

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/224845520>

# Addressing the Impact of Trauma Before Diagnosing Mental Illness in Child Welfare

Article in *Child Welfare* · January 2011

Source: PubMed

CITATIONS

84

READS

1,768

6 authors, including:



**Gene Griffin**

20 PUBLICATIONS 652 CITATIONS

SEE PROFILE



**Gary McClelland**

Northwestern University

44 PUBLICATIONS 6,799 CITATIONS

SEE PROFILE



**Bradley Stolbach**

University of Chicago

18 PUBLICATIONS 3,132 CITATIONS

SEE PROFILE



**Nicole Maj**

Northwestern University

3 PUBLICATIONS 340 CITATIONS

SEE PROFILE

# Addressing the Impact of Trauma Before Diagnosing Mental Illness in Child Welfare

---

**Gene Griffin**

*Northwestern University  
Feinberg School of Medicine*

**Gary McClelland**

*Northwestern University  
Feinberg School of Medicine*

**Mark Holzberg**

*Southern Illinois  
University-  
Carbondale/Illinois  
Department of Children and  
Family Services*

**Bradley Stolbach**

*La Rabida Children's  
Hospital Chicago Child  
Trauma Center/University  
of Chicago Pritzker School of  
Medicine*

**Nicole Maj**

*Northwestern University  
Feinberg School of Medicine*

**Cassandra Kisiel**

*Northwestern University  
Feinberg School of Medicine*

Congress set requirements for child welfare agencies to respond to emotional trauma associated with child maltreatment and removal. In meeting these requirements, agencies should develop policies that address child trauma. To assist in policy development, this study analyzes more than 14,000 clinical assessments from child welfare in Illinois. Based on the analysis, the study recommends child welfare agencies adopt policies requiring that (1) mental health screenings and assessments of all youth in child welfare include measures of traumatic events and trauma-related symptoms; (2) evidence-based, trauma-focused treatment begin when a youth in child welfare demonstrates a trauma-related symptom; and (3) a clinician not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma. The study also raises the issue of treatment reimbursement based on diagnosis.

Congress now requires that child welfare agencies address the issue of trauma when developing a plan for meeting the health and mental health needs of youth in foster care (Promoting Safe and Stable Families Program, 2011). To accomplish this, child welfare agencies should update their policies and procedures.

For example, in 2002, the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) issued a joint policy statement calling for the screening and assessment of all children in foster care for mental health and substance abuse issues:

These most vulnerable and traumatized of children need and deserve appropriate screening, comprehensive assessment and reassessments, effective mental health and use of alcohol and other drugs treatment services/supports provided by appropriately trained individuals, including the active involvement, when indicated, of a child and adolescent psychiatrist. We urge local, state and federal authorities to work together with the mental health, use of alcohol and other drugs and child welfare professions and other relevant child and family serving systems to assure that these children's mental health and use of alcohol and other drugs needs are met and that the children have the skills, capacities, and support necessary to thrive. (p. 5)

Consistent with this call to action, Health and Human Services' Administration on Children, Youth, and Families (ACYF) includes children's mental health as a measure of well-being in its Child and Family Services Review (CFSR).

Researchers are documenting the importance of mental health assessments in child welfare. McMillen, Zima, Scott, Auslander, Munson, Ollie, and Spitznagel (2005) report on the prevalence of psychiatric disorders among older youth in the foster care system and conclude that the "high rates of psychiatric disorder found in this study support the recommendations of a joint policy statement from the [AACAP/CWLA]" (p. 94). While this policy needs to continue it also needs to be informed by the new legislative requirements as well as new research findings.

The most relevant research advance over the last decade is the study of child trauma. Due to the work of the National Child Traumatic Stress Network (NCTSN), its affiliated members and other researchers, there is a much richer understanding of the impact of trauma on children. Bryan Samuels, the Commissioner of ACYF, who played a role in the recent legislative change, incorporated trauma research into his testimony before Congress (Samuels, 2011). AACAP (2010) has also incorporated this new knowledge into its *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder (PTSD)*: Two essential statements in the *Parameter* are that “there is clinical consensus that children with severe PTSD may present with extreme dysregulation of physical, affective, behavioral, cognition, and/or interpersonal functioning that is not adequately captured in current descriptions of PTSD diagnostic criteria” (pp. 415–416) and a formal recommendation that “the psychiatric assessment should consider differential diagnoses of other psychiatric disorders and physical conditions that may mimic PTSD” (p. 420).

Applying these principles to the AACAP/CWLA policy statement, this article argues for a policy requiring that (1) mental health screenings and assessments of all youth in child welfare include measures of traumatic events and trauma-related symptoms; (2) evidence-based, trauma-focused treatment begin when a youth in child welfare demonstrates a trauma-related symptom; and (3) a clinician not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma. All child welfare agencies should consider adopting such a policy.

### ***Child Trauma Is More Than PTSD***

As the AACAP points out, it is important for the child welfare community to understand that the PTSD diagnosis does not adequately capture the full picture of childhood trauma. The AACAP, however, does not offer an alternative definition. In fact, *trauma* is used in multiple ways in the field. The American Psychiatric Association is currently considering what trauma-related terms to include in the child section of DSM-5. Experts are researching

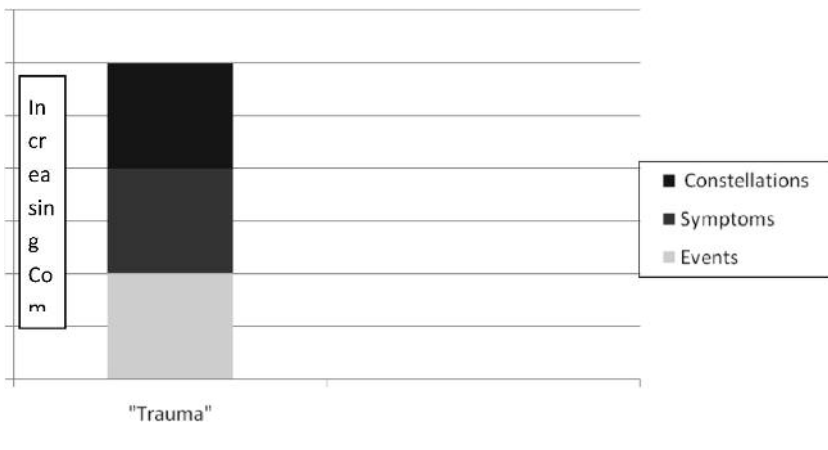
different types of trauma- including complex trauma (Kisiel, Fehrenbach, Small, & Lyons, 2009) and proposed diagnoses, such as developmental trauma disorder (van der Kolk, 2005).

Regardless of what terms are eventually chosen, it is useful to think of child trauma as a continuum, incorporating traumatic events, basic trauma symptoms and specific constellations of events and symptoms. Various trauma studies focus on different aspect of this continuum (see Figure 1).

In the first group are studies focusing on traumatic events, such as the Adverse Childhood Experiences Study ([ACES] Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998), the groundbreaking study of the long-term impact of traumatic events. (For purposes of this article, the term *traumatic event* refers to a single event or a series of events and includes experiences such as neglect.)

The second type of trauma research focuses on youth who have experienced traumatic events and may have a trauma-related symptom. For example, a National Institute of Mental Health definition of trauma is, “The experience of an event by a person that is

**Figure 1**  
Child Trauma Continuum



emotionally painful or distressful which often results in lasting mental and physical effects.” (This article will equate effect with a symptom.) The study of symptoms also includes studies of resilient children who experience a potentially traumatic event but do not develop trauma-related symptoms.

The third type of trauma research examines specific constellations of events and symptoms, such as PTSD, complex trauma, or developmental trauma disorder. For example, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnosis of PTSD requires (1) experiencing a life-threatening event, plus (2) one re-experiencing symptom, (3) two increased arousal symptoms, and (4) three avoidance symptoms. While such constellations of symptoms occur less frequently than single trauma symptoms, they are generally more severe. Viewing child trauma as a continuum allows one to shift the focus from the very large group of youth who experience potentially traumatic events to the much smaller groups presenting with symptom constellations. This has both policy and funding implications.

### ***Symptoms of Mental Illness and Child Trauma Overlap***

The other essential AACAP concept for the child welfare community to adopt is that trauma-related symptoms and symptoms of mental illness overlap (Table 1). The same symptoms can be the result of traumatic experiences or mental illness. For example, both a traumatized child and a child with bipolar disorder may have difficulty with regulating their emotions, even though the child with bipolar disorder never experienced a traumatic event and the traumatized child does not suffer from bipolar disorder. To complicate matters, the two are not mutually exclusive. A traumatic event can exacerbate an underlying mental illness, resulting in greater symptoms. Thus, it is possible to be both traumatized and mentally ill.

To date, no research within child welfare has distinguished the broad trauma continuum from mental illness. For example, Samuels' (2011) congressional testimony cited McMillen et al.'s (2005) findings that the prevalence of major mental illness within the past year for older youth in child welfare included depression (18%), conduct disorder/oppositional defiant disorder (17%), attention deficit/

**Table 1**  
Symptoms that Overlap with Child Trauma and Mental Illness (AACAP, 2010)

| Mental Illness  | Overlapping Symptoms  | Trauma       |
|---|---|--------------|
| 1. Bipolar disorder   | Hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements | Child trauma |
| 2. Attention deficit/hyperactivity disorder   | Restless, hyperactive, disorganized, and/or agitated activity, difficulty sleeping, poor concentration, and hypervigilant motor activity  | Child trauma |
| 3. Oppositional defiant disorder  | A predominance of angry outbursts and irritability  | Child trauma |
| 4. Panic disorder   | Striking anxiety and psychological and physiologic distress on exposure to trauma reminders and avoidance of talking about the trauma   | Child trauma |
| 5. Anxiety disorder, including social anxiety, obsessive-compulsive disorder, generalized anxiety disorder, or phobia | Avoidance of feared stimuli, physiologic and psychological hyperarousal on exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction   | Child trauma |
| 6. Major depressive disorder  | Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleep difficulties  | Child trauma |
| 7. Substance abuse disorder   | Drugs and/or alcohol used to numb or avoid trauma reminders   | Child trauma |
| 8. Psychotic disorder   | Severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium, and fluctuating levels of consciousness                      | Child trauma |

hyperactivity disorder (10%), PTSD (8%), and mania (6%). This is an excellent study on the prevalence of mental illness in the child welfare population, but it did not include measures of the continuum of child trauma, nor did it identify overlapping symptoms. Applying Table 1 criteria to the McMillen et al. findings, it is possible that all the mental illness diagnoses could be explained by the broader definition of traumatic event plus a symptom (with 8% having the right constellation of symptoms to qualify for PTSD).

The prevalence of trauma and mental illness within the child welfare population cannot be estimated from NCTSN databases. NCTSN collects data on trauma and mental health symptoms, but only for children receiving trauma-informed services from an NCTSN center. Because NCTSN does not collect prevalence data on all children in child welfare, the differential diagnosis question for child welfare remains unanswered.

This article explores the distinctions between the prevalence of traumatic events, trauma-related symptoms, PTSD and other mental illness. It uses data from the Illinois Department of Children and Family Services (DCFS), which has been conducting statewide behavioral health assessments on all children coming into custody since 2005. The DCFS assessments identify trauma experiences, trauma-related symptoms, and mental health symptoms. Though limited to one state child welfare agency, these findings can be used to begin the discussion of what child welfare systems might anticipate regarding the scope of trauma issues, the need for evidence-based trauma-focused treatments, the complexity of mental health and trauma diagnoses, and the importance of building resilience in youth.

## Methods

### *Procedures*

The sample included 14,103 children (ages 0–17) entering DCFS custody between July 2005 and June 2011. DCFS assesses all children using the Child and Adolescent Needs and Strengths ([CANS] Lyons, Small, Weiner, & Kisiel, 2008). The CANS is an information integration and decision support tool that incorporates data from



multiple sources (e.g., interview of caregivers, child self-report, teacher report, review of case records, and judgment of the clinician). The CANS is scored by trained and certified clinicians (Lyons, 2004). It collects information on a range of symptoms and domains. At DCFS, the CANS is administered as part of an overall integrated assessment (IA) process that occurs within 45 days of the child's custody. The IA provides a comprehensive evaluation of the safety, health, educational, developmental, trauma, and mental health needs of the child within the context of the youth's family and broader social environment. The IA process forms the foundation for the child's placement decision and service planning.

### *CANS Measure*

The DCFS version of the CANS was developed by Northwestern University in collaboration with NCTSN and DCFS clinical staff for the purpose of addressing the complicated trauma and mental health needs of children and their families. The CANS provides a comprehensive assessment of both child and caregiver on a range of domains. It contains more than 100 items in the following 10 domains: trauma experiences, traumatic stress symptoms, child strengths, life domain functioning, acculturation, child behavioral/emotional needs (which will serve as the mental health measures in this study), child risk behaviors, early childhood needs, independent living needs, and caregiver needs and strengths. The child's lifetime history of exposure to traumatic events is rated in the traumatic experiences domain. In the remaining domains, the child and caregiver are rated on their symptoms, needs, and levels of functioning during the last 30 days.

CANS scoring uses a four-point system based on two criteria: (1) the degree of strength or impairment and (2) the degree of urgency for intervention. Ratings are then incorporated into service plans. Each CANS item has specific descriptors for the four levels, which offer guidance to the rater. In addition, the four-point scoring system is based on "action levels." "Actionable" scores are considered those rated a 2 or a 3 on any of the needs or strength items. The scoring system is structured as follows for needs: 0 indicates no evidence

of impairment (no need for an action plan); 1 indicates a mild degree of difficulty (plan for watchful waiting); 2 indicates a moderate level of difficulty (a plan for intervention is recommended); and 3 indicates a severe level of difficulty (a plan for immediate or intensive intervention is recommended). Strengths are scored in the opposite direction where 0 indicates a core strength (building block for an action plan); 1 indicates a useful strength (a focus for development); 2 indicates a potential strength (possible future development); and 3 indicates no identified strength (not included in an action plan).

In addition to scores at the item level, the CANS can be scored at the domain level by summing the scores for all items within particular domains (e.g., the 5 traumatic stress symptom items or the 13 emotional/behavioral need items). The CANS is not intended to offer an overall summary score. While the CANS does not generate a diagnosis, the ratings capture severity of symptoms or existing diagnoses. A substantial body of research exists on the measurement properties of the CANS. Anderson, Lyons, Giles, Price, and Estle (2003) indicated that the CANS is reliable at the item level so individual items can be used in data analyses. Further, the CANS has demonstrated strong reliability and validity in field applications within child welfare, mental health, and juvenile justice (Leon, Ragsdale, Miller, & Spacarelli, 2008). Psychometric studies indicate that the domains of the DCFS CANS exhibit strong reliability and validity (Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009).

### *Analysis*

Using the Northwestern DCFS database of IA CANS, the authors identify the types of traumatic experiences DCFS youth have had, how many trauma-related symptoms they have developed, and the relationship between the number/types of experiences and the number/types of trauma symptoms. The prevalence of mental health symptoms and their relationship to trauma experiences and trauma-related symptoms are also reported. Next, the association between child strengths and trauma symptoms is examined. Finally, the authors report the prevalence and the overlap between trauma symptoms and mental health symptoms. The report does not prove causation. Analytic

methods included incident rate ratios (IRR), chi-square tests, and odds ratios. More data, item analysis, and IRRs are available on request.

## Results

Table 2 presents basic demographic data. For example, almost 60% of children taken into custody in Illinois are 6 years old or younger.

Table 3 presents the prevalence of mental health symptoms. Categories are not mutually exclusive. The high rate of attachment issues is found within the 0- to 6-year-old group.

In Table 4, the top four overall events were within the top five events for all age groups.

Table 5's trauma symptoms are not mutually exclusive. Overall, 38% of DCFS youth had at least one trauma symptom with an age effect that will be reviewed.

Table 6 reports the number of significant traumatic events (rated a 2 or 3 on the CANS) but not events that are merely suspected or judged as mild (rated a 1 on the CANS). Both trauma symptoms and mental health symptoms increase as the number of significant traumatic events

**Table 2**  
Illinois DCFS CANS Demographics

| Age                | <i>N</i> (14,103) | %     |
|--------------------|-------------------|-------|
| 0–6 years old      | 8,452             | 59.93 |
| 7–13 years old     | 2,799             | 19.85 |
| 13–16 years old    | 2,459             | 17.44 |
| 17+ years old      | 393               | 2.79  |
| <b>Sex</b>         |                   |       |
| Female             | 6,942             | 49.27 |
| Male               | 7,149             | 50.73 |
| <b>Race</b>        |                   |       |
| African American   | 6,519             | 46.91 |
| Non-Hispanic white | 6,513             | 46.87 |
| Hispanic           | 786               | 5.66  |
| Other              | 79                | 0.57  |

**Table 3**

Percentage of Children with Mental Health Symptoms

| <b>Mental Health Symptoms</b> | <b>% of Children</b> |
|-------------------------------|----------------------|
| Depression                    | 16.68                |
| Attachment                    | 15.60                |
| Anger control                 | 14.53                |
| Attention/impulse             | 12.50                |
| Anxiety                       | 11.66                |
| Oppositional                  | 9.97                 |
| Affect dysregulation          | 9.67                 |
| Conduct                       | 5.54                 |
| Substance abuse               | 4.13                 |
| Behavioral regression         | 2.91                 |
| Eating disturbance            | 2.61                 |
| Psychosis                     | 1.72                 |
| Somatization                  | 1.25                 |

**Table 4**

Percent of Youth Experiencing Specific Trauma Events

| <b>Potentially Traumatic Events</b> | <b>%</b> |
|-------------------------------------|----------|
| Neglect                             | 46.12    |
| Family violence                     | 29.25    |
| Traumatic grief/separation          | 25.49    |
| Physical abuse                      | 20.67    |
| Emotional abuse                     | 13.40    |
| Witness to criminal activity        | 10.51    |
| Medical trauma                      | 9.69     |
| Sexual abuse                        | 8.63     |
| Community violence                  | 3.46     |
| School violence                     | 1.58     |
| Natural disaster                    | 0.65     |
| War affected                        | 0.25     |
| Terrorism affected                  | 0.18     |

**Table 5**

Percent of Children with Specific Trauma Symptoms

| Trauma Symptoms      | % of Children |
|----------------------|---------------|
| Adjustment to trauma | 24.02         |
| Reexperiencing       | 8.08          |
| Avoidance            | 8.69          |
| Numbing              | 6.13          |
| Dissociation         | 2.12          |

**Table 6**

Average Number of Trauma and Mental Health Symptoms per Trauma Event

| # of Significant Trauma Events ( <i>N</i> )                         | Average # of Trauma Symptoms       | Average # of Mental Health Symptoms |
|---|------------------------------------|-------------------------------------|
| 0 ( <i>N</i> = 3,412)   | 0.06                               | 0.41                                |
| 1 ( <i>N</i> = 4,081)   | 0.23                               | 0.70                                |
| 2 ( <i>N</i> = 3,039)   | 0.49                               | 1.17                                |
| 3 ( <i>N</i> = 1,792)   | 0.91                               | 1.82                                |
| 4 ( <i>N</i> = 904)   | 1.23                               | 2.42                                |
| 5 ( <i>N</i> = 489)   | 1.63                               | 3.00                                |
| 6 ( <i>N</i> = 184)   | 1.93                               | 3.67                                |
| 7 ( <i>N</i> = 73)  | 2.25                               | 4.51                                |
| 8 ( <i>N</i> = 34)  | 2.85                               | 5.53                                |
| 9 ( <i>N</i> = 10)  | 2.80                               | 6.30                                |
| 11* ( <i>N</i> = 3)   | 2.33                               | 9.33                                |
| 13 ( <i>N</i> = 17)   | 5.00                               | 12.94                               |
| (*no subjects with 10 or 12 trauma events; 65 subjects unavailable) | <b>Incident rate ratio = 1.410</b> | <b>Incident rate ratio = 1.342</b>  |

increase. Note that when there are no significant trauma events, youth do not have trauma symptoms though the youth might still have mental health symptoms. Also note that 17 children were assessed as having the maximum possible number of events (13), trauma symptoms (5) and mental health symptoms (13), which could be a scoring

**Table 7**

Average Number of Mental Health Symptoms per Trauma Symptom

| # of Trauma Symptoms                                 | Average # of Mental Health Symptoms |
|--|-------------------------------------|
| 0  | 0.51                                |
| 1  | 2.04                                |
| 2  | 3.06                                |
| 3  | 3.53                                |
| 4  | 4.64                                |
| 5  | 7.73                                |
| <b>Incident rate ratio <math>\approx</math> 1.74</b> |                                     |

**Table 8**

Average Number of Trauma Symptoms per Strength

| # of Strengths                                       | # of Trauma Symptoms |
|--|----------------------|
| 0  | 1.74                 |
| 1  | 1.55                 |
| 2  | 1.30                 |
| 3  | 1.24                 |
| 4  | 1.11                 |
| 5  | 0.97                 |
| 6  | 0.72                 |
| 7  | 0.60                 |
| 8  | 0.41                 |
| 9  | 0.33                 |
| 10   | 0.20                 |
| <b>Incident rate ratio <math>\approx</math> 0.82</b> |                      |

artifact from some assessors. The IRR shows that, for every additional type of trauma experienced, the average number of trauma symptoms goes up by 41% and the mental health symptoms go up by 34%.

In Table 7, the IRR shows that, for every increase of one trauma symptom, there is a 74% increase in mental health symptoms.

Table 8 shows that strengths have the opposite effect. With each additional strength, the number of trauma symptoms decreases by 18%.

Table 9 presents, by age group, the number of DCFS youth that experienced (1a) any traumatic event (rated a 1, 2, or 3 on the CANS) or (1b) a significant traumatic event (rated a 2 or 3 on the CANS); (2) youth with at least one trauma event and one trauma symptom; and (3) those youth that might qualify for a diagnosis of PTSD based on their CANS symptoms. There is an age effect. (Note that the CANS cannot definitively diagnose PTSD. As PTSD requires a traumatic event plus symptoms of reexperiencing, avoidance and arousal, the CANS provides an upper limit on the percentage of youth who might qualify for a PTSD diagnosis. These youth have at least one significant type of traumatic event, reexperiencing and avoidance symptoms. Hyper-arousal is also required for a diagnosis of PTSD but these data were not available for this sample. In short, the number reported here may overestimate the number of youth who would actually receive a diagnosis of PTSD.)

Taking the percentage for all children from Table 9 and applying that as an estimate per thousand children in a child welfare system results in the continuum estimates in Figure 2.

Table 10 demonstrates the significant overlap between trauma symptoms and mental health symptoms. This overlap increases with age. To assist in visualization, the percentage for each category (A–E) within an age group can be inserted into the appropriate part of the diagram in Figure 3.

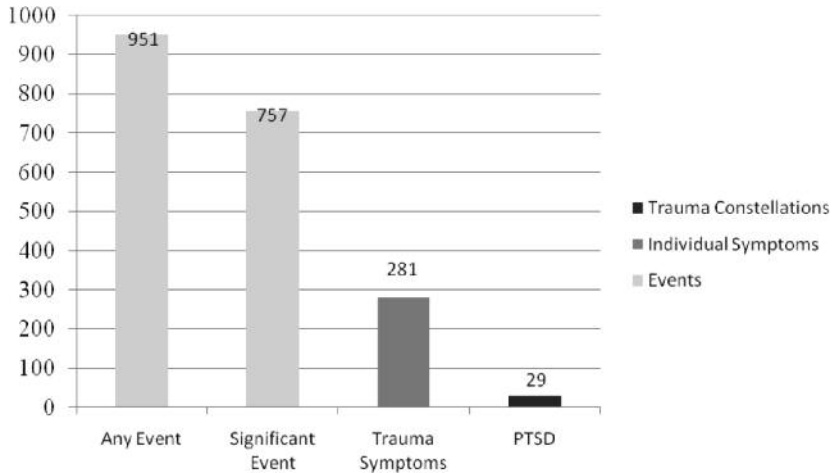
**Table 9**

The Percentage of Children with Trauma Experiences, Trauma Symptoms and Potential Posttraumatic Stress Disorder

|                                    | 0–6       | 7–12      | 13–17     | 17+       | All      |
|------------------------------------|-----------|-----------|-----------|-----------|----------|
| “Child trauma”                     | Years Old | Years Old | Years Old | Years Old | Children |
| 1a. Any suspected traumatic event  | 93.15%    | 98.25%    | 97.93%    | 98.22%    | 95.14%   |
| 1b. Any actionable traumatic event | 69.90%    | 83.78%    | 84.38%    | 88.30%    | 75.69%   |
| 2. Any trauma symptom              | 15.32%    | 42.34%    | 51.24%    | 57.51%    | 28.12%   |
| 3. Potential PTSD                  | 1.25%     | 4.50%     | 5.98%     | 6.87%     | 2.88%    |

**Figure 2**

Child Trauma Continuum: Per 1,000 Children



**Table 10**

The Overlap of Trauma and Mental Health Symptoms by Age

| A. Children in Child Welfare, Illinois | B. No Symptoms | C. Trauma Symptoms Only | D. Mental Health Symptoms Only | E. Both Trauma and Mental Health Symptoms |
|--|----------------|-------------------------|--------------------------------|---|
| 0- to 6-year-olds                      | 68.02%         | 11.76%                  | 7.11%                          | 13.12%                                    |
| 7- to 12-year olds                     | 33.45%         | 13.81%                  | 13.56%                         | 39.18%                                    |
| 13- to 16-year olds                    | 17.03%         | 6.93%                   | 21.92%                         | 54.13%                                    |
| 17-year-olds plus                      | 16.25%         | 6.00%                   | 15.75%                         | 62.00%                                    |
| All youth                              | 50.77%         | 11.16%                  | 11.22%                         | 26.85%                                    |

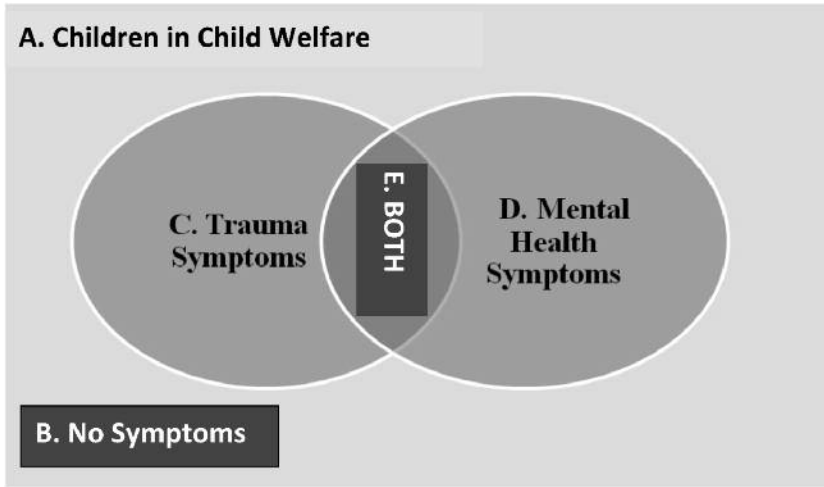
**Discussion**

The results can be used to estimate what child welfare agencies might anticipate when they address trauma events and trauma-related symptoms as part of their mental health assessments. The authors demonstrate that the overall rates of symptoms of mental illness for children in child welfare in Illinois are consistent with McMillen



**Figure 3**

Diagram of Trauma versus Mental Illness Symptoms for Youth in Child Welfare



et al.’s (2005) previous research. Even McMillen et al.’s rate of PTSD (8%) in a 17-year-old population is similar to the estimate for the 17-year-olds in Illinois (6.87%).

The authors show that high rates of experiencing traumatic events and trauma-related symptoms are present among youth in child welfare. This prevalence is why mental health screening and assessments need to include measures of traumatic events and symptoms. These need to be recognized even when they do not constitute full blown PTSD.

Using Illinois estimates, Figure 2 displays the anticipated prevalence of types of child trauma events, trauma-related symptoms and PTSD per thousand children in a child welfare system. These estimates can be used for service planning. At the event level, more than 95% of youth coming into child welfare custody are at least suspected to have experienced a traumatic event, with 75% having actually experienced moderate to major events. For service planning, all these children could be considered for early intervention programs, with additional resilience-building services for the higher

risk group. As Table 8 demonstrates, children with greater strengths have fewer trauma-related symptoms. Thus, these early interventions might help inoculate some children against later trauma-related symptom development.

Moving to service planning for the trauma-related symptom group, the authors maintain that evidence-based, trauma-focused treatment should begin when a youth in child welfare demonstrates a trauma-related symptom. Treatment should not wait until a youth actually qualifies for a diagnosis of PTSD. More intensive services may be required by that point. Applying Table 9, over one-quarter of the children in child welfare exhibit trauma-related symptoms and this rate increases with age. More than one-half of the youth 13 and older exhibit trauma-related symptoms. These percentages represent a huge increase over the number of children who would receive trauma-focused treatment if child welfare systems only provided it for children with PTSD (even using McMillen et al.'s [2005] 8% estimate). The child welfare system needs to address the suffering and complex needs of all those children in the child welfare system who exhibit trauma-related symptoms by offering them evidence-based, trauma-focused treatment.

Though new federal legislation requires child welfare systems to address trauma, current treatment funding policies present a major hurdle to providing treatment for all these youth. At the present time, reimbursement from health insurance or state Medicaid programs for mental health services generally requires a DSM diagnosis. However, as noted, there is no appropriate child-specific trauma diagnosis in the current DSM, only the diagnosis of PTSD. Thus, child welfare systems are faced with the options of not treating youth with trauma-related symptoms; treating the youths but not receiving reimbursement for the services; or treating the youth but using another mental health diagnosis.

The possibility of diagnosing youth with trauma-related symptoms as having a mental illness is not merely speculative. As Table 1 shows, many clinical symptoms can support arguments for both trauma and mental illness. Further, as Table 10 demonstrates, a high percentage of older youth in child welfare have both mental health

and trauma-related symptoms. Further, child trauma and mental illness are not mutually exclusive. It is possible for a mentally ill child to be traumatized. It is also possible that a youth may have a family history of major mental illness (assuming that this was not really previously undetected intergenerational trauma). Thus, it may be possible to diagnose youth with trauma-related symptoms as having a mental illness. There is risk involved, however, when the youth are not actually mentally ill but responding to the trauma experiences in ways that mimic symptoms of mental illness. The diagnostic formulation will drive the treatment.

Treatment for child trauma is different from treatment for mental illnesses such as bipolar disorder, attention deficit disorder or conduct disorder. In general, compared to treatment for mental illness, trauma-informed approaches to treatment

- keep a greater focus on context, safety, and support;
- better address symptoms and risk behaviors as part of a broader set of reactions (Kisiel, Blaustein, et al., 2009);
- develop more strengths and protective factors (Griffin, McEwen, Samuels, Suggs, Redd, McClelland, 2011);
- focus less on medications (dosReis, Yoon, Rubin, Noll, Rothbard, 2011); and
- are less stigmatizing.

Because of the differences in treatment, a clinician should not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma. When a child exhibits symptoms that could be diagnosed as either child trauma or mental illness, and where symptom onset is subsequent to a traumatic event, child welfare clinicians should begin by developing a treatment plan to address child trauma issues before diagnosing mental illness. It is a more targeted and parsimonious approach. If the trauma treatment approach is effective, it may not be necessary to diagnose a mental illness.

More policy changes are needed to resolve the funding issue. Possible solutions might include the addition of new trauma diagnoses in the child section of DSM-5, modification of Medicaid rules to allow for reimbursement of evidence-based, trauma-focused treatment for trauma-related symptoms, or using child

welfare grants to fund these specialized services. Such topics are beyond the scope of this article. However, including child trauma measures in mental health assessments is a first step toward removing this obstacle to funding so that direct reimbursement for evidence-based trauma-focused treatments for youth who have experienced traumatic events and demonstrate trauma-related symptoms might be allowed in the future.

## Conclusion

In meeting new federal requirements, child welfare agencies should develop policies that address child trauma. Using AACAP/CWLA policy as an example, the authors show why it is important to distinguish between traumatic events, trauma-related symptoms, PTSD, and symptoms of major mental illness. This study analyzes more than 14,000 clinical assessments from child welfare in Illinois. Based on the analysis, the study recommends child welfare agencies adopt policies requiring that (1) mental health screenings and assessments of all youth in child welfare include measures of traumatic events and trauma-related symptoms; (2) evidence-based, trauma-focused treatment begin when a youth in child welfare demonstrates a trauma-related symptom; and (3) a clinician not diagnose a youth in child welfare with a mental illness without first addressing the impact of trauma. The study also raises the issue of treatment reimbursement being based on diagnosis.

## References

---

American Academy of Child and Adolescent Psychiatry. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49, 414–430.

American Academy of Child and Adolescent Psychiatry & Child Welfare League of America. (2002). *AACAP/CWLA policy statement on mental health and use of alcohol and other drugs, screening and assessment of children in care*. Retrieved September 16, 2011, from [www.aacap.org/cs/root/policy\\_statements/aacap/cwla\\_policy\\_statement\\_on\\_mental\\_health\\_and\\_use\\_of\\_alcohol\\_and\\_other\\_drugs\\_screening\\_and\\_assessment\\_of\\_children\\_in\\_foster\\_care](http://www.aacap.org/cs/root/policy_statements/aacap/cwla_policy_statement_on_mental_health_and_use_of_alcohol_and_other_drugs_screening_and_assessment_of_children_in_foster_care)

- Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the child and adolescent needs and strengths—mental health (CANS-MH) scale. *Journal of Child and Family Studies, 12*, 279–289.
- dosReis, S. Yoon, Y., Rubin, D. M., Noll, E., & Rothbard, A. (2011). Antipsychotic Treatment Among Youth in Foster Care. *Pediatrics, 128*, e1459–e1466.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245–258.
- Griffin, G., McEwen, E., Samuels, B., Suggs, H., Redd, J., & McClelland, G. (2011). Infusing protective factors for children in foster care. *Psychiatric Clinics of North America, 34*, 185–203.
- Kisiel, C. L., Blaustein, M. E., Fogler, J., Ellis, H., & Saxe, G. N. (2009). Treating children with traumatic experiences: Understanding and assessing needs and strengths. In J. S. Lyons & D. A. Weiner (Eds.), *Behavioral health care: Assessment, service planning, and total clinical outcomes management* (pp. 17-1–17-18). Kingston, NJ: Civic Research Institute.
- Kisiel, C. L., Fehrenbach, T., Small, L., & Lyons, J. (2009). Assessment of complex trauma exposure, responses and service needs among children and adolescents in child welfare. *Journal of Child and Adolescent Trauma, 2*, 143–160.
- Leon, S. C., Ragsdale, B., Miller, S. A., & Spacarelli, S. (2008). Trauma resilience among youth in substitute care demonstrating sexual behavior problems. *Child Abuse & Neglect, 32*, 67–81.
- Lyons, J. S. (2004). *Redressing the emperor: Improving the children's public mental health system*. Westport, CT: Praeger.
- Lyons, J. S., Small, L., Weiner, D. A., & Kisiel, C. (2008). *Child and adolescent needs and strengths: Illinois department of children and family services* (Version 2.0). Chicago: Praed Foundation.
- McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). The prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 88–95.

Promoting Safe and Stable Families Program. (2011). *United States code, title 42, chapter 7, subchapter 4, part B, child and family services, subpart 1—Stephanie Tubbs Jones child welfare services program, and subpart 2—promoting safe and stable families.*

Samuels, B. (June 16, 2011). *Improving at-risk youth programs.* Testimony before the Subcommittee on Human Resources, Committee on Ways and Means, United States House of Representatives. Retrieved September 16, 2011, from [www.acf.hhs.gov/programs/olab/legislative/testimony/2011/SamuelsAtRiskYouth.html](http://www.acf.hhs.gov/programs/olab/legislative/testimony/2011/SamuelsAtRiskYouth.html).

van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals*, 35, 401–408.

Copyright of Child Welfare is the property of Child Welfare League of America and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.