DHS Provides Clarification on Child Welfare and Juvenile Justice Mental Health Screening

TOPIC
Update on the statewide mental health screening for child welfare and juvenile justice populations enacted by the 2003 Minnesota Legislature and implemented in 2004.

PURPOSE
To update county and tribal social services, juvenile probation, court services and juvenile detention centers on child welfare and juvenile justice mental health screening policies, procedures, training and grant reporting requirements.

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BACKGROUND
The Children’s Mental Health Division in the Department of Human Services (DHS) partners with the Child Safety and Permanency Division of DHS and the Department of Corrections to provide means for county and tribal social services and juvenile justice programs to screen children within specific target populations and refer, as needed, for further mental health assessment. Our collaboration began in 2004 and has had success. Screening numbers are recorded for grant allocation purposes and to evaluate how many of the youth within the target population have been screened or exempted from screening based on current services. Even though compliance has increased, there remains a substantial need to increase collective efforts to screen more of the target population. The following table reports the screening number totals used for grant allocations for the past four years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Child Welfare</th>
<th>Juvenile Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>3,864</td>
<td>5,357</td>
</tr>
<tr>
<td>2006</td>
<td>4,081</td>
<td>5,167</td>
</tr>
<tr>
<td>2007</td>
<td>4,366</td>
<td>4,364</td>
</tr>
<tr>
<td>2008</td>
<td>5,438</td>
<td>4,340</td>
</tr>
</tbody>
</table>

According to the 2008 Children and Community Services Act Annual Performance Report: Measure 9—Received Mental Health Screening, there were 12,764 youth eligible for screening in the child welfare target population; 4,260 of those children were screened, and 3,003 were exempted (bulletin #09-68-12). The state’s child welfare system had a 44% rate of screening youth in the target population who were not exempted, which was an increase from 39% in 2007.

In 2008, juvenile probation departments reported to the Department of Corrections that within the juvenile justice target population there were 7,388 youth eligible for screening; 4,340 were screened, 2,993 met an exemption criterion from screening and 1,104 were referred for a diagnostic assessment.

The children’s mental health screening initiative was a response to the Children’s Mental Health Task Force of 2002. The 2003 Minnesota Legislature added a requirement to Minnesota Statutes:

- section 245.4874, subdivision 1, (14),
- section 260B.157, subdivision 1,
- section 260B.176, subdivision 2,
- section 260B.178, subdivision 1,
- section 260B.193, subdivision 2 and
- section 260B.235, subdivision 6

to include Children’s Mental Health Screening as mandatory for specific target populations within the juvenile justice and child welfare systems; these statutes became effective July 1, 2004. During the 2009 session, Minnesota Statute, section 256.01 subdivision 14 (b) was amended to include screening in the American Indian Child Welfare Initiative. The purpose of Children’s Mental Health Screening within the child welfare and juvenile justice population is to provide a mechanism for integrating mental health to current practices, provide earlier mental health intervention in a cost effective and productive manner, prevent further child welfare and public safety violations, use standardized screening tools and
utilize performance based funding.

This bulletin will highlight the following changes to the Children’s Mental Health Screening Allocation grant and children’s mental health screening practice expectations:

- Clarify the target populations
- Add a new exemption for screening
- Add a new children’s mental health screening tool for the child welfare population
- Add criteria for re-screening youth
- Describe models of effective mental health screening programs and technical assistance availability
- Outlining grant reporting standards.

TARGET POPULATIONS

The mandated target populations include children in the child welfare and juvenile justice systems.

**Child Welfare Population--children ages 3 months to 18 years who:**
- Receive child protective case management services
- Parental rights have been terminated: guardianship and adoption case management clients
- Are in out-of-home placement: for 30 days or more and not in the Social Service Information System (SSIS) in a children’s mental health work group.

**Juvenile Justice Population--children ages 10 to 18 years who have:**
- A judicial finding of delinquency, according to Minnesota Statute, section 260B.007, subdivision 6. Youth on probation age 18 to 21 on Extended Juvenile Jurisdiction are excluded.
- Allegedly committed a delinquent act and who have had an initial detention hearing, with the court ordering the child continued in detention.
- Committed a juvenile petty offense for the third or subsequent time.
- RECOMMENDED: Youth whose case is under a continuance for dismissal or stay of adjudication but before a finding of delinquency has been made.

**Frequently Asked Questions**

**Does “Found to Be Delinquent” equate Adjudication?**

Yes, it does. Youth that have been found guilty of committed delinquent acts listed in Minnesota Statute, section 260B.007 may either be adjudicated or continued without adjudication according to the Minnesota Rules of Juvenile Procedure, section 15.05. Under Minnesota Statutes, section 260B.198, subdivision 7 a youth is only continued without adjudication before a finding of delinquency has been entered. Therefore, only youth that have been adjudicated delinquent meet the definition of the phrase “found to be delinquent.”

However, youth under a continuance or stay of adjudication may also benefit from a children’s
mental health screen. The Department of Human Services recommends that county probation departments offer voluntary children’s mental health screens for youth in that situation. Consent needs to be obtained from parents prior to the mental health screen. Screens conducted for youth whose case is under a continuance or stay of adjudication but before a finding of delinquency has been made will count towards grant allocation purposes.

What is considered “detention” to comply with this statute?

Minnesota Statute, section 260B.176, subdivision 2 is specific to youth held in secure, locked detention. Therefore, shelter placements or any other form of detention that is not within a secure and locked placement do not require children’s mental health screening under this statute.

Who is responsible for screening a youth when s/he is ordered continued in detention to a multi-county detention center?

The preference is that the county supervising the probation screen the youth (record and document the screen and provide any follow-up services); however, it is understood that this cannot always occur and other arrangements will need to be made. The screen should count towards the grant allocation formula for the county supervising the probation so that the grant money will follow the child.

What happens for all other youth who are detained, seen at an initial hearing and then sent home with their parents or guardians?

According to Minnesota Statute, section 260B.178, subdivision 1, youth released by the court to their parents, guardians, custodians or other suitable person are subject to reasonable conditions of release that include a children’s mental health screen. A children’s mental health screen at that time is not court ordered and requires parental consent.

Do the children in other child welfare programs count?

Only children in out-of-home placement (for longer than 30 days and not in a children’s mental health SSIS workgroup) or in child protection case management, or for whom parental rights have been terminated are mandated by the statute to be screened.

This means that children in intake/investigation, Parental Support Outreach Project, Minor Moms, Mother’s First or any other voluntary or involuntary case management service does not meet the criteria for the statute or the grant funding. The statute and grant funding are specific to Minnesota state residents; therefore interstate compact children in placement in Minnesota also do not meet criteria for this mandate.

How do we count the screens for probation youth whose residential placement is entered into SSIS for Title IV-E funding?

Youth in the probation system who are not involved in the social service system except for
placement purposes should be screened by their probation agency; therefore, in SSIS their screen should be marked as an exemption due to being screened within the last 180 days, etc. It is inappropriate to document screening the child in both systems.

**Are truancy cases included?**

Truancy cases are only included in cases of a judicial finding of habitual truancy for which the child is receiving child protective case management services.

**Can we screen all children in a family receiving child protection case management or just the identified child?**

The statute is specific to screening any child receiving child protective case management. Therefore, the children’s mental health screening expectation applies to any child who is open as a client in a child protection case management SSIS workgroup.

**SCREENING EXEMPTIONS**

While the statute is specific to the aforementioned target populations, it includes an understanding that not all of those children need or can be provided with screening due to other circumstances. In Minnesota Statute, section 245.4874, subdivision 1(14) the following exemptions are noted:

- Screening has been performed within the previous 180 days
- Diagnostic assessment has been performed within the previous 180 days
- Child or youth is under the care of a mental health professional [mental health professional defined in Minnesota Statute, section 245.4871, subdivision 27]
- Parent or legal guardian prevents the screening, in writing to the court or county or tribal agency.

The 2004 bulletin included the following exemptions that still apply:

- Parent/guardian refuses screening
- Unable to locate child
- Case management case is closed within 30 days of opening.

This bulletin includes:

- Receiving Children’s Mental Health Case Management

Children receiving Children’s Mental Health Case Management will automatically be taken out of the reporting numbers received from SSIS and therefore child welfare workers will not be required to enter an exemption or a screen for those children.

**Frequently Asked Questions**

**What does “under the care of a mental health professional” mean?**
A licensed mental health professional (LMHP), as defined by Minnesota Statute, section 245.4871, subdivision 27, includes licensed psychiatric nurses, licensed independent clinical social workers, licensed psychologists, licensed psychiatrists, and licensed marriage and family therapists. The 2009 Minnesota Legislature added licensed professional clinical counselors to the licensed mental health professional list.

Pediatricians prescribing psychotropic medications (including stimulants and anti-depressants) do not qualify as licensed mental health professionals. To meet this exemption criterion, the youth must be directly seeing a LMHP (as defined by Minnesota Statute, section 245.4871, subdivision 27) for on-going services.

When should “unable to locate” be used?

Unable to locate should only be used at the end of the reporting cycle when all attempts have been made to find the child and provide the service (i.e. if the child is kidnapped, has runaway etc). Unable to locate is not applicable when the child is unavailable the day the worker attempts to administer the mental health screen; it is only applicable if the child cannot be located over a long period of time and that it has become improbable that a screen can be administered.

If a child was just screened by public health can we count that screen for grant reporting?

If another agency has recently screened a child with a children’s mental health standardized tool, s/he would be recorded as an exemption as the child has been screened within the last 180 days. The screen would not count towards the screening total for grant award purposes.

MENTAL HEALTH SCREENING PROCESS

Children’s mental health screening is an important function for determining the need for referring a child for further diagnostic assessment. The Department of Human Services encourages child protection social workers to engage families in a discussion of the importance of children’s mental health screening within the first 30 days of the case management process (during which information is being gathered for the case plan). When a child is in out-of-home placement, it is advised to provide the youth with a screen after the first 30 days of placement. For youth in the corrections system, generally the screen is conducted right after the child has been found delinquent, has been returned to detention after the first hearing, or has been referred to court for the third or subsequent petty offense or during the first probation meeting.

Mental health screens are completed by the youth (i.e. self report) within the corrections settings and by the parent for children in child welfare system. If there is no suitable adult caregiver available then the Youth Pediatric Symptom Checklist may be used; further explanation available in the tools section of this bulletin.

Screeners
County and tribal social services and correctional agencies have the flexibility to decide whether
corrections professionals, social service professionals or mental health practitioners (Minnesota Statute, section 245.4871, subdivision 26) will administer mental health screenings. All screeners must be trained and demonstrate competency on the use of DHS approved screening instruments.

Beginning August 1, 2009, tribes participating in the American Indian Child Welfare Initiative will screen youth meeting the aforementioned criteria and be eligible for grant allocations. During the 2009 session, the state legislature approved 2009 Session Laws, Chapter 163, Article 2, Section 2 which amended Minnesota Statute, section 256.01, subdivision 14 (b) to include mental health screening to the duties expected of the tribes participating in the American Indian Child Welfare Initiative. Not only does this add screening to the tasks of the child protection workers in the initiative, but it also allows the American Indian Child Welfare Initiative tribes (the Leech Lake Band of Ojibwe and the White Earth Band of Ojibwe) to be eligible to receive funds through the Children’s Mental Health Screening Grant.

APPROVED SCREENING TOOLS

Child Welfare Screening Tools:
- The Ages and Stages Questionnaire: Social Emotional (ASQ: SE)
- The Pediatric Symptom Checklist (PSC-35)
- Strengths and Difficulties Questionnaire (SDQ)

Juvenile Justice Screening Tools:
- The Massachusetts Youth Screening Instrument, Second Version (MAYSI-2)
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

For more information on how to purchase or acquire screening tools and their psychometric properties, please see Appendix A of this bulletin.

ELIGIBILITY FOR RE-SCREENING

In child protection, a child not currently receiving mental health services may be re-screened under the following conditions:

1. The child transitions from one program to another (child protection case management to adoption/guardianship)
2. A child in a child protection case management work group has entered into a placement within this calendar year and does not meet an exemption
3. There are considerable changes in behavior/development (and the child does not meet an exemption) and the family wishes to re-screen.
4. In compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards, a child who continues to receive child welfare services should be offered a screen (if not receiving appropriate mental health treatment) at the age of 6 months, 1 year, 18 months, 2 years, 4 years, and every 3 years after the age of 4.
In corrections, a child not currently receiving mental health services may be rescreened under the following conditions:

1. Youth may be re-screened if they commit an additional offense (and then it is court ordered)
2. A youth is held in detention and sent back to detention after the initial hearing more than one time that year; re-screen the youth if there is cause for concern due to the extenuating (i.e. intense emotional reactivity, fluctuation or outbursts) circumstances.
3. Youth receiving supervised probation may be re-screened if there are considerable changes in behavior/development (and the child does not meet an exemption). However, as the re-screen is not court ordered, the probation department needs to obtain parental consent for the mental health screen.

SCREENING NOTICE AND CONSENT

Minnesota Statutes section 245.4874, subdivision 1,(14) states that “the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.” The Department of Human Services actively endorses obtaining written (or verbal followed by written) permission for mental health screening. Mental health screening data is protected health information, and therefore counties and tribes should follow appropriate Data Privacy and Health Insurance Portability and Accountability Act (HIPAA) guidelines in regard to releases of information, confidentiality and appropriate filing of sensitive material.

Only when a children’s mental health screen is conducted in the juvenile justice system as a result of a court order, is consent not required. However, parents retain the ability to contest the court order and prevent the screen. Written consent is required when the youth has been continued in detention or when the child is returned to the custody of a parent/guardian after the initial hearing.

Engaging families in conversations about the benefits of screening, while gaining permission for the screen, makes the subsequent utilization of voluntary mental health services more likely. Numerous counties include a permission form in the client’s file indicating that the family consented to the screen or declined the screen via one of the previously stated exemption criterion. In order for a youth and family to give proper permission for a mental health screening they should be informed about the purpose of the questions, why they are being asked to complete the screen, privacy and confidentiality information, how long it will take and what the benefits are to completing this process.

Frequently Asked Questions About Consent

How do we record permission for screening?

The Department of Human Services encourages counties and tribes to formalize permission for
mental health screening by having the parent or guardian sign a form declining or acknowledging permission to screen the child. An example of a notice form can be located on the DHS website (in the EDOCS section) labeled: DHS-4828-ENG published 9-04. This document may be modified into a permission form. 
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4828-ENG

If the county or tribe has custody but not guardianship how should the consent process proceed?

The county or tribe should their follow their established policies and procedures when seeking consent for medical and mental health services.

Can the county or tribe continue to offer mental health screening even if a family has refused?

Mental health screening is a voluntary service, and thus if a parent declines the opportunity that is their right. However, if the parents change their mind at a later date, please reoffer the screen. Letting the parents make an informed choice is of the utmost importance.

DATA REPORTING

Legislation limits DHS’s authority to collect individual child screening data; therefore, reporting requirements are minimal. The Minnesota Department of Human Service’s Social Service Information System (SSIS) and the multi-county Court Service Tracking System (CSTS) are the dedicated information systems to collect completed screens and exemption categories.

While corrections and detention centers manually turn in numbers to the Department of Corrections, starting in 2010, all probation departments (except Hennepin County) have the option to enter mental health screens to CSTS. Detention centers will continue to turn in numbers manually. Please consult your SSIS mentor or CSTS technical contact for assistance in learning how to appropriately enter screening information.

The following is a list of the reporting requirements:

- Completed mental health screening, including date screening completed
- Exemption categories:
  - Child under the care of a mental health professional
  - Child screened within previous 180 days
  - Diagnostic assessment within previous 180 days
  - Parent/guardian refused screening
  - Unable to locate child
  - Case management case closed within 30 days of opening.
  - Receiving Children’s Mental Health Case Management

The Department of Corrections and the Department of Human Services are asking probation departments (and detention centers when appropriate) to also provide the following aggregate information:
• Total number of youth referred for diagnostic assessment
  o Of youth referred, how many received an assessment
  o Of youth referred, how many did NOT receive an assessment

Frequently Asked Questions about Data Reporting

Are we to document children's mental health screening in the time reporting function within SSIS?

It is not required by DHS, however each county or tribe can encourage their individual expectations for time reporting purposes.

What happens if we think we completed more screens than SSIS or CSTS reports indicate we did?

It is the responsibility of supervisors to run SSIS or CSTS reports frequently to make sure that workers are entering data correctly.

MODELS OF POST-SCREENING PROTOCOL

After mental health screens have been completed and scored there are generally two outcomes: the child has a positive score and would benefit from a referral for a diagnostic assessment or the child has a negative score and requires no further action regarding mental health services (unless the parents wish to pursue services). Each county has created or is in the process of creating its own means of attending to youth who require further assessment and services.

Counties with a high rate of screening completion and accurate data reporting demonstrate the following characteristics:

• Strong commitment from management/supervisors to children’s mental health screening
• Discussing mental health is active within the culture of the organization
• The county or tribe has created informal and formal protocols surrounding screening (including forms, case reviews, placement team discussions, etc)
• Frequent case audits or running computerized reports (at least quarterly) to review whether mental health screens have been done
• The child welfare or probation staff have a clear understanding and knowledge that referred services will occur for their clients
• Partnerships between departments and a commitment to sharing resources
• Clear role definitions and a well-conceptualized flow to the process of screening and post-screening protocol

Children’s mental health services are, for the most part, voluntary in nature—which requires buy in and consent from the youth and parents. Parents may choose to arrange appointments with a local mental health provider or take the feedback from the screen to their healthcare providers. Often times the referral process is facilitated by giving families documentation in writing
including a copy of the screen or a summary of the results so that the conversation with the next provider is more productive.

Most mental health services are paid through by the child’s health insurance carrier (private coverage, fee for service Medical Assistance, or a Prepaid Medical Assistance Plan). However, there are some children who do not have medical insurance or require services that exceed the benefits provided by their primary insurance carrier. As stipulated in the Minnesota Comprehensive Children’s Mental Health Act (Minnesota Statute, sections 245.487 to 245.4889) the county is responsible for providing those services or assisting the family to apply for Medical Assistance or MinnesotaCare. The funding available through the Child Welfare and Juvenile Justice Mental Health Screening Grant may be used to support the county or tribe in providing these services.

The post-screening coordination recommendations made by the Minnesota Juvenile Justice and Mental Health Initiative include the following (directly quoted from the report):

- “A template court order at the Finding of Delinquency hearing that orders the screen and diagnostic assessment if the youth meets the threshold on the screen
- A System Navigator function that is responsible for:
  - Providing parents with information concerning the screening process;
  - Providing parents and youth with the results of the screen and information on accessing a diagnostic assessment when their child meets the threshold;
  - Assisting the parents to link their child to services
  - Assisting parents to navigate county and community based agencies; and
  - Tracking outcomes.
- An integrated system of mental health screening and assessment performed in conjunction with a “risk to re-offend” assessment to inform referral recommendations that balance public safety with the youth’s need for mental health services.
- A multi-disciplinary team that develops a case plan and identifies existing funding streams for services
- A predisposition report and disposition hearing for those families who will not voluntarily follow through to get needed mental health services.
- Methods for tracking to ensure that youth are screened and assessed when appropriate.”

Frequently Asked Questions:

**How do you run reports in SSIS or CSTS to track screening?**

County and tribal supervisors should ask their SSIS mentor or CSTS technical contact for training and access to reports.

**If the youth is on probation, do we have to court order a diagnostic assessment and on-going services?**
No, mental health services do not need to be court ordered—that is at the court’s discretion. Most often mental health services have greater efficacy if the youth and family voluntarily participate in the process.

**How does payment work if the diagnostic assessment is court ordered?**

As documented in Minnesota Statute, section 62Q.535, most health plans that provide coverage for mental health services must cover or provide mental health services that are court ordered if the behavioral care evaluation is performed by a licensed psychiatrist or a doctoral level licensed psychologist. According to Minnesota Statute, section 62Q.535 the health plan must receive a copy of the court order and the behavioral care evaluation. The health plan must pay for the behavioral care evaluation used by the court if it is performed by a provider within the plan’s network. It is imperative to call the insurance company to clarify their procedures and protocols when it comes to paying for court ordered services.

**TRAINING AND CONSULTATION**

The Department of Human Services’ Children’s Mental Health Division will provide training stipulated in the statute:

- Administration of the instruments
- Interpretation of the screening tool outcome
- Overview of state and federal data practices laws and confidentiality standards
- Parental consent requirements
- Ensuring respect for families and cultural values

The Department of Human Services’ Children’s Mental Health Division has regional technical assistance representatives available for consultation onsite or via email/phone on program, protocol, and resource development. Please call 651/431-2322 to find out who is your representative, or reference the attached map (Appendix C).

**FUNDING**

Counties and tribes report how many youth were eligible for screening, how many screens were conducted, and how many met exemption criteria through SSIS, CSTS, and manual reporting to the Department of Corrections. Each year counties and tribes are allocated a different amount of money based on:

a) how many screens completed and recorded;

b) how many screens are completed throughout the state and

c) how much money is available in the grant fund.

The screening numbers are collected in March, award letters for the following year are sent during the summer, and funding begins in January (e.g., 2009 numbers are collected March 2010, award notification letters will be sent summer of 2010 with funds available to counties and tribes January 2011).
The grant is given to the county or tribal board within the Children’s Mental Health Combined Grant (with Children’s Mental Health Case Management grant). The county board or tribal council then gets to determine how it wishes to spend the grant allotment. The intended purpose of the grant funding is to help create infrastructure and support services for the newly identified children’s mental health population, focusing particularly on mental health services for the uninsured and underinsured.

Due to requests from counties, tribes and state agencies, the process of reporting the fiscal side of the grant is now changing. Beginning with calendar year 2011 the Department of Human Services will be requiring a budget from each county or tribe receiving grant funds justifying how they intend to spend the money on mental health services or expenses in relation to screening or post-screening services. The budget for 2011 will be expected by November 1, 2010. Counties and tribes will have the option of turning in a combined budget (including corrections and human services spending) or separate budgets based on what works best for the county or tribe. Counties and tribes participating in children’s mental health screening grant funding will be asked to specify how the funding will be utilized in the following categories: personnel services, operating expenses, ancillary or supportive services, screening equipment, contracts, indirect costs, and administrative costs. Please refer to example budget worksheet in the Appendix B of this bulletin. Counties or tribes receiving less than $5,000 in that year’s grant cycle will not be expected to provide budgetary documentation.
Appendix A
Detailed Information on Screening Tools

Child Welfare Mental Health Screening Instruments
Ages and Stages Questionnaire: Social Emotional (ASQ: SE)
- **Authors:** Jane Squires, Diane Bricker and Elizabeth Twombly
- **Publisher:** Brookes Publishing Company
- **Description:** The ASQ: SE is a series of questionnaires designed to be completed by parents and interpreted by professionals. The questionnaires are specific to eight age groups: 6, 12, 18, 24, 30, 36, 48 and 60 months of age. The tools address seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people. The cut off score changes based on the age of the child and questionnaire used.
- **Age Range:** 3-60 months
- **Administrator:** Parent, teachers and other caregivers

*Psychometric Properties*
- **Standardization Sample:** The standardized sample included 3,014 preschool-age children and families, representing the 2000 Census data for income, education and ethnicity.
- **Reliability:** Test/re-test reliability = .94
- **Validity:** Overall agreement = .93
- **Cost:** $149.95 to purchase questionnaires, $195 to purchase the starter kit. Purchase permits unlimited copying of the instruments. To order the ASQ: SE, contact Brookes Publishing at (800) 638-3775 or at [http://www.pbrooks.com](http://www.pbrooks.com).

Pediatric Symptom Checklist (PSC-35)
- **Authors:** Michael Jellinek and Michael Murphy
- **Publisher:** Authors through Massachusetts General Hospital
- **Description:** The PSC-35 is a one-page questionnaire listing a broad range of items reflecting parents’ impression of their children’s psychosocial functioning. The tool is intended to serve as a method of early identification of psychosocial problems. The PSC-35 consists of 35 items that are rated as never, sometimes or often present and scored 0,1,2 respectively. Item scores are summed to comprise a total score. For children 6 through 16, the cut-off score is 28 or higher. Items that are left blank by screeners are simply ignored. If four or more items are left blank, the questionnaire is considered invalid. The PSC is available in multiple languages including English, Spanish, Hmong, and Somali. The youth version (Y-PSC) is appropriate for teenagers who have had parental rights terminated or do not have a stable caregiver available to complete the screen. Worker should have the person with the most knowledge (i.e. caregiver or if one unavailable, youth) fill out the screening tool.
- **Age Range:** 6-18
- **Administrator:** Parents/guardian, other caregivers and adolescents

*Psychometric Properties*
- **Sample Study:** 21,065 children between the ages of 4 and 15 years were screened in 2
large primary care networks: the Ambulatory Sentinel Practice Network and the Pediatric Research in Office Setting network, involving 395 pediatric and family practice clinicians in 44 states, Puerto Rico and 4 Canadian provinces.

- Reliability: Test/re-test reliability = .84 to .91
- Validity: Specificity of 0.68 and a sensitivity of 0.95
- Cost: No cost. Download the PSC through Massachusetts General Hospital’s website: http://www2.massgeneral.org/allpsych/psc/psc_forms.htm
- Now available on-line through CNS Vital Signs. Please go to http://cnsvsonline.com/ and click on the online assessment button. For the Pediatric Symptom Checklist-Parent the Test Administrator is pscmnp with the password pscmnp. For the Pediatric Symptom Checklist-Youth the Test Administrator is pscmny with the password pscmny. After answering the screening questions a report will be generated indicating the subscale scores, the total score, and information regarding what they mean. This is a free service.

Strengths and Difficulties Questionnaire (SDQ):

- Author: Robert Goodman
- Publisher: Youth in Mind (www.youthinmind.net)
- Description: The SDQ is a series of questions designed to be completed by parents, youth and/or teachers and interpreted by professionals. The questionnaires are specific to 3 to 17 year olds (3-4 year olds, 4 to 10 year olds, 11-17 year olds). The tool addresses Emotional Symptoms, Conduct Problems, Inattention-Hyperactivity, Peer Problems, and Pro-Social Behavior in one subsection and then an Impact subscale addressing impact of symptoms on the child’s family and school environment. Cut off score is receiving a “high” on any of the domains within the diagnostic prediction section.
- Age Range: 3 to 17 years
- Administrator: Parent, Teacher, and/or Youth (all three forms should be completed whenever possible)

Psychometric Properties

- Standardization Sample: The standardized sample included 9,878 children ages 4 to 17, included in the 2001 National Health Interview Survey Supplement.
- Reliability: Test/Retest Reliability= Parents, Teachers and Self .74-.84
- Convergent Validity with Achenbach CBCL (TRF, YSR): .83 Parent, .87 Teacher
- Discriminant Validity (those with and without a mental health diagnosis) AUC (Area Under the Curve/Sensitivity and Specificity) = .74 -.93
- Cost: No cost and is available on line at www.sdqinfo.com

Juvenile Justice Mental Health Screening Instruments

Massachusetts Youth Screening Instrument, Second Version (MAYSI-2)

- Author: Thomas Grisso and Richard Barnum
- Publisher: The MAYSI-2 is copyrighted by Professional Resource Exchange, Inc. and is available through the publisher, Professional Resource Press.
- Description: The MAYSI-2 is a standardized, reliable, 52-item, true-false, paper-and-pencil or computerized method for screening 12- to 17-year-olds entering the juvenile
justice system, for identifying potential mental health problems in need of immediate attention. Requiring less than 10 minutes to administer and using the youth’s self report, the MAYSI-2 is feasible for use by non-clinical staff at probation intake, pretrial detention admission, and reception into a state’s youth authority facilities.

- Age Range: 12-17
- Administrator: Youth self report

Psychometric Properties

- Sample Study: This MAYSI-2 project developed the scales and published initial data on their reliability, validity and norms. These researchers administered the MAYSI-2, the Millon Adolescent Clinical Inventory and the Youth Self Report to over 1,200 youths in three settings throughout Massachusetts: juvenile court probation intake departments, secure pretrial detention centers and assessment centers receiving youths committed to the Department of Youth Services. The sample included boys (68 percent) and girls (32 percent). Ages ranged from 12 to 17 (ages 12-14, 21 percent; ages 15-17, 79 percent). Ethnic composition was white non-Hispanic 44 percent, Hispanic 22 percent, African-American 23 percent, and Asian 4 percent. Suggested cutoff scores are a) caution scores on two or more scales, b) warning score on one or more scales, and/or c) suicide ideation caution score.
- Reliability: Test/re-test reliability = .74
- Validity: Cautionary cut offs identify about 75 percent of youth who demonstrate clinical diagnoses compared to youths in the general population
- Cost: A $85 manual fee and registration agreement is required for the hand scored forms. MAYSI-Ware (computer version) is available for purchase for $124.95. Order the MAYSI-2 at http://www.prpress.com/books/maysi2.html

Problem Oriented Screening Instrument for Teenagers (POSIT)

- Author: Developed through support of the National Institute on Drug Abuse. Principal investigator is Dr. Elizabeth Rahdert.
- Publisher: National Clearinghouse for Alcohol and Drug Information
- Description: The POSIT is cost-effective and easy-to-use with troubled adolescents who may have one or more problems amenable to treatment or a combination of preventative services. The POSIT is considered a domain tool, screening for six different problem areas: substance abuse, mental health, physical health, family relationships, educational status and aggressive behavioral/delinquency. This is a tailored version of the original 10 domain areas. The POSIT can be administered by staff in schools, juvenile justice and family court, and medical, psychiatric, alcohol and drug treatment programs as the first step toward determining potential problems that require a diagnostic assessment. Suggested cut off scores (or when it is appropriate to refer on for a diagnostic): a) it may be appropriate to refer on if there is one functional assessment in the middle risk category; b) it is recommended when 2 or more functional areas score as middle risk; c) it is recommended when any functional area score is in high risk.
- Age Range: 12-19
- Administration: Youth self report

Psychometric Properties
Sample Study: Studies have been conducted using the POSIT in a variety of settings ranging from medical practice to juvenile justice programs.

Reliability: In a study based in public schools, outpatient counseling clinics and juvenile justice correctional institutions, the internal reliability coefficients for substance use/abuse = .93, mental health = .86, physical health status = .56, family relationships = .71, educational status = .82 and aggressive behavior/delinquency = .85.

Validity: The concurrent validity coefficient for mental health with corresponding Symptom Checklist Test = .70 for positive symptom total. In a study of arrested youth screened, 82 percent had potential mental health problems.

Cost: No copyright or cost. Available through EDOCS on the DHS website.
http://www.dhs.state.mn.us/id_000100 using the search function type POSIT and gain access to the tool and scoring materials.

Also available in computerized version for purchase through PowerTrain for $75 to $125 based on the version chosen. http://www.powertrain.com/positpc/index.html
**Appendix B**

Sample Line Item Budget Form

<table>
<thead>
<tr>
<th></th>
<th>Personnel Services, including benefits (employed by the county or Tribe)</th>
<th>Hours</th>
<th>Wage/Hr.</th>
<th>Total</th>
<th>Grant Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<td>3</td>
<td></td>
<td></td>
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<td>$0.00</td>
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<tr>
<td>4</td>
<td></td>
<td></td>
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<td>$0.00</td>
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<tr>
<td>5</td>
<td></td>
<td></td>
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<td>$0.00</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**CMH Screening Grant**

**Award:**

<table>
<thead>
<tr>
<th></th>
<th>Operating Expenses (for example: supplies, postage, printing, screening tools/supplies, translation, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Ancillary or Supportive Services (consultation/collaborative process meetings, evaluation reporting, social/recreational/support groups/programs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Equipment (patient tools machines, computer station for computerized tools, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Contracts (Professionals and Consultant services, contracts with mental health providers/agencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Indirect Costs: (please be specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Administration (a reasonable percentage of all costs not to exceed 15 percent, which includes planning, development, and supervision)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Appendix C

Children’s Mental Health
Technical Assistance Representatives
(Effective March 2009)
### Appendix D

#### Children’s Mental Health Screening Requirements

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Child Welfare</th>
<th>Juvenile Justice</th>
</tr>
</thead>
</table>
| Youth ages 3 months to 18 years: | • Receive child protection case management services  
• Parental rights have been terminated: guardianship and adoption case management clients  
• Are in out-of-home placement: for 30 days or more and not in a children’s mental health work group. | Youth ages 10 years to 18 years:  
• A judicial finding of delinquency, according to Minnesota Statute, section 260B.007, subdivision 6. Youth on probation age 18 to 21 on Extended Juvenile Jurisdiction are excluded.  
• Allegedly committed a delinquent act and who have had an initial detention hearing, with the court ordering the child continued in detention.  
• Committed a juvenile petty offense for the third or subsequent time.  
• RECOMMENDED: Youth whose case is under a continuance for dismissal or stay of adjudication but before a finding of delinquency has been made. |

<table>
<thead>
<tr>
<th>Exemptions</th>
<th></th>
</tr>
</thead>
</table>
| o Child under the care of a mental health professional  
o Child screened within previous 180 days  
o Diagnostic assessment within previous 180 days  
o Parent/guardian refused screening  
o Unable to locate child  
o Case management case closed within 30 days of opening.  
o Receiving Children’s Mental Health Case Management |

<table>
<thead>
<tr>
<th>Eligibility for Re-screening</th>
<th></th>
</tr>
</thead>
</table>
| • The child transitions from one SSIS workgroup to another (child protection program to guardianship)  
• A child in a child protection case management work group has entered into a placement within this calendar year and does not |
| • Youth may be re-screened if they commit an additional offense (and then it is court ordered)  
• A youth is held in detention and sent back to detention after the initial hearing more than one time that year, re-screen the youth if there is cause for concern due to the extenuating (i.e. intense emotional reactivity, fluctuation or |
There are considerable changes in behavior/development (and the child does not meet an exemption) and the family wishes to re-screen.

In compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards, a child should be offered a screen (if not receiving appropriate mental health treatment) at the age of 6 months, 1 year, 18 months, 2 years, 4 years, and every 3 years after the age of 4.

Youth receiving supervised probation may be re-screened if there are considerable changes in behavior/development (and the child does not meet an exemption). However, as the re-screen is not court ordered, the probation department needs to obtain parental consent for the mental health screen.

<table>
<thead>
<tr>
<th>DHS Approved Screening Tools</th>
<th>Ages and Stages Questionnaire: Social and Emotional (ASQ:SE)</th>
<th>Problem Oriented Screening Instrument for Teenagers (POSIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pediatric Symptom Checklist (PSC)</td>
<td>Massachusetts Youth Screening Instrument, Second Version (MAYSI-2)</td>
</tr>
<tr>
<td></td>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td></td>
</tr>
</tbody>
</table>

**Americans with Disabilities Act (ADA) Advisory**
This information is available in alternative formats to individuals with disabilities by calling 651/431-2321 (voice). TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency’s ADA coordinator.