Knowing Who to Help

Experiences from Well-Being Screening in California & Connecticut Child Welfare Systems

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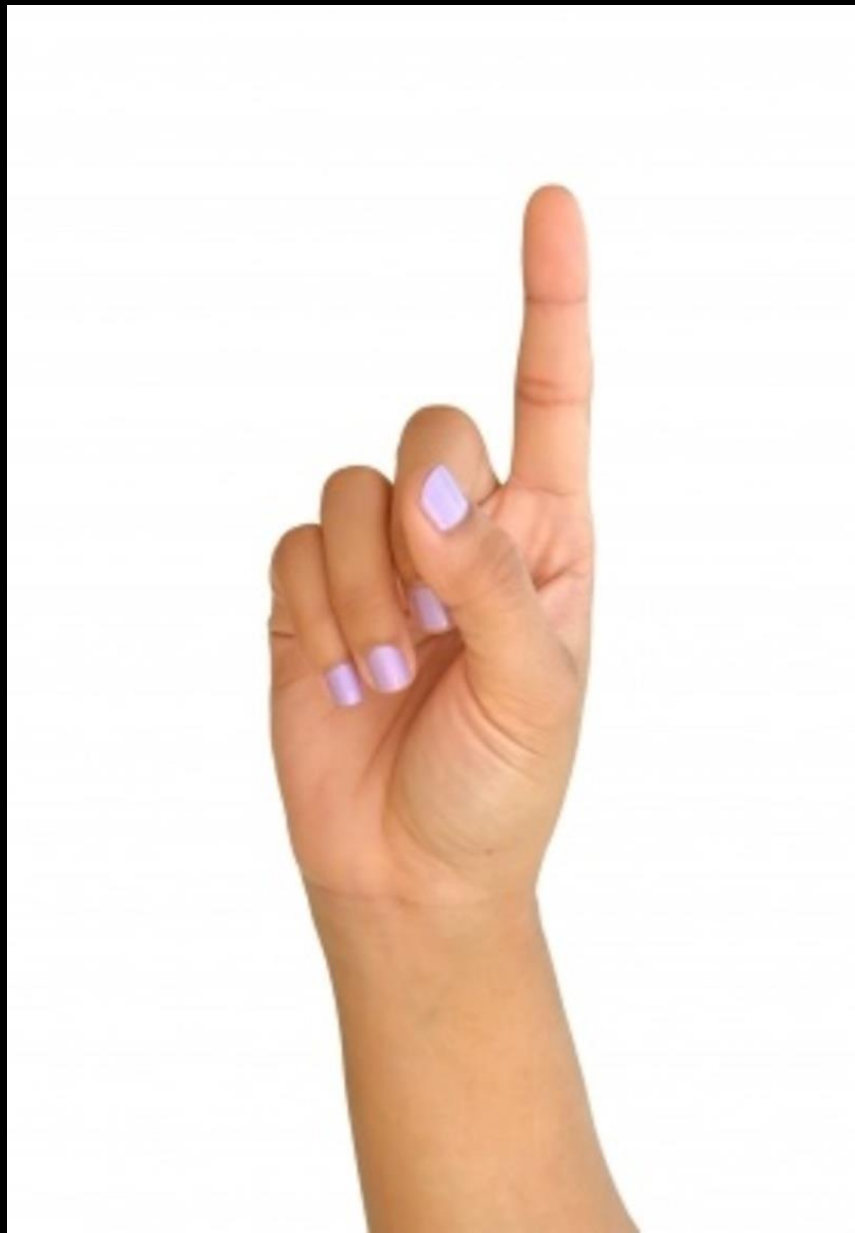
Overview

1. Well-Being Screening in Child Welfare
2. California's Child Welfare Systems & Well-Being Screening
3. Developing & Implementing the Connecticut Trauma Screen
4. Discussion and Action

Acknowledgement

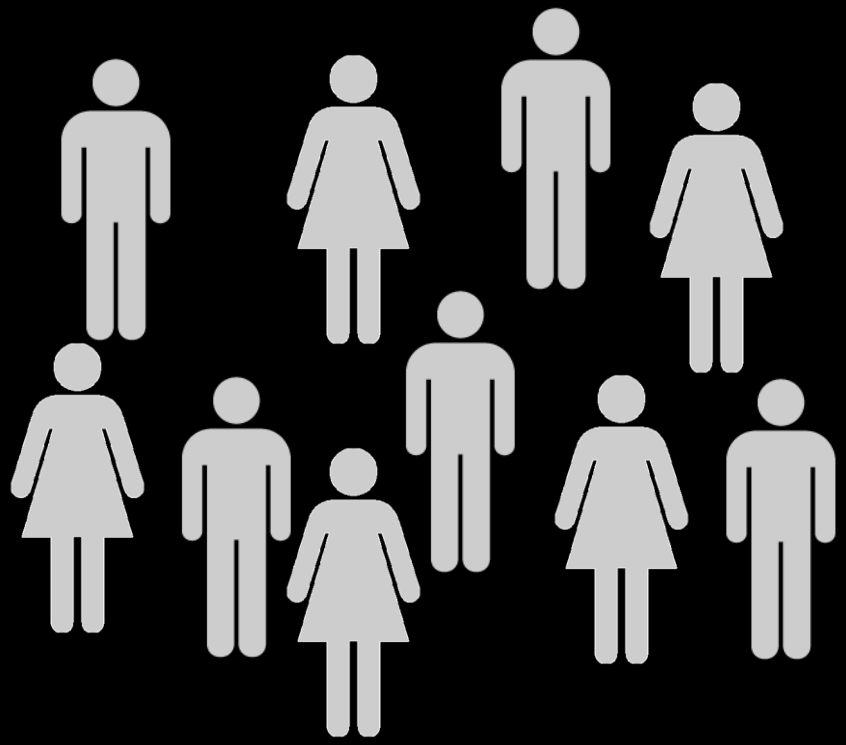
- This work was supported by funding from the Department of Health and Human Services, Administration for Children and Families, Children's Bureau
  - California Screening, Assessment and Treatment Initiative (CASAT; Grant #1101)
  - Connecticut Collaborative on Effective Practices for Trauma (CONCEPT; Grant #0169)

WELL-BEING SCREENING IN CHILD WELFARE



Why Is Well-Being Screening a Priority for Child Welfare Systems?

Out of 10 Youth in the US…

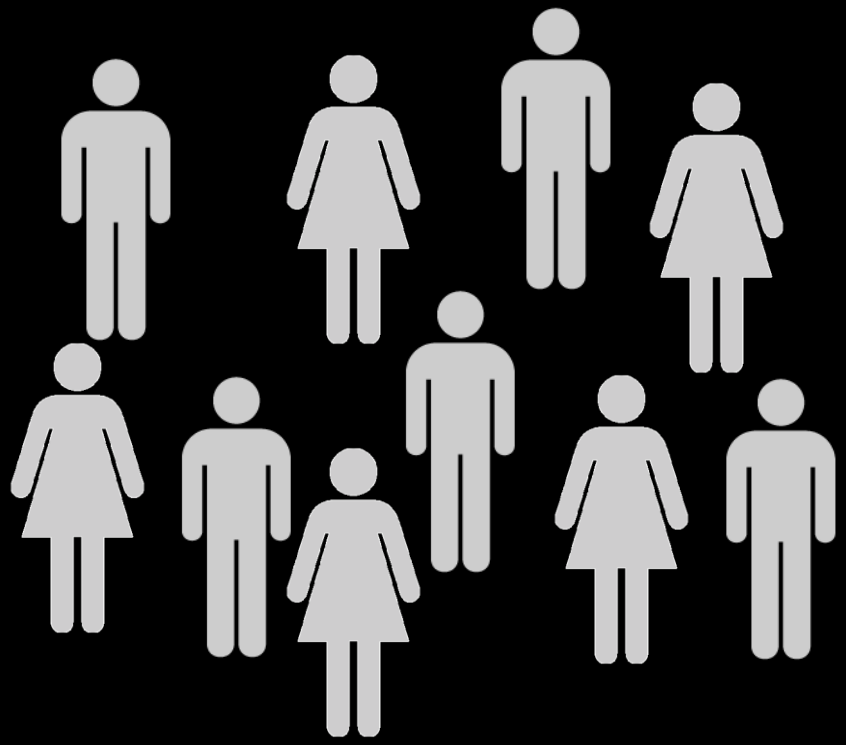


Significant Mental Health Need

22%

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., ... & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*, 980-989.

Out of 10 Young People in Child Welfare…

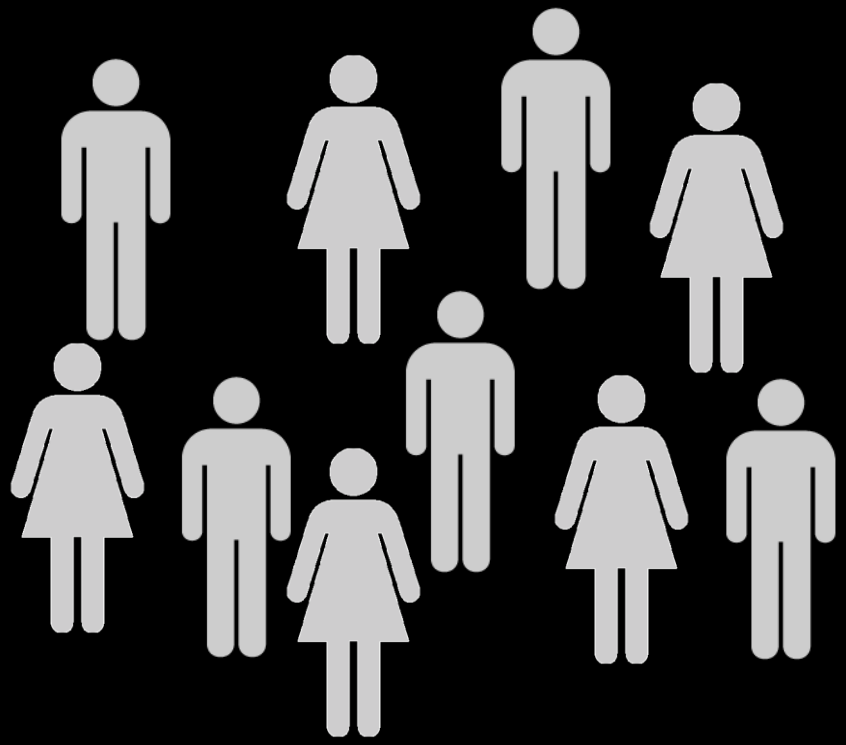


Significant Mental Health Need

48%

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 960-970. [based on children and youth investigated by CW, not open cases]

Out of 10 Young People in Child Welfare with Mental Health Needs….



Receive Mental Health Services

33%*

Horwitz, S. M., Hurlburt, M. S., Goldhaber-Fiebert, J. D., Heneghan, A. M., Zhang, J., Rolls-Reutz, J., ... & Stein, R. E. (2012). Mental health services use by children investigated by child welfare agencies. *Pediatrics*, *130*, 861-869.

Receive Mental Health Services

33%*

*youth of color with MH need less likely to receive MH services than White counterparts

Horwitz, S. M., Hurlburt, M. S., Goldhaber-Fiebert, J. D., Heneghan, A. M., Zhang, J., Rolls-Reutz, J., ... & Stein, R. E. (2012). Mental health services use by children investigated by child welfare agencies. *Pediatrics*, *130*, 861-869.

Kim, M., & Garcia, A. R. (2016). Measuring racial/ethnic disparities in mental health service use among children referred to the child welfare system. *Child maltreatment*, *21*(3), 218-227.

Children served by CWS:

- ↑ exposure to maltreatment
- ↑ mental health need
- Not consistently receiving adequate mental health services

Significant long-term consequences for not accurately identifying and treating children's mental health needs

US Department of Health and Human Services; US Department of Education; US Department of Justice. Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington (DC): US Department of Health and Human Services; 2000. Overarching Vision.

"With the right tools and capacity, child welfare systems can identify the complex needs of children who have experienced maltreatment..."

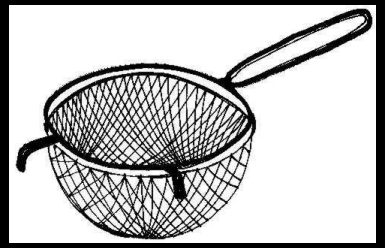
Bryan Samuels

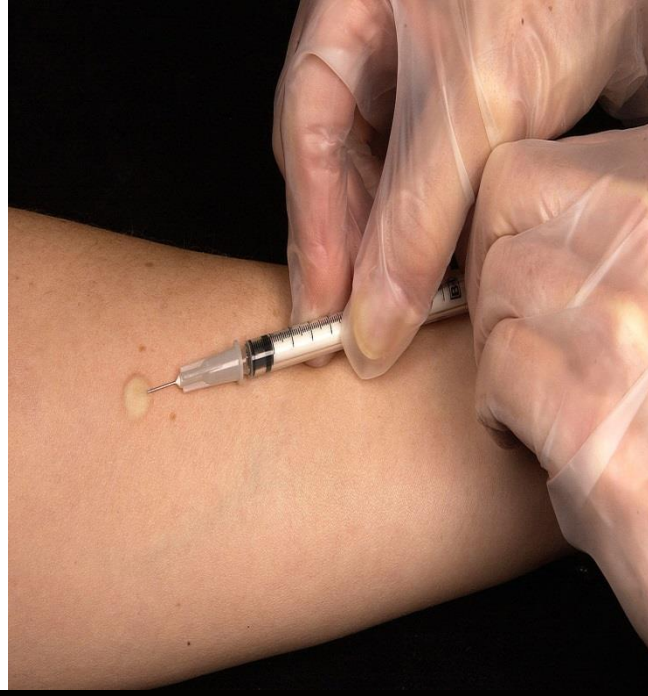
Former Commissioner, Administration on Children, Youth and Families
Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security Senate Committee on Homeland Security and Governmental Affairs United States Senate, Dec 1, 2011

What is Screening?

Assessment:
Defined by Purpose

- Safety 
- Diagnostic 

- Case Planning 
- Outcome 
- Screening 



Screening

- Testing people who have not recognized signs symptoms of targeted condition
- With purpose of reducing risk of future ill health in relation to targeted condition
- Encompasses whole system or program necessary to achieve risk reduction

Adapted from Raffle, A. E., & Gray, J. A. M. (2007). *Screening: evidence and practice*. Oxford University Press.

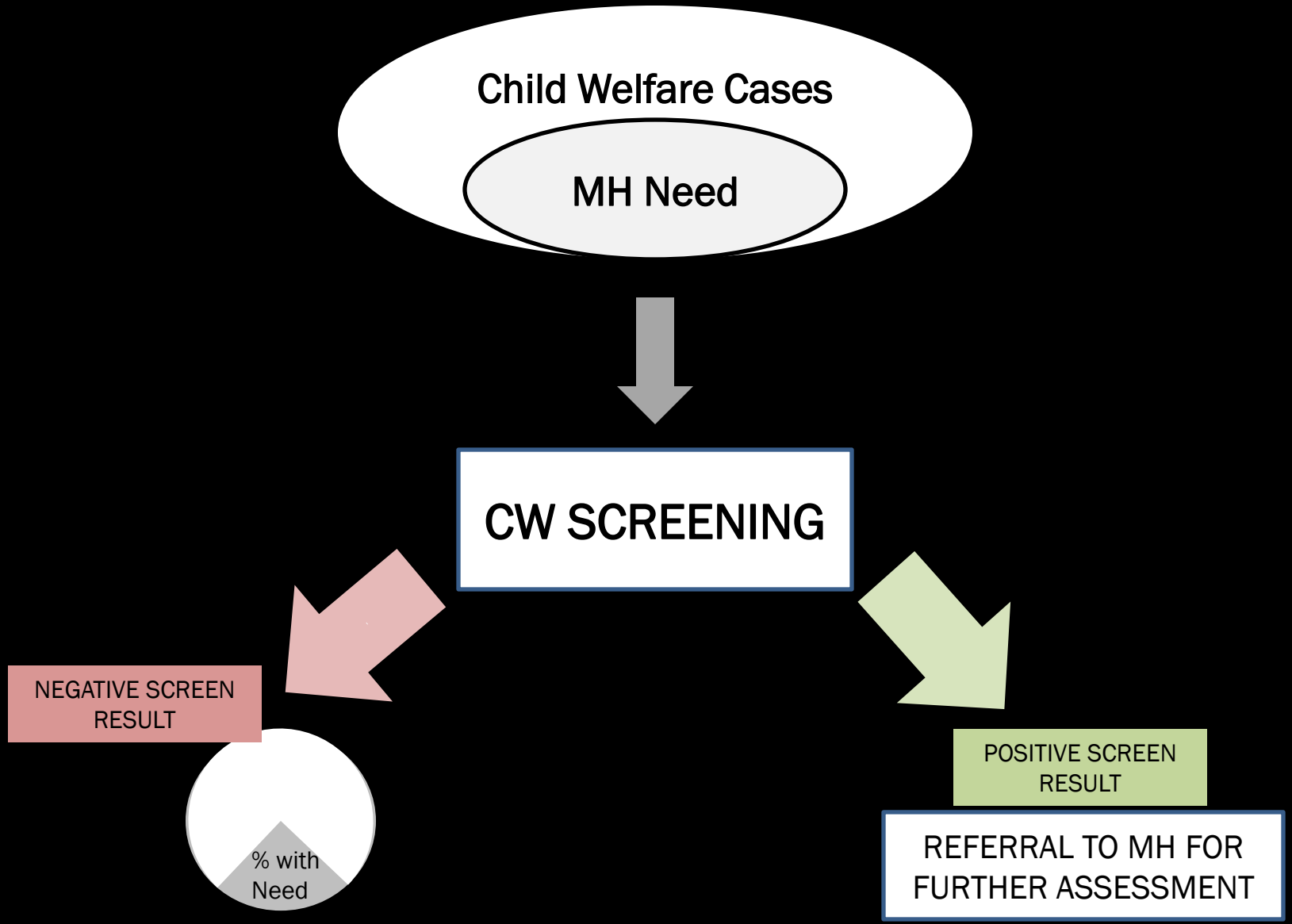
Well-Being Screening Basics

- Screening isn't just a test
  - Should involve a system
  - Starts with uptake and continues with intervention delivery and outcomes

- Includes a sieving and sorting process
  - Sieving: dividing people into ↑ and ↓ risk groups
    - Not usually given certainty
  - Sorting: further assessment to determine intervention

- New and evolving part of CW & MH Systems
  - Several decision points

Adapted from Raffle, A. E., & Gray, J. A. M. (2007). *Screening: evidence and practice*. Oxford University Press.



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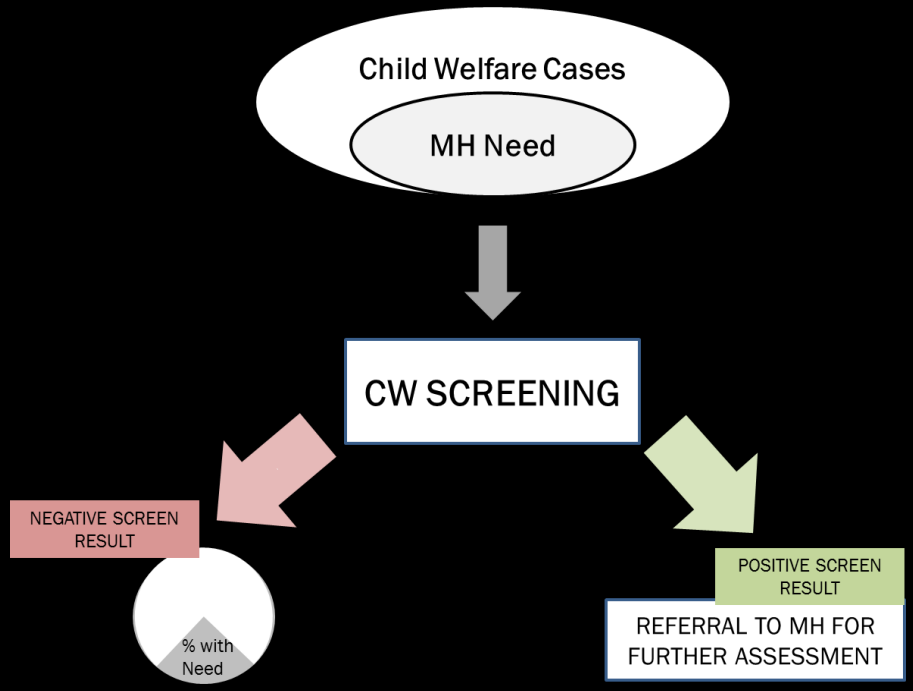

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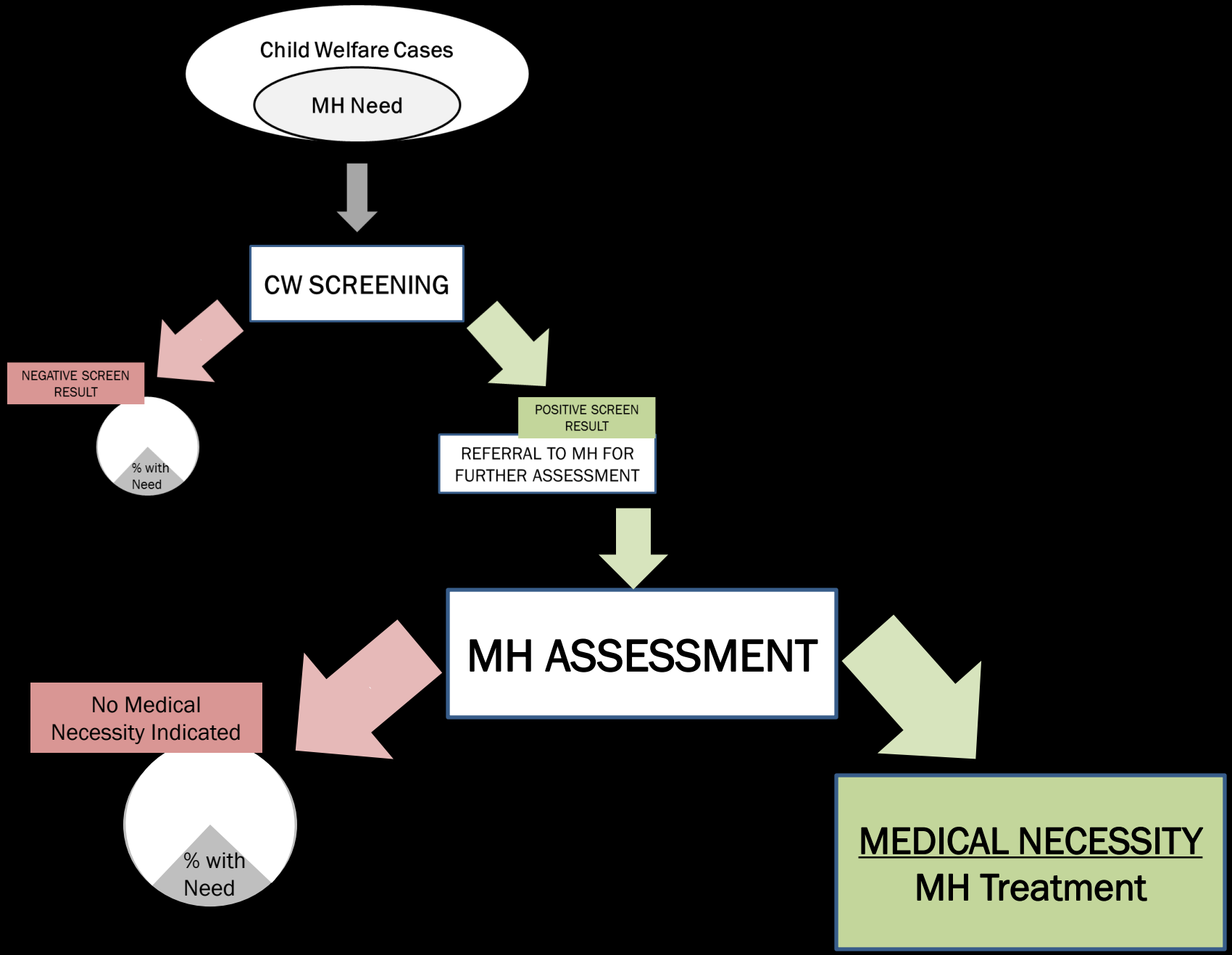

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Deciding What to Screen

- Well-Being
  - Social and emotional functioning
- Mental Health-Related Needs
  - Broad symptomology
- Posttraumatic Stress
  - Specific symptomology
- Potentially Traumatizing Events
  - Event checklist
- Resilience and Strengths

What are we trying to accomplish?
What outcome/risk are we going to reduce?
What are measurable markers of that outcome/risk?
Which tests actually measure those markers?

Deciding How to Screen

- Identifying Best Tool for the Goal
  - e.g., CEBC (http://www.cebc4cw.org/)
  - Administration
    - *Who administers*
    - *Who provides information*
  - Scoring
    - *How scored*
    - *Who scores*
    - *How shared with others*
- Interpretation/Action
  - High vs. Low Risk
- Coordination with MH Systems

Which tools/methods can accurately give us the information we need?
Which systems and individuals are involved in this method?
Which methods are feasible?

MEASUREMENT MATTERS

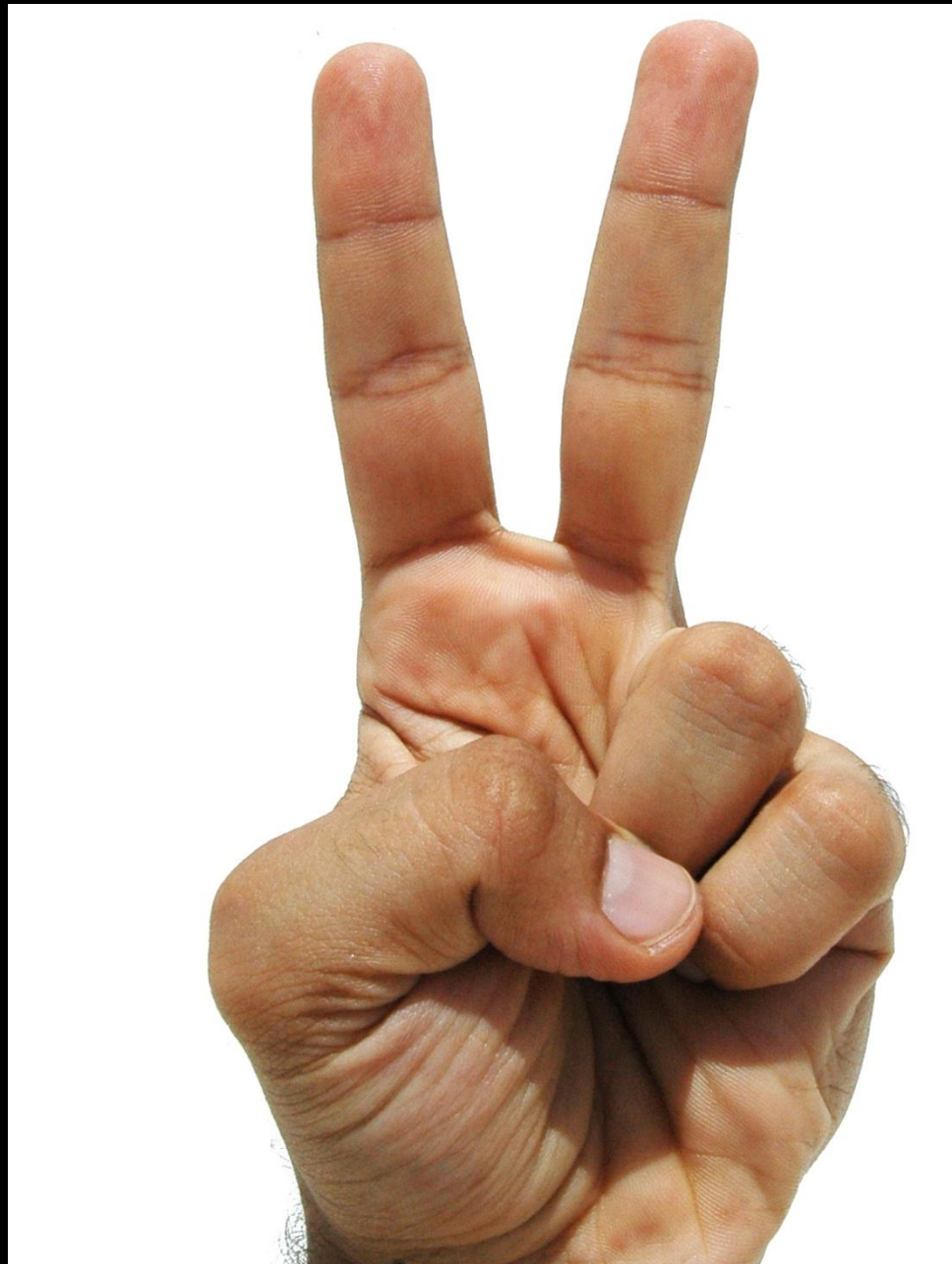
- Test Performance
  - sensitivity, specificity, predictive values, and receiver operating curves
- System Outcomes
  - actual benefits/harm of the structure, process, and results

- Without QA screening results are unreliable

- Consider the Potential for Harm
  - Inappropriate services
    - Over-/under- treatment
  - Inappropriate follow-up (too much and too little)
  - Resource allocation and utilization
  - Systematic cultural and social inequities

Adapted from Raffle, A. E., & Gray, J. A. M. (2007). *Screening: evidence and practice*. Oxford University Press.

CALIFORNIA'S CHILD WELFARE SYSTEMS & WELL-BEING SCREENING



Katie A. in California

July 2002: Katie A. et al. v. Diana Bonta et al.

Class action Lawsuit

Challenges that California failed to provide home-based and community-based mental health services to children in the foster care system or at risk of removal from their families

Child Welfare in California

- Katie A Lawsuit Settlement Agreement (2011)
  - "Pathways to Mental Health Services"
  - Each county established own particular screening approach
- County-administered systems (58)
- Department of Social Services
  - Piloting assessment tools for statewide implementation
  - Partnered on statewide online survey
    - Feb–March 2016
    - 1 survey per county
    - County administrators determined appropriate respondent

California CW Screening Survey

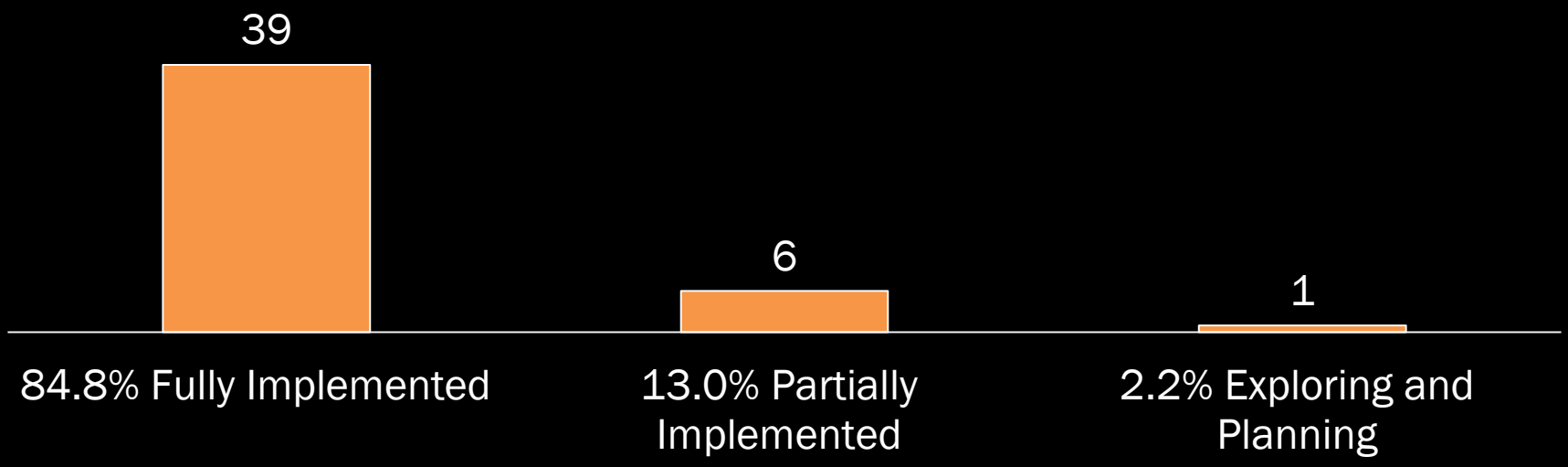
- 46 Counties
  - Closely resembles CA's Urban-Rural distribution
    - Slight ↑ large central metro and ↓ noncore
  - 97.4% of all CW cases in CA
  - Agency Affiliation
    - CW: 69.6%
    - MH: 8.7%
    - HHS: 17.4%
    - HHS & CW: 4.3%

Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Wiegmann, W., Rezvani, G., Wagstaff, K., Sandoval, A., Yee, H., Xiong, B., Benton, C., Tobler, A., White, J., & Kai, C. (2016). CCWIP reports. Retrieved 8/1/2016, from University of California at Berkeley California Child Welfare Indicators Project website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>

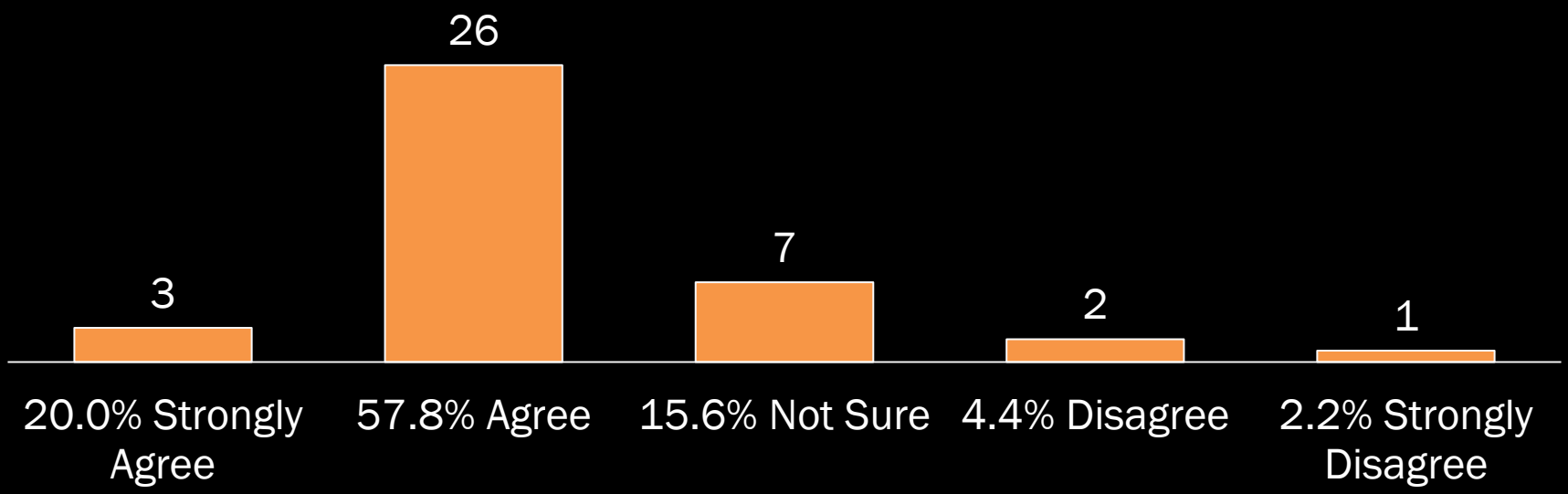
Finding 1
Screening Implemented for Most

Degree of Screening Implementation

(response to Katie A settlement)



Finding 1 (cont.)
Most are Satisfied with Screening



70.0% (32) Fully Implemented AND Satisfied (Strongly Agree/Agree)

Finding 2
Most Ages Screened

Age Group	Ages	% of Counties Reported Screening	Count of Counties Reported Screening
Infants	0-1	84.8%	39
Toddlers	2-3	91.3%	42
Preschoolers	4-5	97.8%	45
Middle Childhood	6-11	100%	46
Young Teenagers	12-14	100%	46
Teenagers	15-18	100%	46
TAY	19-21	71.7%	33

Finding 3
Perceptions of Screening Priorities

Rank	Consideration
1	Evidence-based or supported by research
2	Designed to be completed by staff
3	Children & families like it
4	Satisfies stakeholders (like county or state administrators)
5	Staff like it
6	Doesn't add extra strain on staff
7	Makes sense to me
8	Cost involved in using it
9	Designed to be completed by parents, caregivers, and/or youth
10	Other counties are using it

Finding 3 (cont.)
Perceptions of Screening Priorities

Additional Considerations
Customizability of the tool (can be modified for organizations)
Enhances or supports cross-system collaboration
Usefulness of the results
Accuracy of the results
Identifies traumatic stress & trauma-related needs

Finding 4
Counties Use a Variety of Tools

• MHST (58.7%)	Mental Health Screening Tool
• ASQ: SE (39.1%)	Ages & Stages Questionnaire: Social-Emotional
• CANS (30.4%)	Child and Adolescent Needs and Strengths
• SDM (30.4%)	Structured Decision Making
• SDQ (8.7%)	Strength and Difficulties Questionnaire
• ASC-Kids (6.5%)	Acute Stress Checklist for Children
• CBCL (6.5%)	Child Behavioral Checklist
• SCARED Brief PTS (6.5%)	SCARED Brief Assessment of Posttraumatic Stress
• UCLA PTSD-RI (4.3%)	UCLA PTSD Reaction Index
• *Agency-Developed* (4.3%)	**
• *Unknown* (4.3%)	**
• BAC + LEC (2.2%)	Brief Assessment and Life Event Checklists
• CSDC-SF (2.2%)	Child Stress Disorders Checklist – Screening Form
• NSESSS (2.2%)	National Stressful Events Survey PTSD Short Scale
• TSCC (2.2%)	Trauma Symptom Checklist

Tools Most Commonly Under Consideration: CANS (13.0%) and TOP (8.7%)

Discussion

- Screening Considerations
  - Emphasis on EBP & Completed by Staff
- Actual Screening Tools
  - Iffy on Performance but very high on practicality

Take Home

- Variety with emphasis on practicality
- Screening for well-being in CWS may require contradictory decision points for systems
- Tension between EBP and real-world represents broader tension in the field
- State of the field might better be described as moving toward research and development than having resolved the problem of screening for well-being

New Ideas & Tools Emerging

DEVELOPING & IMPLEMENTING THE CONNECTICUT TRAUMA SCREEN

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Yale School of Medicine

Jason Lang, Ph.D.
Child Health & Development Institute

Objectives

- Describe why trauma screening is important in CW
- Describe results of three validation and/or implementation pilots of our trauma screen
- Describe considerations & recommendations for implementing trauma screening in the CWS

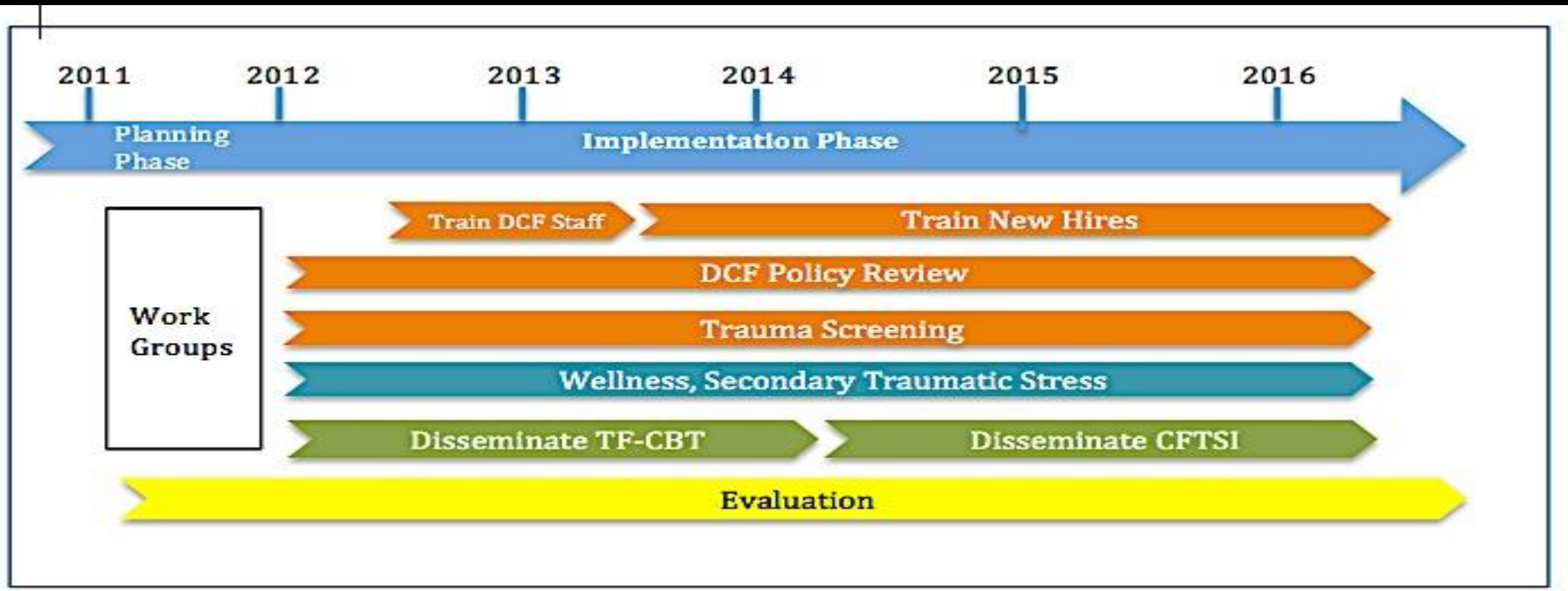
Project Context: Connecticut's Journey toward a Trauma Informed System

- Federal Lawsuit – Juan F. (1989): Needs met, Consent Decree, 22 outcomes
- **Dissemination of a range of Evidence Based Practices (including Trauma EBPs -- 2007-2011)**
- Changing Federal Policies (2010 – Ongoing)
  - Safety (Physical & Psychological Safety)
  - Permanency (Addressing Trauma, Fewer Disruptions, Less Medication)
  - Well-Being (Emotional & Social)
  - CFS Improvement and Innovation Act of 2011 (P.L. 112-34):provisions include: monitoring TX of emotional trauma with child maltreatment/removal, psychotropic meds
- **ACF CONCEPT Grant (2011 – 2016)**
- **Newtown and CT Legislative Result**

Connecticut Collaborative on Effective Practices for Trauma (CONCEPT) – Trauma Grant 2011

- $3.2 million, 5 year grant from ACF
- Improve trauma-focused care for children in child welfare system
  - Workforce development
  - Policy Review
  - Trauma screening & referral to evidence-based treatments
- Disseminate trauma-focused treatments in community settings
  - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
  - Child & Family Traumatic Stress Intervention (CFTSI)
- Prevent or reduce the impact of secondary traumatic stress

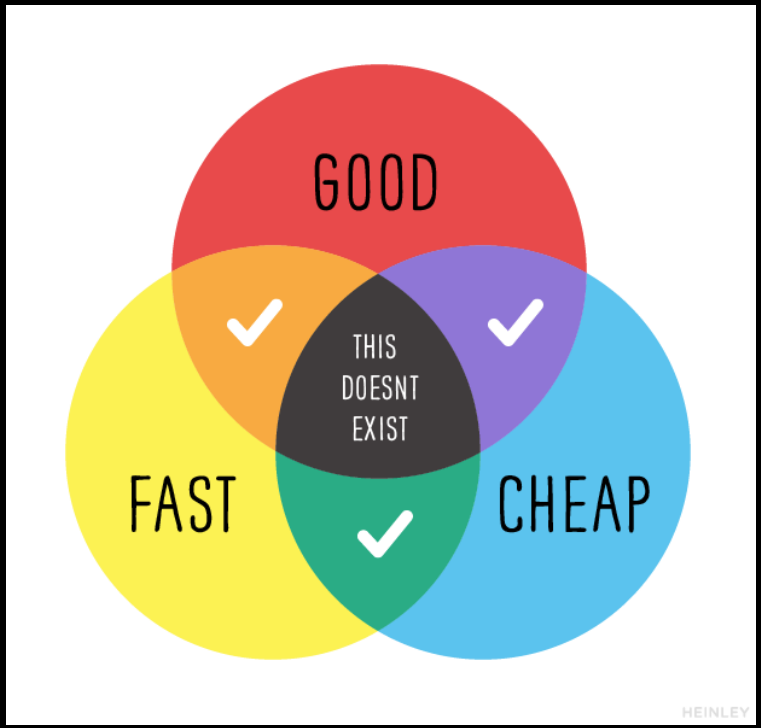
CONCEPT Timeline



Why Trauma Screening?

- Essential element of trauma informed systems
- Early identification
- Connect with trauma-focused assessment and access to clinical services
- Integrate into CPS case planning
- Goal: Screen all children

Selecting a Screening Measure



- Limitation of existing measures
  - Length
  - Ease of use
  - Clinical education requirements
  - Cost
- Need:
  - Brief, validated, low-cost measures for parent & child

Implementation Considerations

- Trauma history, symptoms, or both?
- What are the existing processes/assessments?
- Where does screening fit?
- Who will screen?
- Who will be screened? When? Which programs?
- How will screenings results be used?

Developing a Plan

- Met with staff at area offices
- Trained on life of a CPS case/worker
- Screening implementation workgroup
- Developed clinically-informed tool
- Qualitative Pilot
- Empirical tool development
- Validation & implementation pilots

Systems Effected by Trauma Screening

Concerns about Screening

- Project fatigue/measure fatigue (“one more thing”)
- Time
- Avoidance/concerns about asking families about trauma
- “We already know about their trauma”
- Link to available EBPs (are services even available?)
- How will this added work help me do my job?

Connecticut Trauma Screen (CTS)

- 10 items
  - 4 trauma exposure (lifetime)
  - 6 PTSD symptoms (last 30 days)
- Selection of symptom items a combination of
  - Empirically derived
  - CPS staff input (feasibility/utility)
  - Reflect DSM-5 diagnosis/clusters
- Child and parent report versions

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Connecticut Trauma Screen

Child Report (Age 7+)

Child ID: _____ Date Completed: _____ Administered By: _____

Gender: ☐ Male ☐ Female Age: _____

EVENTS: Sometimes, scary or very upsetting things happen to people. These things can sometimes affect what we think, how we feel, and what we do.

		Yes	No
1.	Have you ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other?	☐	☐
2.	Has someone ever really hurt you? Hit, punched, or kicked you really hard with hands, belts, or other objects, or tried to shoot or stab you?	☐	☐
3.	Has someone ever touched you on the parts of your body that a bathing suit covers, in a way that made you uncomfortable? Or had you touch them in that way?	☐	☐
4.	Has anything else very upsetting or scary happened to you (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? *What was it?* _____	☐	☐

REACTIONS: Sometimes scary or upsetting events affect how people think, feel, and act. The next questions ask how you have been feeling and thinking recently.

How often did each of these happen in the last 30 days?		**Never/ Rarely**	**1-2 times per month**	**1-2 times per week**	**3+ times per week**
5.	Strong feelings in your body when you remember something that happened (sweating, heart beats fast, feel sick).	0 ☐	1 ☐	2 ☐	3 ☐
6.	Try to stay away from people, places, or things that remind you about something that happened.	0 ☐	1 ☐	2 ☐	3 ☐
7.	Trouble feeling happy.	0 ☐	1 ☐	2 ☐	3 ☐
8.	Trouble sleeping.	0 ☐	1 ☐	2 ☐	3 ☐
9.	Hard to concentrate or pay attention.	0 ☐	1 ☐	2 ☐	3 ☐
10.	Feel alone and not close to people around you.	0 ☐	1 ☐	2 ☐	3 ☐

Trauma Screening Pilots

1. Yale Outpatient Clinic Pilot: Validation Study
2. DCF Area Office Foster Care Placement
3. Multidisciplinary Evaluation Intake Pilot

Yale Outpatient Validation Pilot

	Parent Responses n=69		Child Responses n=45	
	Mean	*SD*	Mean	*SD*
Total Exposure Count	1.1	1.0	1.5	1.2
Exposure Items	N	%	N	%
Witness violence	20	29.0	17	39.5
Victim Physical	10	14.5	12	27.9
Victim Sexual	10	14.5	10	22.2
Victim Other	35	50.7	27	61.4
	Mean	*SD*	Mean	*SD*
Total Reaction Score	4.2	4.7	3.9	3.7
Symptom Items (Any Positive Response)	N	%	N	%
Strong feelings in body	19	27.5	16	36.4
Avoid people, places, reminders	18	26.5	15	34.1
Trouble feeling happy	27	39.1	15	34.1
Trouble sleeping	26	37.6	19	43.1
Difficulty concentrating	37	53.6	24	54.5
Not close to people	23	33.9	12	27.2

Lang & Connell, under review

Yale Outpatient Validation Pilot: Convergent & Divergent Validity

	Parent Responses		Child Responses	
	Exposure	Reaction Score	Exposure	Reaction Score
CONVERGENT VALIDITY				
CPSS Total Score	0.49**	0.93**	0.78**	0.88**
CPSS-5 Total Score	0.71**	0.97**	0.74**	0.90**
DIVERGENT VALIDITY				
SCARED Total Score	-0.09	0.06	-0.22	0.01
MFQ Total Score	0.04	0.24	-0.13	-0.03
SNAP-IV (ADD)	-0.13	0.11	--	--
SNAP-IV (Hyperactivity)	-0.09	0.14	--	--
SNAP-IV (ODD)	-0.06	0.27	--	--
Ohio Scales Problem Severity	-0.05	0.28*	-0.10	0.04
Ohio Scales Functioning	0.01	-0.14	0.29	-0.05

* p<.05; ** p<.01

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Yale Outpatient Validation Pilot: Criterion Validity

	Parent Responses			Child Responses		
Cut-Point (≥ #)	Sensitivity	Specificity	Correct Classification (%)	Sensitivity	Specificity	Correct Classification (%)
1	1.00	0.00	22.5	1.00	0.00	33.3
2	1.00	0.42	55.0	1.00	0.38	58.3
3	1.00	0.45	57.5	1.00	0.44	62.5
4	1.00	0.61	70.0	1.00	0.56	70.8
5	1.00	0.74	80.0	1.00	0.69	79.2
6	1.00	0.84	87.5	0.88	0.88	87.5
7	1.00	0.87	90.0	0.63	0.94	83.3
8	1.00	0.90	92.5	0.50	0.94	79.2
9	0.89	0.94	92.5	0.38	0.94	75.0
10	0.78	1.00	95.0	0.38	1.00	79.2
11	0.56	1.00	90.0	0.25	1.00	75.0
12	0.44	1.00	87.5	0.12	1.00	70.8
13	0.33	1.00	85.0	0.00	1.00	66.7
14	0.00	1.00	77.5	--	--	--

Lang & Connell, under review

Take Home

- CTS is a brief, free, empirically derived screen for trauma exposure and symptoms for parents and youth

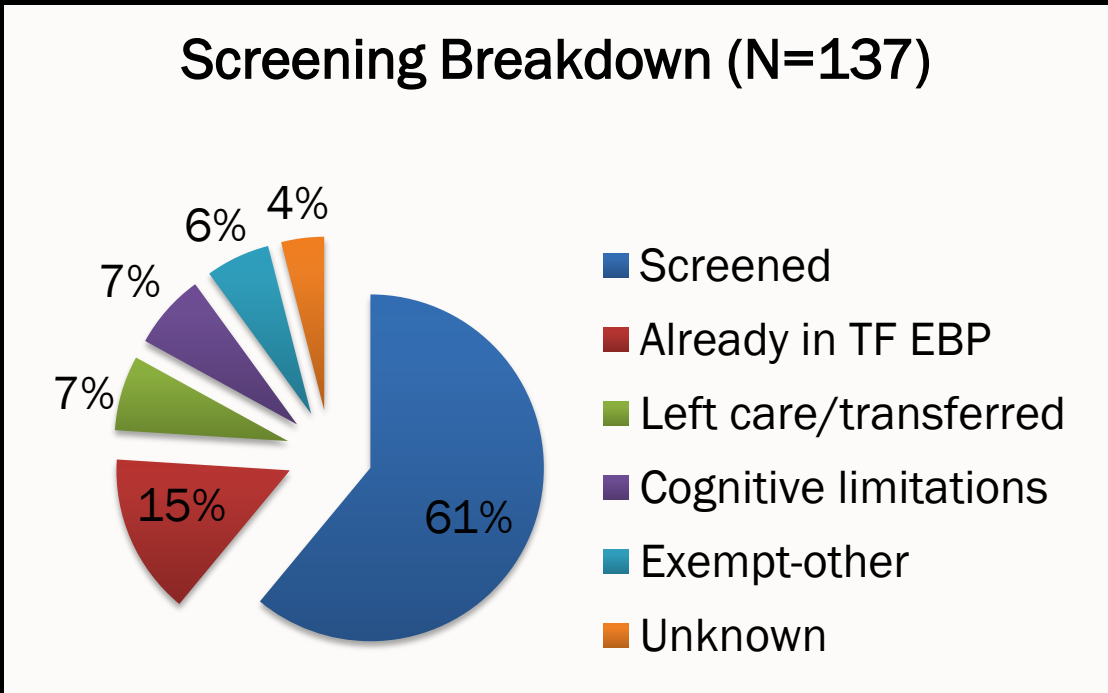
- Preliminary validation study indicates the CTS has
  - Convergent validity with established PTSD screen
  - Divergent validity with other behavioral screens
  - Criterion validity (sensitivity and specificity)

- Cut-points of 8 (parent version) and 6 (child version) recommended; consider a 6 or higher on either screen

DCF Area Office Pilot

- Goal: Evaluate feasibility/utility of trauma screening conducted by foster care case workers

- Population: All children in out of home placements (N=137) in December 2014
  - Caseworkers had worked with child for average of 14 months
  - 83 Children screened
    - 72 caregiver report
    - 76 youth report
    - 65 both reports



DCF Foster Care Pilot: Child Results

Table 1. CTS and CTS-Y Exposure Responses

	Caregiver Data (CTS) n=72		Child Data (CTS-Y) n=76	
	Mean	***SD***	**Mean**	***SD***
Overall Count	2.2	1.2	2.3	1.2
CTS Exposure Item	**N**	**%**	**N**	**%**
Witness violence	48	68.6	54	71.1
Victim Physical (e.g., hit, punch, kick, object)	37	52.1	48	64.0
Victim Sexual (e.g., touched inappropriately)	20	24.1	22	28.9
Victim Other (e.g., other upsetting/scary incident)	54	77.1	58	77.3

Table 2. CTS and CTS-Y Trauma Symptom Responses

	Caregiver Data (CTS) n=72		Child Data (CTS-Y) n=76	
	Mean	***SD***	**Mean**	***SD***
Reaction Score	6.8	4.9	6.2	4.3
CTS Symptom Items (Any Positive Symptom Response)	**N**	**%**	**N**	**%**
Strong feelings in body	31	43.7	36	47.3
Avoid people, places, reminders	33	47.2	35	46.7
Trouble feeling happy	43	60.5	42	55.3
Trouble sleeping	31	43.7	43	56.6
Difficulty concentrating	60	84.5	60	79.0
Not close to people	40	58.0	33	43.4

DCF Foster Care Pilot: Feasibility/Utility

Table 3. CTS and CTS-Y Implementation Questions

	Caregiver Data (CTS) n=48		Child Data (CTS-Y) n=57	
	Mean	***SD***	**Mean**	***SD***
1. Time to administer (minutes)	8.2	5.6	9.9	6.3
2. Time providing services to child/family (months)	13.6	17.7	15.1	16.2
	N	**%**	**N**	**%**
3. Identify new trauma history (% Yes)	8	17.0	13	22.8
4. Identify new trauma reactions (% Yes)	7	15.4	13	23.2
5. Screening impact on engagement:				
Helped	9	19.1	15	26.3
No Effect	37	78.7	40	70.2
Hindered	1	2.1	2	3.5
6. Enhance understanding of child/family needs (% Yes)	16	34.0	19	33.3
7. Seeking further consultation based on results? (% Yes)	12	25.0	14	25.0
8. Screen results change treatment plan? (% Yes)	7	14.6	7	12.5
9. Child/Caregiver uncomfortable with screening				
None	34	73.9	31	55.4
A Little	3	6.5	9	16.1
Some	9	19.6	16	28.6
A Lot/Extremely	0	0.0	0	0.0
10. Manage child's discomfort without support? (% Yes/NA)	46	95.8	57	100.0
11. Filed child abuse report based on screen? (% Yes)	2	4.2	0	0.0
12. Time spent on screen worth information? (% Yes)	34	70.8	40	71.4
13. Ease of administration				
Very Easy	22	46.8	25	43.9
Easy	23	48.9	30	52.6
Difficult	2	2.4	2	3.5
Very Difficult	0	0.0	0	0.0

Take Home

- Rates of trauma exposure and symptoms higher than outpatient care sample
- DCF staff reported CTS was quick and easy to use
- New incidents or symptoms identified in 15-25% of cases; enhanced understanding of cases about 33% of the time
- Despite new information and understanding, less of an impact on treatment planning

Multidisciplinary Evaluation (MDE) Implementation

	CTS Data n=591	
	Mean	***SD***
Overall Count	2.0	1.2
CTS Exposure Item	**N**	**%**
Witness violence	376	63.6
Victim Physical (e.g., hit, punch, kick, object)	277	46.8
Victim Sexual (e.g., touched inappropriately)	119	20.1
Victim Other (e.g., other upsetting/scary incident)	402	68.1
	Mean	***SD***
Reaction Score	5.0	4.4
CTS Symptom Items (Any Positive Symptom Response)	**N**	**%**
Strong feelings in body	216	37.0
Avoid people, places, reminders	264	45.4
Trouble feeling happy	249	42.6
Trouble sleeping	254	43.6
Difficulty concentrating	329	56.6
Not close to people	196	33.7

Lang et al, under review

Implementation Questions

- Prior to CTS:
  - 73% of MDE clinicians asked about exposure to traumatic events most or all of the time
  - 91% asked about trauma-related symptoms
  - Primarily informal questions of the youth, caregiver, or caseworker; or through a review of the youth's file.

- Under revised MDE, youth report was now the primary source of information used to complete the CTS, followed by caseworker report and record review.

Implementation Questions

- Ratings of the CTS were very favorable:
  - enhanced understanding of the child's needs
  - Identified new traumatic exposures or symptoms
  - Information led to changes in case service plans
  - Relatively low levels of discomfort for youth or caregiver

- CTS was quick and easy to use:
  - average of 8.9 minutes (sd=3.0 minutes) to administer.
  - Ease of administration were very high (4.3 out of 5)
  - Worth time spent rated favorably (4.1 out of 5)
  - Didn't impact engagement positively or negatively

Take Home

- Statewide implementation at critical case juncture of (intake) is feasible through MDE process – reaches most youth entering child welfare custody

- Rates of trauma exposure and symptoms higher than outpatient care sample, but lower than foster care sample

- MDE staff reported CTS was quick and easy to use

Lessons Learned

- Integration of screening within child welfare process is complicated – requires buy-in at multiple levels
- Rates of exposure/symptoms are very high – but vary by system context
- CPS workers report trauma screening as helpful, but may require more guidance on integrating to case planning
- Preliminary analyses suggests tool is valid screener for trauma-related symptoms

Next Steps

- Case reviews of children screened
- Integrating into practice (CCWIS)
- Screening in other systems
- Screening young children
- RI Child Welfare Grant: Pairing Screen with other behavioral health tools

DISCUSSION AND ACTION

Zooming Out

Lessons from CA and CT

Sharing other novel approaches & ideas

Identifying screening needs /solutions

Planning next steps

Thank you!

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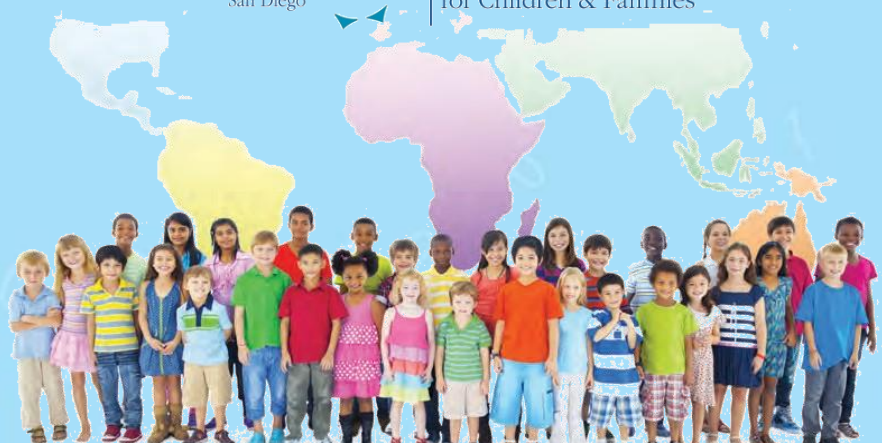

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