# Frequently Asked Questions (FAQs): Screening Children and Youth

The purpose of this document is to provide current demonstration sites, as well as jurisdictions interested in replicating the efforts of the Linking Systems of Care (LSC) for Children and Youth Project, with useful questions to initiate discussions about (a) screening children and youth for victimization, (b) why it is important, (c) considerations for a proper screening environment (e.g., before and after screening), and (d) examples of past initiatives that have screened minors.

## Will there be consent forms?

If project staff plan to collect data from pilot agencies that serve children and youth, it is highly likely that the Institutional Review Board will request that parents/caregivers read and sign a consent form allowing a minor to participate in research-related activities, including the screening process. Project staff may also want to inquire about expectations related to children/youth reading and completing an assent form.

## What is the purpose of screening?

The Vision 21: Transforming Victim Services Initiative[1] seeks to engage and bring together a broad spectrum of service providers, advocates, criminal justice professionals, practitioners, and policymakers to address the needs of crime victims. The Linking Systems of Care (LSC) for Children and Youth state demonstration project is one of several projects stemming from the Transforming Victims Services Initiative. The primary objectives of the LSC state demonstration project are to (a) identify and promote healing for victims of crime, (b) provide or coordinate prevention and intervention services to youth and families experiencing trauma and victimization, and (c) build capacity with communities to meet the needs of youth exposed to violence. The LSC state demonstration project has developed strategic plans for bringing together professionals and relevant systems to provide early identification, intervention, and treatment services for youth victims as well as their families and caregivers. In order to accomplish the LSC project objectives, demonstration sites have elected to develop a screening tool to identify children and youth who have been victimized directly and/or have witnessed or indirectly have been victimized (i.e., observed someone else be assaulted, exposed to shootings, etc.).

## Why is screening important?

| Types of Victimization | Past Year | Lifetime |
|---|---|---|
| Any physical assault | 41.2% | 54.5% |
| Any sexual assault | 5.6% | 9.5% |
| Any child maltreatment | 13.8% | 25.6% |
| Any property victimization | 24.1% | 40.2% |
| Witnessing violence | 22.4% | 39.2% |
| Indirect exposure to violence | 3.4% | 10.1% |

Research shows that a considerable number of children and youth experience various types of victimization annually and across their lifetimes in the United States (see Table 1).[2] Although data from the Youth Risk Behavior Survey (YRBS) suggests a decrease in several types of youth victimization between 2005 and 2015,[3] some types of injury and violence have increased during this decade. The YRBS results also show that over 20% of youth sampled reported being (a) in a physical fight during the last 12 months and (b) bullied on school property during the last 12 months.[4] A crucial first step in the LSC state demonstration project is to develop a process to *identify* children and youth who are in need of further assessment and/or resources due to effects of victimization.

Screening children and youth for victimization is important for several reasons. First and foremost, after being identified through a brief screening tool, children, youth and families can be referred by service providers for more in-depth assessments that will likely result in connecting them to available, local services. Participating in screening, in-depth assessments and referring them to local services may assist the family, as a whole, in beginning to heal from the victimization and trauma they have experienced.

## Can children/youth have access to referral services if they do not have health insurance?

This response may be dependent on your state. Although free or low-cost programs may have some eligibility requirements, they may be useful collaborative partners and worth investigating further. Staff may also want to discuss this specific topic with the potential screening agencies and referral agencies. Each agency may have an internal policy relating to serving children, youth and families with *limited* financial resources. Some agencies, for instance, may offer programs specific to assisting families in need.

## How can screening help kids and families? Does screening harm kids?

Concerns about screening children and youth about any sensitive topic (e.g., victimization) are completely understandable. We often fear that having difficult conversations with youth will cause a negative outcome. Asking a youth about suicidal

thoughts is an example of a topic that often causes fear in individuals. Many individuals think that merely having this conversation will result in a youth attempting suicide or having suicidal ideation. The Office of Suicide Prevention, however, indicates that this is a myth.[5] Talking about suicide is a best practice for suicide prevention as it provides an opportunity for communication.[6] The Centers for Disease Control and Prevention also encourages informal or formal screening strategies as they can be the starting point for linking systems of care by (a) strengthening connections between organizations which offer referrals for treatment services and (b) ensuring that services are delivered.[7]

Although there is little research on the effects of screening on youth, Finkelhor and colleagues found that less than one percent of youth were upset about being asked questions on victimization (e.g., family maltreatment and sexual victimization).[8] More specifically, results showed only 0.3% of the total sample indicated they would not participate in the interview again having known the content.[9] It is important to note, however, that much of their regret about participation was due to the length of the survey, not the content.

In collaboration with the Connecticut Department of Families and Children, the Child Health and Developmental Institute (CHDI) of Connecticut and the Consultation Center developed a brief instrument to screen children/youth for trauma across various child-serving settings. The CHDI recommend the following *best practices* when implementing screenings: (a) Conduct a brief, standardized and validated measure; (b) Use the screening instrument to engage potential clients,; (c) Administer the screening instrument on an annual basis and universally (i.e., across systems); (d) Include questions on exposure and reactions to trauma; and (e) Have trained staff conduct screenings, as well manage disclosures and/or referrals.[10] Researchers from Connecticut are also capturing data on the perceptions of child welfare and juvenile justice staff who are screening children.[11] Primarily data on 996 justice-involved youth suggest that staff rarely have any immediate concerns about screening, with less than two percent of staff reporting that the child/youth appeared uncomfortable with the screening questions and staff indicating feeling they could manage the child's distress.[12]

While it is reasonable that screening may occasionally cause distress in a child or youth, the benefits of screening *outweigh* any potential risk (e.g., distress) experienced. It is important to stress that the screening tools for the LSC demonstration project were carefully and thoughtfully created to elicit the responses necessary to determine if the youth has experienced victimization and to allow for appropriate referrals for assessments and services. Asking screening questions in a straightforward manner allows the screener to obtain unequivocal responses to help identify current and past victimization. Asking vague questions may result in confusion and not provide the information needed to determine if a youth has experienced victimization.

## What happens if a child discloses?

This depends on the *type* of information the child/youth discloses to the person administering the screening tool.

- If a child/youth discloses an *immediate safety* concern, it may be best for the agency administering the screening tool to follow *their* internal policies and procedures for such an event. When interacting with *potential* screening agencies, project staff may want to have detailed conversations about the policies and procedures of each screening agency. Project staff may want to inquire whether screening staff are mandated reporters for their respective agencies. If so, screening staff may be quite experienced with identifying immediate safety concerns. Follow the link for more information about state-level mandated reporters.

- A referral for assessment and/or services may suffice for disclosures that do *not* rise to a safety concern. A conversation with potential screening agencies may inform the project staff about the availability of local services, wait times for appointments, gaps in services, etc.

Because this disclosure information relates to next steps for the person administering the screening tool, the project staff may want to provide detailed instruction on the screening tool and/or in the training manual that accompanies the screening tool about this topic.

Project staff may want to consider setting up in-person meetings with potential screening and referral agencies to understand the resources and gaps in services within each pilot community. Agencies who will be receiving referrals from screening agencies may be able to inform the LSC project staff their capacity for new clients. This information may assist project staff when developing thresholds and/or overrides for referrals based on the screening tool.

## Who should/could administer a screening tool?

Ideally, if instructions and screening questions are clear and direct, a screening tool could be used by non-clinical professionals. It is important to note the objective is to *screen* children/youth, not assess them. Although screening and assessment are often used interchangeably, there is a significant distinction. According to the Substance Abuse and Mental Health Services Administration (SAMSHA), screening is a brief process used to evaluate whether a more thorough evaluation for a particular problem or disorder is warranted and can often be conducted using simple yes or no responses.[13] An assessment, on the other hand, is a lengthy process which may define the nature of a particular problem, determine a diagnosis, and/or develop recommendations for treatments to address the problem or diagnosis.[14]

Individuals administering the screening tool will need to understand its overall purpose, content, scoring protocol, and next steps for referrals.

## Where should a screening tool be administered (i.e., environment)?

In general, screenings should be administered in a quiet, private location.

- If the minor is not in custody, a private office (or interview room) where the child/youth can be seated is the minimum requirement for screening to be administered.

- If the minor is in custody, a private office (or interview room) where the child/youth can be seated, un-shackled, and not required to respond to questions in a safety posture (i.e., sitting on their hands)'[15] are the minimum requirements for the screening to be administered. In ideal circumstances, a screening should not take place in the same room where the child/youth was interrogated by law enforcement or probation concerning their detention. The room should be segregated by sight and sound from other detainees. The child/youth should only be moved to the room individually, and not with other minors. When moving the child/youth to the screening, the correctional officer should not indicate to other detainees *why* he/she is being moved.[16]

## Will screening participation effect court cases?

It is possible that statements made during the screening process, or participation in the screening process itself, may have legal implications for *active* court cases. Nearly all post-arrest actions (e.g., therapeutic treatment and basic health care), however, carry some risk for potentially affecting a court case. The level of effect is impossible to determine without a careful analysis of a minor's individual legal situation by an informed attorney. Below are a couple examples of participation in the screening process affecting court cases.

- A minor on probation for petty theft participates in a screening tool at a routine face-to-face meeting with his probation officer. The minor was initially offered no services, but only ordered to pay a fine and complete community service. Based on the results of the screening tool, the probation officer realizes that the minor is suffering from severe grief at the loss of his friend, but presents as asymptomatic. He then seeks court approval to add individual therapy to the minor's case plan which is paid for by the state.

- A female minor who was recently arrested for battery after school participates in a screening performed by her school counselor. During the screening, the minor states that she "punched Elizabeth several times in the head." The school counselor is later interviewed by the police. Pursuant to state law, the school counselor discloses the statement that the minor made about punching Elizabeth. This statement is recorded in a report which is provided to defense

counsel. The defense counsel then subpoenas the contents of the screening tool for a court hearing.

Although examples may be numerous, these two examples demonstrate how participating in the screening process has the potential of positively (or negatively) impacting a court case. Project staff may also note that any immediate safety concerns disclosed during the screening process could initiate an investigation by child protective services which may lead to a new court case in family court.

## What happens before and after screening?

In nearly all circumstances, parents or children/youth will have questions prior to, or after the screening. The sites conducting the screening should be prepared to answer frequently asked questions (FAQs) about the screening *process* – many of which can be answered by your piloting plan and/or Institutional Review Board (IRB)[17] submission. In some instances, the questions posed by parents or children/youth may have legal implications which should be referred to screener's supervisor (or child/youth's counsel, if applicable).

*Before screening…*

Typically, the screening process begins by ensuring the child/youth is comfortable and building rapport with the child/youth and parent. Follow the link for information on strategies for building rapport.[18] Informing the parent and child/youth about the type of information that will be collected during the screening and how this information will be used should follow. If a screening tool is part of a pilot project, most IRBs will require that (a) a parent reads and signs a consent form, and (b) the child/youth reads and signs an assent form prior to being screened to acknowledge their agreement. Both the consent and assent processes should inform parents and children/youth about mandatory reporting requirements[19] and how concerns of immediate safety will likely result in screening information being shared with other professionals. State law specifies that only certain professions are immune from liability when reporting child abuse as a result of their statutory duties. A screener who adheres to the mandated standard but is not statutorily protected will not be immune from civil or criminal liability. Therefore, it is very important that screeners are aware of whether they are mandated reporters or not. Follow the link for more information about state-level mandated reporters. If a screener must make a mandated report, they should follow the internal protocols of their agency/organization. In most cases, internal protocols will include the following core elements:

A screener will:

- Explain to the child/youth that they need to report the statement to law enforcement or child welfare;

- Explain why they are reporting the statement (e.g., because they are concerned about the minor's welfare, and that it is the *screener's* decision, not the child/youth's actions or behavior that is causing them to report); and
- Reassure the child/youth that they are not in trouble and thank the child/youth for being honest with them.

Liability is a common question which comes up for the implementation of any instrument that involves mandated reporting. In general, individuals conducting the screenings tend to be over-inclusive of situations that may require reporting. The question of precisely what facts would lead a screener to make a mandated report is a legal question, albeit one that is not overly complex. In most cases, a good screener will be able to *identify* a potential mandated reporting situation without sufficient difficulty. The decision to make a mandated report, however, can become unnecessarily clouded with extraneous facts or beliefs which may not be correct. If a pilot agency/organization affirms that all of its screeners understand that mandated reporting is a binary decision pathway (i.e., if I have facts that represent child abuse/neglect, then I must report to local child protective services), there should be few issues of liability other than potential negligence (which is always a concern in any organization).

*After screening…*

After the screening is completed, the parent and child/youth will be informed of any referrals that the screener may wish to make for services and/or treatment. A parent and child/youth may decline services or disagree with referrals. In this situation, the individual conducting the screening can inform the parent and child/youth that a larger goal is to refer families to local services that might be of assistance. If the immediate safety of the child/minor is not a concern, however, it is up to the parent and/or child/youth whether or not they follow-up with referrals made by the screener.

## What have been the results of other large screening projects?

*Connecticut – Trauma Screening*

Lang and colleagues described initial results of a statewide implementation project geared at building a trauma-informed child welfare system.[20] Some of the strategies discussed included workforce development, trauma screening and policy change. Results showed system-wide improvements in partners' capacity for trauma-informed knowledge, practice, and collaboration. The authors made the following recommendations[21] to other sites implementing similar statewide initiatives:

- Identify resources that may sustain the work over time (e.g., staff to lead the implementation project, ongoing training, evaluation, etc.).

- Foster relationships with leadership (at the highest level) to ensure buy-in for systemic change.

- Listen to the strengths and needs of collaborating partners. If possible, implement activities that may respond to some of the local needs (e.g., education on secondary traumatic stress and/or wellness for staff).

- Identify liaisons (at local office) to serve as champions for the project. These individuals held various positions within the child welfare system and were responsible for providing monthly in-service trauma training to their local office.

- Seek opportunities for policy reform and funding. Support for policy changes and being awarded grant funds can be used to promote interest in the project's goals and incentivize participation of local organizations.

*Ohio – Defending Childhood Initiative*

As part of the Defending Childhood Initiative, a demonstration site in Ohio[22] developed a screening tool and referral process for youth in need of services. Below are a few lessons learned by the Ohio team during the implementation phase:

- *Anticipate that pilot sites will be concerned about asking sensitive questions* (e.g., suicide/self-harm). Some agencies felt very strongly that their staff should not be asking some of these questions. The Ohio team ultimately decided to include these items, however, they continue to hear that partnering agencies feel like asking these questions may put ideas into kids' heads. Although there is research to suggest this is not the case, the research often does not comfort people who feel strongly about this approach.

- *Far more youth were referred for additional assessment based on workers overriding rather than merely meeting a threshold on the screener*. For example, a child/youth may need a score of five to be referred to services. However, if the individual administering the screening tool has discretion to override this rule, a child/youth who scores a four could still be referred to services. In theory, this response by the individual administering the screening tool makes sense – we all want children/youth to receive the services and treatment they need. The impact of an override option, however, can place additional strain on the referring agency (or system) that is conducting follow-up services.

- *Preliminary data suggests that caregivers' reports of trauma and violence (for children 0-7 years of age) tend to underestimate the amount of exposure to violence experienced*. These preliminary findings may be due to (a) caregivers being unaware of the exposure or (b) that they deny it is occurring because they are directly or indirectly involved in the exposure. This information may be useful when developing screening thresholds and scoring norms – as overrides were quite common among this age group for that very reason.

- *Anticipate that most individuals will use the paper and pencil version of the screening tool* (even if a web-based version of the screener is available). Sites

were encouraged to use the web-based version of the screener for a few reasons: (a) minimize scoring errors, (b) decrease the number of lost forms, and (c) decrease the number of questions related to how the data would be analyzed. Because many pilot agencies lacked the availability of laptops/tablets, most individuals used paper-pencil screening tools.

[1] Office for Victims of Crime. (n.d.). Vision 21: Linking systems of care for children and youth.
[2] Finkelhor, D., Turner, H., Shattuck, S., Hamby, S., & Kracke, K. (2015). Children's exposure to violence, crime and abuse: An update.
[3] Montana Office of Public Instruction. (n.d). 2015 – Montana youth risk behavior survey: High school results.
[4] Id.
[5] Office of Suicide Prevention. (2014). The myths and facts about youth suicide.
[6] Id.
[7] Center for Disease Control and Prevention. (n.d.). Strategic direction for the prevention of suicidal behavior: Promoting individual, family, and community connectedness to prevent suicidal behavior.
[8] 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,* 217-223.
[9] Id.
[10] Child Health and Developmental Institute, Inc. (2014). Improving care for through trauma screening. Issue Brief #31.
[11] J. Lang, personal communication, January 12, 2017.
[12] Id.
[13] Substance Abuse and Mental Health Services Administration. (2009). *Substance abuse treatment: Addressing the specific needs of women*. Treatment Improvement Protocols (TIP) Series, No. 51, SMA 09-4426. Rockville, MD.
[14] Id.
[15] However, if protocol requires the minor remain in a safety posture during transit, this is permitted.
[16] It is not uncommon for a minor to ask a juvenile correctional officer *where* or *why* he is being moved. In this circumstance, a removing officer should not say "to get screened" or "they want to do a screening tool" etc.
[17] Researchers who conduct research activities involving human subjects must adhere to the federal regulations that ensure the protection of human subjects (e.g., privacy and the assurance of confidentiality). Research procedures and materials are approved members of Institutional Review Boards (IRB) which are typically associated with local universities and/or research entities. Follow the link for more information about human subject protection and the IRB process.
[18] National Children's Advocacy Center. (2015). Rapport in child forensic interviews.
[19] Child Welfare Information Gateway. (2016). *Mandatory reporters of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
[20] Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., & Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment, 21(2),* 113-124.

[21] Id.
[22] J. Kretschmar, personal communication, January 17, 2017.

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