Universal Screening of Children in Care

A Report for the Ministry of Children and Family Development

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Universal Screening of Children in Care

**Introduction**

Universal developmental screening of children in care is a timely topic indeed. As of 2016, over 7000 children were in living in out-of-home care in the province of British Columbia ("Canadian Child Welfare Research Portal," n.d.). Working closely with this population through their early years of life to identify and intervene on potential developmental delays offers many benefits to individual children, their families, and society. Our report, developed through a University of Victoria and Ministry of Children and Family Development research initiative, seeks to address the following research questions as raised by our sponsors, Lori Lucier and Susan Whittemore: i) What jurisdictions are conducting universal screening of children in care? ii) What program models are being utilized? iii) Specific to children in care, what are the outcomes of universal early screening?

**The Importance of Universal Developmental Screening**

Universal developmental screening programs are developed with the goal of being available to all members of a population. Developmental screening is a way to capture the development of a child at different moments in their life and gather information about the child’s abilities and areas to improve (Goelman et al., 2011; Moodie et al., 2014). There is strong evidence in the literature citing the value of universal screening for early identification of all children and follow-up intervention if required. Cairney et al. (2016) stated that, “The first six years of life are the crucial period of human development, and there is broad consensus that investment in optimizing health and development in this period will result in significant individual, social, and economic benefits” (p. 1). Early identification of developmental delays is vital to providing access to specific intervention and increasing the positive benefits of service
The use of universal developmental screening provides the opportunity to families to have discussions about the development of their child, ask questions and seek support.

Although practices vary across jurisdictions, some form of developmental screening is in place in all regions of Canada. Most often, developmental screening is conducted through public health authorities, coinciding with immunization schedules and school districts as children enter kindergarten. A variety of instruments are used with the main caregiver as the chief informant.

**Developmental Screening of Children in Care**

If universal screening is important for all children, it is even more crucial for children in care. When young children are removed from their biological families, it is usually because their early experiences are far from optimal and fail to support healthy development across domains. Children in care have significantly higher rates of mental, developmental, and physical health problems than non-fostered children from similar socioeconomic situations and demographics (Chambers, Saunders, New, Williams, & Stachurska, 2010). Identifying these issues early is crucial to accessing clinical services. A large body of research highlights the benefits of early, targeted assessment for children who have experienced early adversity (Glascoe, 2000).

Chambers et al. (2010) maintained that the most effective assessment practices for children in care were universal, timely (administered shortly after entering care), comprehensive (measures all domains, including mental health), standardized, and provide opportunity for re-assessment. It is also important to consider that the utility of developmental screening rests in follow-up intervention services. Prevention and treatment efforts need to begin as early as possible, as treatment later in life may be less effective in preventing poor outcomes (Cairney et
This report explores some of the difficulties associated with screening and providing intervention to such a young and vulnerable population.

**Methods: Answering the Research Questions**

In our efforts to seek answers, we were tasked with a jurisdictional scan as well as a review of the literature. The latter task provided us with easy access to an abundance of information, as we discovered a rich and growing body of research surrounding universal screening of children in care. Research from Canada, United States, Australia, Sweden, and United Kingdom is shared throughout this report as we address key issues surrounding our topic.

The jurisdictional scan proved more challenging. Our initial attempt included contacting informants through email, including a link to complete a brief online survey. Using contacts from our sponsors, our own work experiences, and email addresses sourced online from ministry sites across Canada, we sent out more than one hundred emails. We were greatly disappointed when we only received one response to our survey.

We changed our strategy and attempted to connect via telephone. This led to many messages left and missed phone calls, but eventually we managed to speak to or communicate via email with someone from most provinces and territories. When this was not possible, we visited provincial/territorial websites to obtain information. We would like to thank those informants who took time from their busy day to provide us with information.

**Developmental Screening Tools**

While conducting a literature review and jurisdictional scan, we discovered that many developmental screening tools are being used across Canada and around the world. The two main instruments that appear in practice in Canada and as well as in the research are the Ages and Stages Questionnaire (ASQ) and the Nipissing District Developmental Screening (NDDS).
The ASQ targets five areas of development, including gross motor, fine motor, communication, problem solving and personal-social. Structured as a questionnaire, the assessment, filled out by a parent or primary caregiver, poses 30 questions regarding the development of the child (McCrae, Calalane, & Fusco, 2011). It is scored and compared to age-appropriate standardized norms for each area of development.

The second part of the Ages and Stages Questionnaire is the Ages and Stages Questionnaire-Social Emotional (ASQ-SE). The ASQ-SE is also completed by parents and focuses on emotional and social capacities, specifically in the areas of self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people (McCrae, Cahalane & Fusco, 2011). Jee et al. (2010) found that using the ASQ-SE increased the detection of social-emotional problems for children in care, compared to relying only on the broader ASQ and surveillance of the child. Assessment practices are most effective when they comprehensively evaluate the child for mental, developmental and physical health and using multiple tools is a holistic way to achieve this (Chambers et al., 2010).

The Nipissing District Developmental Screen (NDDS) is a one-page assessment with a tear-off section of activity suggestions for caregivers to engage in with their child. Recently, Cairney et al. (2016) concluded that the NDDS should not be used as the single tool for screening children from one month to six years old. They argue that instruments are imperfect and because of the complexity of development, it is very difficult based on primary caregiver’s reports to accurately identify children who require intervention through a single instrument.

Other tools used in Canada include the Rourke Baby Record. The tool is a comprehensive health assessment, endorsed by Canadian Paediatric Society, combining growth and physical monitoring, immunization records and developmental screening. The Strengths and Difficulties
Questionnaire measures children behaviour to indicate mental health issues, which research in Sweden found to be relevant to use with children ages 1-3 and 4-5 (Gustafsson, Gustafsson & Proczkowska-Bjorklund, 2017). Measuring emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour, this tool may provide educators and parents with a better understanding of a child’s behaviour and indicate necessary further supports. The list of tools is extensive, each instrument offering numerous strengths and limitations.

Jurisdictional Scan: What is Happening in Canada?

For ease of reporting, we have chosen to group similar provinces together in our discussion. Also, specific names of informants have not been included in this document. Informants represented a variety of organizations and positions, including child welfare agencies, public health regions, and government ministries.

Manitoba, Alberta, and Prince Edward Island

Manitoba, Alberta, and Prince Edward Island do not have special screening programs for children in care. Instead, they are included in developmental screening initiatives administered by regional Public Health authorities. Most often, screening dates coincide with immunization schedules. The most commonly used instrument is the Ages and Stages Questionnaire (ASQ) completed by the parent or foster parent acting as the sole informant. Following the ASQ, the public health nurse makes recommendations and/or referrals to services. Saskatchewan follows a similar model, however their tool of choice is the Nipissing District Developmental Screen (NDDS).
Northern Territories

In Canada’s North, Northwest Territories and Nunavut follow similar models. There are no special programs for screening children in care; developmental screening is conducted by Public Health. A number of pilot programs are currently underway and attempts are being made to standardize screening procedures. Both territories use a modified Rourke Baby Record (Well Child Record) with culturally adapted guidance documents for administration/completion. In 2015-2016, Northwest Territories and Chevron Canada launched an iPad Mini Initiative (“iPad Mini Initiative, Education, Culture and Employment,” n.d.), providing a device to new parents and primary caregivers. The iPad minis are loaded with early childhood development information that was recommended by Northern Elders and child development experts as well as access to Northern programs for children and families. No information is currently available as to the impact of this project.

Ontario

In Ontario, inspired by the Looking After Children model, caseworkers use an Assessment and Action Report. ASQ and ASQ-SE are embedded into the annual Assessment and Action Record (AAR) document. Workers also use the NDDS, particularly for younger children, to inform their plans of care. Children are referred to services as appropriate (Supervisor, Family & Children’s Services, March 19).

Ontario’s Looking After Children (OnLAC) project uses an approach aimed at raising the standard of care for children receiving residential services. It focuses on seven key developmental areas for children: health, education, identity, family, social presentation, emotional and behavioural development, and self-care skills. OnLAC involves collecting information from young people in out-of-home care in these key areas using the Assessment and
Action Record (AAR) data collection instrument. This review is conducted for all young people who are in child welfare care for a continuous 12 months. The AAR tracks and monitors the development of children and youth in care across the developmental areas of health, education, identity, family and social relationships, social presentation, emotional and behavioral development, self-care skills, and transition to young adulthood (Cheung, n.d.). The feedback with this project has been that the AAR questionnaire is very lengthy, which led to poor response rates and a feeling of burden among professionals, caregivers, and young people who completed them.

There is also an 18 month well baby visit in Ontario where children’s development is monitored with the Nipissing District Developmental Screening, which is free to all Ontario residents. This visit also provides the opportunity for parents to ask questions and express concerns.

Quebec

On a provincial level, Quebec does not screen children in care using specific procedures or tools. Early childhood educators, caseworkers, or health care professionals select tools best suited to the difficulties or delays that present. In January 2018, a new initiative was launched to invest more resources and support into screening children.

New Brunswick

There is not a specific screening program in place for children in care. Typically, an early childhood interventionist that works with the children and families uses an Ages and Stages Questionnaire for children under the age of 5 and make referrals if necessary. The effectiveness of the tool is not reassessed (Supervisor, Family Enhancement and Child Protection Services, Department of Social Development, April 3). There is also a HealthyToddler Assessment at 18
months of age with public health nurses (Project Coordinator, Building an Early Start Together, April 3).

**Nova Scotia**

No formal developmental screening occurs for children in care in Nova Scotia. It is completed within the community, by Early Childhood Development Specialists (Coordinator of Foster Care Community Services, Nova Scotia). If a child has a developmental delay in two or more areas of development or is at risk for developmental delays due to documented biological factors, that child is eligible for Nova Scotia Early Childhood Development Intervention Services. Eligibility is determined through a home visit and initial screening.

**Washington State**

The Child Health and Education Tracking program identifies a child’s long-term needs at an out-of-home placement visit to evaluate the child’s well-being. The data collected from the evaluation is used to develop a case plan. Elements of The Denver Developmental Screening Test, administered to infants (birth to one month) and the ASQ (administered to children one to 60 months old) are embedded in the child health and education tracking screening report. The screening report is done by a child health and education tracking screener within 30 days of the child’s original placement date and referrals made to Early Support for Infants and Toddlers (ESIT) within 2 working days. The report is also discussed with the child’s caregiver and caseworker within five days of completion (“Child Health and Education Tracking,” n.d.).

**California**

The Developmental Screening and Enhancement Program in San Diego is structured to address the development and social-emotional needs of children in the welfare system from birth to five years old, eleven months upon entry into the system. The developmental specialists
provide services in the homes of foster parents and caregivers and the Polinsky Children’s Center. These services, which are free of charge include developmental and social-emotional screening, referrals to early intervention and treatment, case management, education and resources for foster parents, relatives and social workers, and referral for comprehensive further evaluation at Rady Children’s Hospital San Diego. This initiative is a collaboration and supported with funds from the San Diego County Health and Human Services Agency, Promises 2 Kids (formerly the Child Abuse Prevention Foundation) and First 5 San Diego (“Developmental Screening and Enhancement Program (DSEP),” n.d.).

**Challenges of Universal Screening Programs**

The effectiveness of the assessment of development in children in care is dependent on if and how the findings are acted upon (Chambers et al., 2010). This becomes especially difficult as children in care experience limited implementation of intervention services. Another challenge for screening children in care is the repeated movement between foster placements that limits the consistent access to services (Chambers et al., 2010). With screening often happening at specific times in a child’s life, such as 18 months and 36 months, children in care may be missed if they come into care after that time period. Opportunities for re-assessment are required to ensure no children are missed.

**Challenges with Informants**

Most developmental screening instruments require an adult informant to complete a questionnaire based on the child’s usual demonstrated behavior and skills. Pritchett et al. (2016) found that one of the main challenges of assessing children in care is finding reliable informants and that whenever possible, multiple informants should be used to develop a more accurate picture. Given that the child has been through a traumatic event and may not have a consistent,
long-term caregiver, this recommendation makes sense. However, the practical reality is much different. Our jurisdictional scan indicated that almost without exception, the main informant completing assessments of children in care is the foster parent.

There are a number of limitations associated with foster parents as the sole informants of developmental screening assessments. Pritchett et al. (2016) suggested that foster parents may have known the child for only a short amount of time, making it difficult to accurately complete assessments. Additionally, the foster parent may have cared for children with a variety of issues, causing them to normalize problematic behaviors (Pritchett et al., 2016). Chambers et al. (2010) echoed these ideas, adding that many carers minimized their concerns for a number of reasons, such as “fears that the children would be removed if the level of difficulty was known, lack of trust in the welfare system, and a detachment from the process as if the carer was outside the child’s difficulties” (p.521).

Interestingly enough, Pritchett et al. (2016) noted that the level of concern a carer has for a child does directly relate to the degree of the issue experienced by the child; however, many worrying symptoms were still under-reported, especially when related to cognitive functioning. This research underscores the importance of including foster parents, case workers, clinicians, child care providers, and biological parents whenever possible to produce a more thorough and accurate developmental assessment.

Cultural Relevance

It is vital to consider the cultural relevance of the tools used for screening children. Translating the language to fit the community is not sufficient. Research by Gladstone et al. (2007) in rural Malawi used the Ages and Stages Questionnaire and questions did not reflect the lived realities of the children. Asking for a child to identify a horse is not indicative of what a
child in that country has experienced. This can also impact the results of the test and scoring and does not authentically evaluate the development of the child in their context.

In a Canadian context, Nunavut and Northwest Territories have adapted the Rourke Baby Record to fit the community needs of who the screening serves. Using many stakeholders, they have worked to develop appropriate tools that measure development contextual to the children being monitored. Often it is acknowledged that these screening tools are not culturally relevant but many practitioners feel stuck using this universal tool. The ASQ is being adapted in British Columbia to reflect Okanagan Indigenous culture and language. The elders of the community have worked to identify five stages of development that have become the focus of the screening. Culturally-adapted programs also need to be implemented to reduce negative long-term outcomes and address the delays identified (Thorne, Macdonald, Thivierge, Whiteduck & Vignola, 2016).

**Recommendations and Next Steps**

**Scale promising regional programs to the entire province.** As detailed in this report, there are a number of very promising programs implemented in regions of British Columbia. It is our recommendation to scale the Fraser Region’s initiative for screening children in care at 18 and 36 months using the ASQ and ASQ-SE. Formalizing procedures for screening children in care, rather than relying on Public Health and foster parents to initiate screening, will enhance individual, social, and economic benefits and provide the additional support needed for this vulnerable population.

**Access multiple informants whenever possible.** A more thorough and accurate assessment of a child’s development is obtained when parties come together to discuss a child’s progress. Often foster parents are relied upon as the sole informants, and this can result in under-
reporting and/or inaccurate assessments. Including biological parents, family members, clinicians, caseworkers, and anyone else who knows the child well will strengthen the assessment process and hopefully enhance reliability.

Assess when children come into care. The Fraser Region program screens children at 18 and 36 months of age. But what about the child who enters care at 20 months old? After giving children a minimum of four weeks to settle into their new homes, we would recommend conducting an assessment to ensure that any delays are identified and intervention services are accessed.

Re-assess when necessary. When a child has just entered care and an assessment is conducted, the data obtained might not be reflective of the child’s true capabilities. Pritchett et al. (2016) suggested watchful waiting (careful observation when symptoms are mild and have occurred for less than four weeks following a traumatic event) and/or repeating the assessment at a later date. Comparing initial and subsequent assessment data will enable caregivers and caseworkers to determine which of the child’s issues are decreasing as the child becomes comfortable in a consistent, caring home situation and which problems are persistent and in need of targeted intervention (Pritchett et al., 2016).

Ensure that data from screenings are acted upon. As mentioned earlier, screening practices are only effective if findings are acted upon. It is important that procedures and accountability exist to ensure that referrals are made and that services are received in a timely manner.

Continue to explore culturally-relevant screening tools and procedures. The conversation and action around how developmental screening tools can reflect the different values, interactions and expectations of children and their development that are expressed
through culture needs to continue. Deep consideration needs to be given as to how existing tools and procedures serve children and their families. Ways in which screening instruments can be adapted to better meet the needs of the diverse population of Canada should be a constant discussion.

**Final Thoughts**

When we examined universal screening practices, we discovered that a great deal of disparity existed across Canada and throughout the province of British Columbia. Differences emerged in the instruments that are used, who conducts the screening, and how frequently it occurs. Universal screening programs targeted to children in care are quite rare and seem to only occur within British Columbia.

Despite all these differences, an important commonality exists across Canada. In every province and territory, adults, governments, and organizations come together to provide some form of developmental screening for young children. It does not look the same everywhere, and some programs are far more comprehensive than others, but in all corners of our country, people recognize the importance of early screening and intervention. This alone is worthy of celebration.

At the same time, there is much work yet to be done. It is our hope that this report acts as a call to action for provincial governments and child welfare agencies to develop universal developmental screening programs to monitor our most vulnerable population--children in care.
References


Child Health and Education Tracking. (n.d.). Retrieved April 17, 2018, from


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