Screening for Mental Health Needs in Child Welfare: Do We Also Need to Screen for Trauma?

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Introduction to the Project

From 2012 to 2018, the California Screening, Assessment, and Treatment (CASAT) Initiative was administered by the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego with funding from the Department of Health and Human Services, Administration on Children, Youth and Families (DHHS). One of the central activities of the CASAT Initiative was building infrastructure across individual counties in California to create comprehensive systems for screening social and emotional strengths and needs among children involved with child welfare services. In this article, we describe results from the project's collaboration on the implementation of a screening approach in a county child welfare system to highlight the importance of screening for trauma-related concerns in conjunction with screening for general mental health needs.

Major Issue

Children involved in the child welfare system are particularly vulnerable to having experienced potentially traumatic events including physical and sexual abuse, neglect, and exposure to violence (e.g., Freeman, 2014). The impact of these experiences can be far-reaching and have long-lasting consequences on development across domains of well-being.

Findings from a nationally representative study of cases investigated by child welfare services indicated that 41.4% of children were at risk for behavioral or emotional problems, but of those with identified risk, only 42.5% of children 1.5-10 years and 51.9% of children 11-17 years received mental health services in the preceding year (Ringeisen, Casanueva, Smith, & Dolan, 2011). Recognition of the gap between rates of mental health and trauma-related needs and use of mental health services has led to the development of guidelines calling for comprehensive screening in child welfare to identify and refer children with potential concerns for further assessment (e.g., Hunter Romanelli et al., 2009). Specific congressional guidance now includes the recommendation that children in the child welfare system receive trauma-focused screening in conjunction with screening for general mental health concerns (e.g., Child and Family Services Improvement and Innovation Act, 2011).

In California, an initiative resulting from a class action lawsuit settled in 2011 (*Katie A v. Bonta*, 2006, 2007) sought to improve the delivery of mental health and other supportive services for children and youth in, or at risk of placement in, foster care. This case established the requirement for all counties statewide to implement screening procedures to identify mental health needs among children involved with child welfare services. California's 58 counties are state-supervised but county-administered, each with its own child welfare and mental health systems. Beginning in 2012, the CASAT project partnered with a county

child welfare agency that was seeking to implement a screening approach to meet state requirements and to improve its practice with regard to identification of children with potential mental health and trauma-related needs in order to increase access to mental health assessment and treatment services. The collaborating county that is the focus of this article is classified as a medium-sized metro county (Ingram & Franco, 2014; population ≈ 450,000; 15% of residents living in rural areas). In 2014, there were 870 case openings in the county's child welfare system, and 651 entries to foster care, which represents an incidence of 4.5 per 1,000 children (Webster et al., 2018). In 2013–2014, 33.2% of eligible children in foster care had at least one visit for specialty mental health services in the county mental health system (California Department of Health Care Services, 2017).

Prior to its collaboration with the CASAT project, the county had not been conducting any formal mental health screening of children involved with the child welfare system. Through implementation support and technical assistance provided by the CASAT project, the county began screening for child mental health and trauma-related concerns using the Strengths and Difficulties Questionnaire (Goodman, 1997) and the Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (Muris, Merckelbach, Korver, & Meesters, 2000). The Strengths and Difficulties Questionnaire (SDQ) is a 25-item mental health screening tool that assesses emotional symptoms, conduct problems, hyperactivity-inattention symptoms, peer problems, and prosocial behavior. In the partner county, the parent/caregiver report version was used for children ages 3-10 years and the self-report version was used for youth ages 11 years and older. The Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (SCARED-PTS) is a youth self-report screening tool consisting of four items that inquire about posttraumatic stress-related symptoms (e.g., I have scary dreams about a very bad thing that once happened to me). Youth ages 7 and older responded to the SCARED-PTS. To screen for trauma symptoms in younger children, the tool was adapted for parent/caregiver report for children ages 3-6 years.

Information is reported on 991 children who had an SDQ and SCARED completed in 2013–2014. Screening was conducted on existing cases as well as new cases entering the child welfare system because the county was interested in ensuring that children already active to child welfare services would be screened in the initial phase of implementation. The mean age of the children was 9.6 years (sd = 4.5). Forty-seven percent were males.

On the SDQ, the *total difficulties* score was classified as not elevated, borderline, and abnormal based on established cutpoints. Similarly, the SCARED-PTS score was classified as *not elevated*, *somewhat concerning*, and *concerning* according to recommended cutpoints. Results shown in Table 1 indicate the extent to which potential concerns were identified on each screening tool and the extent to which indication of potential concerns overlapped on the tools.

On the SDQ, 11.6% of children fell into the *borderline* category and 22.3% fell into the *abnormal* category. On the SCARED-PTS, 12.1% of children were classified in the *somewhat concerning* category and 10.5% in the *concerning* category. Collapsing across the two

Table 1. Screening Results (n = 991).

		Traumatic Stress Disorder Scale of the Screen for Child Anxiety Related Emotional Disorders (SCARED-PTS)	
		Not Elevated	Somewhat Concerning/Concerning
Strengths and Difficulties Questionnaire (SDQ)	Not Elevated	57.6%	8.5%
	Borderline/Abnormal	19.8%	14.1%

categories indicating potential concerns on each tool, 14.1% had elevated scores on both the SDQ and SCARED-PTS, while an additional 19.8% had elevated scores on the SDQ alone and 8.5% had elevated scores on the SCARED-PTS alone.

Perhaps most important was that, overall, 42.4% of children had an identified concern on either or both tools, and 8.5% identified only with the trauma-specific screener. These findings suggest that, with relatively little added burden, the use of a trauma-specific screener has the potential to identify a sub-group of children who otherwise might not be identified for referral to mental health services if a general mental health screener were used alone.

The partner child welfare system had a strong commitment to advancing trauma-informed practices, and it readily opted to implement universal screening for both mental health and trauma-related concerns utilizing standardized tools completed by caregivers and youth. Implementation challenges were encountered, but they were not specific to screening for trauma-related concerns. They included difficulties with supporting consistent use of the screening tools across child welfare caseworkers and with data tracking to monitor metrics such as screening rates and outcomes. By the end of the CASAT project, efforts to address these challenges led to the reorganization of the screening approach, and responsibility for screening and referral shifted to a specialized unit of child welfare staff.

Screening is but the first step in identifying trauma-related and mental health needs and should be followed by a thorough, trauma-informed assessment. The CASAT project has developed a framework for assessment in this area called the Trauma-Informed Mental Health Assessment Process (TI-MHAP; California Screening, Assessment, and Treatment Initiative, 2017) which outlines an approach for gaining a thorough understanding of a child, his or her family, and the social environment, based on the ultimate goal of helping the child resolve issues surrounding potentially traumatic events. TI-MHAP operates with the understanding that every child comes to treatment with a unique history, unique family system, and unique level of developmental, cognitive, and emotional functioning. Cultural factors at the child, family, and community level are also considered. TI-MHAP utilizes standardized assessment measures and assessment-based treatment to help guide decisions made throughout the course of the process. It allows for decisions regarding assessment and treatment interventions to be tailored to the individual needs of each child.

Next Steps

Screening for trauma-related concerns is considered a central component of trauma-informed care in child welfare systems and has been promoted through initiatives sponsored by the following offices: Administration on Children, Youth and Families (e.g., Lang et al., 2017) and the Substance Abuse and Mental Health Services Administration National Child Traumatic Stress Network (e.g., Child Welfare Committee, National Child Traumatic Stress Network, 2013). Yet many child welfare systems are not routinely screening children for trauma-related needs. An examination by the CASAT Initiative of California's efforts to implement screening in child welfare systems following settlement of the *Katie A v. Bonta* (2006, 2007) class action lawsuit revealed that most counties opted to utilize tools focused on broad mental health concerns, and few targeted trauma-related concerns in their screening approach, despite the fact that the initiative included an emphasis on the importance of trauma-informed care (Crandal, Hazen, & Rolls Reutz, 2017). Additional support and consultation could promote wider-scale implementation and sustainment of trauma-informed screening practices in child welfare systems. Only when closely linked with a thorough trauma-informed assessment and subsequent trauma-informed, evidence-based treatments can a screening system be implemented effectively. The challenge raised by this need for coordinated services highlights the path ahead for further work in child welfare systems to support the children, youth, and families impacted by maltreatment.

The Chadwick Center for Children and Families is currently embarking on a project that builds on the work of the CASAT Initiative. The Advancing California's Trauma-Informed Systems (ACTS)

Initiative has been developed to utilize resources and lessons learned from CASAT to first consolidate and refine key trauma-informed system-level practices and then help organizations adopt those practices with gradually decreasing technical assistance. In this way, the CASAT Initiative has provided a foundation upon which next steps for advancing trauma-informed care can be built.

About the Authors

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