2001).

To fill this gap for practitioners and researchers alike, we undertake a review of the research on children's exposure to adult domestic violence with an eye towards understanding what is needed to develop a new assessment tool. To that end we

* This chapter is based on Edleson, J.L., Ellerton, A.L., Seagren, E.A., Schmidt, S.O., Kirchberg, S.L. & Ambrose, A.T. (2007). Assessing child exposure to adult domestic violence. *Children and Youth Services Review, 29,* 961-971.

discuss the pervasiveness of child exposure to domestic violence and the factors that contribute to children's unique experiences with and outcomes from this exposure. We review a selection of commonly-used measures that ask respondents at least one question about domestic violence exposure. We then discuss the degree to which these measures adequately assess the unique experiences of children exposed to domestic violence.

Overview of Children's Exposure to Adult Domestic Violence

Researchers estimate widely ranging numbers of children exposed to adult domestic violence. Many of the estimates are derived by extrapolating from national surveys that were not designed to measure children's exposure. The two most widely cited estimates are those developed by Carlson (1984) and Straus (1992). Based on studies of the number of households experiencing domestic violence each year (Straus, Gelles & Steinmetz, 1980), Carlson estimated that "at least 3.3 million children yearly are at risk of exposure to parental violence" (p. 160). Straus (1992) estimated yet an even higher level of exposure using retrospective accounts by adults of their teen years. He estimated that there may be as many as 10 million American teenagers exposed to adult domestic violence each year. Carlson (2000) has more recently raised her estimate as a result of additional studies. She now conservatively estimates that from 10% to 20% of American children are exposed to adult domestic violence each year (Carlson, 2000). Based on recent US Census data (US Census Bureau, 2000), this would indicate that approximately seven to 14 million American children are exposed to adult domestic violence annually. Finally, Thompson, Saltzman and Johnson (2003) report that 33.2% of Canadian abused women and 40.2% of US battered women responding in national surveys stated that their children had witnessed domestic violence events.

Most of these are rough estimates of the number of children exposed to domestic violence and each relies on imprecise definitions, retrospective accounts or indirect measurement to arrive at a final number. While these estimates give some insight into the extent to which adult domestic violence and children's exposure pervade society, they tell us little about what forms of violence children are being exposed to, how often they are exposed to it and how they are involved in violent events

To delve deeper into children's experiences it is necessary to first define the terms "adult domestic violence" and "exposure". Jouriles, et al. (2001) suggest that a number of issues affect how we define exposure to adult domestic violence. First, the types of exposures children experience may be defined narrowly as only physical violence or more broadly as including additional forms of abuse such as verbal and emotional. Second, even within the narrower band of physical violence exposure, there is controversy about whether we should define adult domestic violence as only severe acts of violence such as beatings, a broader group of behaviors such as slaps and shoves, or a pattern of physically abusive acts (see Osthoff, 2002).

"Exposure" is most commonly defined as being within sight or sound of the violence. However there are compelling arguments to redefine and assess a child's ex-

posure to violent events in broader terms. In their national curriculum for child protection workers, for example, Ganley and Schechter (1996) highlight several ways that batterers expose children to adult domestic violence. These include hitting or threatening a child while in his or her mother's arms, taking the child hostage in order to force the mother's return to the home, forcing the child to watch assaults against the mother or to participate in the abuse, and using the child as a spy through interrogation about the mother's activities. In addition to seeing, hearing, or being used in a direct incident of violence, some mothers and their children describe the aftermath of a violent incident as also having a traumatic effect on them. The aftermath can include a mother who is injured and in need of help, a father who alternates between physical violence and loving care, police intervention to remove a male perpetrator from the home, or moving to a shelter for battered women.

Throughout this article the phrase "exposure to adult domestic violence" will be used to describe the multiple experiences of children living in homes where an adult is using violent behavior in a pattern of coercion against an intimate partner. Violence is experienced in diverse ways in families, including between same-sex partners as well as by women against men. The focus in this paper is on the experience in which most children exposed to domestic violence find themselves, in a home where a man is committing a pattern of violence against an adult woman, who is most often the child's mother.

Factors to Consider in the Assessment of Child Exposure

Child exposure to adult domestic violence is associated with significantly greater behavioral, emotional, and cognitive functioning problems among children, as well as adjustment difficulties that continue into young adulthood. A number of authors have reviewed the research to date on problems associated with children's exposure to domestic violence (see reviews by Appel & Holden, 1998; Edleson, 1999a; Fantuzzo & Mohr, 1999; Lehmann, 2000; Margolin, 1998; Rossman, 2001; O'Leary, Slep, & O'Leary, 2000). More recent meta-analyses by Kitzmann, Gaylord, Holt and Kenny (2003) and Wolfe, Crooks, Lee, McIntyre-Smith and Jaffe (2003) have shown children exposed to domestic violence to exhibit significantly worse problems than children not so exposed but the size of this effect is relatively small (Z_r = .28 in Wolfe et al., 2003). Exposed children were not, however, significantly different than children who were physically abused or who were both physically abused and exposed to violence (Kitzmann et al., 2003).

The wide range of behaviors and consequences associated with exposure to domestic violence found in these reviews indicate that the relationship between exposure and possible impacts is complex. As Graham-Bermann (2001) points out, many children exposed to domestic violence show no greater problems than children not so exposed. At least two studies support this claim (Hughes & Luke, 1998; Grych, Jouriles, Swank, McDonald & Norwood, 2000). How does one explain these variations? Rossman, Hughes, and Rosenberg (1999) suggest that risk factors are additive, meaning that they combine to produce greater impacts on children exposed to domestic violence. This is consistent with the literature on children's resilience

(Masten, Best, & Garmezy, 1990; Hughes, Graham-Bermann & Gruber, 2001). It is, however, also generally suggested that a child is differentially affected depending on the number, type, and level of *both* risk and protective factors present in each child's environment (Masten et al., 1990; Masten & Sesma, 1999). A child's gender and age, the frequency, severity and chronicity of violence in the home and the child's relationship with his or her mother and the man who batters her all may influence the impact of exposure on a child (Edleson 2004; Gewirtz & Edleson, in press).

Children may also be at increased risk of physical harm during violent incidents depending on their own responses to the incidents. Children's responses have been shown to vary from becoming actively involved in the conflict, to distracting themselves and their parents, to distancing themselves from the conflict (Margolin, 1998). Adamson and Thompson (1998) found that children from homes in which there was domestic violence were nine times more likely to use verbal or physical aggression to intervene in parental conflict than were children from violence-free homes (27% vs. 3%). The degree to which a child intervenes in adult domestic violence clearly varies from child to child and is likely related to the impact of exposure.

Children exposed to domestic violence may also be direct victims of physical and sexual maltreatment. A number of reviews have examined the co-occurrence of documented child maltreatment in families where adult domestic violence is also occurring. Over 30 studies of the link between these two forms of violence show a 41% median co-occurrence of child maltreatment and adult domestic violence in families studied (Appel & Holden, 1998) with the majority of studies finding a 30% to 60% overlap (Edleson, 1999b). Behaviors often attributed to domestic violence exposure may also derive from the child's concurrent victimization at the hands of his or her parent or caregiver.

A factor that may moderate the impact of exposure is a child's ability to cope with stressful events. Children appear to interpret and cope with conflict differently based on their perception of the cause or content of that conflict. The child may hold him or herself responsible for events over which he or she has no control, developing an inappropriate belief that he or she has significant control over the violent events. For example, Grych, et al. (1992) found that children tended to blame themselves more when the content of parent conflict involved them. Alternately, one child may have greater skills than another to calm him or herself during conflict between parents. For example, Rossman and Rosenberg (1992) found that children who believed they were more able to calm themselves during conflict were reported to have fewer problems.

Given this brief review, it is likely that a number of different factors may influence the degree to which exposure to adult domestic violence may or may not affect a child's development. It is critical to address this array of child, family and social variables in order to thoroughly assess children's exposure.

Assessment Tools Relevant to Child Exposure

Clearly, there is a need for assessment instruments that assess child exposure. Historically, practitioners have "made do" with a variety of measures to assess

various aspects of child exposure to domestic violence, of which several were not originally meant for this purpose. The bulk of these measures focus on the *impact* of exposure to violence, never addressing the specific aspects of the child's individual experience with the violence that may affect behaviors, emotions and perceptions associated with impact. Because the field has so few measures of exposure and is replete with measures of impact, we will focus our analysis on the former. Measurement instruments most likely to be used in the field will be those readily available and those that are easily administered through self-report formats (Feindler, Rathus, & Silver 2003). Thus, this paper will primarily focus on readily available, self-report assessment instruments that include the measurement of children's exposure to domestic violence.

The measures included in our analysis all contain at least one question specifically regarding domestic violence exposure. Measures asking about general "family conflict" but not exposure did not meet the criterion for inclusion here. We also principally focused on measures that use self-report by children up to age 18. Children have been shown to report differently than their parents and other informants (Sternberg, Lamb, Guterman & Abbott, 2006). O'Brien, John, Margolin and Erel, (1994) found that even when one or both parents report that their children were not exposed to the domestic violence, more than one in five children (21%) could provide detailed descriptions of domestic violence in their homes. Thus, it is important to tap directly into children's reports of their exposure.

Based on the above criteria, we found five measures of exposure which are listed in Table 1 below. Each of the measures selected attempts to evaluate the types and frequency of violence to which a child has been exposed. For each measure, Table 1 contains the measure's name, original publication source, the target of assessment, the types of questions, how each item is scaled, the number of questions regarding exposure, and any available information on the psychometric properties of the measure.

One of the most common methods of measuring child exposure, as stated earlier, is to adapt the adult *Conflict Tactics Scales* (Straus, 1979; Straus, Hamby, Boney -McCoy, & Sugarman, 1996) for use with children. In order to assess children's exposure to domestic violence, Kolbo's (1996) adapted version of the *CTS* added columns requiring a parent or caregiver to rate "how often your child witnessed (saw or heard) each" conflict tactic. Kolbo utilized the same seven-point scale as the original CTS, with responses ranging from "Never" to "Over 20 Times". However, Kolbo's adapted *CTS* asked both how often each conflict tactic occurred and how often the child witnessed it being used. The measurement tool looks at tactics ranging from "discuss the issue calmly" and "bring in or try to bring in someone to help settle things" to "kick, bite, or hit with a fist" and "use a knife or gun" (Kolbo, 1996).

Things I Have Seen and Heard (Richters & Martinez, 1990) measures types of violence both witnessed and directly experienced by children. Using a five-point scale ranging from "zero" to "many times", it asks children how frequently each of 15 types of violence have occurred. Questions include, "Grown ups in my home hit each other" and "Grown ups in my home yell at each other" (Richters & Martinez 1990).

The most recent addition to the compendium of measures of child exposure is

Table 1: Summary of selected measures of child exposure

Measure Name	Author & Year	Respondents	Domain/Subject	Items/Scaling	Questions Regarding Exposure	Psychometric Properties
Conflict Tactics Scale (Adapted)	Kolbo (1996) Revised version of CTS by Straus (1979)	Parents of children ages 8 to 11 suspected of exposure to domestic violence	Type of conflict tactics use by parent or caregiver. Type, severity, & frequency of conflict tactics witnessed by child used by parent/caregiver against another parent/ caregiver	•1 80 items •2 7-point Likert scale •3 "Never" to "Over 20 times"	• 19 questions regarding violent & non-violent tactics used in conflict. • Each question asks how often the parent has engaged in the behavior & how often the child has witnessed the tactic.	• Reliability & validity not assessed
Juvenile Victimization Questionnaire	Finklehor, Hamby, Ormrod, & Turner (2005)	Children ages 8 to 17 (Child self report) and 2 to 8 (Parent report)	Covers five areas of concern: Conventional crime, child maltreatment, peer & sibling victimization, sexual assault, & witnessing and indirect victimization.	•4 37 items •5 3-point scale •6 1 time to 3 or more times •7 Follow up questions regarding frequency, victim & perpetrator	• 3 questions specific to exposure to physical domestic violence	• Internal Consistency: α= .80 • 3-4 week re-test reliability for youth self-report: κ = .63 (fair to good), percent agreement = .95
Things I have Seen and Heard	Richters & Martinez (1990)	Children, ages 6 to 14	Exposure to violence at home and in the community	•8 15 items •9 5-point scale using increasing dots •10 "Zero times" to "Many times"	• 4 items regarding exposure to violence in the home.	• Internal Consistency: α= .74 to .76 • Inter-rater reliability between child & parent on family violence: *r*= .67 • One week test-retest reliability: *r*= .81

Table 1 (continued): Summary of selected measures of child exposure

Measure Name	Author & Year	Respondents	Domain/Subject	Items/Scaling	Questions Regarding Exposure	Psychometric Properties
Violence Exposure Scale for Children – Revised	Fox & Leavitt (1996)	Children, elementary & preschool age Adults, parallel questionnaire given to parent	Exposure to violence within & outside the home. Subsets are: witness to mild violence, victim of mild violence, witness to severe violence, & victim of severe violence	•11 20 items, plus two open ones •12 20 items use a 4-point scale •13 Thermometer pictograms illustrating "Never" to "Lots of times"	• Although there are 22 questions regarding exposure to violence or victimization. However, the perpetrator and/or victim is never specified.	• Internal Consistency: α= .72 to .86
Victimization Scale	Nadel, Spellman, Alvarez-Canino et al (1996)	Middle school students, grades 6-8	Exposure to violence & victimization at home, school, & in neighborhood.	•14 135 items •15 4 point scale •16 "Never" to "Often"	• 12 questions regarding exposure to violence in the home.	• Reliability & validity not available

the *Juvenile Victimization Questionnaire* (*JVQ*) (Finklehor, Hamby, Ormrod, & Turner 2005). The measure is very comprehensive, touching on everything from specific forms of community violence victimization and exposure, to the witness of war and other trauma. It makes a valiant effort to include a wide variety of forms of victimization in order to chart the interrelationship of many of these incidents, pointing out that measures that are too specific often mistakenly attribute children's negative outcomes to the wrong trauma (Finklehor, Ormrod, Turner, & Hamby 2005). The question that most specifically references domestic violence asks, "In the last year did you see one of your parents get hit by another parent, or their boyfriend or girlfriend? How about slapped, hit, punched, or beat up?" (Finklehor, Ormrod, Turner, & Hamby 2005).

A lesser known scale that addresses children's exposure to domestic violence is the *Victimization Scale* (Nadell, Spellman, Alvarez-Canino et al, 1996) as found in the Centers for Disease Control and Prevention's compendium of assessment tools *Measuring Violence-Related Attitudes, Beliefs, and Behaviors Among Youths* (Dahlberg, Toal & Behrens, 1998). Much like the JVQ, the measure addresses several forms of violence exposure and victimization including at school, in the child's neighborhood, at home, and "outside of school". In the section regarding incidents at home, the measure runs the gamut from witnessing hits, kicks, and threats with weapons to verbal and emotional abuse and robbery.

Finally, *The Violence Exposure Scale for Children* (*VEX-R*; Fox & Leavitt, 1996), derived from the *Things I Have Seen and Heard* measure, evaluates children's exposure to a wide range of violent acts both within and outside the home, as well as children's victimization from these acts. It is a novel approach with a comic-book style version of the measure for children and a text version for parents. It asks both the child and the parent how often the child has been victimized by and exposed to specific violent acts. Items include "How many times has a person slapped you really hard?" and "How many times have you seen a person point a knife or a real gun at another person?" (Fox & Leavitt, 1996).

As a group, these measures may be useful as broad screening measures for general violence but are inadequate in their ability to extensively measure children's exposure to domestic violence. For example, Kolbo's (1996) adapted version of the *CTS* defines witnessing as "saw or heard," a rather narrow definition of child exposure. In addition, the scale was never subjected to psychometric development and so its properties are unknown. Richters and Martinez's (1990) *Things I Have Seen and Heard* instrument contains only four items specifically about violence exposure in the home and two more about weapons and drugs in the home, focusing mainly on physical incidents of violence, never identifying the victims and perpetrators. While the *JVQ* takes into account who the victims and perpetrators are, the measure is at the same time lacking in depth when it comes to assessment of exposure to domestic violence. The questions specifically ask about violence the child has *seen*, focusing mostly on physical violence, while asking one question about theft from the home. The *Victimization Scale* addresses more forms of domestic violence than the *JVQ*, but does not identify the perpetrators and victims of the violence. Finally, the *VEX-R* (Fox & Leavitt, 1995) focuses broadly on violence exposure but never identifies the victim and perpetrator and does not specify if any of the violence occurs in the home.

In the parent version of the *VEX-R* there is some indication that additional probes are to be included for each question as to the timing, location and perpetrator of the event, yet there is no place on the test itself to indicate answers to these probes. For the most part the measures included in this analysis either fail to reach beyond exposure to physical violence, do not identify the victims or perpetrators, or ask too few questions regarding domestic violence exposure in general.

Toward More Sophisticated Assessment Tools

Admittedly, few measurement instruments will address the needs of all potential users. However, practitioners, advocates, judges, and police currently lack a measurement tool sensitive enough to assess the varied experiences of children exposed to domestic violence. Without such a tool, the field cannot properly tailor services, interventions, and policies to better serve children experiencing such violence. In order to meet this need, Mohr and Tulman (2000) suggest the measurement of child exposure to violence must consider the multiple contextual variables that affect children. The literature is clear that a number of factors affect the child's experience of violent events, yet no tool currently assesses all of the key domains outlined in this paper that affect children's outcomes from such exposure. Such a measure must first ask directly about a child's exposure to adult domestic violence and the manner in which the child has been exposed. Second, such a measure should include reports on the actions of the child in the violent situation. Third, following Mohr and Tulman's (2000) suggestion for a multidimensional assessment, a measure should include some appraisal of the known risk and protective factors in a child's life, including the co-occurrence of child maltreatment and the child's coping abilities. Gauging the level of risk and protective factors in a child's life will be an important aspect of any future measurement instrument. Fourth, the assessment tool must take the form of a self-report to measure the *child's* perception of the violent incidents, as they may differ from parental perceptions. Finally, the measure must be readily available and easily administered so that researchers, practitioners, law enforcement personnel, and the courts may use it in the field.

Considering the possible negative outcomes, public concern has rightfully turned towards child exposure to domestic violence. Yet, the field has been immobilized, with professionals limiting their study and treatment to children's behavioral and emotional impacts from exposure to domestic violence, without adequate exploration of the variations in experience that may cause these outcomes in the first place. Current notions of child exposure to domestic violence tend to assume a universal experience, which anecdotal evidence and a review of the literature refute. Without exploring the bridge between exposure and impacts, it is nearly impossible to both adequately develop services to intervene in and prevent child exposure to domestic violence, and to understand the nature of the problem on a larger scale. Through the creation of a sophisticated, comprehensive assessment tool we can do better to meet the needs of children exposed to domestic violence. This compelling information in-

spired us to create such a tool. We have developed and psychometrically test the *Child Exposure to Domestic Violence* (CEDV) Scale contained in this user manual.

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Chapter 2: Overview of the CEDV Scale and its Development

Development of the CEDV

This measure was assembled using a number of strategies. First, the research team gathered question items from a number of existing surveys and interview guides based on key areas identified in an earlier review (see Edleson, et al., 2007). A panel of 9 international expert judges working with children exposed to domestic violence was convened and asked to review each item and suggest (1) keeping the question without changes, (2) deleting the question from the measure or (3) revising the question. When revision was suggested the expert judge was provided space to specify what changes should be made as well as a separate space to make comments. At the end of the online review the judges were also provided space to suggest addition items or content that should be included in the measure. A revised CEDV survey based on the feedback of the expert judges was then subjected to a pilot test with 10 children. Further changes were then made based on the pilot testing experience. A copy of the CEDV Survey appears in Appendix A.

The CEDV Scale

The final result is the CEDV consisting of 42 questions in three sections. Part I and Part II of the CEDV contain five subscales that measure (1) Violence, (2) Exposure to Violence at Home, (3) Exposure to Violence in the Community, (4) Involvement to Violence, (5) Risk Factors and (6) Other Victimization. Each question in the first two parts are answered using a four-point Likert-type scale with their choices being “Never,” “Sometimes,” “Often,” and “Almost Always.” Clearly, a higher score indicates more violence, involvement, risks or other victimizations while the lower score indicates less of each category.

Part I: Violence Rates. The first section includes a series of questions that specifically target the types of exposure to domestic violence a child may have experienced. Children are asked to rate 10 different items focused on types of adult domestic violence to which they may have been exposed using the four-point Likert-type scale mentioned above. If a child responds “Never” to a particular question he or she moves onto the next question. However, if she or he indicates exposure to such violence, the child is led by an arrow to an additional set of options that ask how the

* This and the next chapter are based on Edleson, J.L., Shin, N. & Johnson, K.K. (2007). Measuring children’s exposure to domestic violence: The development and testing of the *Child Exposure to Domestic Violence (CEDV)* Scale. Manuscript submitted for publication St. Paul, MN: University of Minnesota.

child was exposed, including five choices ranging from “I saw the outcome (like someone was hurt, something was broken, or the police came)” to “I saw it and was near while it was happening.” After checking applicable exposures the child is instructed to move to the next item.

Part II: Exposure rates, Involvement in Violence, Risks and Other Forms of Victimization. The second section of the CEDV Suvey asks a series of 23 questions using the same four-point Likert-type scale. The child is asked to rate how often he or she intervened in violence events and about other risk factors present in his or her life.

Part III: Demographic Information. This third and final section of the CEDV consists of nine questions asked to gather demographic information, including gender, age, race and ethnicity, current living situation, family composition, and concluding with a question about favorite hobbies.

Appendix B contains a copy of the complete CEDV and it may also be found on our website at http://www.mincava.umn.edu/cedv.

Chapter 3. Validity and Reliability of the CEDV

Study of the CEDV

We conducted a study to validate and test the reliability of the CEDV. First, the research team identified local domestic violence prevention organizations that provide service to large numbers of children. A series of presentations were made to key staff at each agency and they were invited to become partners in the scale development project. Four organizations, representing five shelters for battered women and their children and one non-shelter service agency, agreed to participate. These organizations offer a myriad of services for families experiencing disruption due to domestic violence and abuse, including but not limited to crisis services, legal advocacy, community-based transitional housing, job and education training services, counseling, life skills training, tutoring, and preventative interventions.

Members of the research team then trained staff at each organization according to a specific protocol approved by a university-based Institutional Review Board. The protocol was also provided in written form to the staff members for reference at any time during the project and research team members were available to answer any questions. Agency staff were asked to identify potential mothers or other legal guardians with children between the ages of 10 and 16 who are either residing at the shelter or are participating in other agency programs and services in the community. Agency staff contacted such mothers to explain the purpose of the study, assure confidentiality, review mandated reporting guidelines, and to request their child(ren)'s voluntary participation. A $25 gift card was offered as an act of gratuity for each child's participation. Each agency was compensated $100 for the staff time involved in contacting mothers and administering the measures; fifty dollars during the study, and another fifty after completion of the data gathering.

Those mothers who volunteered their children were given an informed consent form to read and verbally indicate consent for their child's participation. Once mothers or legal guardians consented, staff explained the study to each child who was provided with an assent form for their information and asked to voluntarily participate in the study. Agency staff explained the questionnaires to each child, confidentiality measures, mandated reporting requirements and rules, and that they would receive a $25 gift card upon completion of all measures. All children included in this study provided voluntary assent to participate.

The children were asked to take the CEDV survey twice, one week apart, in order to establish test-retest reliability of the measure. In addition, the children were asked to complete the TISH once, at the same time the first CEDV was administered. The TISH was administered to help establish convergent validity of the CEDV.

Agency staff read the directions on the first page of each survey to the children before getting started and answered any questions that any child may have had be-

fore, during, and after the survey. The measures were administered in both group settings and individually. Agency staff assigned each child a unique research identification number for the purposes of linking each child's completed surveys. The identification numbers on each survey corresponded to the child's name in only one place, on an identification sheet that was maintained by one agency staff member. The completed survey instruments only contained the identification number and no other identifying information. The list of names and corresponding identification numbers were kept for only one week so that staff could be sure to give the same identification number for the administration of the second CEDV survey. Agency staff were given specific instructions not to look at the completed surveys but were advised to follow their agency's mandated reporting requirements for any information that was revealed aloud while the survey administration was in session. After all three surveys were completed, a $25 gift card was given to either the child or to a parent or guardian for use on the child's behalf.

Completed CEDVs and TISHs (see below) were immediately placed in a sealed envelop after administration and retrieved by a member of the research team. Once all the surveys had been completed, staff destroyed the identification sheet to protect the identity of the study participants. The research team never knew the identity of those children who were involved. In addition, a federal Certificate of Confidentiality was obtained to protect data from being subpoenaed by a court of law.

Things I've Heard and Seen (TISH)

The TISH questionnaire, used in this study to establish the convergent validity of the CEDV Survey, is comprised of 19 questions asking a child about the frequency to which perceived direct experience with and exposure to multiple forms of violence has occurred. The original TISH, developed by Richters and Martinez (1990), was tested on children aged 6 through 14 and intended to measure the level of direct and indirect exposure to violence that children experience at home, as well as in the broader community, by asking the respondent how often s/he has been exposed to or involved with particular violent acts and/or situations. The child is asked to respond to each item using a five-point Likert-type scale that includes: "Zero times," "One time," "Two times," "Three times," and "Many times" (Richters & Martinez, 1990). Items include "Somebody threatened to stab me" and "Grown ups in my home hit each other."

The TISH scale has demonstrated relatively strong internal consistency, with Cronbach's Alpha falling between α=.74 and α=.76. Additionally, high reliability has been established through strong test-retest (r=.67) and inter-rater reliability results (r=.81)(Richters & Martinez, 1990). Richter and Martinez (1993) used the TISH is a study of children's exposure to violence and their school performance and parent ratings of child behavior. Other studies have also used the TISH, including a study by Hurt, Malmud, Brodsky and Giannetta (2001) who also used the measure to determine a relationship between child exposure to violence and behavioral problems, school performance, and self-esteem. A more recent study conducted by Bailey, Han-

nigan, Delaney-Black, Covington and Sokol (2006) used the TISH to assess the relationship between child exposure to violence and child functioning.

Study Participants

Participants in the study consisted of 65 children recruited during their stay at one of several domestic abuse shelters or use of the programs' community-based services. Children between the ages of 10 and 16 years were included in the study. Mothers of children between these ages were invited by agency staff to volunteer their children for participation in the study. Mothers were provided with an explanation of the study's purposes, confidentiality procedures as well as the study's risks and benefits.

Table 2. Comparison of child characteristics by group (N=65)

Variable	Mean	SD	%	n
Age of children	12.5	2.1		
Gender				
Male			50.0%	35
Female			42.9%	30
Race				
White/Caucasian			28.6%	20
Black/African American			30.0%	21
American Indian/Native American			5.7%	4
Asian or Pacific Islander			7.1%	5
Multi-racial/No primary identification			5.7%	4
Other			15.7%	11
Where child lived				
House			34.3%	24
Apartment			10.0%	7
Shelter			41.4%	39
Other			7.1%	5
People child lived with				
Father			8.6%	6
Mother			80.0%	56
Grandparent			8.5%	6
Sibling			44.2%	26

As seen in Table 2, child participants varied in age from 10 to 16 with the mean age being 12.5 years (*SD*=2.11). Thirty-five males and an equal number of 35 females participated in the study. Of all participants, 30% (n=21) identified themselves as African-American, 28.6% (n=20) as Caucasian, 10% (n=7) were unsure as to how to categorize themselves based on race, 7.1% (n=5) identified as Asian or Pacific Islander, 5.7% (n=4) as being multi-racial, another 5.7% (n=4) as Native American (n=4), and 1.4% (n=1) chose not to answer the question. More than one in four of the participating children (41%, n= 29) stated that they lived in a shelter during the time the survey was completed, roughly one-third lived in a house (34%, n=24), another 10% (n=7) lived in an apartment and 7.1% (n=5) stated "other" as shown in Table 2. Lastly, one child said that he/she was not sure where home was due to frequent traveling and moves that it interfered with his or her ability to answer the question.

Family composition varied with 80% (n=56) of the children stating that they lived with their mother, a stark contrast to only 2.9% (n=2) who lived with their father (n=2) and the 5.7% (n=4) who lived with a grandparent. More than four out of 10 children (43%, n=31) lived with a sibling in addition to a parent and 2.8% (n=2) said that they also lived with their mother's boyfriend or partner. Step-fathers made up 2.8% (n=2) of other household members, with step-mothers making up an additional 1.4% (n=1).

Data Analysis Procedures

To assess the consistency of results across items, internal consistency reliability using the Cronbach's alpha coefficient was employed. The survey was taken twice with an interval of one week in between. Test-retest reliability was established by Pearson's correlation coefficient, Cronbach's alpha coefficient and paired t-tests between the two reports. For convergent validity, the measure was administered concurrently with the Things I've Seen and Heard (TISH) measure of violence exposure. Additionally, two scales which are designed to assess the same construct were compared to each other using Pearson's correlation coefficient and Cronbach's alpha coefficient.

Results

Cronbach's alpha statistics were calculated to assess the internal consistency of the CEDV Scale. The Cronbach's alpha coefficient for each subscale of the CEDV ranged from α =.59 to .85 at the first week and the overall α of the CEDV scale was a strong .86 according to Table 3. At the second week, similarly, the subscales of the CEDV showed relatively high Cronbach's alpha's ranging from α =.50 to .76. The only subscale that demonstrated a low alpha score was the risk factor subscale (α =.24)

at the first week's administration. The risk factor subscale, however, reported a moderate association at the second week (α =.60).

Table 3. Reliability

	Alphas		N of items	*r*	*Paired t-test*	
	Week 1	Week 2			*t*	*P*
Total	.86	.84	33			
Violence	.78	.74	10	.684**	.564	.576
Home Exposure	.85	.76	(10)	.701**	.336	.739
Community Exposure	.64	.71	8	.674**	.173	.863
Involvement	.67	.50	7	.570**	-2.154*	.035
Risk Factors	.24	.60	4	.632**	.410	.684
Victimization	.59	.70	4	.571**	1.119	.267

*p<.05. *p<.001

In order to examine test-retest reliability, Pearson's correlation coefficients and paired t-test statistics between Week 1 and Week 2 were calculated. As can be seen in Table 3, the Pearson's correlation coefficient for each subscale ranged from .57 to .70, and all of them were statistically significant at p<.001. Relatively strong and statistically significant Pearson's correlation coefficients and non-significant differences on t-tests between administrations showed that Week 1 and Week 2 test scores for the level of violence in the home, home exposure, community exposure, risk factors and other victimization were very similar and stable over the two scale administrations.

To assess convergent validity, Pearson's correlation coefficients between the CEDV and the TISH were calculated. The results indicated that a statistically significant and positive correlation existed both at the level of home violence exposure (*r*=.494, p<.001) and the level of community violence exposure (*r*=.397, p<.001).

Chapter 4: How to Score the CEDV

The Child Exposure to Domestic Violence scale is a self-report tool used to measure the degree of exposure to domestic violence on multiple factors reported by children between the ages of 10 and 16. Parts I and II of the CEDV scale contain six subscales that measure (1) Violence, (2) Exposure to Violence at Home, (3) Exposure to Violence in the Community, (4) Involvement in Violence, (5) Risk Factors and (6) Other Victimization. Responses to each item (except Exposure to Violence at Home) are assigned the following values: Never = 0, Sometimes = 1, Often = 2 and Almost Always = 3. Response values to all items within a subscale are then added together. Higher scores indicate more and lower scores indicate less violence, exposure, involvement, risk factors or other victimization depending on the subscale content. The Exposure to Violence at Home subscale requires the child to choose one or more types of exposure. The child is asked to check off all the ways s/he knew about the violence, and then the number of boxes checked are simply added up. Questions in the final section, Part III, ask for information on the child's demographic characteristics.

As a result of the scoring outlined above, the value assigned to each child's responses on subscales and the overall scale may indicated the level of severity of a child's experience. At this time, however, we do not have a large enough sample to confidently assign labels such as "moderate" or "severe" to a specific value. The range of possible scores on the overall scale and each subscale are indicated in Table 4 below.

Table 4. Range of scores on each CEDV subscale

Subscale	*Item*	*Range*
Total	Q1-33	0-99
Violence	Q1-10	0-30
Home Exposure	Multiple Checkboxes under Q1-10	0-50*
Community Exposure	Q22-29	0-24
Involvement	Q11-17	0-21
Risk Factors	Q18-21	0-12
Other Victimization	Q30-33	0-12

** Not included in Total Score*

We hope that future research with a more representative sample may allow a clearer distinction between and labeling of children's scores on each subscale.

Case #_____
ID # _____

CHILD EXPOSURE TO DOMESTIC VIOLENCE SCALE

(CEDV)

Original artwork by Ida Pearle. Artwork used with permission from the artist.

Assessment of Child Violence Exposure to Domestic Violence

These directions are to be read aloud by the practitioner administering this measure.

This is a list of questions about your life and your family. It will probably take you about 30 minutes to fill out. If you have a question when you are filling this out, ask the person who gave this to you.

Your answers will NEVER be given to other people, but your answers may help identify possible services for your family. If you want to stop taking the survey, you can stop answering the questions anytime you want.

Think about the people you have ever lived with. There are lots of ways to think about the kinds of adults that kids live with or come in contact with. For example, some kids live with a stepparent, or a grandparent, or foster parents. Other kids live with just one parent and maybe a parent's girlfriend or boyfriend too. The questions in the survey are about the adults you have lived with or have come in contact with.

The following questions will typically refer to caregivers and caregiver/adult, so let's try to define those now.
Caregiver-is someone who makes sure that your needs (food, clothing) are met and looks out for you. This is often a mother, father, step-parent, or another adult who typically lives in the home. When answering the questions, this is meant as a caregiver.
Caregiver/adult-when this is seen in a question this means not only a caregiver but also another adult who may live in the home or come to the home often. This may be a parent's boyfriend/girlfriend, another relative, or someone else who is a part of your family's life.

Permission was granted to change the wording of some CEDV questions for this toolkit. Please see http://www.mincava.umn.edu/cedv/cedv.pdf for original wording.

DO NOT WRITE YOUR NAME ON THIS PAPER.

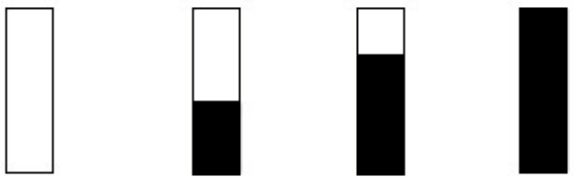
Part One

There are two parts to each question.

⇒ First answer the question about how often something happened by circling your answer.

⇒ Then check off all the ways you knew about what happened.

⇒ If you answer "Never" in the first part, skip the second part and go on to the next question.



Example:

How often have there been fights at your school?

Never

Circle never, then go to the next question.

Sometimes Often Almost Always

How did you know about it?

✓ = I saw the outcome (like someone was hurt, something was broken, or the police came).
= I heard about it afterwards.
✓ = I heard it while it was happening.
= I saw it from far away while it was happening.
= I saw it and was near while it was happening.

1. How often do adults in your family disagree with one another?

Never

Circle never, then go to the next question.

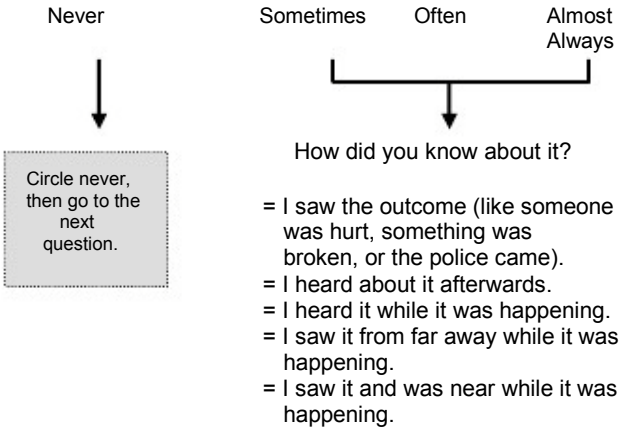
Sometimes Often Almost Always

How did you know about it?

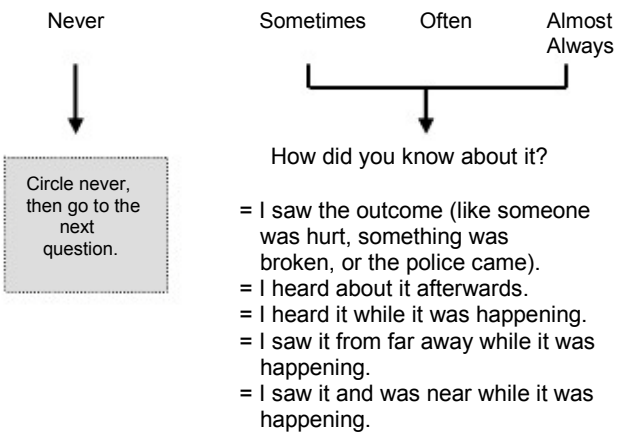
= I saw the outcome (like someone was hurt, something was broken, or the police came).
= I heard about it afterwards.
= I heard it while it was happening.
= I saw it from far away while it was happening.
= I saw it and was near while it was happening.

2. Has a caregiver/adult ever hurt one of your caregivers' feelings by:
   - calling them names
   - swearing
   - yelling
   - threatening them
   - screaming at them
   - other _____

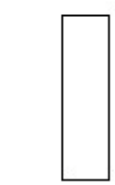
3. How often has a caregiver/adult stopped one of your caregivers from doing something they wanted to do or made it difficult for them to do something they wanted to do? Such as
   - leave the house
   - go to the doctor
   - use the telephone
   - visit their friends or relatives
   - other_____



4. How often has a caregiver/adult stopped one of your caregivers from eating or sleeping, or made it hard for them to eat or sleep?

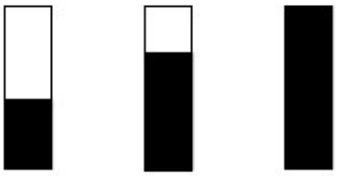


5. How often have caregivers/adults argued about you? [It is not your fault they argue about you.]



Never

Circle never, then go to the next question.



Sometimes Often Almost Always

How did you know about it?

= I saw the outcome (like someone was hurt, something was broken, or the police came).
= I heard about it afterwards.
= I heard it while it was happening.
= I saw it from far away while it was happening.
= I saw it and was near while it was happening.

6. How often has a caregiver/adult hurt, or tried to hurt, a pet in your home on purpose?

Never

Circle never, then go to the next question.

Sometimes Often Almost Always

How did you know about it?

= I saw the outcome (like someone was hurt, something was broken, or the police came).
= I heard about it afterwards.
= I heard it while it was happening.
= I saw it from far away while it was happening.
= I saw it and was near while it was happening.

7. How often has a caregiver/adult broken or destroyed something on purpose, such as:
- punching a wall
- ripping a phone cord out of the wall
- smashing a picture
- other_____

Never

Circle never, then go to the next question.

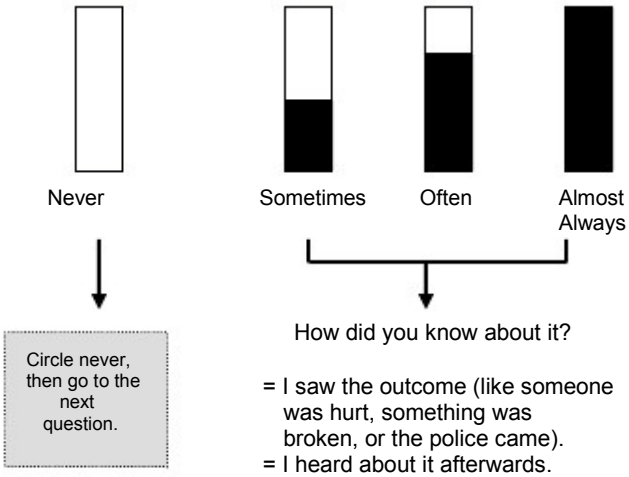
Sometimes Often Almost Always

How did you know about it?

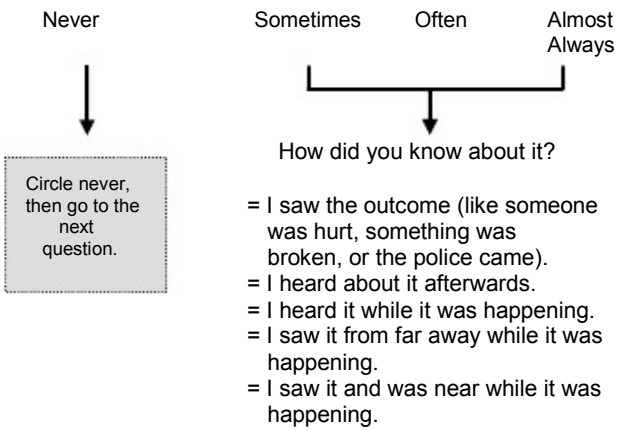
= I saw the outcome (like someone was hurt, something was broken, or the police came).
= I heard about it afterwards.
= I heard it while it was happening.
= I saw it from far away while it was happening.
= I saw it and was near while it was happening.

8. How often has a caregiver/adult done something to hurt a caregiver's body, such as:

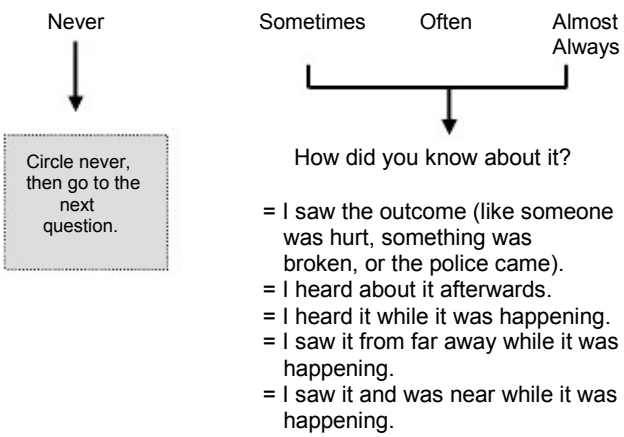
- hitting them
- punching them
- kicking them
- choking them
- shoving them
- pulling their hair
- other _____



8. How often has a caregiver/adult threatened to use a knife, gun, or other object to hurt your caregiver?

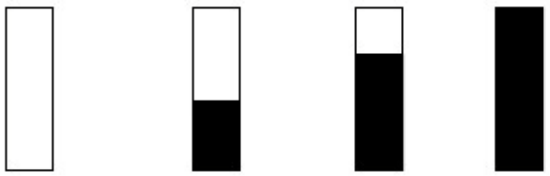


10. How often has a caregiver/adult actually hurt your caregiver with a knife, gun, or other object?



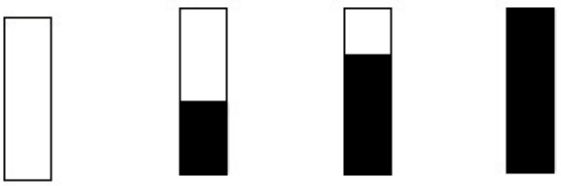
Part Two

It's hard to know what to do when you see someone getting hurt. In the questions on this page the word "hurt" means hurting your caregiver's feelings on purpose, threatening them, physically hurting them, or stopping them from doing things.

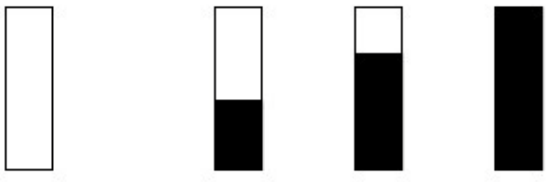


Choose the answer that best describes your situation and circle it. There are no right or wrong answers to these questions.

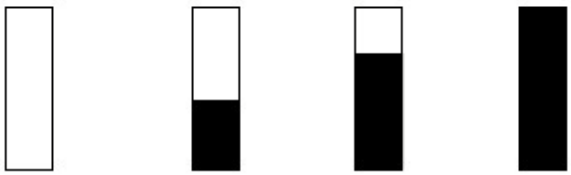
11. When a caregiver/adult hurts your caregiver, how often have you yelled something at them from a different room than where the fight was taking place?	Never	Sometimes	Often	Almost Always
12. When a caregiver/adult hurts your caregiver, how often have you yelled something at them in the same room where they are fighting?	Never	Sometimes	Often	Almost Always
13. When a caregiver/adult hurts your caregiver, how often have you called someone else for help, like calling someone on the phone or going next door?	Never	Sometimes	Often	Almost Always
14. When a caregiver/adult hurts your caregiver, how often have you gotten physically involved trying to stop the fighting?	Never	Sometimes	Often	Almost Always
15. When a caregiver/adult hurts your caregiver, how often has the caregiver/adult done something to you to hurt or scare your caregiver?	Never	Sometimes	Often	Almost Always
16. When a caregiver/adult hurts your caregiver, how often have you tried to get away from the fighting by: • hiding • leaving the house • locking yourself in a different room • other _____	Never	Sometimes	Often	Almost Always
17. How often has a caregiver/adult asked you to tell what your caregiver has being doing or saying?	Never	Sometimes	Often	Almost Always
18. How often do you worry about a caregiver/adult getting drunk or taking drugs?	Never	Sometimes	Often	Almost Always



19. How often do you worry about your caregiver getting drunk or taking drugs?	Never	Sometimes	Often	Almost Always
20. How often does your caregiver seem sad, worried or upset?	Never	Sometimes	Often	Almost Always
21. How often does it seem like you have had big changes in your life? For example: • moving homes • staying in the hospital • your parents getting a divorce • the death of someone you're close to • a parent going to jail • other _____	Never	Sometimes	Often	Almost Always
22. How often have you heard a person hurt another person by making fun of them of calling them names in your neighborhood or at your school?	Never	Sometimes	Often	Almost Always
23. How often has someone from your community or at your school done or said any of these things to hurt you?	Never	Sometimes	Often	Almost Always
24. How often do you hurt a person's feelings on purpose, like making fun of them or calling them names?	Never	Sometimes	Often	Almost Always
25. How often do you physically hurt a person on purpose, such as hitting, kicking or things like that?	Never	Sometimes	Often	Almost Always



	Never	Sometimes	Often	Almost Always
26. How often have you seen someone else in your community or school get hurt by being: • grabbed • slapped • punched • kicked • being hurt by a knife or a gun • other _____				
27. How often has someone at school or in your community hurt you by: • grabbing • slapping • punching • kicking • threatening you with a knife or gun • other _____	Never	Sometimes	Often	Almost Always
28. How often have you seen someone being hurt or killed on television or in a movie?	Never	Sometimes	Often	Almost Always
29. How often have you seen someone being hurt or killed in a video game?	Never	Sometimes	Often	Almost Always
30. How often has an adult in your family hurt your feelings by: • making fun of you • calling you names • threatening you • saying things to make you feel bad • other _____	Never	Sometimes	Often	Almost Always



	Never	Sometimes	Often	Almost Always
31. How often has an adult in your family done something to hurt your body, like: • hitting you • kicking you • beating you up • other _____				
32. How often has someone who is not in your family: • touched your private parts when you didn't want them to • made you touch their private parts • forced you to have sex?				
33. How often has someone in your family: • touched your private parts when you didn't want them to • made you touch their private parts • forced you to have sex				

Part Three

34. If your caregiver and a caregiver/adult, when did the fighting start? (Circle one answer.)

1. I don't remember them fighting.
2. They started fighting this year.
3. They started fighting 2-3 years ago.
4. They started fighting 4 or more years ago.
5. They've been fighting for as long as I can remember.

35. Do you think your family has enough money for the things it needs?

1. No, there are times when my family doesn't have enough money for food or rent or other things we need.
2. We seem to have enough money to pay for what we need.
3. We have enough money to buy extra things we don't really need.
4. I don't know.

36. How old are you? _____

37. Are you male or female? (Circle one answer.)

1. Male
2. Female

38. What race or ethnicity do you consider yourself? (Circle all that describe you.)

1. White/Caucasian/European American
2. Black/African American/African
3. American Indian/Native American
4. Asian or Pacific Islander
5. Latino/Latina/Hispanic
6. Multi-racial/No primary racial or ethnic identification
7. Other (What?) _____
8. I don't know
9. I don't want to answer this question

39. Where did you stay last night? (Circle one answer.)

1. House
2. Apartment
3. Shelter
4. Other (Where?) _____

40. Where do you live? (Circle one answer.)

1. House
2. Apartment
3. Shelter
4. Other (Where?) _____

41. Who are the people you live with? Circle all that apply.

1. Mother	6. Mother's boyfriend or partner	11. Younger brother (s)
2. Father	7. Mother's girlfriend or partner	12. Older brother (s)
3. Step-Mother	8. Father's boyfriend or partner	13. Younger sister(s)
4. Step-Father	9. Father's girlfriend or partner	14. Older sister(s)
5. Grandmother	10. Grandfather	15. Other (Who?) _____

42. What is your favorite family activity?

This measure was created and produced by
Jeffrey L. Edleson and numerous student colleagues.

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X. Resources

A. Independent Living Skills

The Ansell-Casey Life Skills Assessment (ACLSA) is a free service offered by Casey Family Programs to help assess the strengths and areas for improvement for youth in five key domain areas. These domain areas include: communications, daily living, self-care, social relationships, work/study skills, housing/money management, career planning, home life and work life.

The ACLSA is offered in English and Spanish and currently has four levels of assessment that are based on age and developmental levels; the levels vary by the number of questions asked and are written in language appropriate to the age and developmental level. A short version of the ACLSA is available and is appropriate for youth in shelter care when immediate service assessment is needed.

Performance and mastery scores are provided for each domain area. Information from up to three caregiver or other adult supports can be included in the assessment report for other points of view and more insight regarding the youth's strengths and areas for improvement. Youth, caregivers and counselors, workers and parents can all receive an electronic copy of the assessment evaluation; results are provided immediately after the assessment is completed and submitted.

Youth can create a file and save their answers on an assessment if it cannot be completed in one session. In addition to the Life Skills Assessments, there are supplemental assessments available on particular issues. Four education assessments

are available for Upper Elementary School, Middle School or Junior High School, High School and Postsecondary Education or Training. These assessments help counselors, workers and parents to determine youth attitudes toward school, goals that they have, concerns that they express and the supports that they receive or may be needed.

Supplemental assessments are offered for specific populations of youth. American Indian, Pregnancy, Parenting Infants (ages 0-24 months), Parenting Young Children (ages 2-6 years), Homeless Youth, Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) youth and Youth Values.

In addition to the standard ACLSA and supplemental assessments, counselors, workers, parents and youth can develop learning plans and access resources, curricula and other materials to assist youth as they prepare for and transition to adult life. Learning objectives, plans and resources can also be saved to the youth or counselor's file for future reference.

Individual (pre- and post-test) and group data reports are also offered by Casey Family Programs. These reports help counselors, workers and parents assess individual youth, group and program strengths, areas for improvement and needs for development.

As with all Casey services, there is no charge for any of its services or supports. For more information, please go to the Casey website: www.caseylifeskills.org

B. Low or Limited Literacy

Possible Signs of Low Literacy and Illiteracy

DO YOU OBSERVE THESE?

- Is the client consistently missing appointments and meetings that were only communicated to them in writing e.g. letters or email, yet make appointments when they are made verbally?
- Do they ask for an explanation of written instructions?
- Do they not know the names of regularly used medications?
- Are they always bringing someone with them to appointments and will cancel appointments if they have to come alone?
- Do they become upset or frustrated when you give them something to read e.g. plan, instructions?
- Do they avoid reading e.g. say “I don’t have my glasses” or ask to be given it to bring home because they are “in a hurry”?
- Is there an absence of reading materials in the home e.g. no books (adult or child), newspapers, and magazines?
- Do they avoid using the computer or the internet or texting? (This could be unfamiliarity with computers so you have to rule that out).

ASK YOURSELF?

- Are you seeing repetition of this? E.g. more than one or two of these signs?

- Can you rule out unfamiliarity with the English language –Is English their second language?

IF YOU RULE OUT ENGLISH AS A SECOND LANGUAGAE THEN CONFIRM:

Depending upon your relationship with the individual, ask them if reading is problem for them OR engage them in ways that make it safe to acknowledge that they are not able to read.

IMMEDIATE ACTIONS

Read all materials to the individual then check to make sure that they understand by asking them.

Use visual methods e.g. use pictures, pictograms, mark X's on a calendar for an appointment rather than giving them an appointment card.

LONGER TERM ACTIONS

Find resources for the individual to address their literacy challenges e.g. local library often have adult literacy resources.

Some websites:

National Institute for Literacy: http://www.nifl.gov/

National Center for Study of Adult Literacy and Learning: http://www.ncsall.net/

National Center of Adult Literacy (Univ of Pennsylvania):

http://www.literacyonline.org/about_us.html

Adult Literacy Action (Penn State Univ.): http://www.adultliteracy.org/

National Assessment of Adult Literacy & National Assessment of Adult Literacy and Learning (NAAL): http://nces.ed.gov/naal/

American Library Association's Build Literacy.Org: http://www.buildliteracy.org/

American Library Association's Office of Library and Outreach Services

http://www.ala.org/ala/olos/literacyoutreach.htm

C. Co-occurring Disorders

In the child welfare system, social workers come across many families who are encumbered with mental illness, substance abuse or both. Mental illnesses or mental disorders are often exacerbated by substance use and substance abuse or dependence often results in individuals exhibiting psychiatric symptoms, which makes it difficult to make judgments about treatment interventions. Co-occurring means there are two diagnoses that have been established independently of each other. To be truly characterized as someone with a co-occurring disorder, the diagnoses of a substance abuse disorder and a mental illness must be established independently of each other and not represent a constellation of behaviors or symptoms that relate to each other.

Example:
An individual uses cocaine daily and when she does, her behavior becomes erratic. She has hallucinations and becomes somewhat manic signs that also are part of a Bipolar Disorder. However, when the cocaine is no longer in her system, she no longer displays the "psychotic" behaviors. In this scenario, the psychotic symptoms were "substance induced". She also has no history of having a mental disorder so one can rule out any co-occurring disorder.

Prior to the change in nomenclature, the term "co-occurring disorder" was originally referred to as dual diagnosis or dual disorder, implying that in addition to having a substance abuse or dependence disorder, there also existed a mental illness. What followed historically were the acronyms that identified individuals who exhibited disorders of substance abuse and mental illness. Terms such as MICA (Mentally Ill Chemical Abuser); MISA (Mentally Ill Substance Abuser); CAMI (Chemical Abuser Mentally Ill); MICD (Mentally Ill Chemically Dependent) and SAMI (Substance

Abuser/Mentally Ill) are examples of how individuals were categorized. Common examples of individuals with co-occurring disorders include:

- Depression and Cocaine Addiction
- Alcohol Addiction and Panic Disorder
- Alcoholism with Schizophrenia
- Borderline Personality Disorder with Poly-substance Abuse

It is also important to note that many individuals have more than two disorders which are often referred to as multiple disorders. This can include individuals who are diagnosed with Substance Abuse, Major Depression and Borderline Personality Disorder or individuals who are diagnosed with an intellectual disability in addition to Cocaine Abuse and Schizoaffective Disorder. The DSM-IV-TR provides a description of the criteria that must be met for any diagnosis to be established.

The important factors to keep in mind when dealing with individuals with co-occurring disorders are:

1. ***They have more severe and chronic medical problems***: Individuals who have been abusing alcohol or other drugs will present with a range of medical conditions ranging from gastrointestinal problems related to alcohol or cocaine use such as ulcers, acute pancreatitis, HIV, inflammatory bowel disease or hepatitis (Linder et al. 2000). Sexually transmitted diseases are a major medical concern as well. Individuals with significant drug use that requires a detox program will, as a result of that process, show signs of a medical condition that was either pre-existing or evolved over time as a result of substance use. Anemia, cardiovascular disorders,

hypertension and diabetes are other medical conditions frequently experienced by people suffering from substance use. When individuals are referred to treatment, providers may view the substance use disorder or the mental illness as the main problem affecting the person, thus assessment and treatment for medical conditions are often ignored.

2. ***They experience more emotional instability***: Co-occurring conditions lead to an individual's inability to cope or leads to a worsening of the disorder that is untreated. As stated above, psychiatric disorders can be exacerbated by substance use. Often, persons with serious mental illness will self-medicate using substances as an alternative to prescribed psychotropic medication which in turn will cause the exacerbation of their psychiatric disorder. Alcohol or drug withdrawal will also result in the presence of symptoms that mimic a psychiatric illness such as hallucinations, mood swings, agitation, or delusions. Insight and judgment are impaired as well.

3. ***Levels of disability and impairment in functioning may vary****:* Individuals with co-occurring disorders are also high risk for cognitive disorders that range from learning disabilities, intellectual disabilities, or congenital conditions. Assessing reading and learning capacity is important in identifying treatment options and approaches. Impairment in functioning will also look very different in individuals with a serious mental illness such as schizophrenia compared to individuals who have been diagnosed with a secondary or tertiary personality disorder. Individuals with a personality disorder have difficulty in how they perceive and think about the world.

People with personality disorders have a difficult time with relationships, are often impulsive and self-destructive, and experience the world in terms of “black” or “white”.

4. ***They have a significant history of trauma and experiencing trauma-related symptoms***: Individuals, particularly women, with abuse histories and trauma symptoms have a range of mental health disorders including but not limited to Anxiety Disorders, Panic Disorder, Major Depression or Mood Disorders. The use of substances becomes a coping mechanism to soothe one’s feelings or numb the pain inside. Twenty to 30% of women report sexual and/or physical victimization during their lifetime (Mowbray, Oyserman Saunders & Rueda-Riedle, 1998). Ten to 12 percent of women have been sexually abused during childhood and 13 to 17 percent have been physically abused (Commonwealth Fund, 1997; Commonwealth Fund, 1998 and American Medical Association, 1992). Twenty to 27 percent of women experienced sexual molestation during childhood, with 70 to 90 percent of those reporting the perpetrator as someone they know. Experiences of abuse often will increase the risk of mental health and substance abuse problems leading individuals to become even more vulnerable to victimization. According to the National Center for PTSD, at least 10% of men nationally have suffered trauma related to sexual assault, but as the Center reports, their life experiences are different from women due to gender roles and as a result, their responses to such trauma may differ as well. Men are more likely to develop co-occurring substance abuse disorders.

5. ***They are vulnerable to relapse and a worsening of their mental illness:*** Vulnerability and risk in the co-occurring population are multidimensional, relate to an individual's history, involve a degree of change from baseline level of functioning or from their level of functioning prior to the onset of their disorder(s), and integrates their history, ability for self-care, and cognitive functioning. The three highest risk factors for relapse for substance abuse are: a) negative feelings; b) interpersonal conflict; and c) social pressure. Individuals with serious mental illness do not have well-developed social skills to cope with interpersonal conflict (Marlatt & Gordon, 1985). There is also a greater propensity for individuals with co-occurring disorders to be non-compliant with treatment and in taking medication for their illness. They often engage in relationships with other individuals who are addicted to alcohol or other drugs because of the stigma associated with having a mental illness. Living in neighborhoods where drugs are easily accessible, people with mental illness are more susceptible to drug use particularly when they are experiencing a downward spiral in their psychiatric illness.

Substance Use and Psychiatric Symptoms

The use of different substances will result in different types of reactions that mimic psychiatric symptoms. Depending upon the frequency of use, one will see a variation in the types of symptoms. The following is a chart that identifies the category of drug and the psychiatric symptoms that often appear. The categories are also defined by pattern of use.

Psychiatric Symptoms That Present

Type of Substance	Mild Use (1-2 times per week)	Moderate Use (Uses regularly but not to severe intoxication or negative outcomes)	Heavy Use (More than 2 times per week to the point of severe intoxication and impairment)
Alcohol Benzodiazepines Sedatives	None	Anxiety, Depression	Hallucinations (but no bizarre behavior or thought disorder)
Stimulants – Cocaine, methamphetamine	Mild Anxiety Depression	Anxiety, Panic, Depression and Mood Instability	Anxiety, Mood Instability, Personality Disorder
Hallucinogens	Anxiety Depression Occasional psychosis or severe panic	Anxiety, Depression Flashbacks, Sometimes psychosis, mood instability, panic	Psychosis, Mood Instability, Severe Panic
Opiates	None	Mild to Moderate Anxiety Depression	More severe anxiety and depression, Personality Disorders
Marijuana	None	Mental Confusion , agitation, feelings of panic	Acute psychosis, paranoia

The chart provides a quick snapshot of the psychiatric symptoms that may appear when someone has a co-occurring substance abuse disorder. An important point to remember is that a diagnosis of either mental illness or substance use disorder must be made based upon a person's history, past and current patterns of substance use, past and current symptoms of mental illness and observation of patterns and symptoms that meet criteria for each diagnosis to be established. It is also important to note that when there is the existence of a co-occurring mental illness and substance use disorder, both disorders should be considered primary. Common co-occurring disorders for individuals who are addicted to Opioids include (Mason et al. 1998; Brooner, King, Kidorf, Schmidt& Bigelow, 1997:

Axis I (Clinical Disorders and Other Conditions)	Axis II Categories (Personality Disorders and Intellectual Disabilities
Mood Disorders • **Major Depressive Disorder** • **Dysthymic Disorder** • **Bipolar Disorder**	Personality Disorders: • Antisocial Personality Disorder • Borderline Personality Disorder • Narcissistic Personality Disorder
Anxiety Disorders • **Generalized Anxiety Disorders** • **PTSD** • **Social Phobia** • **Obsessive-Compulsive Disorder** • **Panic Disorders**	
Attention Deficit/Hyperactivity Disorder	
Schizophrenia and other Psychotic Disorders	
Cognitive Disorders	
Eating Disorders	
Impulse Control Disorders	
Sleep Disorders	

What Causes Co-Occurring Disorders

There are many models that explain the relationship between co-occurring and substance use disorders (Musser, Drake, & Wallach, 1998). The explanation of these models can provide one with a framework of understanding and “context” of factors that contribute to the development of how co-occurring disorders have evolved.

1. **Disease model**: In this model, it is viewed that most substance use disorders cause co-occurring disorders such as mental illness for the purposes of this discussion. Other co-occurring disorders include medical conditions as defined above. Therefore, treatment is centered on addressing the abuse and/or dependence on the substances.

2. **Self-medication model:** This model makes the argument that pre-existing mental disorders lead to substance use disorders. Individuals who are suffering from mental health symptoms will use substances in order to alleviate symptoms such as anxiety, depression, or auditory hallucinations (Khantzian, 1985). This model was also referred to as the "general dysphoria theory" which postulates that substance use was a way to alleviate unhappiness, boredom, medical illness, trauma and other forms of pain.

3. **Common Pathway model:** In this model, shared genetic and environmental factors cause the co-occurring disorder. For example, as defined by Compton et al. 2000 and Mueser et al. 1999, childhood conduct disorders that persist into adulthood and turn into antisocial or borderline personality disorders are at higher risk for substance abuse (Compton, Cottler, Phelps, Ben Abdallah, Spitznagel, 2000. It is also noted in this study that genetic factors increase one's susceptibility to both addiction and co-occurring disorders.

4. **Secondary Psychosocial Effects Model:** In this model, factors such as poverty, social isolation, cognition, access to drugs, personality traits, family dynamics, vocational and housing consequences of mental illness may predispose individuals to substance use.

The models described above are to give one an understanding of some of the ideas behind why individuals develop co-occurring disorders. The treatment interventions are guided by how the individual presents, their history of illness and substance use, and the biopsychosocial factors that contribute to their situation.

Co-Occurring Disorders and Adolescents

Adolescents may also have co-occurring disorders. Many adolescents suffer from depression but may not recognize why they are depressed or understand what they are feeling. They begin to experiment with drugs to alleviate those feelings of isolation and loneliness. They may also experiment to "fit in" with their peers who may using drugs. Youth with mental health problems and a history of trauma are more vulnerable to substance use. Trauma is a major contributing factor in the development of co-occurring disorders in children and youth. When they resort to drug use, they place themselves more at risk of being further victimized leading to secondary traumas. Children and youth who are victims of all types of trauma may develop emotional and mental health problems which also may lead to problems with substance use. Although adolescents are not viewed as individuals with "co-occurring" disorders, the Center for Substance Abuse Prevention (2001) indicated that 43 percent of youth receiving mental health services in the United States had a co-occurring disorder of substance use. Mental illness often develops as a result of trauma, particularly in childhood and that substance abuse in this vulnerable population of youth is prevalent.

Trauma assessment should be an integral part of the workflow in any social service system. There is a connection between trauma, substance use and the development of mental health disorders. Complex trauma occurs when children and youth are exposed to multiple traumas particularly children and youth involved in the child welfare systems. Understanding these factor, and embracing a trauma-informed framework will assist in screening and treating youth with co-occurring mental health and substance use disorders.

There are gender differences when it comes to co-occurring disorders and their presentation. For example, adolescent males tend to have more disruptive behaviors that fall into the category of Conduct Disorder and Oppositional Defiant Disorder.

Adolescent females have higher rates of Mood Disorders and Anxiety Disorders (Latimer, 2002). It is also important to note that there is often a re-enactment of behaviors that are associated with a child or youth's past trauma(s) such as aggression, self-injurious behaviors, sexualized behaviors, and controlling behaviors particularly in relationships. Seventy five to 95 percent of youth in the juvenile justice system have a mental health disorder and a co-occurring substance use disorder *(Cohen et al., 1993; Milin et al., 1991; Otto et al., 1992)*.

What to look for in Youth with Co-Occurring Disorders

Adolescents may suffer from depression or severe anxiety disorders and may use substances to alleviate the symptoms associated with those disorders. Adolescents often do not recognize that they are experiencing depression or anxiety. The following are signs to look for in adolescents who have been identified as using substances but are exhibiting other signs that can identify them with a co-occurring disorder.

- Personality changes
- Changes in academic performance
- Mood instability
- Increased hyperactivity
- Loss of interest in one or more hobbies or routine activities
- Changes in friends
- Difficulty concentrating
- Aggression, nervousness or agitation

- Unusual borrowing of money
- Stealing small items from home or school
- Changes in physical appearance – disheveled, weight loss/gain, poor hygiene
- Being more secretive
- Withdrawal from taking responsibility
- Running away
- Decline in grades

Youth with co-occurring disorders are more likely to experience a progression to increased substance use after the initial introduction to substances, higher rates of drop out from school, and higher suicide rates. Adolescents often under report their depressive or anxiety symptoms so making a diagnosis of co-occurring disorders takes a longer period of time. Youth, like adults, tend to minimize their symptoms of both mental health and substance use.

Example of a Youth with a Co-Occurring Disorder

John is a 19-year old African American youth who has been in the child welfare system since age 3. Throughout his life, he has been in 20 foster care homes, two residential treatment facilities, juvenile detention and numerous psychiatric inpatient facilities. He returned home to live with his disabled mother. He had been diagnosed with Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder, and Bipolar Disorder. As a youth with a co-occurring disorder, he presents with the following:

-Dilated Pupils

-Increased Motor Activity (walking in and out of classrooms, breaking into a person's personal space, arms moving as he spoke in a manner that was consistent with his pacing).

-Pressured speech (forcing his words out)

-Flight of ideas – talking in phrases and jumping from one subject to another

-Impaired thinking and poor judgment

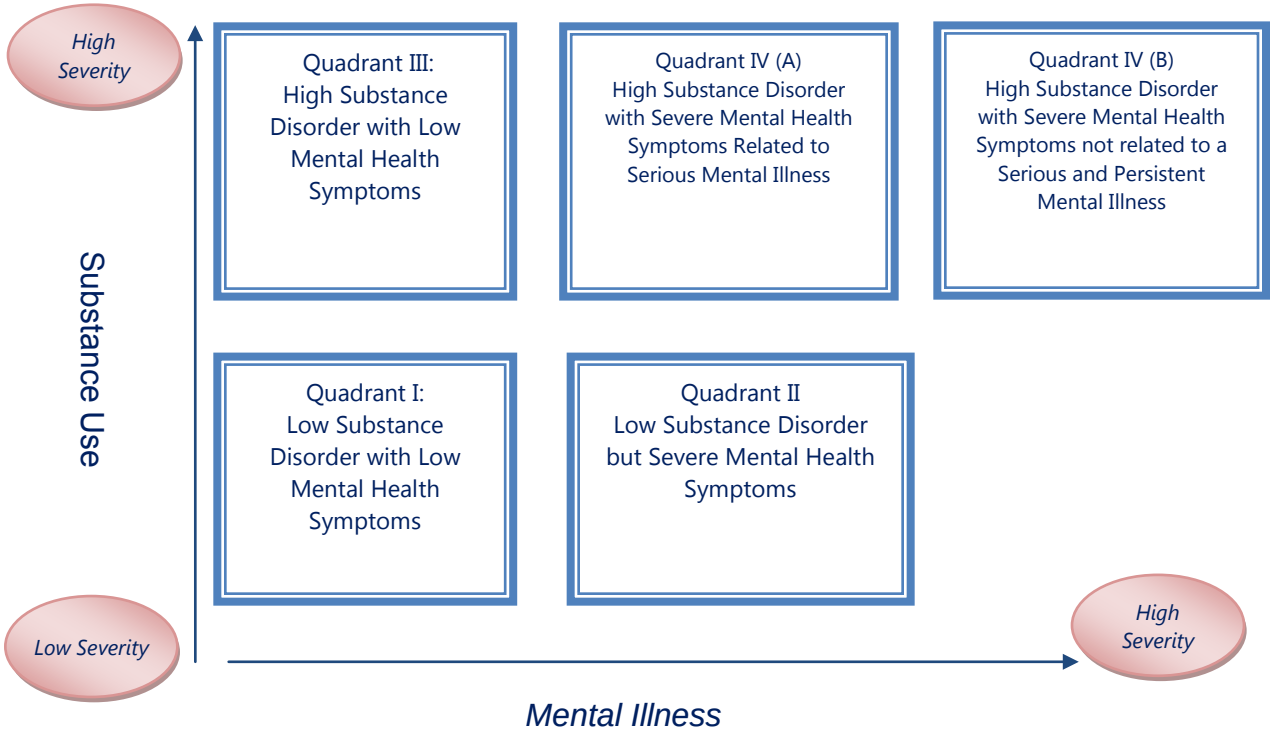
-Bloodshot eyes

-Smoking 4-5 blunts per day - marijuana intoxication can cause distorted perceptions, impaired coordination, difficulty with thinking and problem solving, and problems with learning and memory.

Prior to drug use, this youth met the diagnostic criteria for ADHD, Bipolar Disorder and Reactive Attachment Disorder. His drug use has progressed over time to the point where he now meets the diagnostic criteria for Cannabis Dependence. He refuses to take his psychiatric medications. Cannabis use has significantly impaired his functional abilities and exacerbated the psychiatric symptoms of:

- *Pressured Speech*
- *Rapid cycling of mood (highs and lows)*
- *Inability to sit still for long periods of time*
- *Volatile and Aggressive*
- *Impulsive*
- *Sexualized behaviors often inappropriate to others in gestures (a symptom of Reactive Attachment Disorder)*
- *Suicidal ideation at times but no plan*
- *Intrusive*
- *Increased need for attention*

Severity of Co-Occurring Disorders



BEHAVIORAL HEALTH RECOVERY MANAGEMENT SERVICE PLANNING GUIDELINES CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

KENNETH MINKOFF, M.D.

Dr. Minkoff categorizes co-occurring disorders by using a four-quadrant system in a way that will help with service planning. Each quadrant represents the severity of the symptoms that may be present for individuals with co-occurring disorders. The severity of the symptoms for each illness will determine how one should be assessed and triaged for treatment. For example, the Quadrant I category is for individuals who present with minimal symptoms of substance use and a mental health disorder. Quadrant IV on the other hand represents high severity of symptoms that will require a more intensive and acute treatment setting and supports. For example, an individual with depression may have symptoms that include isolating from others, having difficulty

with appetite or sleep, and having little energy. This person also chooses to smoke cannabis to help alleviate the sad mood. However, in this scenario, the level of functioning for this individual is not impaired, both sets of symptoms are not severe in intensity and are considered low/low (low severity of mental health/low severity of substance use). In this example, one could be referred for outpatient treatment in a setting that has integrated treatment to address the depression and assist in helping the individual develop other ways of coping as a replacement for marijuana use. In a different case scenario, an individual with schizophrenia may be having auditory and visual hallucinations, thoughts of hurting others, and is cocaine dependent which exacerbates her symptoms. This individual has been evicted and is now homeless, living on the streets unable to care for herself or her children. Prior to her eviction, her children were removed from her care and placed in foster care. In this case, the severity of her cocaine use is high since she met the criteria for dependence and her mental health symptoms are severe requiring immediate acute intervention. Quadrant IV (A) above is the category for someone exhibiting severe symptoms with both disorders, with one of the disorders being a serious and persistent mental illness. Quadrant IVB represents a similar scenario but the individual does not have a serious and persistent mental illness such as schizophrenia; instead, they may present with a Personality Disorder, Post-Traumatic Stress Disorder and have a history of admissions to rehabilitation and inpatient psychiatric treatment. The important point to remember is that symptoms of both disorders vary in degree of intensity. The degree of intensity for either disorder or both will determine the path to treatment, case management and supportive services. Integrated treatment is the most effective approach for individuals

with co-occurring disorder including contingency management and case management. In the behavioral health system, there are provider organizations that are licensed to provide both mental health and substance abuse treatment. For a treatment provider to be identified it is important that individuals are screened and assessed appropriately. Screening for co-occurring disorders involves a number of factors: a) understanding the individual's current level of functioning and ability to have self-control, ruling out any suicide risk, aggression or violence towards self or others; b) knowing previous history that includes diagnosis, type of treatment, level of intensity of treatment and duration of such; c) assessing a person's trauma history (e.g. physical abuse, sexual abuse, neglect or witness to or victim of violence) using screening instrument that are developed for assessing such symptoms; and any history of mental disorders or substance abuse disorders among immediate family members including treatment and hospitalizations.

Case Examples of Individuals with Co-Occurring Disorders, Symptoms and Treatment Options

- Susan is the mother of three children ages 5, 7 and 9. Two of her children (5 and 7) are in kinship care with a maternal grandmother. The other child is currently with the biological father. A GPS report was generated when relatives found her intoxicated in her home, and the children left unattended. They had little food, the house was in disrepair, and the 7 and 9 year old children were not attending school. The social worker investigating the circumstances noticed that mother was slurring her words, and her body posturing was such that she appeared to be afraid of those around

her. Her speech was slurred but the words that she was expressing did not make sense nor was it logical or goal directed. Once the children were placed, the mother was court ordered into substance abuse treatment beginning with detoxification. A thorough medical workup indicated that she was HIV+ as a result of having multiple sex partners. Once the alcohol and drugs were out of her system, she began having flashbacks and episodes of different personality states (known as dissociating). A thorough screening and assessment indicated she was sexually abused as a child and over time developed PTSD due to the severity of the abuse. She has flashbacks that are very intrusive and result in her becoming dysphoric. As a result, she drinks alcohol, self-mutilates her arms and binge eats – all indicative of behaviors associated with childhood trauma.

Symptoms related to substance use:

- Drinks quart of vodka daily
- Uses cocaine in addition to vodka daily ($100/day)
- Has Blackouts
- Poor Hygiene
- Bruises on arms and legs from falling
- Has multiple sex partners in exchange for money
- Dilated pupils
- Increase in Liver Enzymes (secondary to alcohol use)
- Medical complications related to prolonged alcohol and drug use

Treatment and Supportive Services:

- A residential rehabilitation program licensed to also provide mental health treatment. Many women with children rehab programs are dually licensed and have trauma-informed care.
- Intensive case manager with a specialty in co-occurring disorders. The Office of Mental Health has ACT teams (Assertive Community Treatment) that provides intensive support to individuals with a history of mental illness and substance abuse.
- Dialectical Behavioral Therapy or Cognitive Behavioral Therapy for her trauma.

Symptoms related to mental illness/emotional disorder:

- Flashbacks
- Blackouts (which now have been distinguished as dissociative states)
- Suicidal Ideation
- Thought blocking
- Sexually promiscuous (having multiple partners)
- Self-injurious behaviors (cutting of arms secondary to trauma)
- Substance use to alleviate flashbacks and painful memories

- James is a 28-year-old African American male who is married to Mary, age 26, who has African American and Native American ancestory. They have four children, three of whom with developmental disabilities. James has schizophrenia and requires a weekly injection to help control his paranoia. He also uses alcohol three times a week exacerbating his paranoia. He and Mary both have intellectual disabilities (IQ 58 and 60 respectively). When James gets paranoid, he often will move his family from one apartment to another. James can't read or write; Mary can read but does not know how to do math. James can recognize numbers but does not know how to put them together (addition, multiplication, etc.). Both Mary and James were in foster care as children themselves, and as a result have a history of being in multiple placements as young children. The Child Welfare System was notified by the school because the children would come to school with soiled clothing or would miss days at a time. James has been in inpatient treatment multiple times and had one rehab episode two years ago. The father in this family has a multiple occurring disorder requiring interventions within three systems of care, which provide treatment and support for mental health, substance abuse and intellectual disabilities. Each system has a case management approach that differs from each

other, and focuses on one aspect of care. In this scenario, an integrated approach with a "lead" person is needed to ensure that all appropriate services are identified and that all appropriate adaptations in approaches are made.

Symptoms related to Alcohol Abuse:

- Drinks 40 ounces of beer three times a week
- Becomes paranoid with auditory hallucinations
- Has Blackouts

Symptoms related to Schizophrenia

- Paranoia
- Auditory hallucinations
- Visual hallucinations
- Thought content focuses on believing that people are after him
- Flight of ideas – switching from one topic to another
- Pressured Speech
- Non-compliance with medication

Symptoms related to Developmental Disability:

- Full Scale IQ tested at 58
- Adaptive Functioning is average requiring support in activities of daily living
- Unable to read or write

Treatment Recommendations and Supports:

- Referral for medication that is given intravenously (IM) so that he can be compliant with medication regiment.
- Weekly outpatient treatment in a program that is licensed to provide mental health and substance abuse treatment but for individuals with intellectual disabilities.
- Supports coordination through the Office of Intellectual Disabilities so that all services and in-home supports are obtained. This would be accessed for both parents.
- Case management for the father that is geared towards individuals with co-occurring serious and persistent mental illness (schizophrenia) and alcohol use.
- Family-based treatment that utilizes a picture exchange approach given the parents limited reading and writing ability and literacy level; and intellectual disabilities.

As stated throughout this document, co-occurring disorders refer to the presence of both a severe mental illness and a substance use disorders. The best form of treatment for these types of disorders is integrated treatment which involves:

a. Combining treatment for mental illness and substance abuse.
b. Modifying traditional interventions such as social skills training that not only improves building healthy relationships but also helps individuals avoid situations where drugs are used.
c. Accommodations that will take into account a person's cognitive deficits, vulnerability to confrontation, negative symptoms and need for ongoing support.
d. Teaching/training an individual how to manage both illnesses.

Integrated treatment programs include the following critical components:

1. Staged interventions: Individuals respond in different ways and according to their level of motivation and engagement. Therefore, treatment interventions occur in stages beginning with developing a level of trust with the individual and helping him or her develop motivation to become involved in treatment. This is not a linear process and individuals may be at different stages with respect to their mental illness and substance use.

2. Assertive Outreach: Individuals with co-occurring disorders have difficulty accessing services, particularly in a system that is often fragmented and

complex. Intensive case management services help in engaging individuals by reaching out to them and assisting them in maneuvering through systems of care.

3. Motivational interventions: Individuals with co-occurring disorders may not be ready to address their disorders or be motivated to enter treatment. Depending upon their cognitive level, they may be unaware of what treatment entails or how to take that first step. Individuals with mental illness may often use drugs to cope better rather than take their psychiatric medication. Providing education, support and counseling are ways to help individuals identify goals that will help them move forward to manage their lives.

4. Counseling: Treatment programs utilize a range of cognitive and behavioral counseling in the form of individual, group and family therapies. Individuals who have co-occurring disorders require a different counseling approach, and often some modification to help them if they have serious mental illness such as schizophrenia and they may require smaller group settings, lower level of stimuli, and more concrete approaches.

5. Social Supports: Including family supports and social networks that can help with skill building, promoting recovery and ensuring that there are “lifelines” of peer support.

D. The Impact of the Economy on Child Welfare

Poverty and child welfare have unfortunately been tied together for a long time. In the 102 years that have passed since the first White House Conference on the Care of Dependent Children, one constant has been the overrepresentation of families with low socioeconomic status involved with the child welfare system. At that first conference, child advocates were charged with refraining from interfering with the lives of families simply because they were poor. Now, many years later, that extraordinary charge, is just as difficult to see to fruition.

What we do know is that most of the reports received by the child welfare system allege neglect (U.S. Department of Health and Human Services, 2008). Another factor we can be sure of is that children living in poverty experience maltreatment more so than children living above the poverty threshold. In the 4th National Incidence Study of Child Abuse and Neglect (NIS-4), Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, and Li, (2010, p. 12) state:

> "…Children in low socioeconomic status households had significantly higher rates of maltreatment in all categories and across both definitional standards. They experienced some type of maltreatment at more than 5 times the rate of other children; they were more than 3 times as likely to be abused and about 7 times as likely to be neglected."

Because of the complexities poverty encompasses, we are unable to assume that poverty categorically predicts maltreatment. Often, the results of poverty are interpreted as maltreatment. Disadvantages such as homelessness or a lack of safe housing, lack

of food, gaps in supervision, inappropriate supervision, lack of support, and lack of health care are just a few of the detrimental effects of poverty.

This toolkit seeks to enhance the child welfare professional's ability to think critically about underlying issues for their families. It is important to recognize the ripples caused by poverty in our communities. The effects are multi-faceted because of the overwhelming number of problems that are positively correlated with economic disadvantage.

We encourage child welfare professionals to view the issue of poverty in child welfare not as an underlying issue but as an issue that is wrought with gaps in services designed to ameliorate the condition of poverty, and the result of a myriad of other influencing factors.

E. Intellectual Disabilities

When working with families, you may suspect that someone has an intellectual disability. Individuals that have an intellectual disability may need a different casework strategy that those without. Below is a quick checklist that can help identify "red-flags" that someone might have an intellectual disability. If you suspect an intellectual disability, follow your agency's procedures for a referral so that they person can receive a full psychological evaluation that includes a full-scale IQ test and adaptive scales.

Intellectually Deficient Parent Safety Checklist

The following may suggest a Parent may have possible Cognitive Deficiencies

	Check Mark
1.	May present as being uncooperative however seems to have difficulty responding to questions about general information
2.	Reluctant to read any information or has difficulty reading, comprehending even what is asked, has child or others to read and/or write information for her/him
3.	Has others to speak for her/him, seems to look to others to understand what is spoken and to respond on his/her behalf
4.	Inability to budget, even the most basic skills, or has others to count or handle money for him/her
5.	Excessive adult/parental responsibilities placed on children, cleaning, cooking, and taking care of siblings
6.	Was previously in a special class/special education
7.	Lack of understanding appropriate developmental milestones for children
8.	Inability to understand physical safety and nurturance with regard to raising and caring for children
9.	Inability or difficulty traveling independently
10.	Inability to initiate and or reciprocate positive interaction or statements to the children

(Rinehart, 2009)

F. Family Advocacy and Support Tool

The Family Advocacy and Support Tool is not a screening measure but it can be quite useful to professionals working with families. Results from the tool can help a worker to assess a family's situation in order to better identify strengths and concerns. The tool reviews various domains including:

1. The Family Together
2. Caregiver Status
3. Youth's Status
4. Caregiver Advocacy Status

FAMILY ADVOCACY AND SUPPORT TOOL

(FAST) Manual

A family planning and outcome tool for understanding family circumstances
And assisting in planning for services and reunification

Division of Service Integration

Thomas Jones

Director

Effective Date: March, 2009

Tennessee Department of Children's Services
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The Family Advocacy and Support Tool (FAST) is the family version of the Child and Adolescent Needs and Strengths (CANS) family of planning and outcome management tools. A large number of individuals have contributed to the design and development of the FAST. It is an open domain tool, free for anyone to use. We recommend training and certification to ensure its proper and reliable use. For more information, please contact:

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FAMILY ASSESSMENT

1. THE FAMILY TOGETHER

This section focuses on the family system. The first step is to define who makes up the family. Generally it is a household but sometimes two households in which the children spend considerable amounts of time could be considered (e.g. divorced parents with 50:50 visitation).

1. Parental/Caregiver Collaboration

This item refers to the relationship between parents (or other primary caregivers) with regard to working together in child rearing activities.

0 Adaptive collaboration. Parents usually work together regarding issues of the development and well being of the children. They are able to negotiate disagreements related to their children.
1 Mostly adaptive collaboration. Generally good parental collaboration with occasional difficulties negotiating miscommunications or misunderstanding regarding issues of the development and well being of the children.
2 Limited adaptive collaboration. Moderate problems of communication and collaboration between two or more adult caregivers with regard to issues of the development and well being of the youth.
3 Significant difficulties with collaboration. Minimal collaboration and destructive or sabotaging communication among any parents regarding issues related to the development and well being of the youth.
NA Not applicable

2. Relationships among Siblings

This item refers to how the children in the family (brothers and sisters as well as step and half siblings) get along with each other.

0 Adaptive relationships. Siblings generally get along well. Occasional fights or conflicts between them occur, but are quickly resolved.
1 Mostly adaptive relationships. Siblings generally get along, however, when fights or conflicts arise there is some difficulty in resolving them.
2 Limited adaptive relationships. Siblings often do not get along. They generally attempt to resolve their fights or conflicts but have limited success in doing so.
3 Significant difficulties with relationships. Siblings do not get along. The relationships are marked by detachment or active, continuing conflicts, and may include physical violence.
N/A Not applicable

3. Extended Family Relationships

This item refers to the family's relationship with other relatives (not necessarily a blood relation) who do not currently live with the family but do live in the same relative geographic area.

0 Adaptive relationships. Extended family members play a central role in the functioning and well being of the family. They have predominately positive relationships with members of the extended family and conflicts are resolved quickly.

1 Mostly adaptive relationships. Extended family members play a supportive role in family functioning. They generally have positive relationships with members of the extended family. Conflicts may linger but eventually are resolved.
2 Limited adaptive relationships. Extended family members are marginally involved in the functioning and well being of the family. They have generally strained or absent relationships with extended family members.
3 Significant difficulties with relationships. Family is not in contact or estranged from extended family members. They have negative relationships with continuing conflicts.
N/A Not applicable

4. Family Conflict

This item refers to how much fighting occurs between family members. Domestic violence refers to physical fighting in which family members might get hurt (also refers to the same geographic area, not limited to household).

0 Minimal conflict. Family gets along well and negotiates disagreements appropriately.
1 Some Conflict. Family generally gets along fairly well but when conflicts arise resolution is difficult.
2 Significant conflict. Family is generally argumentative and conflict is a fairly constant theme in family communications.
3 Domestic violence. Threat or occurrence of physical, verbal or emotional altercations. Family with a current restraining order against one member would be rated here.

5. Family Communication

This item refers to the ability of all family members to talk to each other about their thoughts and feelings. It should only be about communication within the family (does not have to be in the same home but in the same geographic area).

0 Adaptive communication. Family members generally are able to directly communicate important information among each other. Family members are able to understand each other's feelings and needs.
1 Mostly adaptive communication. Family members can communicate important information among each other. Some individuals or certain topics are excluded from direct communication. Mutual understanding is inconsistent.
2 Limited adaptive communication. Family members generally are unable to directly communicate important information among each other. Family members have difficulties understanding each other's feelings and needs.
3 Significant difficulties with communication. Family members communicate mostly through indirect, covert means or there is no sharing of important information at all. They are not able to understand each other's feelings or needs.

6. Family Role Appropriateness

Boundaries refer to the ability of family members to separate themselves as individuals and appropriately separate communication with various family members. Hierarchies refer to the organization of decision-making authority in the family.

0 Adaptive boundaries. Family has strong appropriate boundaries among members. Clear inter-generational hierarchies are maintained.

1 Mostly adaptive boundaries. Family has generally appropriate boundaries and hierarchies. May experience some minor blurring of roles.
2 Limited adaptive boundaries. Family has difficulty maintaining appropriate boundaries and/or hierarchies. Some significant role problems exist.
3 Significant difficulties with boundaries. Family has significant problems with establishing and maintaining reasonable boundaries and hierarchies. Significant role confusion or reversals may exist.

7. Family Safety

This item refers to the degree to which family members are safe from being physically injured in the home.

0 No safety concern. Family provides a safe home environment for all family members.
1 Mild safety concern. Family home environment presents some mild possibility of neglect or exposure to undesirable influences (e.g., alcohol/drug abuse, gang membership of family members) but no immediate risk is present.
2 Moderate safety concern. Family home environment presents moderate possibility to family members including abuse and neglect or exposure to individuals who could harm the youth.
3 Severe safety concern. Family home environment presents a clear and immediate probability of harm to family members. Individuals in the environment present immediate risk of significant physical harm.

8. Financial Resources

This item refers to the income and other sources of money available to family members (particularly caregivers) that can be used to address family needs; please include government assistance.

0 No difficulties. Family has financial resources necessary to meet needs.
1 Mild difficulties. Family has financial resources necessary to meet most needs; however, some limitations exist.
2 Moderate difficulties. Family has financial difficulties that limit their ability to meet significant family needs.
3 Significant difficulties. Family experiencing financial hardship, poverty.

9. Residential Stability

This item refers to the stability of the family's housing. This does not refer to the risk of placement outside of the family home for any member of the family.

0 Family has stable housing for the foreseeable future.
1 Family having some difficulties maintaining housing due to things such as difficulty paying rent or utilities or conflict with a landlord.
2 Family has had to move in the past six months due to housing difficulties.
3 Family has experienced homelessness in the past six months.

10. Physical Condition of the Home

This item refers to the physical condition of the house or apartment in which the family is currently residing. Shelters would be rated "Not applicable".

0 No health or safety concerns on property.
1 Minor health concerns on property that pose no threat and easily correctable.

2 Serious substantiated health or safety hazards, i.e. over crowding, inoperative or unsafe water and utility hazards, vermin, or other health and sanitation concerns.
3 Substantiated life threatening health or safety hazards, i.e. living in condemned and/or structurally unsound residence; exposed wiring, potential fire/safety hazards, or vermin infestation.
NA Not applicable

11. Home Maintenance
This item refers to housekeeping both in terms of cleanliness and organization and safety from dangerous materials and/or objects (e.g. child proofing). Families living in a supported housing arrangement (e.g. shelter) would be rated "Not applicable".

0 Home is clean, maintained well; poisons and medications are locked up/stored away properly and out of reach. Home is child proofed; kitchen and bathroom are functional; all utilities are operational; everyone has a bed and outlets are plugged. No concerns.
1 Most precautions have been taken; no danger to the children, poisons and medication are out of reach but not locked up; home is mostly child proof, utilities are operational; minor cleaning is required, some odor present.
2 Some precautions have been taken, but potential hazards are obvious, e.g. poisons and medication out of sight but within reach of child(ren), overloaded outlets, matches and knives accessible but out of sight. Gas, heating, electricity, or plumbing sometimes don't work because bills have not been paid or needed repairs have not been attended to by the family. Home is somewhat cluttered. House needs general cleaning, e.g. bathroom, bedrooms, kitchen, and basement. Beds are needed.
3 Home is not safe. Poisons and medications are visible and accessible, no screens on second floor windows for toddlers, outlets not plugged, few precautions taken; utilities off, due to neglect of bills or needed repair. No beds for children, parent(s). No refrigerator. Home is dirty, kitchen presents odor due to spoiled food.
N/A Not applicable.

II. CAREGIVER'S STATUS

Each adult living in the family defined above who has any caregiver responsibilities would be rated separately in this section.

12. Caregiver's Emotional Responsiveness

This item refers to the caregiver's ability to understand and respond appropriately to the joys, sorrows, anxieties and other feelings of children.

0 Adaptive emotional responsiveness. Caregiver is emotionally empathic and attends to child's emotional needs.
1 Mostly adaptive emotional responsiveness. Caregiver is generally emotionally empathic and typically attends to child's emotional needs. However, certain psychological issues undermine the Caregiver's emotional responsiveness.
2 Limited adaptive emotional responsiveness. Caregiver is often not empathic and frequently is not able to attend to child's emotional needs.
3 Significant difficulties with emotional responsiveness. Caregiver is not empathic and rarely attends to the child's emotional needs.

13. Caregiver's Boundaries

This item refers to the caregiver's ability to maintain appropriate boundaries. This item may include physical separation, respecting privacy, and preventing children from being exposed to developmentally inappropriate information.

0 Adaptive boundaries. Caregiver has strong, appropriate boundaries between her/himself and her/his children.
1 Mostly adaptive boundaries. Caregiver has generally appropriate boundaries between her/himself and her/his children. Mild boundary violations may occur at times. Minor problems of rigidity of boundaries may occur.
2 Limited adaptive boundaries. Caregiver has problems maintaining appropriate boundaries between her/him and her/his children. Mild boundary violations may be routine or significant boundary violations may be occasional. Boundaries may be rigid.
3 Significant difficulties with boundaries. Caregiver has significant and consistent problems maintaining appropriate boundaries between her/himself and her/his children or is excessively rigid in her boundaries.

14. Caregiver's Involvement in Caregiving Functions

This item refers to the degree to which the caregiver is actively involved in being a parent/caregiver.

0 Caregiver is actively and fully involved in daily family life.
1 Caregiver is generally involved in daily family life. She/he may occasionally be less involved for brief periods of time because she/he is distracted by internal stressors and/or other external events or responsibilities.
2 Caregiver is involved in daily family life but only maintains minimal daily interactions for extended periods of time.
3 Caregiver is mostly uninvolved in daily family life. She/he may not interact with children on a daily basis.

15. Caregiver's Supervision

This item refers to the success with which the caregiver is able to monitor children in his/her care. This item should be rated consistent with the developmental needs of the children.

0 Good supervision. Caregiver demonstrates consistent ability to supervise her/his children according to their developmental needs.
1 Adequate supervision. Caregiver demonstrates generally good ability to supervise children; however, some problems may occur occasionally.
2 Fair supervision. Caregiver has difficulty maintaining an appropriate level of supervision of her/his children.
3 Significant difficulties with supervision. Caregiver has significant problems maintaining any supervision of her/his children.

16. Caregiver's Discipline

Discipline refers to the caregiver's ability to encourage children's positive behaviors through the use of a variety of different techniques including but not limited to praise, redirection, and punishment.

0 Good discipline methods. Caregiver generally demonstrates an ability to discipline her/his children in a consistent and benevolent manner. She/he usually is able to set age appropriate limits and to enforce them.

1 Adequate discipline methods. Caregiver is often able to set age appropriate limits and to enforce them. On occasion her/his interventions may be either too harsh or too lenient. At times, her/his expectations of her/his children may be too high or too low.

2 Inadequate discipline methods. Caregiver demonstrates limited ability to discipline her children in a consistent and benevolent manner. She/he rarely is able to set age appropriate limits and to enforce them. Her/his interventions may be erratic and overly harsh but not physically harmful. Her/his expectations of her/his children are frequently unrealistic.

3 Significant difficulties with discipline methods. Caregiver disciplines her/his children in an unpredictable fashion. There is either an absence of limit setting and disciplinary interventions or the limit setting and disciplinary interventions are rigid, extreme, and physically harmful.

17. Caregiver's Partner Relationship

This item refers to the caregiver's relationship with another adult. If married, this refers to the caregiver's husband or wife or partner.

0 Adaptive partner relationship. Caregiver has a strong, positive, partner relationship with another adult. This adult functions as a member of the family.

1 Mostly adaptive partner relationship. Caregiver has a generally positive partner relationship with another adult. This adult may not function as a member of the family.

2 Limited adaptive partner relationship. Caregiver is currently not involved in any partner relationship with another adult but wishes to have one.

3 Significant difficulties with partner relationships. Caregiver is currently involved in a negative, unhealthy relationship with another adult.

NA Not applicable. A person without a relationship who currently has no interest in one would be rated here.

18. Caregiver's Vocational Functioning

This item refers to the caregiver's work effectiveness including, but not limited to, attendance, productivity, and relationships with co-workers.

0 Good vocational functioning. Caregiver is fully employed with no problems at work.

1 Adequate vocational functioning. Caregiver is partially employed, employed significantly below her/his level of education/experience/training, or is having some work related problems.

2 Fair vocational functioning. Caregiver is having significant work-related problems or is temporarily unemployed because of such difficulties.

3 Significant difficulties with vocational functioning. Caregiver is chronically unemployed or obtains financial resources through activities which are illegal and/or

potentially harmful to her/himself and her/his family members (prostitution, drug dealing, for example).

NA Not applicable. Alternatively, Caregiver may not be seeking employment, retired or chooses to be a full-time homemaker.

19. Caregiver Mental Health

This item refers to mental health needs only (not substance abuse or dependence).

0 No mental health problems. Caregiver has no signs of any notable mental health problems.

1 Mild mental health problems. Caregiver may have mild problems with adjustment, may be somewhat depressed, withdrawn, irritable, or agitated. Or, caregiver may be receiving effective treatment.

2 Moderate mental health problems. Caregiver has a diagnosable mental health problem that interferes with his/her functioning.

3 Significant difficulties with mental health. Caregiver has a serious psychiatric disorder.

20. Caregiver Substance Use

This item includes problems with alcohol, illegal drugs and/or prescription drugs.

0 No problems with alcohol or drug use. Caregiver has no signs of any notable substance abuse problems.

1 Mild problems associated with alcohol or drug use. Caregiver may have mild problems with work or home life that result from occasional use of alcohol or drugs. Or, caregiver may be receiving effective treatment.

2 Moderate problems associated with alcohol or drug use. Caregiver has a diagnosable substance-related disorder that interferes with his/her life.

3 Significant difficulties with alcohol or drug dependence. Caregiver is currently addicted to either alcohol or drugs or both.

III. YOUTH'S STATUS

This section is used to describe the strengths and needs of all children and youth under the age of 18 living in the family defined above.

21. Relationship with Biological Mother

This item refers to the youth's relationship with his/her birth mother only.

0 Adaptive relationship. Youth has a generally positive relationship with biological mother. The youth appears to have formed a secure attachment, and can turn to mother for security, comfort or guidance.

1 Mostly adaptive relationship. Youth has a somewhat positive relationship with biological mother. The youth appears to have mild attachment problems that interfere with his/her ability to turn to mother for security, comfort, or guidance.

2 Limited adaptive relationship. Youth has a somewhat negative relationship with biological mother. The youth appears to have moderate attachment problems that interfere with his/her ability to turn to mother for security, comfort, or guidance.

3 Significant difficulties with relationship. Youth has no ongoing relationship with his/her biological mother. The youth appears to have severe attachment problems.
N/A Not applicable

22. Relationship with Biological Father

This item refers to the youth's relationship with his/her birth father only.

0 Adaptive relationship. Youth has a generally positive relationship with biological father. The youth appears to have formed a secure attachment, and can turn to father for security, comfort or guidance.
1 Mostly adaptive relationship. Youth has a somewhat positive relationship with biological father. The youth appears to have mild attachment problems that interfere with his/her ability to turn to father for security, comfort, or guidance.
2 Limited adaptive relationship. Youth has a somewhat negative relationship with biological father. The youth appears to have moderate attachment problems that interfere with his/her ability to turn to father for security, comfort, or guidance.
3 Significant difficulties with relationship. Youth has no ongoing relationship with his/her biological father. The youth appears to have severe attachment problems.
N/A Not applicable

23. Relationship with Primary Caregiver (if not biological mother or father)

This item refers to the youth relationship with whomever is his/her primary caregiver at the moment.

0 Adaptive relationship. Youth has a generally positive relationship with primary caregiver. The youth appears to have formed a secure attachment, and can turn to primary caregiver for security, comfort or guidance.
1 Mostly adaptive relationship. Youth has a somewhat positive relationship with primary caregiver. The youth appears to have mild attachment problems that interfere with his/her ability to turn to primary caregiver for security, comfort, or guidance.
2 Limited adaptive relationship. Youth has a somewhat negative relationship with primary caregiver. The youth appears to have moderate attachment problems that interfere with his/her ability to turn to primary caregiver for security, comfort, or guidance.
3 Significant difficulties with relationship. Youth has no ongoing relationship with his/her primary caregiver. The youth appears to have severe attachment problems.
N/A Not applicable

24. Relationships with Other Adult Family Members

This item refers to the youth's involvement with adult family members who do not have primary caregiving responsibilities for the youth.

0 Adaptive relationships. Youth is able to have predominately positive relationships with other adult family members and is able to participate in conflict resolution with them.
1 Mostly adaptive relationships. Youth is able to have generally positive relationships with other adult family members. At times, conflicts may occur and linger between them but eventually are resolved.

2 Limited adaptive relationships. Youth is only able to have peripheral relationships with other adult family members or the relationships are strained.
3 Significant challenges with relationships. Adult family members are available emotionally and practically, but the youth is unable to have relationships with them.
N/A Not applicable

25. Child High Risk Behaviors

This item describes any behavior that has the potential of placing the child or others at risk of physical harm. Suicidal behavior, violence, recklessness, A&D use, and sexual aggression would be rated here.

0 No evidence of any high risk behavior.
1 Child has a notable history of high risk behavior but not in the past month.
2 Child engages in high risk behavior that interferes with functioning and may place self or others at risk of physical harm.
3 Child engages in high risk behavior that places him/her or others at immediate risk of physical harm.

26. Health Status

This item is used to describe the youth's current physical health.

0 Good health. Youth is in generally good physical health.
1 Adequate health. Youth gets sick more often than peers, but the health problems do not interfere with his/her general functioning.
2 Fair health. Youth has some health problems that interfere with his/her functioning.
3 Significant health challenges. Youth has significant health problems that may be chronic or life threatening.

27. Mental Health Status

This item is used to describe the youth's current mental health.

0 No mental health challenges. Youth has no signs of any notable mental health problems.
1 Mild mental health challenges. Youth may have mild problems with adjustment, may be somewhat depressed, withdrawn, irritable, or agitated.
2 Moderate mental health challenges. Youth has a diagnosable mental health problem that interferes with his/her functioning.
3 Significant challenges with mental health. Youth has a serious psychiatric disorder.

28. Cognitive Skills

Cognitive skills refers to the youth's intellectual capacity. Problems with include mental retardation and learning difficulties that are a result of learning disabilities.

0 Good. Youth meets or exceeds all cognitive developmental milestones.
1 Adequate. Youth is close to meeting all cognitive developmental milestones.

2 Fair. Youth has a developmental disability or a delay in meeting developmental milestones.
3 Significant difficulties with cognitive development. Youth has a severe developmental disability.

29. Self-Regulation Skills

This item refers to the youth's ability to self regulate him/herself and his/her bodily functions. Self-regulation skills change developmentally so this item should be rated within the context of developmentally appropriate skills.

0 Good. Youth has mature self-regulation. Youth is able to self-soothe, function independently and effectively structure free-time.
1 Adequate. Youth is generally able to self regulate in an age-appropriate way.
2 Fair. Youth has some difficulties with self regulation.
3 Significant difficulties with self-regulation. Youth is unable to manage him/herself in a developmentally appropriate way.

30. Interpersonal Skills

This item refers to the youth's ability to make and maintain friendships and other relationships with peers and adults.

0 Good. Youth has excellent, mature relationship skills.
1 Adequate. Youth has good, developmentally appropriate relationship skills.
2 Fair. Youth has some difficulties with social skills and friendship development and/or maintenance.
3 Significant difficulties. Youth has significant difficulties with social skills and friendship development.

31. Educational Status

This item refers to the youth's status with school. If the youth has completed his/her schooling then use '0'. If youth has dropped out without completing then use a '3'.

0 Good educational functioning. Youth is meeting or exceeding educational expectation at an age-expected grade level.
1 Adequate educational functioning. Youth is mostly meeting educational expectations at an age-expected grade level.
2 Fair educational functioning. Youth is performing below educational expectations and/or requires a specialized educational setting in order to learn at an adequate level.
3 Significant difficulties with educational functioning. Youth has significant educational problems including some behavioral problems related to academic difficulties (chronic truancy, suspensions, expulsions, being held back, etc.). Youth may be placed in a specialized educational setting but remains unable to learn at an adequate level.
N/A Not applicable. Not school aged.

IV. CAREGIVER ADVOCACY STATUS

This section provides an opportunity for your family to assess its current level of ability to advocate for members, particularly youth who have needs. In addition, three items are provided to allow the family to describe its perspective on the appropriateness of living, educational, and services arrangements for youth members. Note: The worker assigned to the family fills this out after speaking with the family and assessing their current situation. The family does not fill out this document.

32. Knowledge of Family/Child needs

This item refers to the caregiver's ability to recognize the needs of the family and individual family members.

0 Caregiver/s have strong understanding of family and child needs.
1 Caregiver/s have understanding of family and child needs but may still require some help in learning about certain aspects of these needs.
2 Caregiver/s require assistance in understanding family and/or child needs.
3 Caregiver/s require substantial assistance in identifying and understanding family and child needs.

33. Knowledge of service options

This item refers to the choices the family might have for specific treatments, interventions or other services that might help the family address their needs or the needs of one of the family's members. This does not include services or information provided by the Department.

0 Caregiver/s have strong understanding of service options.
1 Caregiver/s have understanding of service options but may still require some help in learning about certain aspects of these services.
2 Caregiver/s require assistance in understanding service options.
3 Caregiver/s require substantial assistance in identifying and understanding service options.

34. Knowledge of rights and responsibilities

This item refers to the caregiver's ability to understand and acknowledge the legal and societal expectations and responsibilities of their caregiver roles. This does not factor in Departmental involvement.

0 Caregiver/s have strong understanding of rights and responsibilities.
1 Caregiver/s have understanding of rights and responsibilities but may still require some help in learning about certain aspects of these needs.
2 Caregiver/s require assistance in understanding rights and responsibilities.
3 Caregiver/s require substantial assistance in identifying and understanding rights and responsibilities.

35. Ability to Listen

This item refers to the caregiver's ability to hear both positive and negative feedback about him/herself and family members. This item would include asking clarifying questions.

0 Caregiver(s) is able to listen carefully and understand both good and bad news regarding family and child issues.
1 Caregiver(s) has listening skills but sometimes struggles to hear either good or bad news regarding family and child issues.

2 Caregiver(s) requires help learning to listen effectively.
3 Caregiver(s) requires substantial help learning to listen effectively.

36. Ability to Communicate
This item refers to the caregiver's ability to effectively describe his/her needs as well as needs of other family members in a manner that others can understand.

0 Caregiver(s) is able to express feeling and thoughts effectively with regard to family and child issues. Others hear, understand, and respond.
1 Caregiver(s) is able to express feeling and thoughts but sometimes struggle to express these so that others can listen and/or understand.
2 Caregiver(s) requires help learning to express feelings and thoughts effectively with regard to family and child issues.
3 Caregiver(s) requires substantial help learning to express feelings and thoughts effectively with regard to family and child issues.

37. Natural Supports
This item refers to natural supports refer to help that you do not have to pay for. This could include friends and families or a church or other organization that helps the family in times of need (unpaid supports).

0 Caregiver(s) has substantial natural supports to assist in addressing most family and child needs.
1 Caregiver(s) has natural supports but some limitations exist whereby these supports are insufficient to address some family and child needs.
2 Caregiver(s) has limited natural supports.
3 Caregiver(s) has no natural supports.

38. Satisfaction with Youth's Living Arrangement
This item refers to the caregiver's satisfaction with the current living arrangement of any youth in the family.

0 Caregiver(s) is pleased with identified youth's current living arrangement.
1 Caregiver(s) is satisfied with identified youth's current living arrangement, although some improvements could be made.
2 Caregiver(s) believes a change in living arrangement is desirable.
3 Caregiver(s) believes an immediate change in living arrangement is required.

39. Satisfaction with Youth's Educational Arrangement
This item refers to the degree to which the caregiver is satisfied with the education arrangement of children in the family.

0 Caregiver(s) is pleased with identified youth's current educational arrangement.
1 Caregiver(s) is satisfied with identified youth's current educational arrangement, although some improvements could be made.
2 Caregiver(s) believes a change in educational arrangement is desirable.
3 Caregiver(s) believes an immediate change in educational arrangement is required.
N/A Not applicable. Not school aged.

40. Satisfaction with Services Arrangement

This item refers to the degree to which the caregiver is satisfied with any services (or lack there of) for children in his/her care.

0 Caregiver(s) is pleased with identified youth's current services arrangement.
1 Caregiver(s) is satisfied with identified youth's current services arrangement, although some improvements could be made.
2 Caregiver(s) believes a significant change in services arrangement is desirable.
3 Caregiver(s) believes an immediate and significant change in services arrangement is required.
N/A Not applicable

Service Intensity

Upon completion of the FAST, use the following to determine the appropriate level of service intensity:

Low Intensity

All families that do not meet criteria for either Moderate or High Intensity

Moderate Intensity
Family meets ALL three of the following criteria:

- At least one item with a '2' or '3' in the Family Together
- At least one item was a '2' or '3' on at least one Caregiver
- At least one item with a '2' or '3' on at least one Child/Youth

High Intensity
Family meets ALL three of the following criteria:

- At least one item with a '3' AND two or more items with a '2' or '3' in the Family Together
- At least one item with a '3' AND two or more items with a '2' or '3' on at least one Caregiver
- At least one item with a '3' AND two or more items with a '2' or '3' on at least one Child/Youth

The Family Advocacy and Support Tool (FAST) is the family version of the Child and Adolescent Needs and Strengths (CANS) family of planning and outcome management tools. A large number of individuals have contributed to the design and development of the FAST. It is an open domain tool, free for anyone to use. We recommend training and certification to ensure its proper and reliable use. For more information, please contact:

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FAMILY ADVOCACY & SUPPORT TOOL (FAST)

Type: ☐ Initial
☐ End of services

Family Name: _____ Region/County: _____

Assessor: _____ Date Completed: _____ Supervisor: _____ Date Reviewed: _____

"**0**" indicates no evidence of a need, can also indicate **a clear strength**
"**1**" indicates **watchful waiting/prevention, further assessment, or opportunities for strength building**
"**2**" indicates **a need for service action** (may already be in place by family or other supports)
"**3**" indicates **a need for immediate or intensive service action** (may already be in place by family or other supports)

I. THE FAMILY TOGETHER

	0	1	2	3	NA
1. Caregiver Collaboration	☐	☐	☐	☐	☐
2. Relations among Siblings	☐	☐	☐	☐	☐
3. Extended Family Relations	☐	☐	☐	☐	☐
4. Family Conflict	☐	☐	☐	☐	
5. Family Communication	☐	☐	☐	☐	
6. Family Role Appropriateness	☐	☐	☐	☐	
7. Family Safety	☐	☐	☐	☐	
8. Financial Resources	☐	☐	☐	☐	
9. Residential Stability	☐	☐	☐	☐	
10. Physical Condition of Home	☐	☐	☐	☐	☐
11. Home Maintenance	☐	☐	☐	☐	☐

II. CAREGIVER A

Name: _____

	0	1	2	3	NA
12A. Caregiver's Emotional Response	☐	☐	☐	☐	
13A. Caregiver's Boundaries	☐	☐	☐	☐	
14A. Caregiver's Involvement	☐	☐	☐	☐	
15A. Caregiver's Supervision	☐	☐	☐	☐	
16A. Caregiver's Discipline	☐	☐	☐	☐	
17A. Caregiver's Partner Relationship	☐	☐	☐	☐	☐
18A. Caregiver's Vocational Functioning	☐	☐	☐	☐	☐
19A. Caregiver's Mental Health	☐	☐	☐	☐	
20A. Caregiver's Substance Abuse	☐	☐	☐	☐	

II. CAREGIVER B

Name: _____

	0	1	2	3	NA
12B. Caregiver's Emotional Response	☐	☐	☐	☐	
13B. Caregiver's Boundaries	☐	☐	☐	☐	
14B. Caregiver's Involvement	☐	☐	☐	☐	
15B. Caregiver's Supervision	☐	☐	☐	☐	
16B. Caregiver's Discipline	☐	☐	☐	☐	
17B. Caregiver's Partner Relations	☐	☐	☐	☐	☐
18B. Caregiver's Vocational Functioning	☐	☐	☐	☐	☐
19B. Caregiver's Mental Health	☐	☐	☐	☐	
20B. Caregiver's Substance Abuse	☐	☐	☐	☐	

II. CAREGIVER C

Name: _____

	0	1	2	3	NA
12C. Caregiver's Emotional Response	☐	☐	☐	☐	
13C. Caregiver's Boundaries	☐	☐	☐	☐	
14C. Caregiver's Involvement	☐	☐	☐	☐	
15C. Caregiver's Supervision	☐	☐	☐	☐	
16C. Caregiver's Discipline	☐	☐	☐	☐	
17C. Caregiver's Partner Relationship	☐	☐	☐	☐	☐
18C. Caregiver's Vocational Functioning	☐	☐	☐	☐	☐
19C. Caregiver's Mental Health	☐	☐	☐	☐	
20C. Caregiver's Substance Abuse	☐	☐	☐	☐	

II. CAREGIVER D

Name: _____

	0	1	2	3	NA
12D. Caregiver's Emotional Response	☐	☐	☐	☐	
13D. Caregiver's Boundaries	☐	☐	☐	☐	
14D. Caregiver's Involvement	☐	☐	☐	☐	
15D. Caregiver's Supervision	☐	☐	☐	☐	
16D. Caregiver's Discipline	☐	☐	☐	☐	
17D. Caregiver's Partner Relations	☐	☐	☐	☐	☐
18D. Caregiver's Vocational Functioning	☐	☐	☐	☐	☐
19D. Caregiver's Mental Health	☐	☐	☐	☐	
20D. Caregiver's Substance Abuse	☐	☐	☐	☐	

FAMILY ADVOCACY & SUPPORT TOOL (FAST)

III. CHILD FUNCTIONING A

Gender: ☐M ☐F Age: _____ Name:_____

	0	1	2	3	NA
21A. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22A. Relationship w/Bio Father	☐	☐	☐	☐	☐
23A. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24A. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25A. Child High Risk Behavior	☐	☐	☐	☐	☐
26A. Health Status	☐	☐	☐	☐	
27A. Mental Health Status	☐	☐	☐	☐	
28A. Cognitive Skills	☐	☐	☐	☐	
29A. Self-Regulation Skills	☐	☐	☐	☐	
30A. Interpersonal Skills	☐	☐	☐	☐	
31A. Educational Status	☐	☐	☐	☐	☐

III. CHILD FUNCTIONING B

Gender: ☐M ☐F Age: _____ Name: _____

	0	1	2	3	NA
21B. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22B. Relationship w/Bio Father	☐	☐	☐	☐	☐
23B. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24B. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25B. Child High Risk Behavior	☐	☐	☐	☐	☐
26B. Health Status	☐	☐	☐	☐	
27B. Mental Health Status	☐	☐	☐	☐	
28B. Cognitive Skills	☐	☐	☐	☐	
29B. Self-Regulation Skills	☐	☐	☐	☐	
30B. Interpersonal Skills	☐	☐	☐	☐	
31B. Educational Status	☐	☐	☐	☐	☐

III. CHILD FUNCTIONING C

Gender: ☐M ☐F Age: _____ Name: _____

	0	1	2	3	NA
21C. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22C. Relationship w/Bio Father	☐	☐	☐	☐	☐
23C. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24C. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25C. Child High Risk Behavior	☐	☐	☐	☐	☐
26C. Health Status	☐	☐	☐	☐	
27C. Mental Health Status	☐	☐	☐	☐	
28C. Cognitive Skills	☐	☐	☐	☐	
29C. Self-Regulation Skills	☐	☐	☐	☐	
30C. Interpersonal Skills	☐	☐	☐	☐	
31C. Educational Status	☐	☐	☐	☐	☐

III. CHILD FUNCTIONING D

Gender: ☐M ☐F Age: _____ Name: _____

	0	1	2	3	NA
21D. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22D. Relationship w/Bio Father	☐	☐	☐	☐	☐
23D. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24D. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25D. Child High Risk Behavior	☐	☐	☐	☐	☐
26D. Health Status	☐	☐	☐	☐	
27D. Mental Health Status	☐	☐	☐	☐	
28D. Cognitive Skills	☐	☐	☐	☐	
29D. Self-Regulation Skills	☐	☐	☐	☐	
30D. Interpersonal Skills	☐	☐	☐	☐	
31D. Educational Status	☐	☐	☐	☐	☐

III. CHILD FUNCTIONING E

Gender: ☐M ☐F Age: _____ Name: _____

	0	1	2	3	NA
21E. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22E. Relationship w/Bio Father	☐	☐	☐	☐	☐
23E. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24E. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25E. Child High Risk Behavior	☐	☐	☐	☐	☐
26E. Health Status	☐	☐	☐	☐	
27E. Mental Health Status	☐	☐	☐	☐	
28E. Cognitive Skills	☐	☐	☐	☐	
29E. Self-Regulation Skills	☐	☐	☐	☐	
30E. Interpersonal Skills	☐	☐	☐	☐	
31E. Educational Status	☐	☐	☐	☐	☐

III. CHILD FUNCTIONING F

Gender: ☐M ☐F Age: _____ Name: _____

	0	1	2	3	NA
21F. Relationship w/Bio Mother	☐	☐	☐	☐	☐
22F. Relationship w/Bio Father	☐	☐	☐	☐	☐
23F. Relationship w/Primary Caregiver	☐	☐	☐	☐	☐
24F. Relationship w/other Family Adults	☐	☐	☐	☐	☐
25F. Child High Risk Behavior	☐	☐	☐	☐	☐
26F. Health Status	☐	☐	☐	☐	
27F. Mental Health Status	☐	☐	☐	☐	
28F. Cognitive Skills	☐	☐	☐	☐	
29F. Self-Regulation Skills	☐	☐	☐	☐	
30F. Interpersonal Skills	☐	☐	☐	☐	
31F. Educational Status	☐	☐	☐	☐	☐

IV. CAREGIVER ADVOCACY

	0	1	2	3	NA
32. Knowledge of Family/Child Needs	☐	☐	☐	☐	
33. Knowledge of Service Options	☐	☐	☐	☐	
34. Knowledge of Rights & Responsibilities	☐	☐	☐	☐	
35. Ability to Listen	☐	☐	☐	☐	
36. Ability to Communicate	☐	☐	☐	☐	
37. Natural Supports	☐	☐	☐	☐	
38. Satisfaction w/Youth's Living Arrangement	☐	☐	☐	☐	
39. Satisfaction w/Youth's Educational Arrangement	☐	☐	☐	☐	☐
40. Satisfaction w/Services Arrangement	☐	☐	☐	☐	☐

XI. Peer to Peer Facilitated Discussion Guide

Why thinking and reflecting are as important as doing!

Introduction

Cleaver and Freeman wrote that working in child welfare requires the skills of Machiavelli, the wisdom of Solomon, the compassion of Augustine and the hide of a tax inspector (Cleaver & Freeman, 1995, p. 19). A great deal has previously been written about the inherently stressful nature of the work and the importance of reflection in making the job manageable for workers. We also know that reflecting on the work leads to better decisions. For example, a caseworker might react in a certain manner in dealing with an individual or a family without a conscious understanding of why or what is influencing them, or how this impacts the safety, permanency and well-being of the children in the family. Without a "space" or a forum in which to not only discuss reactions, thoughts and ideas and examine feelings, but to also receive guidance and generate hypotheses (Jones, Treseder & Glennie, 2002), workers can arrive at solutions without fully understanding the meanings and intentions behind their actions. Research from other fields such as medicine (Croskerry, 2003), education (Ashraf &. Rarieyab, 2008; Weiss & Weiss, 2001) and public health (Parker et al., 2009) tell us that taking the time to "think about our thinking and our feelings" is a valuable use of time.

In this facilitated discussion guide, we hope to convince you that taking the time to talk with your peers in a semi-structured fashion is a good use of YOUR time, and the time of your colleagues. There are many advantages. First, it helps you to feel less alone in your work, and therefore less stressed. Secondly, there is research to suggest that we

all take “thinking short cuts” that we are not aware of on a conscious level. However, when we open up the “box” of our thinking through discussion, others can point out things that we are missing, or that we are making assumptions about or over-focusing on without our knowing or recognizing it. And it just doesn’t have to be when we are at a major decision point such as a placement change or removal. When people practice in facilitated discussion, it can begin to change their thinking processes and they become better at looking at all perspectives.

This facilitated discussion guide is designed for use in facilitating peer-to-peer discussion in three separate phases. The phases include Case Presentation, Desired Outcomes and Action Planning. Included are the following:

Facilitated Discussion: Guiding Questions is a list of suggested questions that can be considered during each phase of the meeting; and

Facilitated Discussion: Information Gathering Worksheet is a tool for organizing information discussed as it relates to the Six Domains.

The first phase, **Case Presentation**, is the child welfare professional’s opportunity to present the family’s story to his/her peers. Information presented during this phase should be comprehensive and should include information such as, what led to this case being presented in a peer-to-peer forum, current goals and engagement efforts, teaming, strengths, barriers, etc... Additionally, peers should be given the opportunity to ask clarifying questions.

During the second phase, **Desired Outcomes**, the discussion should focus on the current case goals. They should be viewed from the perspective of whether they are the right goals to address the identified underlying issues. This also requires the group to consider whether other underlying issues exist, but have not yet been identified. Further assessments may be warranted and should be discussed in the third phase, which is Action Planning.

During the third phase, **Action Planning**, the discussion should focus on next steps. It is important to remember that while goals may be identified during this discussion, it does not replace the family service planning process in which family engagement is paramount. The group should develop recommendations to improve engagement efforts, planning and service provision to provide the family with the highest possible level of service.

The **Facilitated Discussion: Information Gathering Worksheet** is included to assist the group in recording pertinent information as it relates to the Six Domains. While the process of facilitated discussion is not prescriptive or overly structured, it is still important to be able to track the discussion in an organized manner. Prior to the Facilitated Discussion, a member of the group should be identified to record information on the worksheet. This member's role will be to follow the discussion with the Six Domains in mind, and record pertinent information as it is presented. This worksheet is intended to serve as a supplement to the Facilitated Discussion, not as an agenda.

Once completing the peer-to-peer discussion, caseworkers should meet with their supervisor to discuss recommendations and next steps.

Presentation

- What goals are you currently working toward?
    - Why have those goals been chosen?
- What resources/supports have you made use of?
    - Have they been successful?
        - If no, what does the family feel is inhibiting their ability to achieve the goals?
        - What do you think is inhibiting the family's ability to achieve the goals?
- Describe what the family has done to address and resolve obstacles in the past?
- Describe how the family views their progress.
- Describe how the family views CYS.
- Describe where you believe this family is in the stages of change.
- Describe your relationship with the family.
    - What efforts have been made to engage the family?
- Describe the make-up of the team and how it functions.
    - Who will be present to support the family once formal services have ended?
    - Is anyone not on the team that should be?
- Describe what barriers prevent these goals from being accomplished.
- What do you need to know that you do not know?

Desired Outcomes

- Describe the underlying issues you have identified.
- What goals need to be met to address the underlying issues?
    - Based on the identified underlying issues, are these goals appropriate?
    - Will the achievement of these goals allow for safe case closure?
- Describe the family's level of investment in achieving those goals.
    - What was the family's role in creating those goals?

Action Planning

- Based on the discussion that has taken place thus far, what are recommendations for next steps? Areas to consider include:
    - Engagement efforts;
    - Goals;
    - Resources and supports;
    - Teaming; and
    - Additional assessments to accurately identify underlying issues.

	Type of Maltreatment	Nature of Maltreatment	Child Functioning	Adult Functioning	Parenting Discipline	General Parenting
Case Presentation • What is happening now? • Strengths • Concerns						
Desired Outcomes • Where do we want to be?						
Action Planning • What do we do next?						

XII. Conclusion

Child welfare professionals have a difficult job. Supervisors and caseworkers provide the same feedback when it comes to paperwork, they are feeling overwhelmed. Feeling this way may cause many child welfare professionals to be reluctant or apprehensive towards implementing the use of the screening tools, provided in this Toolkit, into their day-to-day practice. It is important to remember, however, that the use of the screening/assessment tools does not actually result in an increase in paperwork. These tools are to be used in the field while the caseworker is meeting with the family. The tools can be discussed/administered with the family member directly or when the caseworker is meeting with another family member. In fact, there actually might be a slight decrease in the amount of overall paperwork due to some of the questions contained in the tool being similar to those that caseworkers would typically ask and document in their structured case note. These tools are intended to enhance caseworkers' abilities to identify underlying issues in a family and at times, improve upon the critical thinking skills of caseworkers.

The Matrix, provided in the Toolkit, also does not result in an increase in paperwork and is intended to improve upon the critical thinking skills of caseworkers in helping to identify the underlying issues in a family. The peer-to-peer facilitated discussion guide, provided in the Toolkit, allows a group of child welfare professionals to come together and critically examine the possible underlying issues involving a family. The Toolkit was created with the intent to serve as an invaluable aid to child welfare professionals in their on-going assessments of families involved in the child welfare system. The

creators of the toolkit truly believe that both families and child welfare professionals can benefit from the use of the Toolkit when it is applied to service planning. We strongly encourage all child welfare professionals to the items contained in this toolkit in their day-to-day practice, and experience for themselves the benefits from using it.

XIII. References

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