Screening and Referral in Child Welfare for Effective Mental Health and Trauma Support

Lessons Learned from Early Adopter Counties

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

CASAT
California Screening, Assessment, and Treatment

ADMINISTRATION FOR CHILDREN & FAMILIES

Agenda

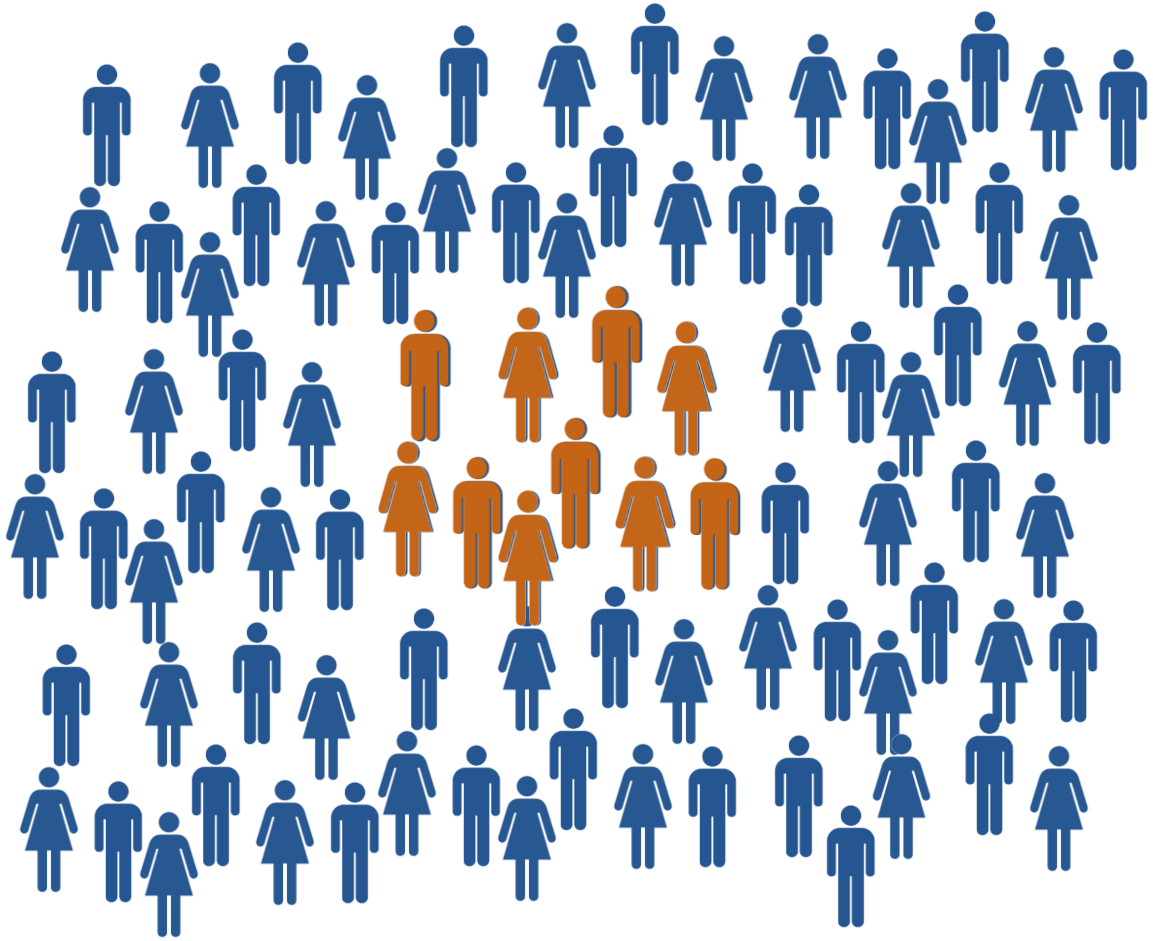
- Overview: Screening and Referral
- Approaches to Screening Implementation
- Implementation of Standardized Screening in Tulare County Child Welfare Services
- The Mental Health Referral Process
- Conclusion & Discussion

How well do you think the screening and referral process is working in your county to help kids in child welfare get mental health services when they need them?

Text a **CODE** to **37607**

WHAT IS SCREENING?

Among kids involved in CW there are some who need to be referred to MH treatment…



WHY IS SCREENING SO IMPORTANT IN CWS?

Out of 10 Youth in the US…

Potentially Traumatizing Events

62%

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*, 815-830.

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…

Maltreatment

≈100%

US Department of Health and Human Services. (2013). Child Maltreatment 2012.

Significant Mental Health Need

48%

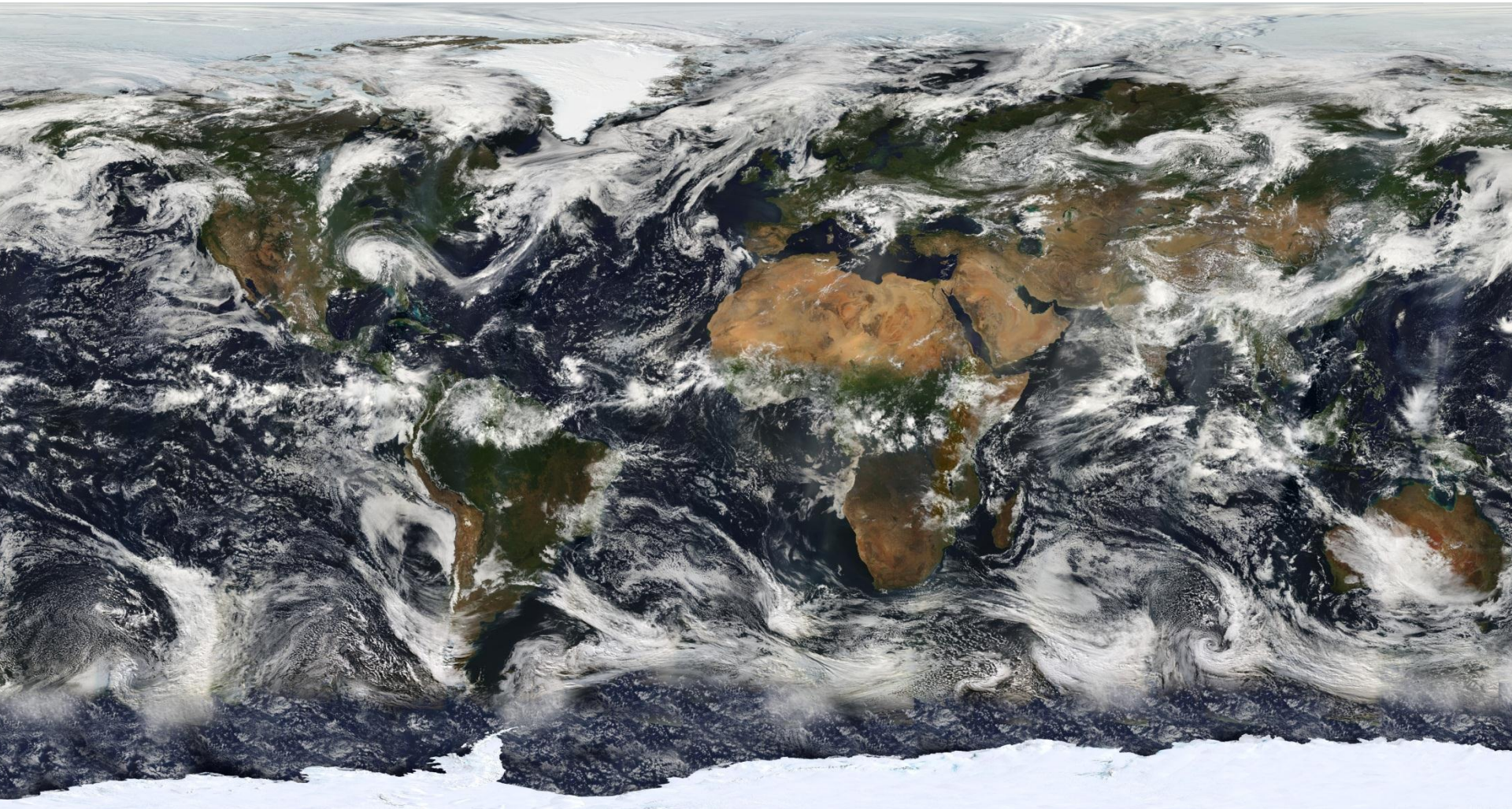
Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 960-970.

[*based on children and youth investigated by CW, not open cases]

PURPOSES OF SCREENING IN CWS

- Katie A Requirement
- Federal Mandate
- Real Reason
  - CW system has the capacity to enhance well-being in a meaningful way

SURVEYING AN EVER CHANING LANDSCAPE



3

MAIN SCREENING APPROACHES TO IDENTIFY MENTAL HEALTH NEEDS IN CWS

1 NO USE OF SCREENING TOOL

- AKA The Eyeball Test or “Needs-Based Screening”

- No standardized tools used in screening process OR tools used **after** referral decision already determined.

1 NO USE OF SCREENING TOOL

Strengths

- Least resources and time needed (only upfront)

1 NO USE OF SCREENING TOOL

Concerns

- Referrals heavily impacted by bias, memory, and judgment
- No direct report from client/families
- Strong evidence this approach is ineffective

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

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.

2 ASSESSMENT INFORMATION CONSOLIDATED BY WORKERS

- Tools used to standardize process and document worker perceptions during assessment process, later used to make referrals.
  - E.g., CANS, MHST, SDM

2 ASSESSMENT INFORMATION CONSOLIDATED BY WORKERS

Strengths

- Easy access to respondents (workers)
- Can reduce errors caused by memory or inconsistency between workers (not always)
- Sometimes includes collateral information

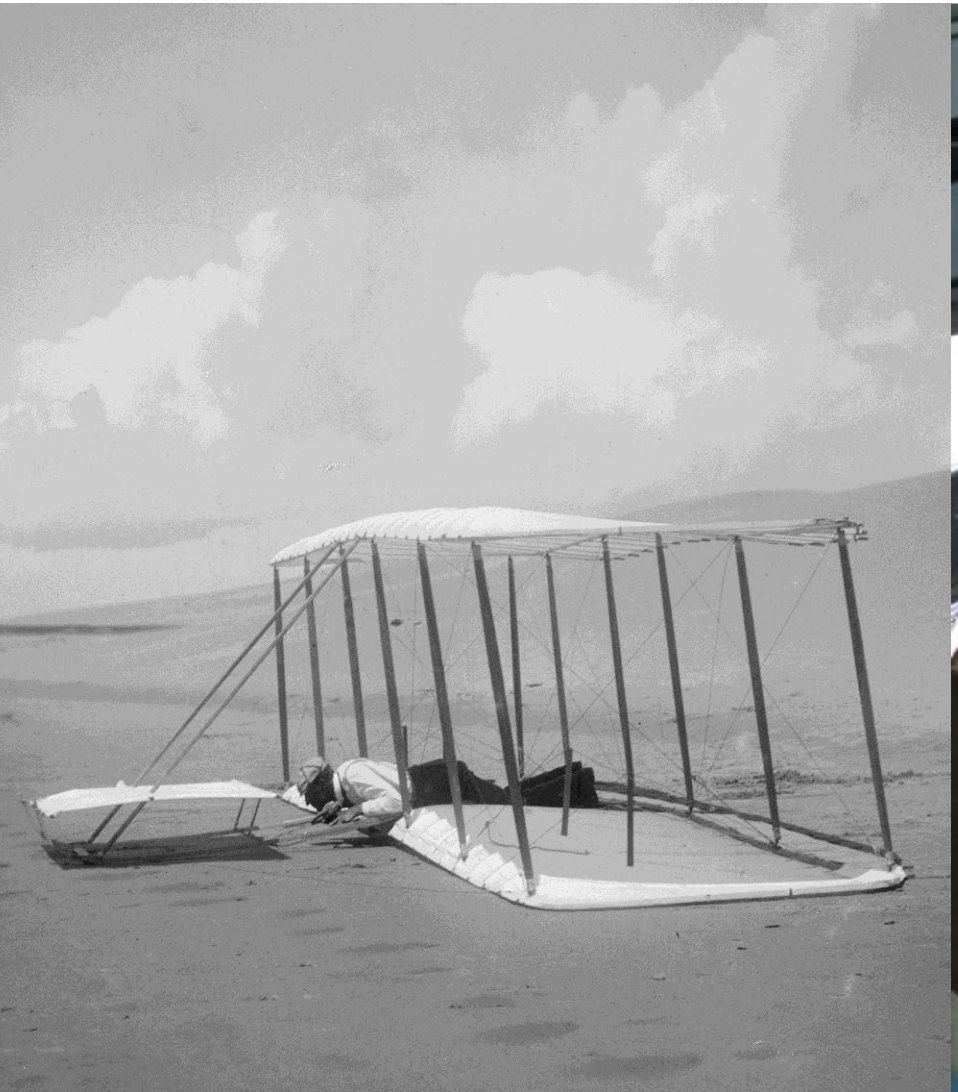
2 ASSESSMENT INFORMATION CONSOLIDATED BY WORKERS

Concerns

- Heavily relies on perceptions, judgment, and training (for accuracy and consistency)
- Often influenced by bias
- Does not include direct report from client/family
- Typically not an evidence-informed approach to screening.


INFORMATION FROM
THE SOURCE

Building a Better Cockpit



3 REFERRAL DECISIONS INFORMED BY EVIDENCE-INFORMED MEASUREMENT TOOLS

- Evidence-informed tool(s) completed by caregivers, youth, and others in the assessment process to inform referral decision making.

3 REFERRAL DECISIONS INFORMED BY EVIDENCE-INFORMED MEAUSREMENT TOOLS

Strengths

- Direct feedback from the youth/family
- Evidence-informed (tool & information source)
- Eliminate dependence on memory, bias, judgment alone
- Reduce inconsistency between workers
- Can include collateral information

3 REFERRAL DECISIONS INFORMED BY EVIDENCE-INFORMED MEAUSREMENT TOOLS

Concerns

- Can require more upfront resources and time
- Implementation needs to be thoughtful
- Training and ongoing oversight needed to ensure appropriate use

Appropriate Tools

Schoenwald, S. K., Garland, A. F., Chapman, J. E., Frazier, S. L., Sheidow, A. J., & Southam-Gerow, M. A. (2011). Toward the effective and efficient measurement of implementation fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 32-43.

What's under the umbrella?

Mental Health & Trauma Needs

General Mental Health Screening Tools

ASQ:SE-2: Ages and Stages Questionnaire: Social-Emotional
Ages Covered: 1-72 months
Languages Available: English, Spanish
Administration Time/# Items: 10-15 minutes/30 items
Filled Out By: Caregiver
Cost: $275 Inro Kit (http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-se-2/)

PSC-17: Pediatric Symptom Checklist
Ages Covered: 4-18+
Languages Available: English, Spanish, Chinese, Vietnamese
Administration Time/# Items: 5 minutes/ 17 items
Filled Out By: Child/Youth, Caregiver
Cost: None

SDQ: Strengths and Difficulties Questionnaire
Ages Covered: 2-17+
Languages Available: English, Spanish, Arabic, Chinese, Farsi, French, German, etc.
Administration Time/# Items: 5 minutes/25 items
Filled Out By: Child/Youth, Caregiver
Cost: None

Trauma Screening Tools

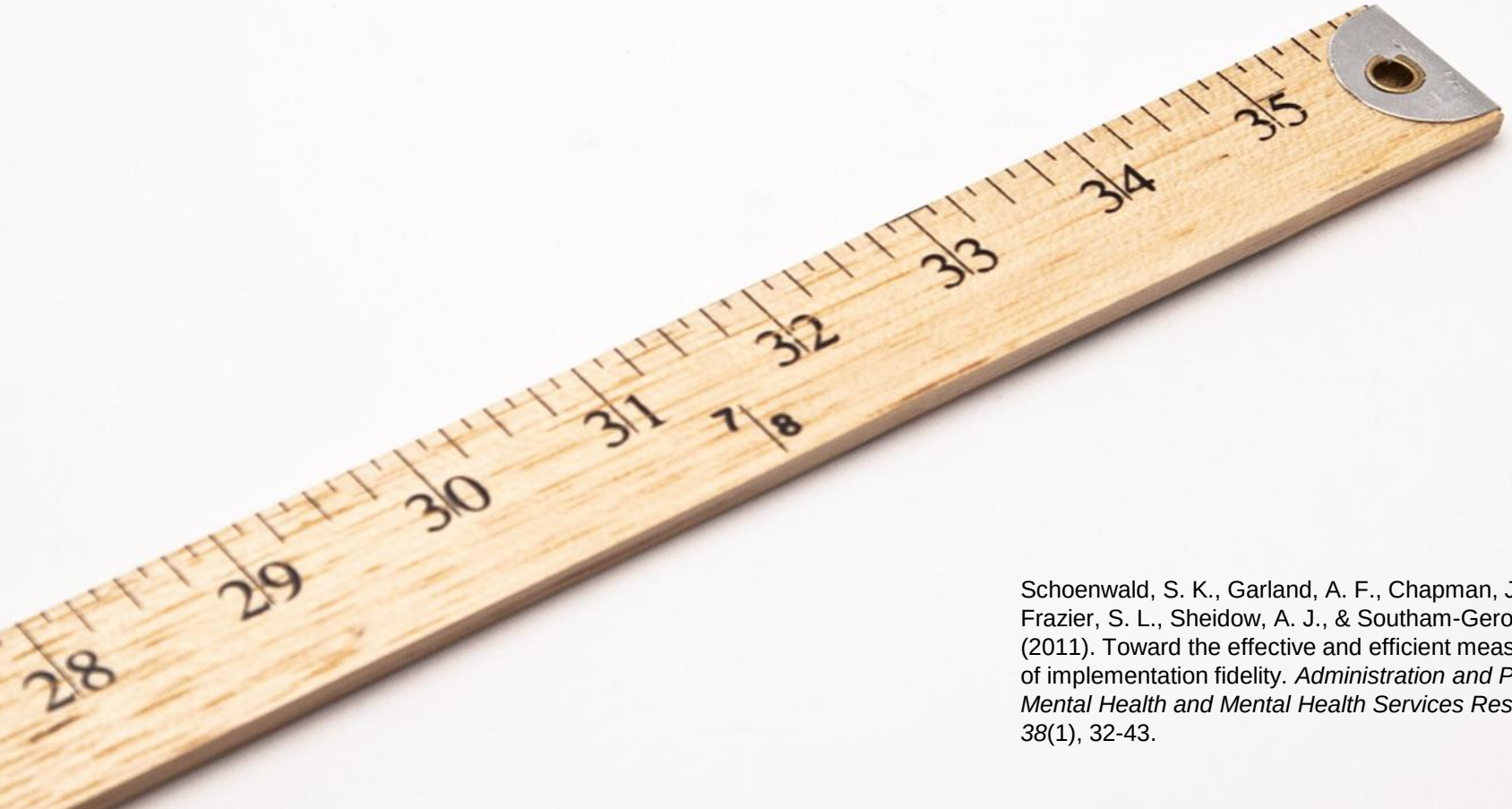
ASC-Kids: Acute Stress Checklist for Children
Ages Covered: 8-17+
Languages Available: English and Spanish
Administration Time/# Items: 10 minutes/29 items
Filled Out By: Child/Youth
Cost: None

CPSS: Child PTSD Symptom Scale
Ages Covered: 8-18+
Languages Available: English, Spanish, Korean, Russian
Administration Time/# Items: 10 minutes/17 items
Filled Out By: Child/Youth
Cost: None

CRIES-8: Children's Revised Impact of Event Scale
Ages Covered: 8-18+
Languages Available: English, Spanish, Arabic, Chinese, Farsi, French, German, etc.
Administration Time/# Items: 5 minutes/8 items
Filled Out By: Child/Youth
Cost: None

SCARED Brief Assessment of PTS Symptoms
Ages Covered: 3-18+
Languages Available: English, Spanish
Administration Time/# Items: 5 minutes/4 items
Filled Out By: Child/Youth, Caregiver (supplemental version for case workers and teachers available)
Cost: None

Effectively & Efficiently Implemented



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Referral Process: Case Workers

- **Discuss what was identified with the family.**
- **Educate and collaborate on what might help address needs.**
- **Create a plan with the child and family.**
  - **Promote continuity of care through collaboration with mental health providers.**
- **See the referral through and ensure the family was able to overcome any unexpected barriers.**
  - **Keep accurate documentation of the referral plan**

Adapted from the Health Care Toolbox (https://www.healthcaretoolbox.org/what-providers-can-do/when-and-how-to-refer-for-mental-health-care.html#Referral)

ISN'T IT RISKY TO ASK KIDS AND FAMILIES ABOUT TRAUMA?

Distress from Asking about Trauma

- Telephone Survey
  - 2,012 youth
    - 10-17 years old
    - Experiences to 54 types of victimization
  - 4.6% reported any upset
  - 0.3% who would not participate again
  - **0.05% (n=1) said it was because of nature of the questions**

Finkelhor, D., Vanderminden, J., Turner, H., Hamby, S., & Shattuck, A. (2014). Upset among youth in response to questions about exposure to violence, sexual assault and family maltreatment. *Child abuse & neglect*, *38*(2), 217-223.

Talking about Trauma

- Pros/Cons of Knowing and Not Knowing?
- "Validating to be asked" (Felitti on ACE Study)
- Training
  - Help staff effectively and confidently engage in conversations

    - General Tips:
      - Inform of purpose and what to expect
      - Have a plan - resources
      - Understand common reactions to trauma
      - Empathy and Understanding
      - Check-in on Emotions/Distress

APPROACHES TO SCREENING IMPLEMENTATION

Work with CA Counties on Screening

- Initial work with Tulare County
- In 2013, Tulare began to use 2 standardized tools to screen for mental health and trauma needs in children in CW

Work with CA Counties on Screening (*continued*)

- Northern Region Screening Implementation Community (NRSIC)
  - Learning Community with 4 Northern Region counties
- Implementation of evidence-informed, standardized tools to screen for mental health and trauma needs of children involved with CW

Work with CA Counties on Screening (*continued*)

- Northern Region Screening Implementation Community (NRSIC)
- Examination of current practice
  - training staff on screening procedures
  - use of screening information including referrals to mental health
  - tracking screening information
  - quality assurance activities

Northern Region Screening Implementation Community (NRSIC) – Participating Counties

County	County Population*	Entries to Foster Care*
Del Norte	27,212	76
Humboldt	134,809	168
Yolo	207,590	149
Yuba	73,966	111

* 2014 statistics

Northern Region Screening Implementation Community (NRSIC)

- At the start of the Learning Community

  -3 of the 4 counties were using the Mental Health Screening Tool, completed by CW staff, to identify mental health needs

  -One county was using the Strengths and Difficulties Questionnaire (SDQ) and Ages and Stages Questionnaire (ASQ-3)/Ages and Stages Questionnaire - Social-Emotional (ASQ-SE) for younger children

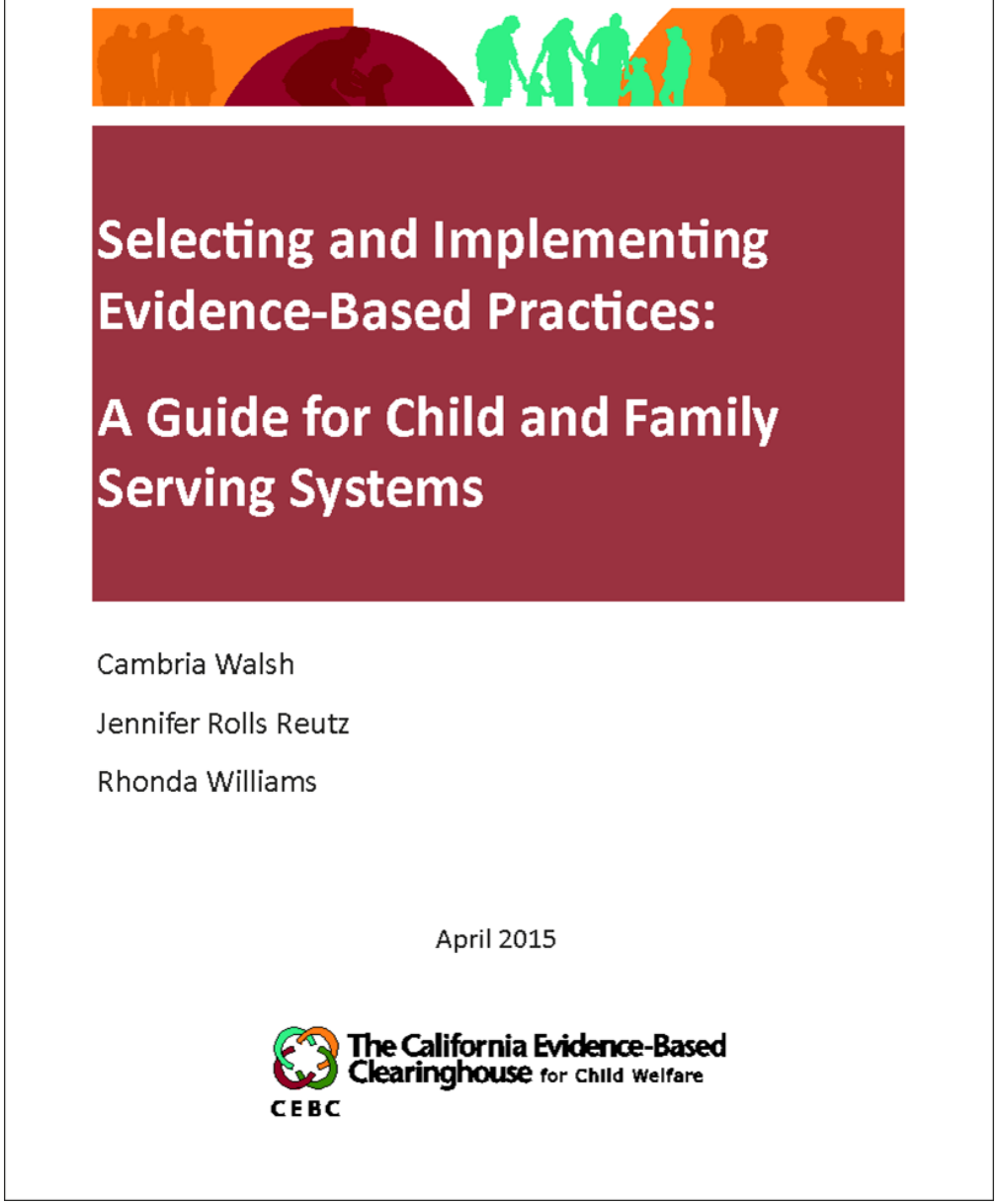
  -None of the counties were using a tool to specifically screen for trauma

- All counties were interested in adopting a trauma screening tool and looking at aspects of their screening processes

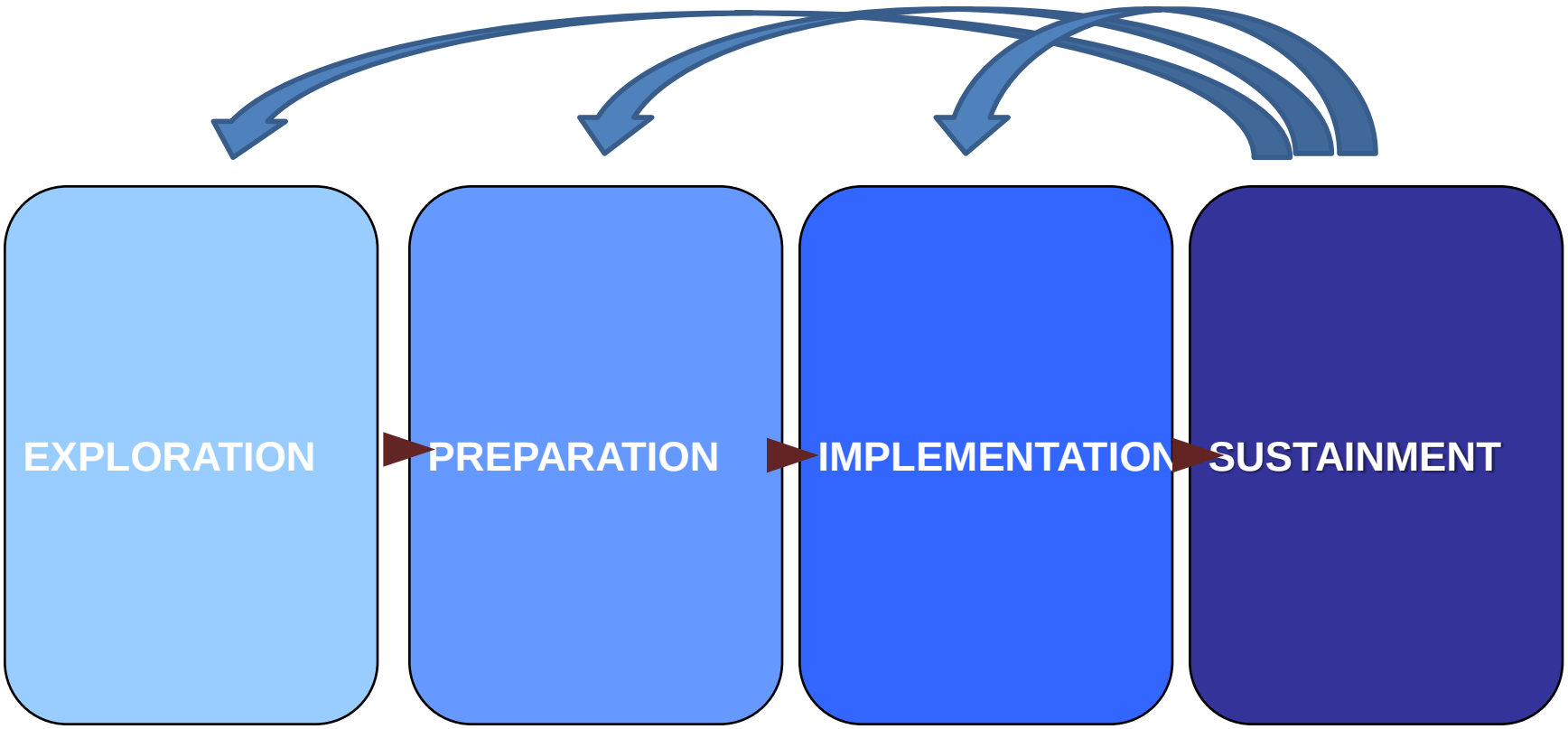
Northern Region Screening Implementation Community (NRSIC) - Approach

- Informed by Implementation Science principles
- Conceptual framework
  - Exploration, Preparation, Implementation, Sustainment (EPIS) model
  - Organizing framework that considers stages of implementation for evidence-based practices and activities associated with each stage
- Utilized materials from the California Evidence-Based Clearinghouse “Implementation Guide”

Available at
www.cebc4cw.org



EPIS Phases of Implementation

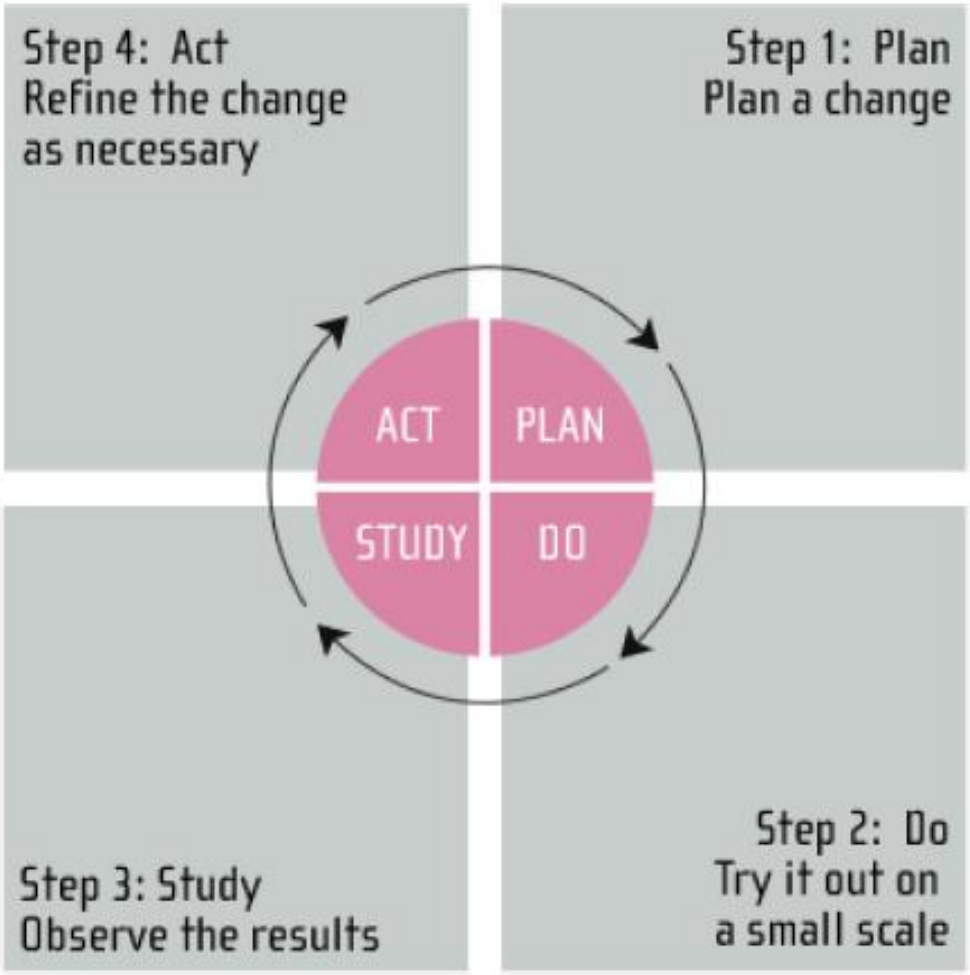


Source: Aarons, G.A., Hurlburt, M., & Horwitz, S.M. (2011). Advancing a conceptual model of implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), 4-23.

NRSIC: Key Areas Addressed in "Preparation" and "Implementation"

- Tool selection
  - Menu of evidence-informed screening tools for trauma and mental health needs
  - Stakeholder review of tools
  - Small scale tests of tool(s)

PDSA: Plan-Do-Study-Act



Plan hunch, theory & predict

Do small scale

Study to learn

Act adopt, adapt, abandon

PDSA Cycle Worksheet

Goal Being Addressed: *What are we trying to accomplish?*	
Desired Outcome: *What data will tell us a change is an improvement?*	
Strategy: *What change can we test that will result in improvement?*	
PDSA Title:	
PLAN: What are we going to do? (What is the change being tested?)	
Who is going to do it?	
When will it be done?	
Hypothesis (What do we expect will happen?):	
DO: What happened? (briefly)	
STUDY: Did what we expect to happen actually happen? What was different than what we expected? What did we learn?	
ACT: What learnings will we apply to our next text cycle? What will our next PDSA be?	

NRSIC: Key Areas Addressed in "Preparation" and "Implementation" (*continued*)

- Staffing and training
  - Staffing plan for administering the screening tools
  - Training that will be required
    - Initial training for existing staff
    - Periodic retraining
    - Training for new staff
  - Developed general staff training slides on conducting screening

NRSIC
CASAT

Staffing Plan

An important part of preparing for implementation is to review the staffing plan for the screening program. Below are questions to consider as the plan for staffing the program is being created:

- Which staff will administer the screening? Caseworkers (ER, on-going, etc.), MH providers, clerical staff, etc.
    - Does the screening measure you have selected require any specific qualification? Master's level, licensed, etc.?
- Are there any specific staffing needs to be considered? On call, 24-hour coverage, evening coverage, weekend coverage, etc.?
- Are the staff already in place in the agency that will deliver the program, or will they need to be hired?
    - If using existing staff (e.g. caseworkers), how different is this from their current work? May need to do additional work to ensure transition goes smoothly and workers are on board with, as well as part of, the changes.
    - If staff is to be hired (e.g. setting up screening coordinator position), job descriptions will need to be created.
- Are there any union issues to consider regarding staff?
- Timeline for staff – need to get staff in place in time to complete training before services begin. Allow plenty of time for hiring new staff and plan for what they will do before starting training - do they need to be oriented to the agency, the community, etc.?

NRSIC

CASAT

Training & Coaching Considerations

There are several considerations that must be made regarding training and coaching for any new program:

- What training is required for staff to implement the screening measures?
  - Who can provide the training, how long is it, where is it provided, how much will it cost, etc.?
- Does staff need to be certified in order to administer the measure(s)?
  - How is the certification maintained?
- Develop a training timeline to ensure that it is clear on what needs to be done and how long it will take.
- Clarify training requirements for supervisors and staff. At a minimum, supervisors should complete the standard staff training; ideally, they will receive some additional training.
- Will periodic booster trainings be provided? All staff or only those with concerns? What will the timing be?
- How will training be paid for? Does the funding source allow for an initial funding budget? Will it cover ongoing trainings?
- What is the plan for training new staff when turnover occurs?
  - If possible, incorporate into existing training for new staff so that it becomes part of the routine.

NRSIC: Key Areas Addressed in "Preparation" and "Implementation" (*continued*)

- Administration and tracking issues
  - Scoring of the tool(s)
  - Entering information
    - CWS/CMS
    - Other?

NRSIC: Key Areas Addressed in "Preparation" and "Implementation" (*continued*)

- Administration and tracking issues (*continued*)
  - Capacity to track/monitor the information
    - Track completion of tools
      - Tools completed for all target cases?
      - Completed correctly/fully? (e.g., correct version(s), missing information)
    - Track results of the screening tools (e.g., scores)
    - Track what is done with the information
      - referrals to mental health and outcomes of referrals

Implementation of Standardized Screening in Tulare County Child Welfare Services

Tulare County Demographics

- Medium size county
  - Population 450,000
- Rural and agriculture
- Average 1050 out-of home CWS dependents
- CWS Demographics
  - ER/10 day- 46 social workers(sw)
  - Court Report Writers- 12 sw
  - Continuing- 64 sw

Screening in Tulare

- A look at 2013-2014 and the Katie A. Initiative
  - 1088 back screens completed
  - 560 referrals to mental health for an assessment
  - 510 received mental health services
  - 80 receiving *intensive* mental/behavioral health services

Screening and the Court Report Timeframes

- Incorporate screening into an already established process.
  - Court Report Timeframe- every 6 months

- First screen:
  - Initial assessment within 30-45 days of entry
  - Prior to case plan development
  - Include information into the Jurisdictional/Dispositional court report

- Subsequent screens:
  - As needed or every 6 months (30 days prior to the court hearing)

How to make the “sell”…

- Guided conversation during investigations
- Helps “explain” symptoms and behaviors
- Information for court report
- Proactive vs. reactive social work
- Guides the referral process
- Becoming a trauma informed system
- Consistent social work practice
- Youth, care provider and parent voice

Resource Parents

- Increase awareness about trauma and reactive behaviors in children
- Connection between presenting behaviors and prior trauma experiences
- Decreases the labeling of:
  - “out-0f-control” children
  - ADHD
  - RAD

Training

- Time training to implementation
- Train at the beginning of the month
  - “road show”
- Practice the screens during the training
  - Social workers and resource parents
- Child Welfare Trauma Training Toolkit-NCTSN

Barriers/Limitations

- Balance of not under estimating a new initiative and not making it more complicated than it is.
  - Initiative fatigue
- CWS Documentation in CWS/CMS database
- Technology with the scoring tool
- Not relying just on the tool for mental health referral decisions
- Creating autonomy and support around decisions

Sustainability

- Screens are attached to mental health referral packets.
- Information is used in court reports
- Screens are listed on transfer summary and case transfer check-off list
- Listed on court report review check-list
  - Tools are attached to the court report review guide and report is not signed off unless completed.
- Supervisors use the tool information as part of their consultation with social worker
  - “Ticket” to consult with supervisor

The Mental Health Referral Process

Example of Referral

TULARE COUNTY CHILD WELFARE SERVICES
CHILDREN'S MENTAL HEALTH LETTER OF REFERRAL (LOR)
ICC Eligibility Screening

Initial ☐ Annual ☐ Unscheduled ☐ Date Opened to CWS:
Date Social Worker Initiated referral:
Social Worker: Phone Number: Next Court Date:

IDENTIFYING INFORMATION:

Client Referred: Date of Birth: SSN:
Client's Preferred Language: Ethnicity:
Address: Phone#:
Case Name (mother): Case#:
Program Component: ☐ ER ☐ FM ☐ FR ☐ PP ☐ Adoptions ☐ Voluntary Services ☐ EFC/AB12
Individualized Educational Plan (IEP): Yes ☐ No ☐
Name of minor's current substitute care provider: Phone#:
Approved to Participate in Treatment: Yes ☐ No ☐
Address:

Names of Biological Parents: Phone#:
Approved to Participate in Treatment: Yes ☐ No ☐
Address:

MEDICAL/MENTAL HEALTH RIGHTS HELD BY (name): Phone #:
Approved to participate in Treatment: Yes ☐ No ☐
Address:

SUBCLASS ELIGIBILITY CRITERIA:

1. Does the above mentioned child have full-scope Medi-Cal? Yes ☐ No ☐
2. Is the above mentioned child already receiving or been referred to a mental health clinic? Yes ☐ No ☐
   If yes, name of clinic: Name of assigned therapist:
   ***If No, does social worker believe client would benefit from mental health treatment?** Yes ☐ No ☐ Parent/Child ☐ Declined
   If yes, name of clinic where social worker would like to refer client:
3. Is the child currently receiving or being considered for any of the following services: Yes ☐ No ☐

If yes, select at least one of the following boxes:	Currently receiving service	Being considered for the service
Wraparound	☐	☐
Intensive Therapeutic Foster Care (ITFC)	☐	☐
Specialized Care Rate due to behavioral health needs	☐	☐
Therapeutic Behavioral Services	☐	☐
Crisis Intervention	☐	☐
Placement in an RCL 10 or above facility	☐	☐
Psychotropic Medication	☐	☐
Placement in a Psychiatric hospital (e.g., 5150)	☐	☐

4. Has the child had three or more placements within 24 months due to behavioral health concerns? Yes ☐ No ☐

ATTACHMENTS:

☐Consent for Treatment ☐Release of Mental Health Records ☐Request of Records ☐SDQ ☐SCARED

DO NOT WRITE BELOW THIS LINE

A. Child meets criteria for ICC Subclass: Yes ☐ No ☐ Pending ☐
B. Child referred to mental health clinic? Yes ☐ No ☐
If yes, name of clinic:_____ Date referred:_____
☐ Completed referral and attachments approved by Katie A. Coordinator:
ICC Coordinator_____ _____ _____
Reviewers Name (*Please Print*) Date Signature

Katie A. screen within the Mental Health Referral

SUBCLASS ELIGIBILITY CRITERIA:

1. Does the above mentioned child have full-scope Medi-Cal? Yes ☐ No ☐
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Specialized Care Rate due to behavioral health needs	☐	☐
Therapeutic Behavioral Services	☐	☐
Crisis Intervention	☐	☐
Placement in an RCL 10 or above facility	☐	☐
Psychotropic Medication	☐	☐
Placement in a Psychiatric hospital (e.g., 5150)	☐	☐

4. Has the child had three or more placements within 24 months due to behavioral health concerns? Yes ☐ No ☐

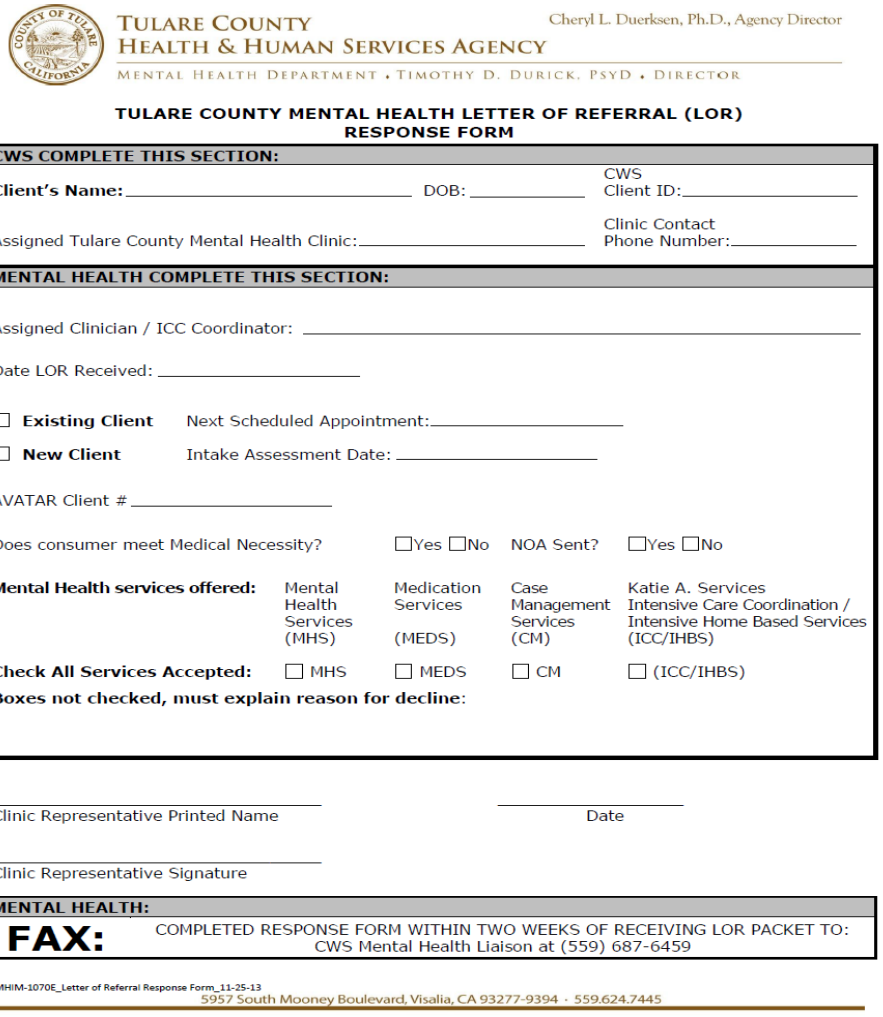
ATTACHMENTS:

☐Consent for Treatment ☐Release of Mental Health Records ☐Request of Records ☐SDQ ☐SCARED

Referral Process

- CWS completes mental health packet
  - Mental Health Referral which includes Katie A. screen
  - SCARED and SDQ screens
  - Release of Information and Consent to Treat Forms
- Mental health packet is sent to one person in managed care that tracks all Katie A. referrals and sends to appropriate children's clinic.
- Mental Health completes assessment and mental health response form within two weeks of receiving the referral from CWS
- Schedules initial CFT meeting within 30 days of referral to mental health.

Mental Health Response Form



TULARE COUNTY
HEALTH & HUMAN SERVICES AGENCY
Cheryl L. Duerksen, Ph.D., Agency Director
MENTAL HEALTH DEPARTMENT • TIMOTHY D. DURICK, PSYD • DIRECTOR

TULARE COUNTY MENTAL HEALTH LETTER OF REFERRAL (LOR) RESPONSE FORM

CWS COMPLETE THIS SECTION:

Client's Name: _____ DOB: _____ CWS Client ID: _____

Assigned Tulare County Mental Health Clinic: _____ Clinic Contact Phone Number: _____

MENTAL HEALTH COMPLETE THIS SECTION:

Assigned Clinician / ICC Coordinator: _____

Date LOR Received: _____

☐ **Existing Client** Next Scheduled Appointment: _____

☐ **New Client** Intake Assessment Date: _____

AVATAR Client # _____

Does consumer meet Medical Necessity? ☐Yes ☐No NOA Sent? ☐Yes ☐No

Mental Health services offered:	Mental Health Services (MHS)	Medication Services (MEDS)	Case Management Services (CM)	Katie A. Services Intensive Care Coordination / Intensive Home Based Services (ICC/IHBS)
Check All Services Accepted:	☐ MHS	☐ MEDS	☐ CM	☐ (ICC/IHBS)

Boxes not checked, must explain reason for decline:

_____ Clinic Representative Printed Name

_____ Date

_____ Clinic Representative Signature

MENTAL HEALTH:

FAX: COMPLETED RESPONSE FORM WITHIN TWO WEEKS OF RECEIVING LOR PACKET TO: CWS Mental Health Liaison at (559) 687-6459

MHIM-1070E_Letter of Referral Response Form_11-25-13
5957 South Mooney Boulevard, Visalia, CA 93277-9394 · 559.624.7445

Coordination and Communication between Mental Health and CWS

- Coordinating continuing CFT Meetings
- Mental Health liaison position in CWS and Mental Health
  - Shared funding between CWS and Mental Health
  - CWS mental health position to have Avatar access
- Clinical Review Questions (CRQ) received from mental health 30 days prior to court hearing.
- Monthly Children System Improvement Committee

Clinical Review Questions

CLINICAL REVIEW QUESTIONS

Tulare County Medi-Cal Providers: Please submit this form to the Child Welfare Services Clinical Social Worker or other representative indicated below. Submit this form by the date requested on the initial Letter of Referral (LOR) that you received or as requested.

Mail, e-mail or FAX this form to Natalie Bolin, CWS Liaison.

Address: Child Welfare Services
26500 S. Mooney Blvd
Visalia, CA 93277

E-mail:NBolin@tularehhsa.org

Fax:(559) 687-6459

Name of Clinic: Reporting Therapist: Review Date:

Client's Name: DOB: Mother's Name:

List Others Involved in Treatment:

Date of Assessment:
Date Treatment Initiated:
Frequency of sessions:

Number of session's client attended:
Number of session's client missed or cancelled:

Number of Conjoint or Family sessions scheduled: Attended:

Target date for discharge: Reason for discharge:

1. At the time of the referral for services, what were the initial risk factors related to abuse and/or neglect?

2. What progress has been made in reducing the identified risk factors?

3. Provide a clinical impression of the client's current functioning and a DSM IV Diagnosis if applicable below:

   Axis I: Axis II:
   Axis III: Axis IV:
   Axis V:
   Current: Past Year:

   Clinical Impression:

4. List any other treatment issues or concerns below.

_____ (Signature) _____ (Title) _____ (Date)

Data Tracking

- CWS Screens documented in CWS/CMS
- The number of CWS referrals sent to mental health
- List of Katie A. dependents receiving services
- Clinical Review Questions
  - Report sent to each clinic monthly with due date

QUESTIONS & COMMENTS

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