The Provision and Utilization of Mental Health Screenings in New York State Child Advocacy Centers: A Statewide Survey

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Child Advocacy Centers (CACs) were designed to facilitate collaboration among agencies that are involved in the investigation of suspected cases of child abuse and neglect (Cross, Jones, Walsh, Simone, & Kolko, 2007). Prior to the establishment of the CAC model, there was concern that children were likely to be seen by staff at multiple settings and, therefore, had to repeat their story each time they met with a new investigator (i.e., law enforcement, medical, CPS) or professional involved with the care and treatment of the child. This process very possibly contributed to the trauma experienced by child abuse victims. Moreover, the information obtained from the child was not routinely shared between agencies and efforts were not always coordinated, resulting in extraneous obstacles and undue burdens with regard to achieving a successful outcome for the children involved (Jaudes & Martone, 1992).

To alleviate this repetition and lack of coordination, the CAC model was established with the expectation that it would improve child forensic interviewing processes following allegations of child abuse. Some features of the CAC model include coordination among multiple investigations, child-friendly interviewing locations, state of the art audio and video equipment (for some), and limiting redundant interviewing (Newman, Dannenfelser, & Pendleton, 2005). The CAC model is designed to bring the system to the child in a seasmlesss one-stop shopping experience, rather than dragging the child through the system (Wolfteich & Loggins, 2007).

Once the law enforcement officer or the child protection investigator brings the child to the CAC, a multidisciplinary team investigation (MDT) begins. The process includes a forensic interview of the child and the provision of core services. These services must minimally include a medical exam or treatment and specialized trauma-focused mental health and child victim advocacy. The interviews conducted within the CAC must be made by a trained interviewer who is part of the MDT. The interview needs to be observed by other members of the MDT who could benefit from the information, thus reducing the need for additional interviews. The interview is observed from behind a one-way mirror or via closed circuit video equipment installed in the interview room.

The first CAC was created in 1985 (Newman, Dannenfelser, & Pendleton, 2005). Today, there are nearly 800 CACs nationwide (National Children's Alliance [NCA], n.d.a). Most of the children brought to CACs are suspected victims of sexual abuse. Data from 2013 reveal that of the 294,000 children seen at CACs nationwide, 62% were suspected victims of sexual abuse, compared with the 17% suspected victims of physical abuse and the 7% that were suspected of being neglected (NCA, 2013a). The remaining cases comprised witnesses to interpersonal violence, drug endangerment, and other miscellaneous maltreatment experiences.

The vast majority—if not all—children seen at CACs are suspected of having suffered the kinds of adverse childhood experiences associated with mental health problems. These children, especially those who have endured sexual abuse, are likely to have elevated rates of mental health problems at the time of the investigation (e.g., Briggs & Joyce, 1997; Cheasty, Clare, & Collins, 1998) and an increased risk of developing a range of psychopathologies in the aftermath of the abuse (for those who were abused), including PTSD, depression, anxiety, and dissociation (e.g., Maniglio, 2009). Untreated, the effects of child abuse and neglect can profoundly influence the victims' physical and mental health, ability to regulate emotions and impulses, achievement in school, and the interpersonal relationships they form as children and as adults (Institute of Medicine and National Research Council, 2014).

Moreover, children identified as at risk of one type of maltreatment are likely to be at risk of other types in light of the data on polyvictimization. For example, in a nationally representative sample of 4,053 youth, Turner, Finkelhor, and Ormond (2010) found that almost 66% of the children were exposed to more than one type of victimization, 30% experienced five or more types, and 10% experienced 11 or more different forms of victimization in their lifetimes. They concluded that "poly-victims comprise a substantial portion of the children who would be identified by screening for an individual victimization type, such as sexual assault or witnessing parental violence" (p. 323).

Children seen at CACs who are not found to be victims of childhood maltreatment may still have untreated mental health issues due to other life stressors such as poverty, bullying, exposure to community violence, and a host of other bio-psychosocial factors that impinge on children.

Therefore, it should come as no surprise that another core function of CACs is to ensure that clients and their non-offending family members receive the appropriate mental health services (NCA, n.d.b). According to the standards set

forth by the National Children's Alliance (NCA), the national association and accrediting body for CACs, children seen by NCA-accredited CACs must have specialized trauma-focused mental health services routinely made available on site or through linkage agreements at no cost to the children or non-offending family members. Specialized trauma-focused services include, but are not limited to, trauma-specific assessment, including a full trauma history and use of standardized assessment tools. NCA (2011) acknowledged that without such a strict standard for intervention, many traumatized children seen by the CACs "will suffer ongoing or long-term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetimes" (p. 24).

Despite the standards set forth by the NCA and the emphasis placed upon their significance, not all children seen at a CAC receive mental health services. For example, based on a set of data provided by the NCA (2013b), New York CACs served a total of 17,339 children in 2013, which is 6% of the national total of 297,761. Of those served by New York CACs, 51% of the children received counseling, compared with the national average of 27%, and an additional 24% of the children seen at New York CACs were provided with referrals to therapy, compared with the national average of 37%. These data suggest that there might be some limitations in the methodologies employed by CACs with respect to the screening and assessment of mental health problems of referred children.

The Current Study

The current study was designed to survey New York State Child Advocacy Centers (CACs) regarding their general mental health or trauma-specific screening procedures, or both, in order to determine the types of screening procedures being utilized and the degree to which they are found to be helpful during the initial investigation and evaluation process. We also wanted to identify some of the barriers to provision of mental health screenings and referrals in light of their importance for the well-being of children. Before appropriate referrals for mental health services can be made, there needs to be a process of identifying which children have mental health needs that require further assessment or mental health treatment.

Methods

Identification of Child Advocacy Centers

A list of all New York State CACs was provided by one of the authors and was used to identify the universe of potential survey participants. This resulted in a sample of 40 CACs, each in a different county (not all counties had a CAC that provided direct service and no county had more than one). The name of the director of the CAC and his or her contact information was included on the information provided.

Study Procedures

An introductory letter was sent via e-mail to the 40 New York State CAC directors or contact persons inviting them to complete a brief survey via an online survey software, Qualtrics. The letter explained that the survey was confidential but not anonymous. Between February 21, 2014, and April 14, 2014, 38 of the 40 potential participants completed the survey (a response rate of 95%).

The Survey

The 22-item survey asked the respondents to report on the CAC's mental health and trauma screening procedures for the children seen at their CAC. The survey asked a series of specific questions in the following four general topic areas: (1) What proportion of children evaluated at a CAC was screened for mental health problems, and what were the barriers? (2) What methods and measures were used for conducting mental health screenings? (3) How were the results of the mental health screenings shared and utilized? And (4) How satisfied were the CAC directors with the process of conducting mental health screenings?

Results

To address the first question, what proportion of children evaluated at a CAC was screened for mental health problems and what were the barriers, we found that all but two of the agencies offered mental health screenings to at least some children, and around 70% of the CACs reported providing on-site mental health/trauma screenings for at least half of the children seen at their CAC. None of the responding CACs provided mental health/trauma screenings to every child seen at the CAC. Table 1 presents reasons why a child might not have been administered a screening measure.

Table 1.

Reasons a Child Not Screened
(more than one reason could be endorsed)

Reason	N	%
Child or family refuses services	25	65.7
Child is too young	19	50.0
No disclosure of abuse	10	26.4
Lack of CAC resources	8	21.0
Already receiving services/screened	4	10.5
Only upon request	1	02.6

Almost two thirds of the respondents reported that some families refused assessments, and one fourth reported that when no abuse was found, a screening might not be conducted. One half reported that screenings were not conducted because the child was too young. A fifth reported lack of resources as the reason for screenings not being conducted.

With respect to the second research question, what methods and measures were used, we found that the vast majority of survey respondents (80%) reported that screenings were conducted by professionals from a wide range of mental health backgrounds. A few notable exceptions were reported, wherein screenings were conducted by law enforcement (one agency), an advocate (two agencies), medical personnel (one agency), or by child protective services (two agencies).

One half of the survey respondents reported using what they considered to be a validated screening tool or a validated trauma measure, or both. Within these 19 agencies, eight different tools were reportedly used as being valid measures.

As we could locate no single definitive listing of validated measures, we undertook a search of every listing of measures that are considered valid. We searched 13 databases of measures, including the following: The National Center for Posttraumatic Stress Disorder, the National Child Traumatic Stress Network, the Substance Abuse and Mental Health Services Administration, the California Institute of Mental Health. We created a combined listing of every measure that had been included in at least one database. As depicted in Table 2, of the eight measures reported by survey respondents as valid measures, six could be considered valid measures of child's behavior and functioning (i.e., were on at least one database) while two measures were not listed on any of the databases. One measure was not a measure of child behavior or functioning (the Trauma History Questionnaire).

Table 2.

Trauma/Screening Measures Utilized and Listed as "Valid" by Respondents

Measure	#Agencies	#Database
Child and Family Traumatic Stress Intervention (CFTSI)	2	0
Child PTSD Symptom Scale (CPSS)	4	5
Child Report of Posttraumatic Symptoms (CROPS)	2	2
Mood and Feelings Questionnaire (MFQ)	1	1
Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI)	4	6
Trauma History Questionnaire (THQ)	6	3
Young Child PTSD Checklist (YCPC)	3	0
	4	2

The third question of the study asked how the results of the mental health screenings were shared and utilized. Agencies reported that results of the mental health screening were often, but not always, provided to the other members of the MDT team, as well as others outside of the MDT.

As shown in Table 3, two thirds of the agencies that conduct screenings (i.e., 36 of the 38 respondents) reported sharing the results with members of the multidisciplinary team. The same number reported that they shared the results with the family, and almost half of the agencies reported sharing the results with the child. Only four agencies (11.1%) said that they did not routinely share the results.

Table 3.

Recipient of Results of a Mental Health Screening (n=36)

Recipient	N	%
Multidisciplinary team (MDT) member	23	63.8
The child	16	44.4
The family	22	61.1
Outside agencies	09	25.0
Results are not routinely shared	04	11.1
Mental healthcare provider upon referral	02	05.5

We also asked survey respondents about the proportion of children who were referred for mental health treatment based on the results of the assessments. These data are presented in Table 4.

Table 4.

Percentage of Children Referred for Mental Health Treatment Based on Screening (n=36)

Percentage	N	%
100%	3	08.3
75% to 99%	11	30.6
50% to 74%	15	41.7
25% to 49%	4	11.1
1% to 24%	2	05.6
0%	1	02.7

One agency reported that no children were referred based on the assessment process, six agencies reported that between 1% and 49% were referred, 15 agencies reported that between half and three fourths of the children were referred based on the results, and 14 agencies reported that three fourths to all of the children were referred. We did not ask what the reasons were for not referring children.

The final question in this study related to how satisfied the agencies were with their mental health screening assessment procedures. First, we asked if the measures used were helpful for identifying children with mental health needs. A little over half (52.8%) of the responding CACs reported that they found the mental health screening measures to be "very important" for identifying children with mental health issues, and the remaining respondents reported that the measures were only "somewhat important." Next, we asked if the screening process as a whole was helpful for determining whether mental health services were needed. About half of the agencies found the process to be "very helpful" (48.4%), and about half reported it to be only "somewhat helpful" (48.4%). One agency reported that the screening process was only "a little helpful."

Discussion

Thirty-eight of 40 CACs in New York State responded to a survey about the mental health screening and referral process for children. Several notable findings were identified in the survey.

First, no agency reported screening all of the children. Thus, the agencies were missing an important opportunity to determine whether children—already at risk—were suffering from mental health problems and were in need of services. The reasons that screenings were not conducted on all of the children included the family resisting or declining the offer of a screening, the children being perceived to be too young to be screened, no disclosure of abuse, and lack of resources. Each of these reasons suggests an area for improvement in light of the high likelihood that all children referred to CAC may be at risk for mental health issues regardless of the status of the abuse investigation.

The most often-cited reason for not providing a mental health screening was that families refused assessments. This suggests that families are being presented with the opportunity for a screening without sufficient information to help them understand the risks and benefits of such a screening. They may be declining for reasons that can be overcome with sufficient information (e.g., fear of labeling the child, fear of traumatizing or stressing the child). Regardless of the reason, it is possible that the concerns could be resolved or overcome with sufficient information and engagement from the staff. There are known available engagement strategies and motivational interviewing techniques that may help to engage families and improve compliance with the mental health screening process (e.g., Gopalan, et al., 2010). Data were not collected about what process is used when parents refuse to have their children screened; however, it seems likely that in at least some of these situations, greater attention to how the screening is described and how initial resistance is handled would result in a higher proportion of children being screened.

The second most-often cited reason (half of the agencies) was that the child was too young to be screened. This suggests that information about appropriate screening methods for young children is not available to the staff at many CACs in this state. This is unfortunate because it is critical to assess young children for mental health problems, and problems identified earlier are more likely to be addressed than problems that remain untreated. Early detection is vital for achieving positive mental health outcomes (Albers, Kratochwill, & Glover, 2007). Moreover, a recent review of the literature identified four mental health screening measures designed specifically for children ages 3–5 years old that were reliable and valid (Feeney-Kettler, Kratochwill, Kaiser, Hemmeter, & Kettler, 2010). The findings in our data suggest that information about appropriate measures for young children should be routinely made available to CAC staff responsible for screening children to ensure that young children are not unnecessarily omitted from the process.

The third most-cited reason (one fourth of the agencies) was that no abuse was found. Thus, once the CAC performed its primary function of investigating child abuse allegations, some failed to perform an equally important function of screening children for mental health problems. These data reveal a misunderstanding about the potential for mental health problems to be present in the sample of children seen at the CAC, even those with unfounded abuse allegations. That is, other mental health issues might be identified if the child were screened at the CAC.

Another significant finding was that not all of the supposedly valid measures used to screen children seen at CACs actually were valid. There is no single listing of valid measures for assessing mental health of children. In fact, we identified 13 different compendia of such measures. Of the eight measures mentioned by the survey respondents as valid measures, six were listed in at least one of the compendia.

Also notable is that the results of the mental health assessments that were conducted at the CACs were not consistently shared with the team, the family, the child, or outside mental health providers. Reasons why these data were not routinely shared need to be investigated and suggest an important area for future work.

When asked what proportion of children was referred for treatment based on the results of the survey, a range of responses was provided. Three agencies said all children, while one agency reported that no children were referred based on the assessment process. The remaining agencies reported anywhere from 1% to 99%. In light of such variation, it might be helpful to understand some of the reasons why referrals are not made. It is likely that not all children need to be referred but equally likely that some children who should be referred are not.

A final notable finding is that only half of the agencies reported that the screening process was "somewhat" helpful for identifying children with mental health needs and about half reported that that the process itself was only "somewhat helpful" overall. Future research should endeavor to understand the myriad of reasons for this high rate of mid-level satisfaction.

Limitations

This survey had a high response rate (95%) but represents only 38 agencies, all of which are in a single state. It is important not to overgeneralize the findings. Replication of the survey in other states would go a long way to determining whether there are geographical patterns with respect to the mental health screenings of children in CACs

and the extent to which some of the troubling patterns observed here are reflected in national data as well. There is no reason to believe that staff working in New York State CACs are more likely to have difficulty engaging families or identifying appropriate measures. For that reason, the data should be considered by CACs around the country as potentially reflective of their own practice and can be used to spur self-analysis and improvement.

Implications and Directions for Future Treatment and Research

The following recommendations are offered:

First, all children and youth should be offered a screening for mental health problems regardless of the result of the MDT investigation because there could be other reasons for mental health problems in the child, regardless of a finding of maltreatment or disclosure of maltreatment. Just because a child was not validated as having been abused or neglected does not mean that the child did not experience maltreatment or inadequate parenting or adverse childhood experiences that may result in mental health issues. The investigation process itself may be a trigger for adverse experiences of the child, also suggesting that the child could benefit from mental health screening or treatment, or both.

Second, valid mental health screening tools should be made available and used by CACs. A compendium of possible measures by age of child, fee, length of time to administer the measure, scoring options, and so forth needs to be included in the compendium to facilitate the selection of proper measures by CAC staff.

Third, mental health screening tools specifically for children under age 6 should be made available and used by CACs. There is no need for this very young population of CAC clients to be omitted from the screening process.

Fourth, all staff responsible for conducting mental health screenings or making referrals for screenings at CACs should be trained to discuss their purpose and importance to decrease the likelihood of families refusing to cooperate.

Fifth, a qualified mental health practitioner—or someone supervised by such a person—should conduct the screenings and interpret the results whenever possible.

Sixth, CACs should be provided with information about evidence-based treatments (when available) and information about best practice when evidence-based treatment is not available. This information is helpful for treating children of different ages and developmental levels with various mental health issues and can be incorporated into their practice for treatment and for referring to treatment in the community.

Seventh, the National Children's Alliance should consider conducting a national survey to determine the extent to which the findings from this survey are applicable to other states across the country.

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