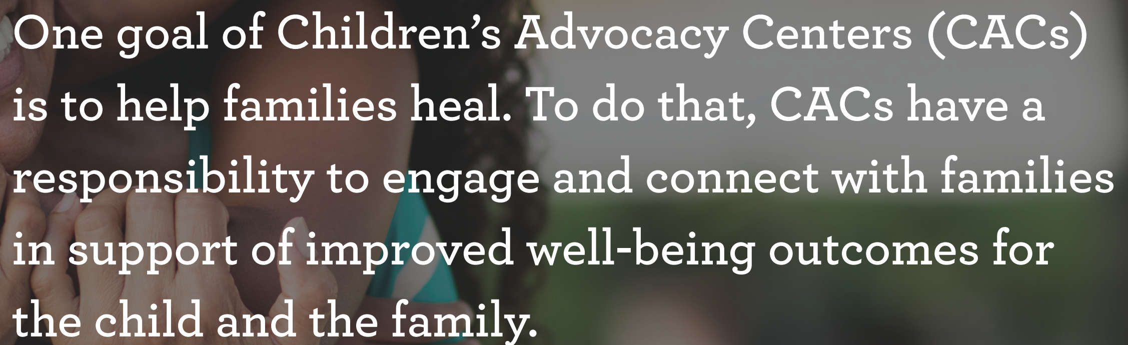
# HELP FAMILIES HEAL

## Engaging Families in Mental Health Treatment



One goal of Children's Advocacy Centers (CACs) is to help families heal. To do that, CACs have a responsibility to engage and connect with families in support of improved well-being outcomes for the child and the family.

## What is family engagement? And how are we doing?

Family engagement includes family attendance at, participation in, and completion of mental health treatment. Engagement is about motivating and empowering families to recognize their own needs, strengths, and resources and to become involved in the therapeutic process to help themselves and their family members. Family engagement and involvement is a collaborative relationship between providers and family members. This relationship can assist with the success of mental health treatment as well as support the child and family in adapting to adversity.

While rates of caregivers reporting they were referred to mental health services are rising, rates of children seen at CACs using mental health services have continued to decline, from 69% in 2014 to just 57% in 2018 (*Healing, Justice, & Trust 2019*).[1] The most common reason cited by caregivers was that they did not believe their child needed these services. In order for children who present with trauma symptoms to thrive, it is critical that they have access to, attend, participate in, and complete an evidence-based treatment (EBT) that has been shown to be effective in reducing the negative impact of the trauma of abuse.

## The role of the victim advocate

Victim advocates—also referred to as family advocates—play a critical role in supporting families served through CACs, and caregivers and family members play a critical role in supporting and healing children from adversity and trauma. Therefore, National Children's Alliance (NCA), in collaboration with the University of Oklahoma Health Sciences Center and subject-matter experts, has developed a training to shift and expand the focus of victim advocates to the needs of the family (family advocate) in a way that is consistent with the Mental Health Standard in the 2017 edition of NCA's *Standards for Accredited Members*.

**Training Intervention for the Engagement of Families (TIES)** consists of focused engagement strategies implemented as early as the initial contact with the family seeking help that can have significant, positive effects on family attendance and engagement throughout mental health service use. Using these engagement strategies, victim advocates can help to increase family members' understanding of trauma, their knowledge of the value of evidence-based treatment, and their ability and motivation to access and receive quality mental health care. Strategies include:

- **IDENTIFY** and problem-solve perceptual and concrete barriers.
- **DEVELOP** mutual understanding of caregiver and child needs.
- **PROVIDE** information.
- **LISTEN** and express empathy.
- **COLLABORATE** with the provider and the family.
- **EMPOWER** and validate caregivers.

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tiesengagement.com

**Motivational interviewing (MI)** involves asking open-ended questions, making aspirational statements, and reflecting on and summarizing conversations. MI assumes that the client is the expert and is the only one who can decide to change and what to change. These techniques are delivered with compassion and acceptance, empathy, and in a non-judgmental and non-confrontational manner.

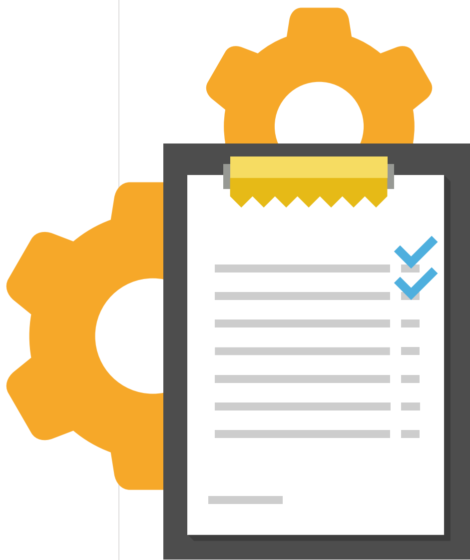
Using MI strategies from the initial contact to join with the caregiver in a partnership to help the child heal, defining the caregiver as the expert about their child, and eliciting the caregiver's opinions about the strengths, needs, and problems are all collaborative engagement strategies. Many of the functions of the victim advocate offer opportunities for using family engagement strategies:

- **IDENTIFY** and overcome barriers to the family's engagement in treatment.
- **SCREEN** for potentially traumatic events and the impact of those events on the child/family.
- **SHARE** feedback from the screening/assessment.
- **TIE** identified symptoms to caregiver observations regarding problems/needs.
- **DESCRIBE** the value of EBTs.
- **PROVIDE** the family with the training, experience, and expertise of the mental health referral.
- **MAKE** a face-to-face referral and utilize a warm, collaborative approach to support connection with the provider.
- **ADDRESS** concerns related to mental health treatment including stigma and cultural issues.
- **SHARE** testimonials and your successful experiences from other families.
- **ASSIST** with completing paperwork and scheduling the appointment.
- **INSTILL** hope by highlighting supportive/protective factors and treatment effectiveness.
- **FOLLOW UP** with the family on their mental health treatment progress.

## Supporting family engagement

Implementation of these research- and data-informed changes requires that CAC staff and multidisciplinary team (MDT) partners embrace: the outcome goal of healing; the shift of focus of the victim advocate to the family advocate; acknowledging the caregiver/family as the expert about their child; and identifying a family-centered process that supports input from the family into services needed and provided through the CAC. In addition, **the victim advocate must be identified and acknowledged as an integral, valued, professional MDT partner who offers the voice and experiences of the family and serves as a conduit between the MDT and the family.** CACs and their MDTs will need to support the changes in functions and structure—and the training—required to implement those changes within the CAC.

## Screening vs. assessment



A screening is a brief measure designed to identify mental health symptoms that a child or caregiver is experiencing. It may indicate a need for further assessment or a referral for services. These instruments may be completed by the caregiver and/or children themselves. A screening contains a series of questions that will give a quick snapshot of how the child is doing, and responses generally will be either yes/no or rating the frequency of the symptoms, such as "never," "sometimes," and "often." Screenings are not diagnostic, and children exhibiting symptoms should be considered for referral to a mental health provider who can do a mental health assessment to assist with diagnosis. The purpose of the mental health assessment is to determine if treatment is necessary and, if so, what type of treatment is indicated. Not all children completing a mental health assessment will require treatment.

### DID YOU KNOW?

In a 2019 survey of hundreds of victim advocates at CACs, **57.2%** of respondents said they were not using a screening tool.

## Who conducts screenings? When?

A clinical background is not required to administer screening instruments; therefore, victim advocates and other CAC personnel can administer the screenings. Prior to using a screening instrument, the person administering it should be familiar with the measure so that they can score it and provide results to the caregiver and the child.

The best time to screen children is during the initial CAC visit. If you're using a caregiver measure, it can be filled out while the child is in the forensic interview. If administering a screening to the child, this should only be administered after the forensic interview. If you're thinking about having the caregiver and/or child come back to the CAC on a different day for the screening, keep in mind that it can be difficult to get families to return.

**DID YOU KNOW?**

In that 2019 survey, **49%** of victim advocates report that they are not tracking whether children make it to their first therapy appointment. Those who are tracking found that only about **50%** of children referred attend the first appointment.

## How screenings help

Many CACs lack the mental health resources to refer all children to therapy, and all children do not need it. In a recent survey, nearly 45% of victim advocates reported waitlists for therapy, and 35% reported a lack of mental health services as barriers.[2] Screenings can help identify children who need immediate services.

It is estimated that approximately 34% of youth who come to a CAC have either experienced suicidal ideation or have a history of an attempt.[3] Many screenings include questions related to suicidal ideation, problematic drinking, and/or problematic sexual behavior. If the caregiver or the child endorses one or more of these critical items, it is very important that it be addressed prior to the family leaving the CAC. In order to be well prepared, we recommend that CACs have policies and procedures on responding to these critical items.

# Engaging children and families

The screening results allow victim advocates to have a conversation with the caregiver about any concerns they may have about their child—and it allows the advocate to personalize the reason they are making the mental health referral. For example, if a parent reported that the child is having anger outbursts, the victim advocate could tell the caregiver that anger is a common response to experiencing trauma and refer him or her to a mental health provider with specialized training to help reduce the child's angry outbursts. The results of the screening could be sent to the mental health provider along with other referral information to assist them in an assessment.

### Examples of screening instruments commonly used by CACs:

- Trauma Symptom Checklist for Children Screening Form (TSCC-SF)
- Trauma Symptom Checklist for Young Children Screening Form (TSCYC-SF)
- Mood and Feelings Questionnaire (MFQ)
- Strengths and Difficulties Questionnaire (SDQ)
- Child and Adolescent Trauma Screen (CATS)
- Pediatric Symptom Checklist (PDS) modified

# Evidence-based treatments

### The following are commonly available at a CAC or as a community referral:

- Child-Parent Psychotherapy (ages 0-5; PTSD symptoms; childparentpsychotherapy.com)
- Parent-Child Interaction Therapy (ages 2-7; behavior difficulties; pcit.org)
- Eye Movement Desensitization and Reprocessing (ages 2-17; PTSD symptoms; emdr.com)
- Trauma-Focused Cognitive Behavioral Therapy (ages 3-18; PTSD symptoms; tfcbt.org)
- Problematic Sexual Behavior - Cognitive Behavior Therapy (ages 3-14; PSB; psbcbt.ouhsc.edu)
- Alternative for Families; A Cognitive Behavioral Therapy (ages 5-17; physical abuse/conflict/ physical discipline; afcbt.org)
- Child and Family Trauma Stress Intervention (ages 7-18; acute stress; medicine.yale.edu/ childstudy/communitypartnerships/cvtc/cftsi)

**LEARN MORE**
California Evidence-Based Clearinghouse for Child Welfare
cebc4cw.org

> It's not just the child who goes through this, it's the whole family."

— **Maureen Fletcher**

Family advocate/forensic interviewer,
Children's Advocacy Center of Texarkana

## How to identify the right mental health providers

Many evidence-based trauma treatments maintain a list of mental health providers on their websites who have successfully completed training and/or have become nationally certified. Several states maintain their own state specific rosters of mental health providers trained in EBTs. Contacting your local providers and asking about availability and use of evidence-based trauma treatments may also be helpful.

### Helpful questions for providers

- What evidence-based trauma treatments have you been trained in? Please describe the training. Can you provide documentation?
- What assessments are used related to trauma exposure and symptoms to determine if trauma treatment is necessary?
- What is your comfort, experience, and willingness to collaborate with the CAC and other systems involved with the family?
- Do you involve caregivers?
- What ages do you treat?
- What insurance do you take? Do you accept Crime Victim Compensation?
- What are your preferred populations to work with (e.g., trauma, developmental/intellectual disabilities, behavior difficulties, anxiety/depression, problematic sexual behaviors)?
- Do you have experience working with diverse populations, i.e., sexual and gender identity, ethnicity, race?
- Do you typically have a waitlist?
- What languages do you speak, or do you have access to a translator?
- What is the typical frequency of appointments?
- Do you or your agency provide evidence-based treatment services for adults with trauma and other mental health symptoms?
- Do you participate in clinical supervision of your trauma treatments?

**Victim advocates are valued members of the MDT. They have the opportunity to offer the voice and experiences of the family. In addition to supporting families through the criminal justice system, victim advocates are in a unique position to help families heal by connecting and engaging them in mental health services.**

1. *Healing, Justice, & Trust 2019: A National Report on Outcomes for Children's Advocacy Centers.* National Children's Alliance: Washington, DC. September 5, 2019.

2. Victim advocate and director surveys, National Children's Alliance, 2019.

3. Jeffrey N. Wherry, Spenser Baldwin, Kacee Junco, & Belinda Floyd (2013). Suicidal Thoughts/Behaviors in Sexually Abused Children, *Journal of Child Sexual Abuse*, 22:5, 534-551, DOI: 10.1080/10538712.2013.800938.

## Resources

*CAC Director's Guide to Quality Mental Healthcare*, nationalchildrensalliance.org/mhguide

Child Victim Web, cv.musc.edu

The California Evidence-Based Clearinghouse for Child Welfare (CEBC), cebc4cw.org

National Child Traumatic Stress Network, nctsn.org

This project was supported in part by a grant from the National Institute of Mental Health (NIMH) (R34MH118486). The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the National Institute of Health.

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