Enhancing Understanding of the Mental Health Needs of Children and Youth in Foster Care: Validity of Foster Parents as Reporters and Progress Monitoring

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Children and youth in the foster care system have high rates of emotional and behavioral health problems (Burns et al., 2004; McMillen et al., 2005). When unmet, these mental health needs contribute to increased placement disruptions, longer time to permanency, unsuccessful reunifications, and more restrictive placements (Akin, 2011; Horwitz et al., 2012; Iteld, 2010; James, 2004; Leathers, 2006). Mental health is integrally connected to the three primary goals of the child welfare system of safety, permanency, and child well-being. Thus, adequately addressing the emotional and behavioral health needs of children and youth in care is a priority for many child welfare systems across the country.

One widely used strategy in the child welfare system, though not often systematically applied, is the use of mental health screening tools to assist in the identification of children's strengths and needs and facilitate referrals to treatment (Hayek et al., 2014). These tools take the form of self-report surveys or structured interviews that can be administered to youth and those who know them (e.g., parents, out-of-home caregivers, and teachers). Such tools can be useful to inform initial case planning and decisions to obtain more extensive assessments, as described by Berliner and colleagues (2015). Periodic ongoing screening supports child welfare professionals to track progress and identify emerging problems. Ideally, such a strategy is accompanied by community-based high-quality, effective, and engaging treatment. When robust screening protocols are combined with first-rate mental health services, we would expect to see meaningful change at a population level (meaning that fewer children in child welfare would have unmet mental health needs). In addition to informing case planning and treatment needs at the individual level, aggregated data collected through the systematic use of screening tools can inform child welfare and community mental health planning around what types of interventions would be valuable to have in the service array.

This article describes the opportunities and challenges experienced when implementing Creating Connections (Children's Bureau Administration for Children, Youth and Families Grant #90CO1103 HHS-2012-ACF-ACYF-CO-0279). The goal of the project is to increase linkages with mental health services for children and youth in foster care through enhanced screening and progress monitoring.

Screening Context in Washington State

In Washington State, a robust screening protocol called the Child Health and Education Tracking program (CHET) has been in place since the end of 2001. Briefly, this protocol ensures that nearly all children and youth who are expected to be in foster care for 30 days or longer receive a comprehensive health, mental health, educational, social connections, and developmental screen within their first 30 days of care (see Kerns et al., 2016, for a detailed description). While the screening program was successful in completing screens, as of 2012 the screening measures did not specifically identify symptoms of traumatic stress. The funding for Creating Connections allowed for the following: (a) the planning and implementation of a screen for traumatic stress symptoms; (b) an opportunity to evaluate how the screening program was associated with mental health service receipt; and (c) a chance to examine perceptions of mental health screening from the perspectives of the screeners who administer it and the social workers who receive and use the screening results.

Key Partners and Project Goals

The Creating Connections project is a collaborative state-academic partnership managed by a core team of partners, featuring leadership and devoted project leads from the University of Washington (grantee), Children's Administration (CA), and the Division of Behavioral Health and Recovery (DBHR). The project was also advised by representative stakeholders, including a biological parent ally, foster parent, and alumna of care.

The project aimed for trauma-informed, system-level change to enhance identification of mental health symptoms, including traumatic stress, in children and youth in foster care. The purpose of identifying mental health symptoms through screening was to provide a strategy to ensure the linkage of youth to effective services to address identified concerns. Ideally, mental health services should be provided by licensed practitioners who understand the child welfare system and the unique needs of children and youth in foster care. Specific strategies employed by the grant to achieve these goals included the following: (a) adding a traumatic stress-specific measure to the statewide screening program (CHET; administered within the first 30 days in care), (b) introducing an ongoing progress monitoring program for children and youth who remain in the child welfare system for more than six months, (c) training child welfare professionals in identifying and responding to mental health needs, and (d) training mental health providers to be sensitive to the specific challenges of working with children and youth in foster care (see Kerns et al., 2016, for a description of the training approach).

Initial Considerations About Screening

Validity of Screening Within 30–60 Days of Placement

During the needs assessment phase of Creating Connections, many child welfare professionals expressed concerns about the validity of screening during the initial period of transition to foster care when foster parents may not yet know a child well enough to be accurate reporters of mental health symptoms. Further, children and youth may exhibit non-typical behaviors during the initial period of removal; some child welfare professionals indicated that there could be a "honeymoon" period, while others noted that the stress associated with removal from home could result in temporary increases in challenging behaviors. Although we have been unable to find empirical research specifically examining these potential phenomena, we had an opportunity to compare reporting by biological parents, foster parents, and the youth themselves to look for systematic differences in symptom reporting.

Ongoing Progress Monitoring: The Importance of Tracking Changes Over Time

Baseline screening is an essential starting point for identifying children and youth with emotional and behavioral health needs. Ongoing monitoring is important to ensure that children with mental health need improve and that those who develop needs over time are identified and linked to services. Changes after the first 30 days in care due to adjustment (adaptive or maladaptive), mental health symptoms

deteriorating over time, or symptoms improving over time all require attention by child welfare professionals. At the time the project began there was no systematic collection of this information.

Service Array Implications

Initial and ongoing child welfare screening results, when aggregated at the system level and combined with information about mental health diagnoses and service receipt, can provide valuable information about the existing service response. The project analyzed rates of problems youth are experiencing (e.g., internalizing vs. externalizing, trauma-related) that were stratified by age, geographic location, and receipt of and engagement with services. These variables can inform decisions about where and what types of services are needed and where they are sufficient. When these data are combined with ongoing screening, some further inferences about how services are accessed and the benefits of treatment can begin to emerge.

Solutions

Overview of Findings From PSC–17 Psychometrics Study

We compared PSC–17 scores from 2,389 children and youth as well as from self-report, foster parent report, and biological parent report (described in more detail in Parker, Jacobson, Pullmann, & Kerns, 2018). The PSC–17 provides cutoff scores for three mental health subscales and an overall score: internalizing, externalizing, attention, and total score. Scores above the cutoff are considered in the clinical range and below the cutoff are considered in the "normal" range, meaning no or minimal concerns are noted. Scores in the clinical range generally warrant a comprehensive mental health evaluation (Gardner et al., 1999).

We compared percentage agreement in scores provided by the three raters. Agreement was defined as occurring when both raters scored the youth either above or below cutoff on the PSC–17 scales. Our results indicated that foster parents and biological parents identify child symptoms similarly. The extent to which foster parents and biological parents' report of symptoms matched youth self-report was highly similar on the total score and attention subscale. Foster parents had slightly higher agreement with the youth's report on the internalizing and externalizing subscales (see Parker et al., 2018, for more specific details). Nevertheless, such agreement may not be indicative of more accurate reporting, as previous studies have found limited agreement between youth and adult reporters (Briggs-Gowan, Carter, & Schwab-Stone, 1996; Masters, Achenbach, McConaughy, & Howell, 1987). These findings, however, indicated that foster parents were roughly equivalent to biological parents as sources of information, even when they had only known the child or youth for a limited amount of time. Future research, such as use of cognitive interviewing, could help understand how foster parents and biological parents make decisions on symptom rating scales and what types of information are used to determine their perceptions of whether a youth is exhibiting symptoms.

Ongoing Mental Health Program

To enable ongoing progress monitoring, Creating Connections initiated a new program called the Ongoing Mental Health (OMH) screening program. In current practice, the OMH screening program operates with a supervisor and four full-time screeners who re-screen children and youth six months after placement into care, and at subsequent six-month intervals if ongoing mental health concerns are present. This program uses the same validated screening tools as the CHET program. The specific screening tools vary depending on the age of the child. For those under 5½ years of age, the Ages and Stages Questionnaire—Social Emotional (ASQ-SE) is administered. For those over 5½, the Pediatric Symptoms Checklist—17 (PSC–17) and, for those over age 7, the Screen for Child Anxiety-Related Emotional Disorders (SCARED) anxiety and trauma subscales are administered by telephone. In most cases, a foster parent is the sole respondent, though youth over 11 years of age are invited to complete a self-report screen. The information from the screen, including any recommendations, is communicated directly with the primary social worker and the caregiver.

Careful attention was taken to align the OMH program with existing practice (see Table 1 for alignment strategies). As can be seen in Table 1,

Table 1. Compatibility and Alignment of the OMH Program.

Philosophical	Training	Practical
The OMH Program was aligned with CA's goal of identifying and treating trauma symptoms.	OMH Screeners were easily incorporated into the existing training for CHET Screeners.	Able to mirror the CHET screening process. OMH was able to adapt existing CHET processes and documentation formats.
Staff hired to conduct the OMH Screeners had some background or knowledge of the importance of trauma screening.	OMH Screeners were centrally located at headquarters. This allowed the team to work collaboratively and receive direct supervision as needed.	IT infrastructure successfully accommodated the new trauma screening.
Management was supportive of the innovative format of the new screening program.	OMH Screeners were already experienced screening and communicating telephonically.	The OMH Screening team created user-friendly documents and processes to communicate results with staff and caregivers.

chosen strategies aligned with current structures. On a philosophical level, strategies aligned with current goals and interests in enhancing the screening program. Training and support opportunities were designed such that they did not add substantial burden within the system. Strategies and approaches with practical alignment with existing support structures were prioritized.

Data were collected via time diary to learn more about the amount of time and effort required to complete the screens. On average, full-time screeners were able to complete nearly three screens per day. While the screens themselves were relatively brief, substantial time was required to collect case information and create documentation associated with the screens. Over the course of a year and a half, the average amount of time required to complete screenings decreased slightly, indicating that the screeners improved in efficiency.

Results From the Ongoing Screening System

Between its inception in July 2014 and September 2017, the OMH screening program completed 4,314 individual screens, completed a report for each screen, and coordinated with caregivers and social workers regarding ongoing child needs.

We evaluated outcomes for a subset of 1,427 children and youth for whom we had received both the initial CHET screens and the 6-month follow-up OMH screening results. Children and youth were considered to have scored above criteria if they had scores above criteria on any screening tool and according to any rater. Four groups emerged, in order of frequency: (a) continued problems: both CHET and OMH screens were above clinical cutoff (34% of the sample); (b) improved: CHET screen was above cutoff, OMH was below (31%); (c) continued resilience: both CHET and OMH screens were below clinical cutoff (25%); and, (d) deteriorated: CHET screen was below cutoff, but OMH screen was above (10%). Of note, these

labels provide a simplistic way to characterize the groups. There may be nuances not captured by the labels. For example, some youth in the "continued resilience" group may have symptoms not identified by the screening tools. The "deteriorated" group may include youth who had mental health concerns at baseline but took some time to exhibit symptoms once placed in the new environment (i.e., the honeymoon phenomenon).

We compared screening outcomes with receipt of mental health services to determine whether OMH screening results were used to identify and address mental health needs that were not present at the time of CHET screening. Specific findings are reported in Pullmann et al. (2018). To summarize, we found that screening above cutoff at either time point was associated with a higher likelihood of receiving mental health treatment; nearly twice as many of those who screened above cutoff received services within 4 months, compared with those who screened below cutoff. One important potential confound to consider, however, is that children and youth with more substantial mental health needs are more likely to be referred to services regardless of their screening results, even if they were not screened at all (Leslie et al., 2005; Pullmann et al., 2018). However, those children and youth who initially screened below clinical cutoff, but later had a mental health concern picked up by the OMH screen (the "deteriorated" group), were more likely than any other group to initiate mental health services after the OMH screen. This finding provides some support for the hypothesis that child welfare professionals proactively use OMH screening results to guide their decisions regarding mental health referral, though we are cautious about this recommendation as there is the same potential confound that those with high levels of need may be referred regardless of screening scores.

Next Steps

The Creating Connections project enhanced the existing screening efforts and documented how screening influences receipt of needed care. The next steps are to provide the results of these studies to the screening units, child welfare professionals, and leadership. Scoring high on a screening measure is clearly associated with increased access to services. Yet, questions remain regarding the mechanisms through which screening leads to the desired outcome of children in state custody receiving needed mental health care. This is particularly important to understand given the potential for psychological impacts and economic costs associated with screening (see Finkelhor, 2017, for a thoughtful overview of key challenges). If we consider the flow between screening, referral, and service receipt as a series of "decision points," each warrants further examination. Who receives the screening? Of those who get screened, who has a clinical need identified? Of those with identified clinical needs, who gets referred to services? And of those referred to services, who ends up actually receiving a service and is that service matched to their identified needs? We know there are interpersonal, systemic, and sociocultural factors that influence each of these decision points. However, we do not yet have strategies to reliably enhance each pathway from need identification to service receipt.

Commentary

Barbara J. Putnam, MSW, LICSW

Creating Connections contributed important support to the Washington State Children's Administration at a very critical time. When this project initiated in 2012, the Child Health and Screening Track (CHET) program was an established program that provided broad screening to children in their first 30 days in care. There was an awareness that the screening tools didn't include a measure for trauma symptoms. It was unknown to what degree the CHET report findings were applied in the case planning process. Having the opportunity to go through a more formalized and structured needs assessment helped inform what additional supports and directions would be helpful to make the program even more useful and relevant. The two aspects of the project presented in this article are only a small component of the overall Creating Connections project that we hope is having a meaningful impact within our state's child welfare system.

While the potential importance of having an ongoing

mental health screening program was apparent, embedding such a program within an already complex system presented unique challenges. We initially considered a number of different options for the program, including having the child welfare professionals with case-carrying responsibilities administer the screening or adding the responsibilities to the current CHET screening team. However, neither of these options was viable given the context of the existing system. Therefore, it was decided that a centralized unit was the most efficient way to take on the responsibility of conducting the screens. The benefits of this approach included the ability to have close supervision of the program to support fidelity and quality assurance, ability to make timely tweaks and adjustments to aspects of the program, and increased visibility within the central administration. Additionally, centralizing provided an efficient staffing model for coverage if staff members were ill or on vacation. However, like in any new program, there were challenges and unexpected directions.

One such example is that we did not fully anticipate the amount of time that would be required to gather the background information prior to conducting the screen. Collection of such background information is critical in that it provides contact information, verifies status in the foster care system, builds context for the screener concerning the child's needs, and helps the screener have an informed conversation with the caregiver and social worker.

Another example is the necessity of developing training to support CHET, OMH, and field staff in the mental health needs of children and youth in foster care and how to use screening results in case planning. We developed a protocol to inform the case-carrying social worker and caregivers so they would understand screening results and be informed when discussing recommendations. The OMH screeners send area-specific mental health treatment information to the social worker. This includes a booklet of information that informs the caregiver of the program and offers trauma-informed care strategies for a range of developmental stages. Further, OMH screeners complete a screen if requested by the social worker or caregiver. Occasionally additional screenings are provided when a caregiver requests screening for additional children in their home, or when the social worker has a concern about a child or youth.

In summary, projects such as Creating Connections are valuable to child welfare. Washington State Children's Administration continues to be very engaged in the project and is pleased for the opportunity it afforded to embed trauma-informed care into our practices and participate in valuable evaluation analysis.

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