TI-MHAP

TRAUMA-INFORMED MENTAL HEALTH ASSESSMENT PROCESS

CASAT
California Screening, Assessment, and Treatment

Rady Children's San Diego | **Chadwick Center** for Children & Families

resource guide

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Many children experience traumatic events. Some of these experiences happen once in a child's lifetime, whereas others are re-occurring. Not all children (or adults) respond to traumatizing experiences in the same way. It is important therefore to determine whether or not an event was experienced as traumatizing by the child involved. Screening for potentially traumatic events or trauma symptoms should be an important first step in both Child Welfare and Behavioral Health systems. When a child has screened for a potentially traumatizing event or symptom, the next step is a thorough, trauma-informed assessment. The Trauma-Informed Mental Health Assessment Process (TI-MHAP) involves gaining a thorough understanding of a child and their family and social environment with an ultimate goal of helping the child resolve issues surrounding a potentially traumatic event(s). TI-MHAP utilizes standardized assessment measures and assessment-based treatment to help guide the decisions made throughout the course of treatment for any individual child, regardless of age. This allows for decisions regarding assessment and treatment interventions to be tailored to the individual needs of each child receiving services through this process.

TI-MHAP operates with the understanding that every child comes to treatment with a unique history, a unique family system, and a unique level of developmental, cognitive, and emotional functioning. Cultural factors at the child-, family-, and community-level also must be considered. Understanding the child through the use of a comprehensive evaluation that incorporates a clinical interview, observation, and standardized assessment measures is the first step in effectively treating the child. This solid understanding becomes the basis for identifying an effective, individualized treatment intervention for the child. The result is a more individually designed approach to the child's healing.
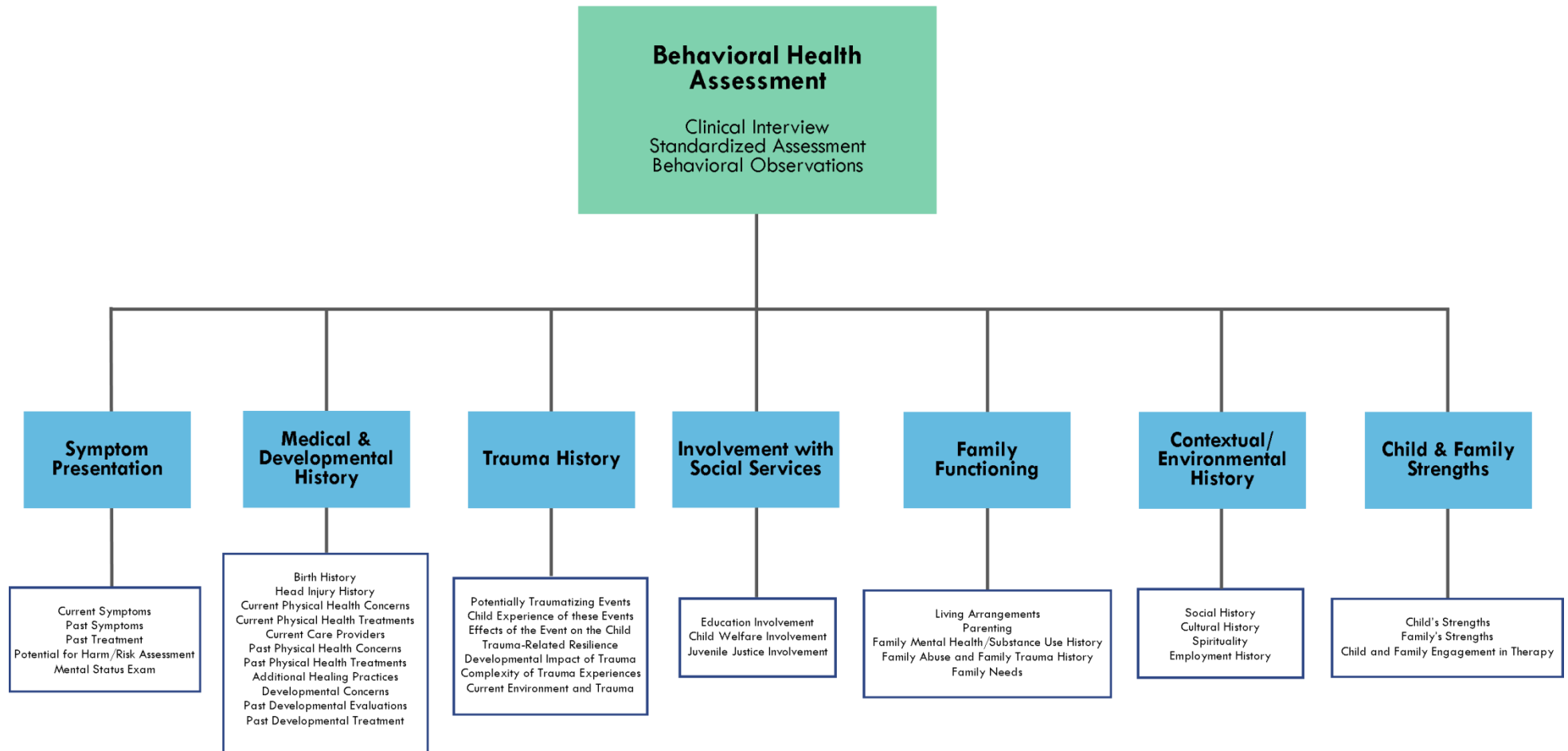
When it has been determined that events experienced by the child were indeed traumatizing, trauma resolution needs to be a central goal of treatment. Trauma resolution involves not only making sense of the traumatic event, but also helping a child learn to regulate their emotions, working with the family to establish a safe environment, and enhancing the child's resiliency and social supports (Cook et al., 2003). Because many of these goals relate to the child's environment, it is important, whenever possible, to engage the family or other supportive individuals in the child's life and teach them how to support the child through the therapeutic process.

This document provides an overview of the TI-MHAP assessment phase, so that communities and agencies can decide how to best incorporate it into their own practices. The TI-MHAP Principles (Table 1) outline the basic tenets that underlie the entire process and clarify how the components fit together.

table 1

Trauma-Informed Mental Health Assessment Process (TI-MHAP) Principles

1. TI-MHAP will be **flexible** to account for the varying strengths, needs, and challenges across diverse providers.
   a. TI-MHAP will build off of existing assessment practices.

2. TI-MHAP will be **applicable to children and families** involved in mental health services, including those involved in the child welfare system.

3. TI-MHAP will assist in **engaging children and families** in mental health services.

4. TI-MHAP will provide a **structure** for clinicians to gather all critical assessment information, including trauma and behavioral health needs.
   a. A **core set of domains** should be examined in every assessment - refer to Unique Client Picture (Figure 1).

5. TI-MHAP will include the **use of research-supported measures** to assess for trauma and behavioral health needs.
   a. These will consist of core measure(s) for all children and additional measures to address client-specific concerns.

6. TI-MHAP will suggest guidelines that help the clinician **make sense of assessment information.**

7. The results of the assessment phase of TI-MHAP should be clearly linked to **treatment planning** and the **use of appropriate practices.**
   a. Practices should be evidence-based or evidence-informed whenever possible.

8. TI-MHAP will help clinicians **provide meaningful and timely assessment feedback** to clients.

9. **Training** on TI-MHAP must be provided to both mental health **clinicians and supervisors**, including its use for **engagement and treatment planning.**
   a. It should include initial training, booster/ongoing training, clinical supervision, and ongoing coaching/support.

10. TI-MHAP will enable clinicians to **monitor individual client change over time** through periodic re-assessment.

11. TI-MHAP will enable administrators to **monitor aggregate or system-level data.**

figure 1

Unique Client Picture

Behavioral Health Assessment

Clinical Interview
Standardized Assessment
Behavioral Observations

Symptom Presentation	Medical & Developmental History	Trauma History	Involvement with Social Services	Family Functioning	Contextual/ Environmental History	Child & Family Strengths

Symptom Presentation
Current Symptoms
Past Symptoms
Past Treatment
Potential for Harm/Risk Assessment
Mental Status Exam

Medical & Developmental History
Birth History
Head Injury History
Current Physical Health Concerns
Current Physical Health Treatments
Current Care Providers
Past Physical Health Concerns
Past Physical Health Treatments
Additional Healing Practices
Developmental Concerns
Past Developmental Evaluations
Past Developmental Treatment

Trauma History
Potentially Traumatizing Events
Child Experience of these Events
Effects of the Event on the Child
Trauma-Related Resilience
Developmental Impact of Trauma
Complexity of Trauma Experiences
Current Environment and Trauma

Involvement with Social Services
Education Involvement
Child Welfare Involvement
Juvenile Justice Involvement

Family Functioning
Living Arrangements
Parenting
Family Mental Health/Substance Use History
Family Abuse and Family Trauma History
Family Needs

Contextual/ Environmental History
Social History
Cultural History
Spirituality
Employment History

Child & Family Strengths
Child's Strengths
Family's Strengths
Child and Family Engagement in Therapy

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The clinical assessment delves into a client's past and current experiences; psychosocial and cultural history; and strengths and resources. TI-MHAP has a core set of domains that should be assessed for every client. Information is provided on these domains in summary form in the table below and in detailed form in Appendix A. Many of these domains are likely to be addressed in a typical mental health assessment, however, TI-MHAP's domains are typically more comprehensive and must all be addressed as part of the TI-MHAP assessment phase.

Summary: Trauma-Informed Mental Health Assessment Protocol (TI-MHAP) Domains for the Unique Client Picture
Symptom Presentation
o   Current Symptoms (Mental Health, Substance-Related, or Both)
o   Past Symptoms (Mental Health, Substance-Related, or Both)
o   Past Treatment (Mental Health, Substance-Related, or Both)
o   Potential for Harm/Risk Assessment
o   Mental Status Exam
Developmental and Medical History
o   Developmental History
o   Transition to Adulthood
o   Medical History
Trauma History
o   Potentially Traumatizing Events
o   Child's Experience of these Events
o   Effects of the Event on the Child
o   Trauma-Related Resilience
o   Developmental Impact of Trauma
o   Complexity of Trauma Experiences
o   Current Environment and Trauma
Involvement with Social Services
o   Education Involvement
o   Child Welfare Involvement
o   Juvenile Justice Involvement
Family Functioning
o   Living Arrangements
o   Parenting
o   Family's Mental Health/Substance Use History
o   Family's Abuse and Trauma History
o   Family's Needs
Contextual/Environmental History
o   Social History
o   Cultural History

○ Spirituality
○ Employment History
○ Sexual Health
<u>Child's and Family's Strengths</u>
○ Child's Strengths
○ Family's Strengths
○ Child's and Family's Engagement in Therapy

Materials to provide assistance with assessment of sexual health and trauma, two areas that can be problematic or difficult for clinicians to assess, are included as handouts in Appendices B and C. These materials give examples of probes to use for these domains, and guidance on how to respond to client disclosures.

Clinical assessment can be visualized as a three-legged stool with the clinical interview, behavioral observations, and standardized measures being the legs.

Clinical Interview and Behavioral Observation

As part of the TI-MHAP assessment phase, the clinical interview should be consistent across all providers, so that every client receives the same level of assessment regardless of which specific provider or agency is completing the assessment. In most cases, a standard clinical intake interview/assessment form is used to ensure this consistency. A sample intake interview form that shows how one agency has operationalized the TI-MHAP domains is included in Appendix D. It is not intended that this measure be used in its entirety. In most cases, agencies are best starting with the assessment forms that they currently use and making adjustments to meet the TI-MHAP recommendations, rather than implementing an entirely new form.

TI-MHAP does not have a standardized approach to behavioral observation though it is expected that clinician observe their client's behaviors as part of the clinical assessment.

Standardized Measures

As mentioned before, standardized measures are one of the three legs on the stool of assessment and complement the clinical interview and behavioral observation. The goal of utilizing standardized measures is to help clinicians identify the client's strengths and difficulties at intake and monitor the client's progress through the administration of a reliable and valid tool at multiple time points. Similar to the clinical assessment, as a part of TI-MHAP, the core standardized measure(s) should be consistent across all providers as client age dictates, so that the information obtained from/about clients of the same age is consistent regardless of the specific provider of services.

Standardized measures enable the provider to obtain information directly from the youth, caregiver, and other important partners in order to provide a comprehensive picture of the client

and family. Self-administered measures, such as paper questionnaires, may provide information that is not easily disclosed or obtained during a clinical interview, and allow the clinician to collect relevant information from external partners, such as teachers, with a decreased time burden. The information gained by utilizing standardized measures helps guide treatment goals and the selection of appropriate interventions. Standardized measures also aid in assessing changes in symptoms over time as well as monitoring treatment progress of the clients. *Enhancing Mental Health Treatment through Measurement* (found in Appendix E) provides a suggested list of steps to follow when adding measurement tools to an agency's assessment and treatment program.

When selecting standardized measures, the agency or provider should make sure that the features of each of the possible measures are considered and compared. Factors such as the length of time it takes to complete and score the measure, the cost to purchase the measure, the available translations, and cultural appropriateness of the measure are all important to determining how a measure will work within the organization. In addition, factors such as the informants who complete the measure, the age range covered by the measure, the types of scores provided, and the psychometric support for the measure (e.g., reliability, validity, etc.) should be considered. A list of potential standardized measures for use in children's mental health settings, along with a brief description and basic descriptors of each measure are included in Appendix F.

Finally, it is important that measures allow for quick scoring and timely feedback to clinicians and families, while providing both client and agency level information. An agency must determine whether measures will be administered on paper or electronically, and how the measure will be scored. Their existing Electronic Health Record system may support these functions, or it may be necessary to establish an external system to score and track the results of standardized measures. Some of the measures in Appendix F have electronic scoring systems available for purchase.

Case Conceptualization

Once a clinician has completed the clinical interview, utilized behavior observation to gain additional information about a specific client, and incorporated information from standardized measures, conceptualization of all of the information into a treatment plan that is targeted towards meeting the needs of the client can take place. Case conceptualization involves summarizing diverse information about a client from multiple sources in a brief and coherent manner in order to gain a better understanding of what strategies to use to best treat the client. Clinical case conceptualization provides information that communicates the treatment plan along with the rationale and justification for that plan. The conceptualization process is how the therapists will work with the client to achieve the goals of treatment and resolve the problem.

Through the conceptualization process, the provider will be able to identify the problem areas, guide treatment planning, evaluate whether progress is actually occurring, and provide criteria for termination of therapy. Outcome goals should be directly related to client needs and consistent with client values.

A sample behavioral health case conceptualization and treatment form is included in Appendix G. This form provides examples of domains that are often assessed during the conceptualization process. By utilizing this form, or something similar that their agency has developed, providers will be able to develop a treatment plan that meets the needs of their clients.

Client Feedback

A vitally important and sometimes overlooked component of the assessment process is the feedback to the client (and/or client's caregiver). A separate time should be set up to review all the measures given and describe how they fit into the case conceptualization. This conversation can enhance engagement and affords the client and/or client's caregiver the opportunity to ask questions and challenge clinical assumptions. They are more committed to the treatment when they have been an active part of the entire assessment process. This conversation also helps to strengthen their willingness to complete future assessment measures because they have a fuller understanding of the importance and significance of this process. Overall, the discussion should be geared toward the age and developmental level of the client and can be expanded or contracted depending on the child's and caregiver's level of interest in the feedback.

Scripts for and video examples of client feedback discussions are available at
http://www.taptraining.net/TapTraining/Section2/AssessmentP30.htm

Please note that Critical items, such as suicidality, harm to others, etc., should be addressed immediately with a risk assessment and safety plan as necessary and not held for the client feedback session.

Clinical Assessment and Beyond

While this resource guide is meant to provide only an overview of the assessment phase of the Trauma-Informed Mental Health Assessment Process (TI-MHAP), it is important to realize that TI-MHAP includes clinical re-assessment on a periodic basis throughout the treatment process including, ideally, an assessment at termination of services. Therefore, the assessment phase is also a part of the treatment phase. It is hoped that this guide has offered a sufficient overview of the assessment phase of TI-MHAP and assists communities and agencies in constructing a vision of how TI-MHAP principles and procedures can be incorporated into their own practices if they wish to move forward with the model.

The tools and resources in the Appendices are examples of how to use the TI-MHAP principles in practice, and are not intended to be adopted verbatim. Each community should examine their existing practices and determine what adaptations, if any, are need to make their assessment process more trauma-informed.

Detailed: TI-MHAP Domains for Developing a Unique Client Picture

Symptom Presentation

- o Current Symptoms (Mental Health, Substance-Related, or Both)
  - Frequency/Intensity/Duration
  - Level of Impairment
  - Course of Current Symptoms
    - Most Recent Baseline
    - Time/Age of Onset
    - Precipitating Events
- o Past Symptoms (Mental Health, Substance-Related, or Both)
  - Frequency/Intensity/Duration
  - Level of Impairment
  - Course of Past Symptoms
    - Time/Age of Onset
    - Precipitating Events
    - Period(s) of Remission
    - Reasons for Remission (Strengths)
- o Past Treatment (Mental Health, Substance-Related, or Both)
  - Psychotherapy
    - Location
    - Period(s) of Treatment
    - Type (Family, Individual, Substance-focused, Cognitive-Behavioral Therapy [CBT], Narrative, etc.)
    - Treatment Effectiveness
      - o Obstacles/Barriers
      - o Successes/Progress
  - Psychiatric
    - Location
    - Period(s) of Treatment
    - Type (Dosage/Frequency)
    - Treatment Adherence/Engagement
      - o Obstacles/Barriers
      - o Successes/Progress
  - Family/Parenting Interventions
    - Type/Duration/Results

- Community/Social Interventions
  - Type/Duration/Results
- Potential for Harm/Risk Assessment
  - Suicidal Intent/Homicidal Intent
  - History of Sexual Offending
  - Auditory Hallucinations/ Visual Hallucinations/ Delusions
  - Mania/Severe Depression
  - DV, Abuse, Eminent Risk of Violence in Home
- Mental Status Exam

Developmental and Medical History

- Developmental History
  - Birth History
    - Complications/Concern(s)
    - Exposure to Teratogens (substances that can cause birth defects)
  - Developmental Concerns (Past/Current)
    - Area (Social, Physical, Cognitive, etc.)
    - Age of Onset
    - Symptoms
      - Frequency/Intensity/Duration
      - Concerns with Relationships/Attachments
      - Level of Impairment
  - Developmental Evaluation History
    - Location/Evaluator
    - Age
    - Type
    - Results/Outcome
  - Developmental Treatment History
    - Location
    - Period(s) of Treatment
    - Type (Family, Individual, Substance-Focused, CBT, Narrative, etc.)
    - Treatment Adherence/Engagement
      - Obstacles/Barriers
      - Successes/Progress
- Transition to Adulthood
  - Basic Needs (Food, Clothing, Shelter)
  - Emotional-Behavioral/Psychiatric
  - Access to Health Care
  - Employment/Education
  - Social Support

- o Medical History
  - ■ Current Primary Care Physician
    - • Most Recent Exam
    - • Most Recent Vision/Hearing Exam
  - ■ Current Dentist
    - • Most Recent Exam
  - ■ Current Physical Health Concerns/Issues
    - • Medical/Adaptive Devices
  - ■ Head Injury History
    - • Age
    - • Precipitating Events
    - • Treatment
    - • Impairment
  - ■ Current Medications
    - • Treating Physician
    - • Targeted Illness/Symptoms
    - • Period(s) of Treatment
    - • Type (Dosage/Frequency)
    - • Treatment Adherence/Engagement
  - ■ Vitamins or Additional Healing Practices

Trauma History
- o Potentially Traumatizing Events
  - ■ Frequency/Intensity/Duration
  - ■ Chronic/Episodic
  - ■ Time/Age of Onset
  - ■ Precipitating Events
- o Child's Experience of these Events
  - ■ Reactions Around Time of Event(s)
- o Effects of the Event on the Child
  - ■ Posttraumatic Stress
    - • Intrusive Thoughts Memories
    - • Avoidance Behaviors
    - • Negative Changes in Thoughts and Mood
    - • Changes in Arousal and Reactivity
  - ■ Other Symptoms Possibly Connected to Trauma
    - • Comorbidity and Complex Reactions
  - ■ Triggers and History of Re-experiencing
- o Trauma-Related Resilience

- Developmental Impact of Trauma
- Complexity of Trauma Experiences
- Current Environment and Trauma
  - How it Supports the Child
  - How it Creates Additional Stress
  - Caregiver(s)' Reactions, Involvement, and Trauma History
  - Sibling(s)' Reactions, Involvement, and Trauma History
  - Extended Family's or Acquaintances' Reactions, Involvement, and Trauma History
  - Cultural/Spiritual-Related Attitudes, Messages, Connections with Trauma History
  - Impact of Trauma
    - Contact with Others Involved in Trauma
    - Current Status of Investigation/Case (if applicable)
    - Current Safety Concerns
    - Changes in Placement

Involvement with Social Services

- Education Involvement
  - Current Education Type/Location
  - Last Grade Completed
  - Concerns (Past/Current)
    - Age of Onset
    - Symptoms
      - Frequency/Intensity/Duration
      - Level of Impairment
  - Strengths (Past/Current)
    - Source
    - Impact on Performance
    - Examples
  - Individualized Education Plan
  - Special Education/Support Programs
- Child Welfare Involvement
  - Past and Current
    - Custody Changes/Foster Care Placement
      - Age of Child/Reason/Course
        - How many moves
        - Visitation Process
      - Impact on Child
        - Child's Relationship with Caregivers/Parents (Past/Current)
        - Changes in Social Networks
        - Child's Interactions with Community

- - - Cultural Considerations
    - Reunification or Adoption Process/Plans
  - Placement Preference
  - Permanency Plan
- Juvenile Justice Involvement
  - Past and Current
    - History of Violence
    - History of Arrests
    - History of Incarceration
    - History and Current Status of Probation

Family Functioning

- Living Arrangements
- Parenting
  - Style/Approach
  - Attachment
  - Stress
- Family's Mental Health/Substance Use History
  - Past/Current Symptoms
    - Emotional/Mental Health, Developmental Delays, Arrests, Suicidal/Homicidal Thoughts/Attempts, Substance Use, Other Addictions
  - Immediate Family Members
    - Frequency/Intensity/Duration
    - Level of Impairment
    - Course of Symptoms
      - Time/Age of Onset
      - Precipitating Causes/Events
- Family's Abuse and Trauma History
  - Past/Current Symptoms
  - Precipitating Events/Experiences
  - Immediate Family Members
    - Frequency/Intensity/Duration
    - Level of Impairment
    - Course of Symptoms
      - Time/Age of Onset
    - Potential for Harm/Risk Assessment
  - Past/Current Relationship with Child
- Family's Needs
  - Basic Needs (Food, Clothing, Shelter)
  - Emotional-Behavioral/Psychiatric

- Family Stress/Cohesion
- Financial
- Access to Health Care
- Legal Involvement
- Employment/Education
- Immigration/Citizenship
- Language
- Spiritual

Contextual/Environment History

- Social History
  - Number of Close Friends (School-Based/Other)
  - Experiences with Bullying
  - Experiences with Gangs
  - Experiences with Peer Substance Use
  - Concerns (Past/Current)
    - Age of Onset
    - Symptoms
      - Frequency/Intensity/Duration
      - Level of Impairment
  - Strengths (Past/Current)
    - Source
    - Impact on Performance
    - Examples
- Cultural History
  - Identity
  - Family's Cultural History
    - Identity
    - Immigration History
    - Acculturation
    - Language
  - Influences on Functioning/Symptoms
  - Influences on Strengths
    - Impact on Performance
    - Examples
- Spirituality
  - Identity
  - Family's Spiritual History
    - Affiliation

- Role in Family
  - Influences on Functioning/Symptoms
  - Influences on Strengths
    - Impact on Performance
    - Examples
- Employment History (Voluntary/Paid)
- Sexual Health
  - Development
  - Concerns (Past/Current)
    - Age of Onset
    - Symptoms
      - Frequency/Intensity/Duration
      - Level of Impairment
  - Strengths (Past/Current)
    - Source
    - Impact on Performance
    - Examples

Child's and Family's Strengths

- Child's Strengths
  - Top Strengths
  - How Developed
  - How Helped in Past/Currently
    - Examples of Strengths in Action
  - How Might They Impact Child in the Future (Functioning and Resilience)
  - What Strengths Would the Child Like to Have or Are Currently Working On
- Family's Strengths
  - Top Strengths
  - How Developed
  - How Helped in Past/Currently
    - Examples of Strengths in Action
  - How Might they Impact Family in the Future (Functioning and Resilience)
  - What Strengths would the Family Like to Have or Are Currently Working On
- Child's and Family's Engagement in Therapy
  - Past Experiences with Therapy/Therapists
  - Experiences with Referral Process
  - Primary Concerns/Potential Barriers
    - Potential Solutions for Primary Concerns/Potential Barriers
  - Current Expectations and Goals for Therapy

Sexual Health Assessment

Sexual Health can be difficult for clinicians to discuss with clients, but is an important part of the assessment process, especially for adolescent clients. Below are some question prompts that have been identified as helpful in encouraging discussion in this area.

Stages of Development

- Do you have any questions or concerns about your looks or appearance?
- Do you have any questions or concerns about your sexual development?

Gender Identity

When a person's sex and gender do not match, they might think of themselves as transgender. Sex is determined at birth based on anatomy. Gender is how a person feels.

Which one response best describes you?
- I am not transgender
- I am transgender and identify as a boy or man
- I am transgender and identify as a girl or woman
- I am transgender and identify in some other way

Sexual Orientation/Sexual Attraction

Teens often explore new relationships:

- Do you have a crush on anyone?
- Are you dating or seeing anyone?
- Are you attracted to guys, girls, those who are gender nonconforming, or any/all of the above?

Sexual Activity

- For many teens, relationships are really important. Sometimes sexuality is too. Is your sexual health an important topic to you?   How?
- Follow-Up Questions:
    - Are you comfortable talking about your sexual health?

- o   If so, who can you talk to about your sexual health?

- Sexual health is an important part of everyone's development and overall health. Would it be ok with you if I asked you a few more questions about your sexual health?
  - o   If yes:
    - Have you ever had sexual experience with someone else?
    - How old were you the first time you had sex?
    - Do you have sex with guys, girls, those who are gender nonconforming, or any/all of the above?
    - How often do you have sex?
    - How many people have you had sex with in the last 3 months?
    - In your life?

Sexual Experience

For some people, sex is generally a fun experience; for others, it is not all that fun and may even hurt most of the time.

- What is usually your experience with sex?
- Has there ever been a time that you had sex but didn't want to?
- Have you ever had sex when you were high on drugs or alcohol?
- Have you ever been hurt in a sexual way or forced to have sex when you didn't want to?
- Have you ever traded sex for money, drugs, a place to stay or other things that you need?
- Do you feel safe in your relationships?
- Who do you talk to about sex?

Sexually Transmitted Infections (STIs)

- Have you or your partner ever been tested for sexually transmitted infections (STIs) or HIV? Had an STI?
- What questions do you have about STIs and HIV?
- Are you doing anything to protect yourself against STIs/HIV and pregnancy?
- What are you doing?

Trauma Assessment

A significant number of children are exposed to traumatic life events. A traumatic event is one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs. Traumatic events include sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters, suicides, and other traumatic losses. It is more common than not for children and adolescents to be exposed to more than a single traumatic event. Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. When children, adolescents, and families come to the attention of helping professionals, the identified trauma may not be the one that is most distressing to the child. For this reason, gathering a thorough, detailed history of traumatic exposure is essential.[1]

One of the fundamental characteristics that many people experience who have dealt with a traumatic event is a strong need for a sense of physical and emotional safety. It is important when assessing children for trauma that the clinician try to maximize the amount of control that the child has in the situation. This can be achieved at a very basic level by informing the child how long the assessment will last and informing the child that they can choose to not answer any question that is asked of them. In order to maximize the sense of safety and trust, it is highly recommended that the assessment begin with general questions that may not elicit feelings of fear or anxiety (e.g., "What school do you go to?" "What activities do you like to participate in?") Once some rapport is established, more specific trauma-related questions should be asked.

Below are some question prompts that have been identified as helpful in encouraging discussion in this area.

For Youth:

- Have you ever been pushed or slapped by a parent or other adult?
- Has anyone ever touched your penis, vagina, breast, or buttocks without your permission?
- Have you ever seen your parents or caregivers physically hurt one another?
- Has anything ever happened to you that caused you to feel physically or emotionally unsafe?

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[1] Excerpt from the APA Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. (2008). *Children and Trauma: Update for Mental Health Professionals.* Retrieved from the American Psychological Association's website: http://www.apa.org/pi/families/resources/update.pdf

- Do you ever have bad dreams, nightmares or other intrusive thoughts about something that happened to you?

For Parents:

- To your knowledge, has your child ever experienced physical, sexual or emotional abuse by anyone?
- Has your child ever been involved in a serious accident?
- Has your child ever been exposed to family or community violence of any sort?

appendix d

Sample Intake Assessment Form

CHILDREN'S ASSESSMENT

Triage Level:	Refer To:
☐ I	☐ MD
☐ II	☐ PhD
☐ III	☐ Case Staffing

Consumer Name:

Record/ID #:

Date of Birth:_____ **Age:**_____ **Ethnicity:** _____ **Preferred Language:**_____

BIOLOGICAL PARENT(S): ———————————————— Relationship: ———————————— Phone: ——————

Address: City: State: Zip:

PRIMARY CAREGIVER(S): ———————————————— Relationship: ———————————— Phone: ——————

Address: City: State: Zip:

Restrictions on Parental rights:

Parental rights held:

Additional siblings / notes (include birth order if known):
Residential information (whom the child resides, how long, age, length and time at residents) share room with whom?

Comments:

Language spoken at home assessment:	Interpreter: ☐ Yes ☐ No If yes then who?

Referral and sources of information:
(School, Family, Self, Relative, Primary Care, Family Resource Center, Probation, CWS, AOD,)

Date of Referral: _____

Reason for referral:
(_____)

Primary Concerns/Target Symptoms: (User's / Caregiver's words when possible.)

(frequency, duration, level of impairment, most recent baseline, time/age of onset, precipitating events, and intensity of presenting symptoms)

22 a

SYMPTOM CHECKLIST

Check the "Ever" box if symptom was ever Present.
Also check the "6 months" box if symptom was present in the past 6 months.

	Ever	6 months		Ever	6 months	
DEPRESSION ☐ Yes ☐ No	☐	☐	Depressed mood	☐	☐	Suicidal behavior
	☐	☐	Tearful	☐	☐	Irritable, easily annoyed
	☐	☐	Loss of interest of pleasure	☐	☐	Often feels angry
	☐	☐	Isolative or withdrawn	☐	☐	Homicidal ideation
	☐	☐	Hopeless and/or helpless	☐	☐	Over-reactive (quick to anger)
	☐	☐	Fatigue	☐	☐	Excessively happy or silly
	☐	☐	Worthlessness, shame or guilt	☐	☐	Labile (sudden mood shifts)
	☐	☐	Bored	☐	☐	Distinct mood cycles
	☐	☐	Thoughts of non-suicidal self-harm	☐	☐	Episodes of excess energy, insomnia, and euphoria or rage
	☐	☐	Non-suicidal self-harm	☐	☐	euphoria or rage
	☐	☐	Suicidal thoughts	☐	☐	Other (describe below)

	Ever	6 months		Ever	6 months	
ANXIETY ☐ Yes ☐ No	☐	☐	Anxious mood	☐	☐	Avoids talk or reminders of trauma
	☐	☐	Separation anxiety	☐	☐	Hyper-vigilance or excessive startle
	☐	☐	Feels tense or stressed	☐	☐	Panic attacks
	☐	☐	Excessive worry	☐	☐	Agoraphobia
	☐	☐	Fears or phobias	☐	☐	Dissociation
	☐	☐	Intrusive memories	☐	☐	Obsessions or compulsions
	☐	☐	Flashbacks (trauma re-experience)	☐	☐	Other (describe below)

	Ever	6 months		Ever	6 months	
SLEEP, APPETITE AND ELIMINATION ☐ Yes ☐ No	☐	☐	Initial insomnia	☐	☐	Poor appetite
	☐	☐	Middle insomnia	☐	☐	Rapid weight gain
	☐	☐	Late insomnia	☐	☐	Weight loss (unintentional)
	☐	☐	Sleeps excessively	☐	☐	Excessive weight loss (intentional)
	☐	☐	Nighttime fears	☐	☐	Bed wetting
	☐	☐	Frequent nightmares	☐	☐	Daytime enuresis
	☐	☐	Night terrors	☐	☐	Encopresis
	☐	☐	Excessive appetite	☐	☐	Other (describe below)

	Ever	6 months		Ever	6 months	
THOUGHT AND PRECEPTION ☐ Yes ☐ No	☐	☐	Difficulty concentrating	☐	☐	Visual hallucinations
	☐	☐	Disorganized thought process	☐	☐	Other hallucinations
	☐	☐	Delusions	☐	☐	Perceptual distortions other than hallucinations
	☐	☐	Auditory hallucinations	☐	☐	Bizarre behavior
	☐	☐	Irrational or odd but not delusional thoughts (e.g., of persecution)	☐	☐	Other (describe below)

ACTIVITY, ATTENTION & IMPULSE	Ever	6 months			Ever	6 months	
	☐	☐	Overactive or fidgety		☐	☐	Difficulty completing tasks
	☐	☐	Slowed or lethargic		☐	☐	Talks excessively
☐ Yes ☐ No	☐	☐	Short attention span		☐	☐	Impulsive (act without thinking)
	☐	☐	Easily distracted		☐	☐	Other (describe below)

CONDUCT	Ever	6 months			Ever	6 months	
	☐	☐	Defiant, uncooperative, oppositional		☐	☐	Threatens, bullies, or intimidates
	☐	☐	Frequent lying		☐	☐	Runaways
	☐	☐	Blames others for own misbehavior		☐	☐	Cruel to animals
	☐	☐	Controlling, bossy, or manipulative		☐	☐	Truancy
☐ Yes ☐ No	☐	☐	Breaks rules		☐	☐	Breaking into car or building
	☐	☐	Provokes		☐	☐	Stealing
	☐	☐	Property destruction		☐	☐	Vandalism, tagging/graffiti
	☐	☐	Physical aggression toward others		☐	☐	Gang involvement
	☐	☐	Impulsive, reactive aggression		☐	☐	Fire-setting
	☐	☐	Physical aggression toward others		☐	☐	Other (describe below)

ATTACHMENT	Ever	6 months			Ever	6 months	
	☐	☐	Poor eye contact		☐	☐	Physically intrusive
	☐	☐	Disinterest in relationships		☐	☐	Resistant to being touched
☐ Yes ☐ No	☐	☐	Difficulty making relationships		☐	☐	Overly attached to objects
	☐	☐	Clingy		☐	☐	Other (describe below)

SEXUAL BEHAVIOR PROBLEMS	Ever	6 months			Ever	6 months	
	☐	☐	Sexualized behavior		☐	☐	
	☐	☐	Inappropriate or high-risk sexual behavior		☐	☐	
☐ Yes ☐ No	☐	☐	Inappropriate sexual comments		☐	☐	
	☐	☐	Forced sexual contact - Perpetrator		☐	☐	Other (describe below)

NEURO-COGNITIVE	Ever	6 months			Ever	6 months	
	☐	☐	Low intellectual functioning		☐	☐	Motor delay
☐ Yes ☐ No	☐	☐	Learning disorder		☐	☐	Head injury
	☐	☐	Speech or language delay/disorder		☐	☐	Other (describe below)

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TRAUMA ☐ None

☐ Physical	☐ Sexual	☐ Emotional	☐ Neglect
☐ Domestic Violence	☐ Illness/medical trauma	☐ serious injury accident	☐ war/terrorism
☐ natural/manmade disasters	☐ kidnapping/trafficking	☐ traumatic grief/separation	☐ forced displacement
☐ community violence exposure	☐ school violence exposure	☐ extreme personal/ interpersonal trauma	☐ other trauma

☐ Suspected Child Abuse Report Filed?

What potentially traumatizing events have occurred?
(frequency/intensity/duration, chronic/episodic, time/age of onset, and precipitating events)

How did the child experience these events? (reactions around time of event(s))

What were the effects of the event on the child?

Post-Trauma: (intrusive thoughts/memories, avoidance behaviors, negative changes in arousal and reactivity, triggers and history of re-experiencing.)

RISK ASSESSMENT
Document special situations that present a risk to the child or others, Safety Concerns, and Safety Plan if Necessary.
(e.g. DV, Unsafe Home Environment)

CONSUMER'S MENTAL HEALTH HISTORY

☐ Yes

☐ No

☐ Unknown

Previous outpatient mental health services? When / Where?

_____

_____

"How has therapy gone for you in the past?"

_____

_____

Past Symptoms: _____

_____

☐ Yes	☐ No	Previous crisis contact in past 6 months?: Most recent date:_____ Number of Crisis Contacts_____
☐ Yes	☐ No	Previous psychiatric hospitalization? Most recent date: _____ Number of psychiatric hospitalizations in past 6 months:_____
☐ Yes	☐ No	Previous diagnosis (if yes, list in comments):
☐ Yes	☐ No	Use of traditional or alternative healing practices (describe with results, below):
☐ Yes	☐ No	Neurological Testing Date if known: Examiner if known:
☐ Yes	☐ No	Psychological Testing Date if known: Examiner if known:

Comments: Include earliest symptoms, age at onset, other support/stressors at time of onset, family understanding of problem, response to treatment.

SUBSTANCE USE/ABUSE

Answer the following questions about all current drug and alcohol use. List applicable drug(s) for items marked "Yes".

TYPE OF SUBSTANCE	Prenatal Exposure		Age At First Use	CURRENT SUBSTANCE USE							Last Date Of Use
	Yes	None/ Unknown		None/ Denies	Current Use	Current Abuse	Current Dependence	In Recovery	Consumer-Preceived Problem		
☐ Not Applicable (Comments required)											
☐ Alcohol	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Amphetamines (Speed/Uppers,Crank Ritalin	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Cocaine/Crack	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Opiates (Heroin, Opium,Methadone)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Hallucinogens (LSD,Mushrooms,Peyote, Ecstacy	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Sleeping Pills, Pain Killers, Valium, or Similar	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ PCP (Phencyclidine) or Designer Drugs (GHB)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Inhalants (Paint, Gas, Glue, Aerosols)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Marijuana/Hashish	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Methamphetamines (Meth)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Tobacco/Nicotine	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Caffeine (Energy drinks, Sodas, Coffee, Etc.)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Over the Counter: specify in comments Below (ie: diet pills, cough syrup)	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	
☐ Other Substance(s): specify in comments below	☐	☐		☐	☐	☐	☐	☐	☐ Yes	☐ No	

Does the child report receiving any alcohol and drug services: ☐ Yes, from this program   ☐ Yes, from a different program   ☐ No

Comment on any co-occurring substance abuse/use as they relate to mental health symptoms and behaviors.

MEDICAL HISTORY

☐ Unknown	☐ Not Available	**Current Primary Medical Care Provider:**		**Phone:**	

Last Physical Exam:		☐ Within Past 12 months	☐ More than 12 Months	☐ Unknown	☐ No- Explain below
Last Dental Exam:		☐ Within Past 12 months	☐ More than 12 Months	☐ Unknown	☐ No- Explain below
Are there any health concerns (medical illness, medical symptoms?		☐ Unknown / None Reported	☐ No	☐ Yes- Explain below	
Non-Medication Allergies (Food, Pollen, Bee sting, etc)		☐ Unknown / None Reported	☐ No	☐ Yes- Explain below	
Medication Allergies (list type)		☐ Unknown / None Reported	☐ No	☐ Yes- Explain below	

Has the child or caregiver reported any of the following problems/experiences? (check all that apply)

☐ Asthma	☐ Heart Problems	☐ Surgery of any kind. Explain below:
☐ Broken Bones	☐ High or Low Blood Pressure	☐ Thyroid Problem
☐ Convulsions or Seizure	☐ Immune System Problems	☐ Tuberculosis (TB)
☐ Diabetes	☐ Lever Problems or Hepatitis	☐ Obesity
☐ Exposure to Toxic Lead Levels	☐ Motor or Movement Problems	☐ Weight Gain or Loss. Explain below:
☐ Respiratory Problems	☐ Urinary Tract or Kidney Problems	☐ Eating Disorder
☐ Cancer	☐ Serious Rash or Other Skins Problem	☐ Appetite Changes
☐ Head injury	☐ Pregnancy	☐ Speech or Language Problems. Explain below:
☐ Hearing Problems	☐ Miscarriage	☐ Other
☐ Vision Problems	☐ Sexually Transmitted Disease (STD)	☐ Unknown
☐ Enuresis	☐ Encopresis	☐ Non/None Reported

Comments:

CURRENT MEDICATIONS

If known, include drug names, dosages, when prescribed, and who prescribed them.

Document any experienced side effects and/or compliance issues

Current medications including psychiatric, if known:

Past medications including psychiatric, if known:

Additional Comments:

☐ Yes ☐ No	**FAMILY MENTAL HEALTH HISTORY** (other potential contributing factors, relevant family history and history of mental health, describe which family members)

☐ Yes ☐ No	Psychiatric Treatment	
☐ Yes ☐ No	Mental health treatment	
☐ Yes ☐ No	Psychiatric medications?	
☐ Yes ☐ No	Suicide (completed or attempt) ?	
☐ Yes ☐ No	Mental health diagnosis/symptoms? (mood, anxiety, psychosis)	
☐ Yes ☐ No	Substance Use or Treatment?	
☐ Yes ☐ No	Trauma? (DV, sexual/physical/emotional abuse, military)	
	Other Comments:	

☐ Yes ☐ No	**DEVELOPMENTAL STATUS** (potential contributing factors due to child development milestones, attachment, pre/post-natal or childhood illnesses)

☐ Yes ☐ No	Pregnancy/Delivery Issues?	
☐ Yes ☐ No	Perinatal Issues? (Mood Anxiety Disorders, In utero drug exposure)	
☐ Yes ☐ No	Problems with Infancy/Toddlerhood?(walk, talk, smiling, potty training)	
☐ Yes ☐ No	Attachment Issues ?(describe the child's attachment hx)	
☐ Yes ☐ No	Major childhood illnesses?	
☐ Yes ☐ No	Puberty Issues?(menstrual cycle and mood regulation)	
	Other Comments:	

SOCIAL FACTORS

What social factors are impacting consumers functioning and treatment? (ie: bullying, social media, gang influence, video games, relationships)

CULTURAL FACTORS

What cultural factors are impacting consumers functioning and treatment? Include socio-economic, immigration, acculturation, spiritual values and beliefs.

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SEXUAL BACKGROUND
(Sexual Development/Sexual Orientation/Gender Identity)

How often does the family talk about issues around sexual health?

What is the families/youth's understanding or definition of sexual health?

MENTAL STATUS EXAMINATION
Note cultural and age factors for descriptors when applicable

						Describe:
APPEARANCE	☐ Older than stated ☐ Younger than stated ☐ Eccentric	☐ Meticulous ☐ Appropriate grooming/dress for age/culture		☐ Seductive ☐ Unique features ☐ Poor hygiene		
EYE CONTACT	☐ Good	☐ Fair		☐ Poor		
SPEECH	☐ Normal for age/ situation ☐ Soft ☐ Loud ☐ Overly talkative ☐ Brief responses	☐ Non-verbal ☐ Rapid ☐ Pressured ☐ Rambling ☐ Monotone		☐ Excessive Profanity ☐ Slurred ☐ Stammer/Stutter Vocal tic ☐ Other speech difficulty		
ATTITUDE	☐ Responsive ☐ Engaging ☐ Cooperative ☐ Uncooperative	☐ Superficial ☐ Guarded/Distant ☐ Provocative/Limit testing ☐ Manipulative/Deceitful		☐ Angry/hostile ☐ Shy/timid ☐ Dramatic ☐ Demanding/Insistent		
BEHAVIOR/MOTOR ACTIVITY	☐ Normal for age/ situation ☐ Slowed ☐ Overactive/restless	☐ Impulsive ☐ Agitated ☐ Unusual mannerism		☐ Tremor ☐ Other involuntary movement		
MOOD	☐ Happy ☐ Sad	☐ Irritable or Angry ☐ Bored		☐ Anxious ☐ Fearful		

AFFECT	☐	Euthymic (normal)	☐	Angry	☐	Labile (rapidly shifting)	
	☐	Sad	☐	Silly	☐	Flat blunted, constricted	
	☐	Tearful	☐	Anxious			
	☐	Overly happy	☐	Fearful	☐	Incongruent with topic or thoughts	
	☐	Irritable	☐	Bored			
PERCEPTIONS	☐	Normal	☐	Hallucinations ☐ Auditory ☐ Visual ☐ Other	☐	Other perceptual distortion	
THOUGHT FORM/PROCESS	☐ ☐	Linear and rational Racing	☐	Disorganized or Loose	☐	Pervasive	
THOUGHTS OF HARMING SELF OR OTHERS	☐	None	☐	Thoughts or intent of non-lethal self-injury	☐	Thoughts or intent of harming another person	
	☐	Suicidal ideation					
	☐	Plan			☐	Current homicidal ideation (Plan or any identified victims)	
	☐	Suicidal intent					
	☐	Access to means					
	☐	Previous attempts					
SENSORIUM	☐	Oriented to: Person	☐	Alertness: Alert	☐	Intellectual functioning: Average or higher	
	☐	Place	☐	Clouded/confused	☐	Below average	
	☐	Time	☐	Other			
	☐	Situation					
		Memory intact for:		Attention:		Insight/judgment:	
	☐	Immediate	☐	Good	☐	Good	
	☐	Recent	☐	Fair	☐	Fair	
	☐	Remote	☐	Poor	☐	Poor	

FUNCTIONAL IMPAIRMENT

Describe how symptoms are impacting the consumer's life (home, school, community, peer relationships)

School Information (ie: Discipline/IEP/SBC/Truancy/Grades)**:**

"What are your hopes and goals for therapy?"

FAMILY STRENGTHS AND RESOURCES

What natural support(s) does the family have to overcome barriers identified?
(Availability, Involvement, Financial Picture, Barriers to Treatment, and Other)

CONSUMER STRENGTHS AND RESOURCES

Describe all known consumer strengths and resources in achieving Consumer Plan goals.
(Interpersonal relationships, interests, academic, physical activity, employment, other skills interests and desires of child/youth)

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Case formulation: Substantiate diagnostic impressions; describe current functional impairment or risk thereof without mental health treatment; planned services: mental health (specific type of psychotherapy), medication, or case management; anticipated duration of services. Please address if client meets medical necessity requirements.

DSM IV CODE:	
Axis I Primary (ICD Code, if different):	
Axis I Secondary:	
Axis II (Code and description):	
Axis III:	
Axis IV (Primary):	
Axis IV (Secondary):	
Axis V:	

Enhancing Mental Health Treatment through Measurement

1. Establish Goal for Use of Measurement in Treatment Setting
   a. Define the Purposes for Assessment
      i. Case Conceptualization
      ii. Triage/Referral[2]
      iii. Determine Medical Necessity/Enrollment
      iv. Establish Baseline (in order to monitor progress/outcomes)
   b. Determine Assessment Framework
      i. Assessment Specialists vs. Collective Assessment
         1. Implications and Considerations for Both Approaches
      ii. Timing of Assessment
   c. Identify the Role of Measurement
      i. Enhance Case Conceptualization
      ii. Establish Baseline/Monitor Progress & Outcomes

2. Identify Target Construct(s) Based on Goal
   a. Target Construct(s) to Enhance Case Conceptualization
      i. General mental health and specific key constructs not effectively or consistently identified through clinical methods (e.g., trauma-related needs)
   b. Target Constructs to Establish Baseline/Monitor Progress & Outcomes
      i. General mental health and specific key constructs important due to type of treatment or administrative emphasis
   c. Prioritize Construct(s) and Refine Goal Based on:
      i. Treatment Setting Characteristics
      ii. Client/Family Needs and Characteristics

3. Identify Early Implementation Considerations
   a. Consider Possibilities Related to:
      i. Administration (e.g., cost, setting, timing, respondents, languages, age range)
      ii. Scoring (e.g., cost, method, timing)
      iii. Interpretation (e.g., ease of interpretation, intended consumers)

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[2] In mental/behavioral health treatment settings, a comprehensive case conceptualization often informs triage/referral decisions. In some cases, however, triage/referral decisions are made with the use of screening procedures and do not require a comprehensive case conceptualization.

        iv.   Use of Scores (e.g., utility for intended consumers, changes over time, long-term uses)

4. Identify Measurement Instruments and Evaluate for Effectiveness and Efficiency
   a. Effectiveness
      i. Robustness of Empirical Support for Intended Setting/Population/Use
   b. Efficiency
      i. Administration (i.e., cost, setting, timing, respondents, languages, age range)
      ii. Scoring (i.e., cost, method, timing)
      iii. Interpretation (i.e., ease of interpretation, intended consumers)
      iv. Use of Scores (i.e., utility for intended consumers, changes over time, long-term uses)

5. Identify Instrument(s) that Best Aligns with Intended Use and Maximizes Balance of Effectiveness/Efficiency

6. Prepare for Implementation of Measurement Instrument(s) in New Context through Training and PDSA Approach
   a. Training
      i. Encourage effective administration, scoring, interpretation, and use of scores
   b. Plan Do Study Act (PDSA) Cycles
      i. Feedback from Key Stakeholders (those involved in administration, scoring, interpretation, and use of scores)
      ii. Calibration of Scores by Comparing to Complimentary Data of Related Construct (whenever feasible)

7. Implement Use of Measurement Instrument(s)
   a. Monitor Implementation and Respond to Obstacles
   b. Enhance Sustainability through Supervisor Trainings, New-Hire Trainings, Quality Assurance (QA) and Administrative Practice/Policy Changes[3]

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[3]The likelihood of sustained effective use of measurement in MH treatment settings will be strengthened through connecting the measurement practices with therapist goals and requirements. How therapists approach case conceptualization and/or monitor progress and outcomes will significantly influence the perceived utility of measurement (and consequently the sustainability of measurement).

Core Behavioral Health Assessment List

1. *Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ: SE-2)*
2. *BASC-2 Behavioral and Emotional Screening System (BASC-2 BESS)*
3. *Behavior Assessment System for Children, Second Edition (BASC-2)*
4. *Behavioral and Emotional Rating Scale-2nd Ed. (BERS-2)*
5. *Brief Infant Toddler Social Emotional Assessment (BITSEA)*
6. *Brief Problem Monitor (BPM)*
7. *Child Behavior Checklist (CBCL)/Teacher Report Form (TRF)/Youth Self-Report (YSR)*
8. *Conners Comprehensive Behavior Rating Scales (Conners CBRS)*
9. *Conners Early Childhood (Conners EC)*
10. *Infant Toddler Social Emotional Assessment (ITSEA)*
11. *Pediatric Symptom Checklist (PSC)*
12. *Preschool and Kindergarten Behavior Scales - Second Edition (PKBS–2)*
13. *Social Skills Improvement System (SSIS) Rating Scales*
14. *Social-Emotional Assessment/Evaluation Measure (SEAM)*
15. *Strengths and Difficulties Questionnaire (SDQ)*
16. *Symptoms and Functioning Severity Scale (SFSS)*
17. *Youth Outcomes Questionnaire (YOQ)*

Name of measure	Description
1. *Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ: SE-2)*	The *ASQ: SE-2* is a screening tool that identifies infants and young children whose social and emotional development requires further evaluation to determine if referral for intervention services is necessary. Nine questionnaires are available for different age groups: 2, 6, 12, 18, 24, 30, 36, 48, and 60 months of age. Each screens for self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people.
2. *BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS)*	The *BASC-3 BESS* consists of brief forms that can be completed by teachers, parents, or students. It is designed for use by schools, mental health clinics, pediatric clinics, communities, and researchers to screen for a variety of behavioral and emotional disorders that can lead to adjustment problems. The system includes three forms, which can be used individually or in any combination: Teacher form with two levels: Preschool (for ages 3 through 5) and Child/Adolescent (for Grades K through 12); Student self-report form with one level: Child/Adolescent (for Grades 3 through 12); Parent form with two levels: Preschool (for ages 3 through 5) and Child/Adolescent (for Grades K through 12). A wide array of behaviors that represent both behavioral problems and strengths, including internalizing problems, externalizing problems, school problems, and adaptive skills are assessed.
3. *Behavior Assessment System for Children, Second Edition (BASC-3)*	The *BASC-3* is a set of rating scales and forms including the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP), Student Observation System (SOS), and Structured Developmental History (SDH). Measures adaptive and problem behaviors. Clinical scales on the TRS and PRS include aggression, anxiety, attention problems, atypicality, conduct problems, depression, hyperactivity, learning problems, somatization, and withdrawal; adaptive scales include activities of daily living, adaptability, functional communication, leadership, social skills, and study skills.
4. *Behavioral and Emotional Rating Scale-2nd Ed. (BERS-2)*	The *BERS-2* measures the strengths and competencies of children from 5-18 years. Examines the child's interpersonal strengths, functioning in and at school, affective strength, intrapersonal strength, family involvement, and career strength.
5. *Brief Infant Toddler Social Emotional Assessment (BITSEA)*	The *BITSEA* is a brief comprehensive screening instrument used to evaluate social and emotional behavior. Provides Problem Total Score and Competence Total Score.
6. *Brief Problem Monitor (BPM)*	A brief multi-informant assessment, the *BPM* provides a measure of a child's functioning and response to intervention that parallels the *CBCL/6-18*, *TRF*, and *YSR* [see next row]. The *BPM* evaluates responses to interventions designed to reduce problems and improve adaptive functioning; it is closely linked to comprehensive outcome assessments for evaluating post-intervention functioning.

Name of measure	Description
	Internalizing, Attention, Externalizing, and Total Problems scales are included. Items and scales are parallel with those on the *CBCL*, *TRF*, and *YSR*. Can be completed at user-selected intervals of days, weeks, or months.
7. *Child Behavior Checklist (CBCL)/Teacher Report Form (TRF)/Youth Self-Report (YSR)*	The *CBCL* allows a clinician to obtain information about problematic behavior in pre-school and school-age children from parents. Versions are available for 1½ -5 years and 6-18 years. Raw scores, T scores, and percentiles are provided. All norms are based on a U.S. national sample, and all forms have parallel Internalizing, Externalizing, and Total Problems scales. [Note: *Teacher Report Form* and *Youth Self-Report* also available.]
8. *Conners Comprehensive Behavior Rating Scales (Conners CBRS)*	The *Conners CBRS* is designed to provide a complete overview of child and adolescent concerns and disorders. The *Connors CBRS* includes the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV-TR)* Symptom scales, Content scales, Other Clinical Indicators, Critical items, and Impairment items. The age range for this assessment is 6–18 for the parent and teacher forms, and 8–18 for the self-report forms.
9. *Conners Early Childhood (Conners EC)*	The *Connors EC* assesses behavior in preschool-aged children. Aids in the early identification of behavioral, social, and emotional problems. Also assists in measuring whether or not the child is appropriately meeting major developmental milestones (Adaptive Skills, Communication, Motor Skills, Play, and Pre-Academic/Cognitive). Includes Full-length, Short, Behavior, Developmental Milestones, and Global Index forms. Forms are available for use by parents and teachers/childcare providers.
10. *Infant Toddler Social Emotional Assessment (ITSEA)*	The *ITSEA* is an empirically validated clinical tool that was developed to assess social-emotional and behavior problems as well as delays or deficits in the acquisition of competencies that may arise between the ages of 12 and 36 months. The *ITSEA* includes parent and childcare provider forms that can be completed independently as a questionnaire or administered verbatim as an interview. Provides T scores for four broad domains, 17 specific subscales, and three index scores
11. *Pediatric Symptom Checklist (PSC)*	The *PSC* consists of 35 items on a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The tool is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. There is also a youth self-report version and a briefer 17 item parent report version (*PSC-17*). (Note: on the *PSC* website, it is noted that although the *PSC-17* can be used as a youth self-report, neither the total score nor the individual subscale scores have been validated yet.). The *PSC* has been used as an outcome measure for mental health treatment.

Name of measure	Description
12. *Preschool and Kindergarten Behavior Scales - Second Edition (PKBS–2)*	The *PKBS-2* provides an appraisal of the social skills and problem behaviors of young children. The scales can be completed by a variety of behavioral informants, such as parents, teachers, and other caregivers. The Social Skills scale includes 34 items on 3 subscales: Social Cooperation, Social Interaction, and Social Independence. The Problem Behavior scale includes 42 items on 2 subscales: Externalizing Problems and Internalizing Problems. In addition, 5 supplementary problem behavior subscales are available for optional use.
13. *Social Skills Improvement System (SSIS) Rating Scales*	The *SSIS Rating Scales* evaluates social skills, problem behaviors, and academic competence: Social Skills: Communication, Cooperation, Assertion, Responsibility, Empathy, Engagement, Self-Control; Competing Problem Behaviors: Externalizing, Bullying, Hyperactivity/Inattention, Internalizing, Autism Spectrum; Academic Competence: Reading Achievement, Math Achievement, Motivation to Learn.
14. *Social-Emotional Assessment/Evaluation Measure (SEAM)*	The *SEAM* is designed to assess and monitor social-emotional development in infants, toddlers, and preschoolers at risk for delays or challenges. *SEAM* can be used by a wide variety of early childhood professionals, including those with little or no training in mental-health or behavioral interventions. The main *SEAM* includes three intervals with different developmental ranges: Infant (2–18 months), Toddler (18–36 months), and Preschool (36–66 months). Each interval assesses 10 child benchmarks critical to social-emotional competence, including empathy, adaptive skills, self-image, emotional responses, and healthy interactions with others. The *SEAM* system also includes *SEAM with Ages*, an alternate version of the tool annotated with a helpful list of age ranges for each item. This version makes it easy to give caregivers general guidance on how social-emotional skills typically develop and where their child's development fits on the continuum. The *SEAM Family Profile* assesses parent and caregiver strengths and helps identify areas in which they need more supports and resources to foster their child's social-emotional skills. Like the main *SEAM*, the *Family Profile* assessment includes three intervals—Infant, Toddler, and Preschool. Each interval measures four benchmarks key to a nurturing home environment: responding to needs, providing activities and play, providing predictable routines and an appropriate environment, and ensuring home safety.
15. *Strengths and Difficulties Questionnaire (SDQ)*	The *SDQ* is a brief behavioral screening questionnaire about 2-17 year olds. Consists of 25 items divided between 5 scales: emotional symptoms (5 items), conduct problems (5 items),

Name of measure	Description
	hyperactivity/inattention (5 items), peer relationship problems (5 items), prosocial behavior (5 items). Extended versions are available with an impact supplement which asks whether the respondent thinks the young person has a problem, and if so, inquire further about chronicity, distress, social impairment, and burden to others.
16. *Symptoms and Functioning Severity Scale (SFSS)*	The *SFSS* was designed to assess youth progress in mental health treatment in terms of the reduction of symptom severity (e.g., worry less or sleep better) and increase of functionality (e.g., getting better along with peers and family). The goal for the development of the *SFSS* was to create a symptom and functioning scale that is not only psychometrically strong but can also be used easily and frequently without much burden on the respondents. The *SFSS* has three forms, *SFSS-Full*, *SFSS Short-Form A*, and *SFSS Short Form B* created for three respondents: caregiver, clinician, and youth. Each form contains two subscales: Internalizing and Externalizing behaviors. The *Full* form contains 26 items (clinician version contains 27) that ask the respondent to rate the frequency of certain symptoms and behaviors over the last two weeks. The brief forms (*Short Form A* and *Short Form B*) were developed for more frequent assessment. All *SFSS* forms are parallel across respondents. In other words, items are identical across respondent forms except for slight changes in wording to match the respondent type (e.g., "this youth" instead of "I").
17. *Youth Outcomes Questionnaire (Y-OQ)*	Several tools are available as part of the Y-OQ. The *Y-OQ-2.01* contains 64 items and is completed by the parent/guardian. It is a measure of treatment progress for children and adolescents (ages 4-17) receiving mental health intervention. It is designed to reflect the total amount of distress a child or adolescent is experiencing. The *Y-OQ 2.01 TA* includes the *Y-OQ 2.01* and 4 questions about the therapeutic alliance. The *Y-OQ SR 2.0* is the self-report version of the *Y-OQ 2.01*. It can be used in tracking treatment progress for adolescents receiving therapy or counseling. It is important to note that the *Y-OQ 2.0 SR* is NOT an equivalent form of, or interchangeable with, the *Y-OQ 2.01*. The *Y-OQ SR TA 2.0* includes the *Y-OQ 2.01* and 5 questions from the *OQ-ASC* about the therapeutic alliance. The *Y-OQ 30.2* is designed to be administered to either a parent/guardian or a youth/adolescent and takes less than 5 minutes to complete. The *Y-OQ 30.2 PR* is designed to be completed by the Parent/Guardian. The *Y-OQ 30.2 SR* is designed to be administered as a self-report.

Name of measure	Description
	The *Y-OQ® Treatment Support Measure (TSM)* is a tool designed to work in conjunction with the *Y-OQ 2.01, Y-OQ SR 2.0,* and *Y-OQ 30.2.* It was designed as a treatment planning tool to assist therapists working with children, youth, and their parents or guardians and as a clinical support tool to provide therapists with actionable feedback when youth are not making expected progress in treatment. *Y-OQ TSM* results obtained at the beginning of treatment can be used to identify client strengths and weaknesses which can be used in treatment planning.

Name of measure	Age range	Informants	Administration time	User /purchaser qualifications	Language other than English	Publisher
1. Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ: SE-2)	1-72 months	Parents/ caregivers	10-15 minutes	No	Spanish	Brookes Publishing Co.
2. BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS)	3-18 years	Parents/ caregivers, teachers, youth	5-10 minutes	Yes	Spanish	Pearson
3. Behavior Assessment System for Children, Second Edition (BASC-3)	2-25 years	Parents/ caregivers, teachers, youth/young adults	10-30 minutes (varies by form used)	Yes	Spanish	Pearson
4. Behavioral and Emotional Rating Scale-2nd Ed. (BERS-2)	5-18 years	Parents/ caregivers, teachers, youth	10 minutes	Yes	Unsure	PAR, Inc.
5. Brief Infant Toddler Social Emotional Assessment (BITSEA)	12-36 months	Parents/ caregivers	7- 10 minutes	Yes	Spanish	Pearson
6. Brief Problem Monitor (BPM)	6-18 years	Parents/ caregivers, teachers, youth	1-2 minutes	Yes	Multiple	ASEBA

Name of measure	Age range	Informants	Administration time	User /purchaser qualifications	Language other than English	Publisher
7. *Child Behavior Checklist (CBCL)/Teacher Report Form (TRF)/Youth Self-Report (YSR)*	1½-18 years	Parents/ caregivers, teachers (TRF), youth (YSR)	15-20 minutes	Yes	Multiple	ASEBA
8. *Conners Comprehensive Behavior Rating Scales (Conners CBRS)*	6-18 years	Parents/ caregivers, teachers, youth	25 minutes	Yes	Spanish	Multi-Health Systems Inc.
9. *Conners Early Childhood (Conners EC)*	2-6 years	Parents/ caregivers, teachers /childcare providers	5-25 minutes (varies by form used)	Yes	Spanish	Multi-Health Systems Inc.
10. *Infant Toddler Social Emotional Assessment (ITSEA)*	12-36 months	Parents/ caregivers	25-30 minutes	Yes	Spanish	Pearson
11. *Pediatric Symptom Checklist (PSC)*	4-18 years	Parents/ caregivers (PSC/PSC-17), youth (PSC)	3-8(?) minutes	No	Multiple	M.S. Jellinek and J.M. Murphy, Massachusetts General Hospital
12. *Preschool and Kindergarten Behavior Scales - Second Edition (PKBS–2)*	3-6 years	Parents/ caregivers, teachers	12 minutes	No	Spanish	PRO-ED

Name of measure	Age range	Informants	Administration time	User /purchaser qualifications	Language other than English	Publisher
13. *Social Skills Improvement System (SSIS) Rating Scales*	3-18 years	Parents/ caregivers, teachers, youth	10-25 minutes	Yes	Spanish	Pearson
14. *Social-Emotional Assessment/Evaluation Measure (SEAM)*	2-66 months	Parents/ caregivers	?	No	Spanish	Brookes Publishing Co.
15. *Strengths and Difficulties Questionnaire (SDQ)*	2-17 years	Parents/ caregivers, teachers, youth	5 minutes	No	Multiple	Youthinmind Ltd
16. *Symptoms and Functioning Severity Scale (SFSS)*	11-18 years (plan to extend to younger children)	Parents/ caregivers, youth, clinicians	5-10 minutes	No	Unsure	Center for Evaluation and Program Improvement Peabody College of Vanderbilt University
17. *Youth Outcomes Questionnaire (Y-OQ)*	4-17 years	Parents/ caregivers, youth	5-20(?) minutes	No?	Spanish	OQ Measures

Behavioral Health Case Conceptualization & Treatment Form

Consumer Behavioral Health and Functioning	Domain Assessed	Further Assessment Needed to Strengthen Conceptualization		Treatment Area	Prioritization Rank treatment areas (1= top)*
Risk Assessment (e.g. SI, HI)	☐	☐ Yes	Plan:	☐	
Psychosis	☐	☐ Yes	Plan:	☐	
Attention/Hyperactivity	☐	☐ Yes	Plan:	☐	
Mood, Depression, Anxiety, PTSD	☐	☐ Yes	Plan:	☐	
Disruptive Behavior	☐	☐ Yes	Plan:	☐	
Conduct/Delinquency	☐	☐ Yes	Plan:	☐	
Bipolar/Mania	☐	☐ Yes	Plan:	☐	
OCD, Eating Problems	☐	☐ Yes	Plan:	☐	
Substance Use/Abuse	☐	☐ Yes	Plan:	☐	
Developmental Status/Disorders	☐	☐ Yes	Plan:	☐	
Neurological Impairment/Learning Disability	☐	☐ Yes	Plan:	☐	
Physical Health problems	☐	☐ Yes	Plan:	☐	
Trauma History/Symptoms	☐	☐ Yes	Plan:	☐	
Sexual Health	☐	☐ Yes	Plan:	☐	
Attachment	☐	☐ Yes	Plan:	☐	
Cultural Factors	☐	☐ Yes	Plan:	☐	
Family Behavioral Health and Functioning					
Parenting Style/Stress	☐	☐ Yes	Plan:	☐	
Family Living Needs	☐	☐ Yes	Plan:	☐	
Parent/Caregiver/Sibling Trauma	☐	☐ Yes	Plan:	☐	
Parent/Caregiver Mental Health or Substance Use/Abuse	☐	☐ Yes	Plan:	☐	
Engagement					
Consumer Treatment Engagement	☐	☐ Yes	Plan:	☐	
Caregiver/Parent Treatment Engagement	☐	☐ Yes	Plan:	☐	
Setting – Concerns in the following areas?					
☐ Home		☐ School		☐ Community	☐ Peers
Strengths in the following areas					
☐ Home		☐ School		☐ Community	☐ Peers