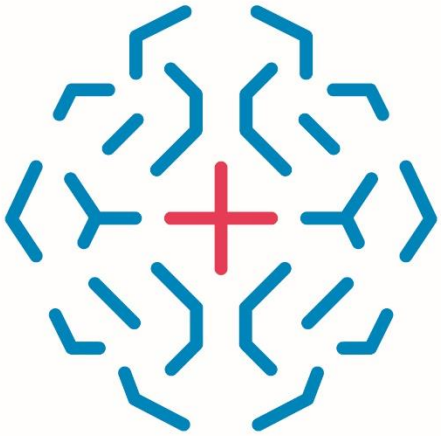

NCA Institute for Better Mental Health Outcomes℠

The Mental Health Digital Notebook Resources User's Guide

Updated: September 29, 2023

NCA Institute for Better Mental Health Outcomes℠

The Mental Health Digital Notebook Resources User's Guide

To move between the different Desk Cards, you can either use the Bookmark tool in Adobe Acrobat, or if using a browser click in the upper left corner to access the bookmark list. Click on the Desk Card from the menu to go to it.

The symbol on a web browser is: The symbol in Adobe Acrobat is:

National Children's Alliance/CAC Digital Mental Health Notebook

A Resource to support the implementation of the NCA Mental Health Accreditation Standard

This notebook is a resource for both the Enhance Early Engagement (E3) training and the Executive Director Mental Health Academy.

Enhancing Early Engagement (E3) Training:

The goal of the Enhancing Early Engagement (E3) training is to increase the number of child victims and their families seen at CACs who are screened for mental health symptoms, receive mental health assessment and treatment when indicated, and successfully complete treatment to heal from any negative impact of their abusive experience. Victim Advocates learn evidence-based strategies to support clients through the steps required to engage children and families in mental health services. During this process the Victim Advocate builds a collaborative relationship with mental health providers who meet the 2023 NCA MH Accreditation Standard and see CAC clients. The Victim Advocates provide support to identify and overcome any barriers to treatment success and to monitor and track services from initial screening to successful treatment completion.

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The Executive Director Mental Health Training Academy (EDMHTA)

The ED MH Training Academy supports the role of the EDs and Senior Leaders of CACs who do not have a mental health background to ensure that there are policies and procedures in place to support the mental health process and to support the successful implementation of the NCA Mental Health Accreditation Standard. The resources in the notebook provide EDs and Senior Leaders with information to help them make decisions around mental health programming and supporting clinicians. Some examples include CAC protocols for Screening Policy/procedure, Interagency Mental Health Agreements, and other documents that can be shared with their staff and MDT partners.

The NCA Mental Health Digital Notebook

This Digital Notebook contains Desk Cards with content that supports both the E3 and ED MH training as well as the implementation of the NCA MH Accreditation Standard.

The actual process of Family Engagement and the steps in the Mental Health services process Roadmap provided a guide for resource placement in this Notebook.

The NCA Digital Mental Health Notebook was designed to be accessed via the NCA Engage site and/or to be downloaded for hands on access.

The format of the NCA Mental Health Digital Notebook provides the potential for the content to be updated as research informs the mental health response to support the healing of child victims and their caregivers from the trauma of maltreatment.

We welcome any feedback regarding this resource and ideas regarding what to add, remove and otherwise to modify the content of this Notebook.

As always, thank you for the work you do to support positive mental health outcomes for the children and families served through your CAC.

NCA Institute for Better Mental Health Outcomes℠

Table of Contents

NCA Institute for Better Mental Health Outcomes℠

DESK CARD (10) - Comprehensive Mental Health Assessment (including an Assessment of Trauma)

DESK CARD (11) - Developing and implementing an individualized treatment plan based on the assessment results that include Measurable Behavioral Treatment Outcome Goals

DESK CARD (12) – What is Family Engagement?

DESK CARD (13) - Types of Potential Barriers to Family Engagement

DESK CARD (14) - Steps for Building Positive Expectation for Mental Health Treatment with a Child and Caregiver

DESK CARD (15) - TIES Evidence-Based Family Engagement Strategies

DESK CARD (16) - Cheat Sheet (Script) for Initial Contact Core Engagement Components

DESK CARD (17) – Motivational Interviewing: (OARS) Open-ended question, Affirmations, Reflection, Summaries

DESK CARD (18) - Some ways to initiate a discussion about perceptual barriers with a caregiver or older child

NCA Institute for Better Mental Health Outcomes℠

DESK CARD (19) - Opportunities for Family Engagement Roadmap

DESK CARD (20) - Identifying and Delivering Evidence-Based Mental Health Treatment for Children Served by the Children's Advocacy Centers

DESK CARD (21) - The Importance of CAC and MDT Data to Answer the Question "Do Children served at our CAC Get Better"?

DESK CARD (22) - Mental Health Standard Implementation Roadmap - Steps to developing, implementing and monitoring a treatment plan

DESK CARD (23) – CAC Mental Health Linkage Agreement Sample

DESK CARD (24) – Template for CAC Mental Health Screening Policy Procedure

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DESK CARD (1)

2023 NCA Mental Health Accreditation Standard

(See below)

Standard 06

Mental Health

Evidence-based, trauma-focused mental health services, designed to meet the unique needs of the child and caregivers, are consistently available as part of the multidisciplinary team response.

06. Mental Health

Rationale

A CAC's mission is to promote and foster safety, healing and justice for children and families. The common focus of the MDT is to foster healing and avoid potential retraumatization of children and families by the systems designed to respond to their needs. The CAC's response begins at first contact with the child and family. Without effective therapeutic intervention, many children who have experienced trauma may suffer ongoing or long-term adverse social, emotional, developmental and health outcomes. Evidence-based treatments and other practices with strong empirical support help reduce the impact of trauma and the risk of future abuse and other negative consequences. For these reasons, an MDT response must include screening for trauma exposure and/or symptoms by identified members of the MDT as part of the MDT response, who then use that information to link to mental health services for assessment and trauma-focused mental health treatment for child victims and caregivers.

Evidence shows parental/family support is often the key to the child's recovery and ongoing protection, and mental health services are often an important factor in a caregiver's capacity to support their children. Therefore, family members may benefit from counseling and support that aids in addressing the emotional impact of abuse allegations and related emotional triggers, and in reducing or eliminating the risk of future abuse. Mental health treatment for caregivers is a critical component of CAC services, given that many may have trauma histories themselves or are current victims of intimate partner violence. Such services include information, support and coping strategies for themselves and their children about sexual abuse, dealing with issues of self-blame and grief, family dynamics, parenting education and the impact of abuse and trauma histories. Siblings, other children in the family such as cousins, and, in some cases, extended family members may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic setting. The nature of the impact on children and families underscores the importance of collaboration with community providers to improve outcomes for their health and well-being. The CAC case review process provides a vehicle for these collaborative discussions.

Essential Component A

Mental health services are provided by professionals trained in delivering trauma-focused, evidence-supported mental health treatment. All mental health providers for CAC clients, whether providing services on-site or by referral and linkage agreement with outside individuals and agencies, must meet the following training and education/license requirements:

EDUCATION/LICENSE REQUIREMENT

1. The CAC must demonstrate that its mental health provider(s) meets at least ONE of the following academic training standards:

   A. Master's degree/licensed/certified in a related mental health field.

   B. Master's degree in a related mental health field and working toward licensure; supervised by a licensed mental health professional.

C. Student intern in an accredited mental health related graduate program, when supervised by a licensed/certified mental health professional. Both the student intern and supervising licensed mental health professional must meet the indicated 40-hour training requirements. Students who are currently enrolled in a training to deliver an EBT may provide services to children as a part of their EBT training.

TRAINING REQUIREMENT

2. The CAC must demonstrate its mental health provider(s) has completed 40 contact hours in training and consultation calls to deliver an evidence-supported mental health treatment to children who have experienced trauma from abuse. (Examples include TF-CBT, PCIT, AF-CBT, CFTSI, EMDR — see "Putting Standards into Practice"). Training programs that include fewer than 40 hours (including consultation calls) may be supplemented with contact hours in evidence-based assessment.

Essential Component B

Clinicians providing mental health treatments to CAC clients must demonstrate completion of continuing education in the field of child abuse, trauma, clinical practice and/or cultural applications consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT

Because new research constantly emerges regarding the efficacy of mental health treatment modalities and the importance of ensuring cultural relevance of said services, it is vital for clinicians to remain updated about new research, evidence-supported treatment methods, and developments in the field that would help ensure the delivery of high-quality, relevant, and accessible services to clients.

Essential Component C

Evidence-supported, trauma-focused mental health services for the child client are consistently available and include:

1. Trauma-specific assessment of traumatic events and abuse-related trauma symptoms to determine the need for treatment;
2. Evidence-based assessments to inform treatment;
3. Individualized treatment plan based on assessments that are periodically reassessed;
4. Individualized evidence-supported treatment appropriate for the child clients and other family members;
5. Child and caregiver engagement in treatment;
6. Monitoring of trauma symptom reduction;
7. Referral to other community services as needed.

All services should be culturally informed and culturally responsive.

STATEMENT OF INTENT

The above description of services should guide discussions about expectations with all professionals who may provide mental health services, whether on-site or by referral and linkage agreement. This will ensure that appropriate, relevant, and accessible services are available for child clients and that the services are outlined in linkage agreements.

Essential Component D

Mental health services are available and accessible to all CAC clients regardless of their ability to pay.

STATEMENT OF INTENT

CACs have a responsibility to identify and secure alternative funding sources to ensure all children and caregivers have access to appropriate, specialized mental health services.

Essential Component E

The CAC/MDT's Interagency Agreement/MOU or written protocols and guidelines include access to appropriate trauma-informed mental health assessment and treatment for all CAC clients.

STATEMENT OF INTENT

Because mental health is a core component of a CAC's multidisciplinary team response, the CAC/MDT's Interagency Agreement/MOU or written protocols and guidelines must detail how such care may be provided and accessed by all CAC clients.

Essential Component F

The CAC/MDT's written protocols and guidelines define the role and responsibility of the mental health professional(s) on the MDT, to include:

1. Attending and actively participating in MDT case review and case management
2. Sharing relevant information with the MDT while protecting the clients' right to confidentiality and the mental health professional's legal and ethical requirements
3. Serving as a clinical consultant to the MDT regarding child trauma and evidence-based treatment
4. Monitoring and sharing with the MDT the child's and caregiver's engagement in, and completion of, treatment.

STATEMENT OF INTENT

Evidence shows the importance of collaboration among community professionals serving children and families to improve outcomes. A trained mental health professional participating in the MDT case review process assures that the child's and caregiver's treatment needs and mental health can be monitored, assessed and reassessed, and taken into account as the MDT makes case decisions. In some CACs, the child's and caregiver's treatment provider(s) serves in this role; in others, it may be a mental health consultant.

Essential Component G

The CAC/MDT's written protocols and guidelines include provisions about the sharing of mental health information and how client confidentiality and mental health records are protected in accordance with state and federal laws.

STATEMENT OF INTENT

The forensic process of gathering evidentiary information and determining what the child may have experienced is separate from mental health treatment processes. Mental health treatment is a clinical process designed to assess and mitigate the long-term adverse impacts of trauma and/or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Each CAC must be aware that medical and mental health treatment records containing identifiable protected health information (PHI) are protected by HIPAA. Records pertaining directly to an investigation of child abuse can be exempt from HIPAA and do not require caregiver consent for release. The CAC should maintain a log of disclosures of medical and mental health treatment information per HIPAA regulations.

MDT protocol must include specific guidelines for the MDT and mental health providers regarding what and how information can be shared with the MDT during case review, in accordance with state laws and professional ethical practice standards.

Essential Component H

The CAC must provide services for caregivers to address:

1. Safety and well-being of the child
2. Caregiver involvement in their child's treatment when appropriate
3. Emotional impact of abuse allegations
4. Risk of future abuse
5. Issues or distress that the allegations may trigger, including own history of trauma and/or current experience of abuse, violence and/or other trauma

These services may be provided directly by the CAC and/or with linkage agreements with other appropriate providers.

STATEMENT OF INTENT

Evidence clearly demonstrates that caregiver support is essential to sibling support, the recovery of children directly experiencing or exposed to abuse and violence, and overall family functioning and well-being. CACs have long provided such supportive services for caregivers and siblings through support groups, mental health services and ongoing follow-up, either on-site or by linkage agreement.

It is important to consider the range of mental health issues that could impact the child's recovery or safety with particular attention to the caregiver's mental health, substance abuse, domestic violence, and other trauma history. Caregivers, siblings, and other family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues that the allegations may trigger. Assessments and supports may be provided by clinicians, victim advocates or others, either on staff at the CAC or via linkage agreement.

Essential Component I

Clinicians providing mental health treatment services to CAC clients must participate in ongoing clinical supervision and/or consultation.

STATEMENT OF INTENT

Clinical supervision and/or consultation with others trained in evidence-based treatment is necessary to ensure appropriate and quality services to the clients. Moreover, this clinical supervision is required for licensure in many states. Individual and/or group supervision options for meeting this standard include:

- Supervision by a senior clinician on staff at the CAC
- Supervision with a senior clinician in the community who serves children and families and accepts referrals from the CAC (when a CAC does not have more than one clinician)
- Participation in a supervision call with mental health providers from other CACs within the state, either individually or as a group
- Participation in a State Chapter or one or more CAC contracts with a senior clinician to provide supervision and consultation calls

Most clinical professions (i.e., clinical social workers, licensed professional counselors, marriage, and family therapists, etc.) have a structure for clinicians to become clinical supervisors. CACs may wish to investigate this option in their state. CACs can also negotiate Trauma-Focused Cognitive Behavior Therapy (TF-CBT) master trainers for ongoing clinical consultation. As supervision for one evidence-based treatment does not necessarily encompass all the clinical interventions needed within a CAC, comprehensive interventions will need to be addressed throughout ongoing clinical supervision.

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DESK CARD (2)

2023 NCA Victim Support and Advocacy Standard

(See below)

Standard 04

Victim Support and Advocacy

Victim support and advocacy services are provided to all CAC clients and their caregivers as part of the multidisciplinary team response.

04. Victim Support and Advocacy

Rationale:

Research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members. Client access to, and participation in, investigation, prosecution, treatment, and support services are core components of MDT response, and are informed and supported by coordinated victim advocacy services. Up-to-date information and ongoing access to comprehensive services are critical to a child and family's well-being and ability to participate in an ongoing investigation, possible prosecution, intervention, and treatment.

Victim support and advocacy responsibilities are implemented consistent with legal and, where relevant, state constitutional victims' rights and the complement of services in the CAC's coverage area. Many members of the MDT may advocate for children and families within their discipline systems or agencies. However, victim advocacy is a discipline unto itself with a distinct and central role on the MDT. Victim advocates provide services and resources to ensure a consistent and coordinated comprehensive network of support for each child and family.

Children and families in crisis need assistance in navigating the multiple systems involved in the CAC response. More than one victim advocate may perform these functions at different points throughout a case, requiring continuity and consistency in service delivery. Coordination of victim support is the responsibility of the CAC and must be defined in the CAC/MDT's written documents, including understanding of relevant statutes and ethics regarding confidentiality and privilege. Specific victim support services may be provided in a variety of ways, as dictated by the needs of the CAC clients and case, such as:

- Employing staff members with varying job titles to perform advocacy functions (e.g., family advocates, care coordinators, victim advocates and child life specialists, among others)
- Linking with local community-based advocates, including, but not limited to domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates and advocates at culturally specific organizations
- Linking with system-based advocates (e.g., law enforcement victim advocates, prosecutor-based victim witness coordinators)
- Combining victim support services depending upon the individual needs of children and families

All advocates who serve on the MDT and are providing services to CAC clients must meet the prescribed training and supervision requirements. This includes advocates on staff at the CAC and/or advocates from outside organizations providing advocacy services and serving as members of the MDT.

Essential Component A

Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training that includes a minimum of 24 hours of instruction, including, but not limited to:

1. Dynamics of child abuse
2. Trauma-informed services
3. Crisis assessment and intervention
4. Risk assessment and safety planning

5. Professional ethics and boundaries
6. Understanding the coordinated multidisciplinary response
7. Understanding, explaining, and affording of victim's legal rights
8. Court education, support, and accompaniment
9. Knowledge of available community and legal resources, referral methods and assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, and interpreters, among others as determined for individual clients
10. Cultural responsiveness and addressing implicit bias in service delivery
11. Caregiver resilience
12. Domestic violence/family violence/children's exposure to domestic violence and poly-victimization

STATEMENT OF INTENT

Victim support and advocacy is fundamental to the MDT response. These professional support/advocacy responsibilities may be filled by a designated victim advocate who is an employee of the CAC or another victim-serving agency. Another MDT member with appropriate experience and training in victim advocacy may also serve in this role; however, in doing so, it must not conflict with the other MDT functions they may have.

Essential Component B

Individuals who provide victim advocacy services for the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who provide advocacy services to receive specialized training and peer support. As with all other disciplines represented on the MDT and serving CAC clients, it is vitally important that victim advocates remain current on developments in fields relevant to their delivery of services to children and families.

Essential Component C

Victim advocates serving CAC clients must provide the following constellation of services:

1. Crisis assessment and intervention, risk assessment and safety planning and support for children and family members at all stages of involvement with the CAC
2. Assessment of individual needs, cultural considerations for child/family and help to ensure those needs are being addressed in concert with the MDT and other service providers
3. Presence at the CAC during the forensic interview in order to participate in information sharing with other MDT members, inform and support the family regarding the coordinated, multidisciplinary response, and assess needs of children and nonoffending caregivers
4. Provision of education and assistance in ensuring access to victim's rights and crime victim's compensation
5. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance, civil legal services, etc.)
6. Provision of referrals for trauma-focused, evidence-supported mental health and specialized medical treatment, if not provided at the CAC

7. Facilitating access to transportation to interviews, court, treatment, and other case-related meetings
8. Engagement with the child and family to help them understand the investigation/prosecution process and help ensure understanding of crime victims' rights
9. Participation in case review to communicate and discuss the unique needs of the child and family and associated services planning; and help ensure the coordination of identified services and that the child and family's concerns are heard and addressed
10. Provision of case status updates to the family, including investigations, court date, continuances, dispositions, sentencing and inmate status notification (including offender release from custody)
11. Provision of court education and support, including court orientation and accompaniment

STATEMENT OF INTENT

While the particular combination of services required will vary based upon the child and family's unique needs and the legal requirements of any civil and/or criminal cases, all children and families need support in navigating the various systems they encounter that are often unfamiliar to them. Crisis and risk assessments and intervention, advocacy, and support services will help to identify the child and family's unique needs, reduce fear and anxiety, and expedite access to appropriate services and resources. Families can be assisted with crisis management, including problem solving, access to critical treatment and other services, and ongoing education, information, and support. Crises may recur with various precipitating or triggering events, including, but not limited to, financial hardships, child placement, arrest, change/delay in court proceedings and preparation for court testimony. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including victims of child abuse, are informed of their rights as crime victims, including information about, and eligibility for, crime victim compensation. Caregivers who are affected by the crime are also entitled to services and may be eligible for victim compensation. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained at the outset of their involvement with the CAC/MDT and made available to all children and their caregivers.

Essential Component D

Active outreach and follow-up support services for caregivers consistently occurs.

STATEMENT OF INTENT

Often, families have never been involved in this multi-system response, which can prove intimidating and confusing. Active outreach requires follow-up with families beyond initial investigation, assessment, and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case.

In the aftermath of victimization, the child and family typically feel a significant loss of control. Education provides information that is empowering. Victim education must be ongoing and even repetitive as needed, as families may be unable to process so much information at one time, particularly in the midst of a crisis. The family may be dealing with immediate safety issues and may be coping with the emotional impact of the initial report and ensuing forensic interview and investigation process. They may need a variety of concrete medical, mental health, and social services. As the case dynamics change, and as the case

proceeds through the various systems, the needs of the child and family will also change. It is important that their needs continue to be assessed, so that additional relevant information, support, and services can be offered and so that said services are accessed and relevant.

Essential Component E

The CAC/MDT's written protocols/ guidelines include availability of victim support and advocacy services for all CAC clients throughout the life of the case and participation of victim advocate(s) in the MDT case review. This participation must be in accordance with legal requirements regarding confidentiality.

STATEMENT OF INTENT

Because victim support/advocacy is a central function of the CAC response, the availability and provision of ongoing victim support and advocacy by designated, trained individuals must be included in the CAC/MDT's written documents. Service coordination, both within and outside the CAC, must be clearly defined, including the role of the victim advocate during the interview process, follow-up, and case review.

Essential Component F

Coordinated case management must occur with all individuals providing victim advocacy services to CAC clients.

STATEMENT OF INTENT

If multiple advocacy agencies share the delivery of services, the CAC is responsible for establishing protocols and linkage agreements agreed upon by the MDT that clearly define the victim advocacy roles and ensure seamless coordination of victim advocacy services.

In any community or jurisdiction a CAC serves, there may be various agencies and programs providing advocacy and support services to child and adult victims and survivors who have experienced abuse and trauma. In addition to victim advocates who may be employed by the CAC, there may be advocates on staff in law enforcement agencies, prosecutors' offices, domestic and sexual violence community-based agencies, hospitals, and CASA programs, among others. While specific job titles may vary, children and families engaged with the CAC/MDT may also be receiving services from some or all of these agencies/ programs. To better understand each other's roles, optimize cross-referrals for CAC clients, avoid unnecessary duplication and ensure meaningful coordination of services, the CAC must develop a process for achieving these goals in collaboration with one another. This process will need to include understanding and respect for issues of confidentiality and methods for sharing case-specific information accordingly.

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DESK CARD (3)

Is your CAC and MDT Trauma Informed

1. Do all CAC staff and MDT partners understand how trauma impacts children behaviorally, emotionally, developmentally, socially, and physically?
2. Do they all understand the potential impact of trauma on the response of the child and of the child's caregiver/s during the investigation of allegations of maltreatment?
3. When there is a question concerning the abuse of a child, do the professionals consider the possibility the child has experienced a trauma which has resulted in traumatic stress that is playing a role in their response?
4. Do they consider the impact of trauma in determining how to best respond to the needs of children and their caregiver?
5. Does the CAC staff and MDT routinely review the results of trauma screens and trauma assessments during the case review process to rule out PTSD and to inform the interventions with a traumatized child?
6. Do they routinely recommend and make referrals for trauma-focused, evidence based mental health interventions based on information provided by standardized trauma assessments as indicated through screening?
7. Does the CAC staff and MDT understand the role of mental health interventions in building competency in the caregiver and the child in the management of their experience, including their ability to discuss the (maltreatment) experience?
8. Do they understand that participation in evidence-based, trauma focused treatment can strengthen the child's ability to describe their maltreatment experience and their ability to participate in court?
9. Do they all understand the need for and how to access trauma focused, evidence-based mental health treatment interventions for the child and families they serve?
10. Do all MDT members participate in the case review process to provide input into the identification and monitoring of the treatment process to completion?
11. Do all understand the value of collaboration and working together to assess what has happened to account for an allegation of abuse, to assess the impact of trauma on the child and family and the community?
12. Does your CAC/MDT provide coordination of the delivery of services, including forensic interviews, screening and assessment, treatment planning, treatment referral and monitoring of treatment to outcome in a timely manner?
13. Do they accept and share responsibility for the outcome of interventions for the children and families serviced?

14. Does your CAC/MDT routinely review research from the trauma and abuse field and "look" outside of your own agency to inform and update your services and work?
15. Does CAC/MDT take the time from "what is and providing their services" to learn how to understand how to improve trauma focused services and to implement those improvements?

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DESK CARD (4)
Building Collaborative Relationships between Victim Advocates and Mental Health Professionals

The expanded role of the Victim Advocate involves providing support and advocacy to the family regarding their engagement in the mental health process. Engagement is a critical component in determining the need for treatment and as well as the participation in needed mental health treatment to completion and healing. This role and these responsibilities are new for many Victim Advocates. Senior leader engagement in support of this expanded role is very important to ensure that the VA knows and understands how their CAC meets the MH accreditation standard. If gaps are identified to meeting this standard the Senior Leaders can work with the VA and the mental health staff/partners to take the action necessary to meet this standard.

Identifying and affirming that the MH professional meets NCA MH standard

The NCA MH accreditation standards require that the MH professionals who provide services to CAC clients meet specific educational, training and supervision requirements. The VA needs to know and understand these requirements and to work with the CAC leadership to ensure that these standards are met.

Collaboration with the MH professionals

Just as it is critical for the Victim Advocate to develop a collaborative and positive relationship with the family, it is also critical that the Victim Advocate work closely and collaboratively with the mental health professional/s within the CAC and/or the mental health professionals referred to through linkage agreements with MH providers in the community.

This relationship can serve as a learning resource for the VA; a supportive relationship as the VA deals with issues presented by the family and a collaborative partner in the mental health Screening, Assessment, Treatment and Monitoring process.
The mental health professional is a critical resource for providing input regarding the engagement of the family in the need for treatment, treatment type, monitoring progress or lack of progress in treatment, the identification and reduction of treatment barriers, the

tracking of treatment to completion, and as an MDT partner in supporting the outcome of children healing and thriving.

Developing and implementing the CAC policy/procedure regarding client risk

The Victim Advocate and CAC will need to involve the MH professional as they determine how the CAC will respond to issues presented by clients that involve potential harm to themselves or to others. Questions asked in the Screening Tool that may identify such risk, and a decision about an agency risk/safety policy needs to be made, documented, and implemented immediately to provide guidance to the VA as to how to respond to a child or caregiver who endorses these concerns during the Screening.

Reviewing the Screening results

The VA may want to consult and collaborate with the MH professional as they review the Screening results, decide regarding the need for a referral to a mental health professional for a mental health assessment, and provide feedback to the family.

Identifying/understanding the training and expertise of MH professionals

The VA will need to know the training, experience, and expertise of the mental health professionals on the CAC staff and/or in the community to whom they refer. Questions to facilitate gathering this information are shared on DESK CARD (5). This information is needed as the VA works with a family and makes a referral to a mental health provider for an assessment and/or mental health treatment. A collaborative relationship between the VA and the MH professional facilitates and supports this process. A collaborative relationship also supports the sharing of information between the MH professional and the VA necessary to identify and reduce barriers to treatment as well as information regarding the engagement and progress in treatment to success. This information or data is critical to the CAC being able to answer the questions: Do the children we serve get better?

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DESK CARD (5)

Questions to Ask Mental Health Providers Consistent with the NCA 2023 MH Accreditation Standard

Adapted from Chadwick Trauma-Informed Systems Project Desk Guide

These questions can be helpful in determining issues that may impact the Mental Health providers qualification to meet the NCA MH Accreditation Standard

Do you conduct a comprehensive trauma-focused mental health assessment with clients to determine treatment needs?

- What specific standardized assessment measures do you use?
- What did your assessment show?
- What were some of the major strengths and or areas of concern?

Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine if the child needs trauma specific therapy?

How familiar are you with evidence-based treatment (EBT) models designed and tested for treatment of child trauma-related symptoms?

Do you have specific training in an EBT model? If so, what model(s), when and where were you trained and by whom? How much training did you receive?

Do you receive ongoing clinical supervision and consultation on any of the EBT models that you have been trained in?

Can you describe the core components of your treatment approach? Approximately how many treatment sessions are required?
How many treatment sessions do you typically have with a child client?

How are parent support, conjoint therapy, parent training and or psychoeducation provided?

How do you address cultural competency and special needs issues?

Are you willing to provide feedback regarding treatment engagement and progress?

How do you determine treatment success?

Are you willing to participate in the multidisciplinary team (MDT meetings and in the court process as appropriate?)

Mental Health professionals who have participated in training in evidence-based trauma focused mental health treatment will be able to report the treatment model or models they have been trained in, the length of the training, who provided the training, that they participated in consultation calls to support them as they implemented the treatment with children/caregivers.

They will be able to tell you what tools they use to assess the treatment needs for a child/caregiver and how they use the results of the assessment to determine the treatment needs for that child/caregiver. They will also report that they re-administer the assessment at the end of treatment to determine success.

They will be able to describe how caregivers are involved in their child's treatment, how the EB treatment they provide enhances parenting and the parent-child relationship, and how the treatment is culturally competent.

Negotiating with the MH professional to participate in the MDT, especially the case review process to discuss treatment needs, treatment barriers, and treatment progress is critical as research has demonstrated that collaboration between mental health and other professionals working with maltreated children improves the outcomes for those children.

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DESK CARD (6)

What is an Evidence Based Mental Health Treatment (EBT)?

- It has been identified as effective through research and review of available evidence.
- The treatment is structured and follows clear protocols.
- Treatment typically includes weekly sessions and lasts between 12 and 20 sessions.
- Focuses on reducing trauma symptoms.
- Time-limited and culturally informed
- Involves caregivers.
- Provides education on trauma and trauma symptoms.
- Provides support in parenting practices.
- Builds coping skills and enhances safety as well as other supportive and protective factors.
- Allows the child and caregiver to process their traumatic experience.
- Is available for all age children who experienced traumatic events.

EBTs are effective in:

- Improving acute stress (i.e., symptoms immediately following traumatic events)
- Improving posttraumatic stress symptoms (i.e., symptoms present more than a month after experiencing traumatic events)
- Improving other trauma-related symptoms such as depression, anxiety, behavior difficulties, and/or problematic sexual behavior.
- Improving caregivers with post-traumatic stress symptoms by virtue of participating in their child's treatment.
- Improved communication between the caregiver and the child.

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DESK CARD (7)

Common Characteristics of Trauma-Focused Evidence-Based Mental Health Treatments (EBTS)

- Many EBTs Include both children and caregivers in treatment.
- Some EBTs include both individual and joint sessions for the child and the caregiver.
- Skill building or teaching the child and caregiver ways to manage symptoms such as physical symptoms, distressing thoughts, or disruptive behaviors is a part of many EBTs.
- The EBTs are structured and most follow clear protocols.
- EBTs typically include weekly 60-to-90-minute sessions and most last between 12 and 20 sessions.
- Therapist training in EBT models typically include three steps:
    1. Reading introductory materials
    2. Attending a multi-day in-person training with a certified trainer in the model.
    3. Receiving ongoing case consultation in the model typically for 6 to 12 months.
- Some EBTs have additional training requirements for therapists to become certified in the model such as completing a knowledge test.
- Therapists trained in an EBT participate in on-going clinical supervision to support their delivery of the treatment as it was designed to be delivered (fidelity).
  The NCTSN Website and the California Child Welfare Clearing House provide up to date information to inform decisions regarding mental health models with evidence of their effectiveness in reducing symptoms consistent with trauma.

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The following Evidence Based Treatments that meet the NCA MH Accreditation Standard as they have evidence of effectiveness with children served through Children's Advocacy Centers and include:

Trauma-focused Cognitive Behavioral Treatment (TF-CBT)
Alternative for families: A Cognitive Behavioral Treatment (AF-CBT)
Child and Family Traumatic Stress Intervention (CFTSI)
Parent Child Interaction Therapy (PCIT)
Eye Movement Desensitization and Reprocessing (EMDR)
Child-Parent Psychotherapy (CPP)
Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT)

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DESK CARD (8)
Trauma-Focused Evidence-Based Mental Health Treatment Models that meet the NCA MH Standard as Appropriate for CAC Clients

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

(Cohen, Mannarino & Deblinger, 2006) TF-CBT was first developed for children with histories of sexual abuse or of witnessing domestic violence. TF-CBT also has several effective uses including treatment of children with problematic sexual behaviors (rating of 2 on the CEBC), children who have experienced or witnessed community violence, traumatic natural disasters (Hurricane Katrina), and combat. TF-CBT has research support for its efficacy in reducing traumatized children's internalizing of symptoms and moderate effectiveness in reducing children's externalizing of symptoms. In randomized trials, TF-CBT has been directly compared and found to be more effective than routine community care, nondirective supportive therapy, and child-centered therapy. Given the variety of trauma types for which it is relevant, and the problems targeted are among the most common experienced by traumatized children it is reasonable that TF-CBT is the most common evidence-based treatment provided through CACs and the problems targeted are among the most common experienced by traumatized children.

Target Population

Children aged 3-18 with histories of trauma exposure (e.g., sexual abuse, domestic violence, traumatic grief, multiple/complex trauma) and their non-offending caregivers.

Problems Targeted

Posttraumatic stress symptoms and trauma-related anxiety and depression are the key targets of treatment. Research has also shown reductions in sexualized behaviors among preschool-age children (2-7 years) and moderate gains in trauma-related behavioral problems.

TF-CBT Components (PRACTICE):

Psychoeducation and Parenting

Relaxation

Affect Identification and Regulation

Cognitive Coping

Trauma Narrative and Processing

In vivo Mastery

Co-Joint Child-Parent Sessions

Enhancing Safety and Future Development

Training

TF-CBT currently has 65 national trainers, some of whom have experience and/or knowledge of CACs. The ideal training group size is 21-70 clinicians. The minimum training is a two-day workshop followed by 12 consultation calls while completing training cases. TF-CBT Web 2.0 is an 11-hour web-based course that is usually a required prerequisite to attending the two-day in-person training.

Parent-Child Interaction Therapy (PCIT)

(Eyberg 2005**) PCIT** is an excellent evidence-based treatment option for children who have disruptive behavior problems and their caregivers. Over 50 randomized controlled trials support the effectiveness of PCIT in reducing parent stress levels and children's behavioral problems in children with or without histories of maltreatment. PCIT has been used for children and caregivers with a history of physical abuse and has shown to be effective in lowering both abuse and the risk for further abuse to occur. PCIT has been successfully implemented with children in foster care, and there is some evidence of effectiveness with reducing trauma symptoms.

Target Population

Children aged 2-7 and their caregiver.

Problems Targeted

Child behavior problems and problematic parenting.

Treatment Components

Child Directed Interaction. The parent/caregiver is taught relationship-building skills: Praise, Reflection, Imitation, Description, and Enthusiasm (PRIDE.) and receives live coaching and feedback as skills are practiced with the child in session.

Parent Directed Interaction. In this phase of PCIT, the parent/caregiver is taught and coached in a positive discipline program including effective delivery of commands, with an appropriate parent response for child compliance/noncompliance. All skills are gradually expanded for use in a structured home setting to unstructured home setting to public settings.

Training

PCIT.org provides a list of trainers for ease of access to CACs and others. This training requires a specified number of face-to-face hours (40), consultation calls and the completion of cases. It is recommended that the training be completed in two multi-day sessions separated by a few months. Consultation calls are every other week through the completion of two full cases. For most trainees, this takes approximately 12 months.

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)

AF-CBT (Kolko et al. 2011) was developed for caregivers and children who have a history of physical abuse by the caregiver, harsh or coercive parenting practices, or high conflict between caregiver and child. AF-CBT is one of few treatments for this population with research support for the child and caregiver. Randomized controlled trials have shown it to be superior to routine community care for reducing children's conduct and oppositional behaviors, as well as in

reducing internalizing symptoms. Parents who received AF-CBT demonstrated significantly greater decreases in the use of physical discipline and anger at post-treatment compared to those in routine community care. The fact that the population of physically abused children is twice that of victims of sexual abuse and makes up a large portion of children involved with child welfare makes it a valued intervention for CACs. AF-CBT differs from TF-CBT in that it was developed specifically for families with histories of physical abuse and that it includes the caregiver who engaged in physical abuse, harsh parenting, or high conflict. This is particularly relevant for child welfare populations, as up to 80% of these children remain living in (or are returned to) homes with their offending caregiver.

Target Population

Children aged 5-17 with histories of child physical abuse and/or inappropriate discipline and their offending caregiver.

Problems Targeted

Behavior problems and trauma symptoms in the child; problematic parenting and/or physically abusive behaviors in the caregiver.

Treatment Components

AF-CBT involves several treatment modules, including engagement, parenting, anger management, individual therapy, family therapy, and trauma treatment. This treatment is highly relevant to child abuse populations

Training

The training includes pre- and post-training, workshop training, monthly consultation calls for nine to 12 months, delivery of service to two families, presenting two cases and submitting two audio samples. There is a train-the-trainer program that provides the opportunity for agencies to sustain with in-house trainers. However, additional national trainers would likely be needed to scale up nationally.

Child and Family Traumatic Stress Intervention (CFTSI)

CFTSI (Berkowitz, Epstein, Marans, 2010) was developed specifically for children in the immediate (acute 45 days or less) time frame after a traumatic event occurred. CFTSI is a short-term (five to eight sessions), early intervention designed to reduce traumatic stress symptoms and interrupt PTSD development by increasing caregiver support of the child and helping them cope with the traumatic event. The goal is to address and prevent trauma symptoms such as nightmares, feeling scared, worried, having trouble concentrating in school, feeling lonely, not wanting to play, and having intrusive thoughts. This treatment may be indicated for CACs with a high population of children in acute stress. CFTS has been evaluated in one randomized controlled trial and is considered a promising practice on the CEBC. A Multi-Site Meta-Analysis (MSMA) that found significant symptom reduction for children who receive CFTSI as well as findings that parents who participate in CFTSI also experience significant relief from their own trauma symptoms, which is a vital piece in helping the child recover.

Treatment Components

CFTSI includes increasing communication between the caregiver and child about the child's traumatic stress reactions, providing skills to help the family cope with traumatic stress reactions, and reducing concrete external stressors (e.g., housing issues, systems negotiation, safety planning, etc.).

Target Population

Children aged 7-18 within 45 days or less of exposure to trauma (e.g., sexual abuse, domestic violence, vehicle accident) and their non-offending caregiver.

Problems Targeted

CFTSI was developed to address immediate reactions to trauma exposure, and to prevent posttraumatic stress disorder from developing. Youth must have at least one new and distressing symptom since exposure to the potentially traumatic event to meet treatment criteria.

Training

It is a two-day training followed by 14 consultation calls. The clinicians are required to complete three cases during the period of the consultation calls.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment for School Age Children (PSB-CBT-S) Program

(Silovsky, Niec, Bard & Hecht, 2007) PSB-CBT-S is a group treatment for reducing children's sexual behavior problems. One unique and important part of this EBT is the emphasis on community involvement. These cases typically involve a number of professionals in the child's community such as law enforcement, schools, and child protective services, among others. This makes the treatment of the child in a vacuum less successful and is why CACs are a good fit for this treatment given the experience with multidisciplinary team. The training model supports this collaborative philosophy by using a community-based learning collaborative implementation methodology. Data suggests that a high number of cases of child sexual abuse involve child on child sexual behaviors which suggests this is appropriate for delivery by CACs. This is a *program*, rather than simply a treatment and when a CAC can execute it with fidelity it has impacts beyond the individual child.

Target Population

Children ages 6-12 display problematic sexual behavior. There is a model for adolescents (PSB-CBT-A) ages 13-17 with problematic and/or illegal sexual behavior which does not currently have equivalent research support.

Problems Targeted

Problematic sexual behaviors.

Training Components

PSB-CBT-S includes both parent training, rules about sexual behavior, sexual education, abuse prevention skills, anxiety management and coping skills, empathy development, and plans for safety. These elements occur both individually with caregivers and in groups (concurrent child and caregiver groups), and there is a family component. It has a community engagement component intended, in part, to reduce stigma. This can be comforting to parents and increase their willingness to seek treatment for their child. The treatment can be delivered to a family or to a group of families

Training

The training occurs over a 12–18-month period in a combination of 2 two-day live sessions, web-based, session recording review, and consultation calls. The training requires a four- or five-person training team to carry out the treatment with fidelity.

Eye Movement Desensitization and Reprocessing (EMDR)

(Shapiro, 2001) EMDR was originally developed and studied for adults experiencing symptoms from multiple types of traumatic events. Studies have consistently found that EMDR effectively decreases/eliminates the symptoms of posttraumatic stress. Adults also often report improvement in other associated symptoms (anxiety). Some research suggests that the cognitive processing element vs the bilateral stimulation of EMDR is the active component of

treatment. In support of this, one study, conducted in Finland, compared EMDR with TF-CBT and found similar outcomes. While the evidence with adults is strong, questions remain regarding the applicability to children with complex trauma exposure. EMDR is used in CACs by trained clinicians, and CACs are reporting that newly hired clinicians are often already trained in EMDR, though it is not clear whether they have attended the advanced training for applying EMDR with children.

Target Population

Originally developed and studied for adults experiencing symptoms from traumatic events. An advanced child focused EMDR training has been developed but not yet studied regarding effectiveness.

Problems Targeted

Posttraumatic stress resulting from multiple types of traumas.

Treatment Components

EMDR therapy is an "integrative psychotherapy," with an eight-step protocol.

Eight –step protocol includes:1. Client History, 2. Preparation, 3. Assessment, 4. Desensitization, 5. Installation, 6. Body Scan, 7. Closure and, 8. Re-evaluation

Training

Training in this treatment requires that Clinical staff first be trained in adult EMDR and then advanced training specific to children. There are approximately 70 EMDR trainers in the U.S. but only about 30 trained in the applications with children and fewer knowledgeable about the collaborative CAC model of working with an MDT. Basic EMDR training consists of 50 hours of training usually delivered in two three-day training sessions and a practicum and consultation call component. The additional advanced training on EMDR for children ranges between 8 and 24 hours.

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DESK CARD (9)
Screening as a Mental Health Service

A Screening is a brief checklist or questionnaire completed by a client and designed to:

- Provide an opportunity for the early identification of potentially traumatic experiences and of mental health symptoms.
- Offers a "Snapshot in time" regarding issues impacting a child and family at the time the screening is administered.
- Is administered face to face to gather information from the caregiver and from the child if the child is old enough to complete the questionnaire or checklist.
- Can be administered by a non-mental health provider, i.e., the Victim Advocate at a CAC.
- Is not a diagnostic tool, i.e., does not result in a mental health diagnosis.
- Gathers information from the family about any history of exposure to potentially traumatic events and about any family/child concerns/issues.
- Is typically administered to determine if there is a need for a referral to a mental health professional for a comprehensive mental health assessment including a trauma specific assessment.
- Can be used to triage and provide referrals for only those children who are identified through screening as needing a mental health assessment, thus potentially reducing the wait time for services for children who need them.
- Does not duplicate the mental health trauma assessment which is completed by a mental health professional.

Purpose of the Mental Health Screening:

To identify which children coming through the CAC would benefit from a more comprehensive trauma-informed mental health assessment to identify the potential effect of the trauma experience. Screening is the first step in the CAC response to the provision of MH services. There are a number of MH screeners available that are appropriate for use by CACs.

Guidelines for Administering and Scoring Mental Health Screeners.

- Age Range: All children over the age of three coming through the CAC will be screened when the child is seen for an interview or a medical exam.
- (Identify the screener or screeners that will be used in each CAC)
- Victim Advocates will administer the screening and consult with mental health providers, when needed.

The screener is administered by a non-mental health professional and is most often administered by the CAC Victim Advocate. The Victim Advocate should be well trained in the use of the screener including how to introduce the screener to the caregiver, how to administer the screener, how to score and how to share the results with the caregiver. This screening process offers the Victim Advocate an opportunity to strengthen the engagement of the caregiver in any mental health services identified as needed.

The purpose of the screener is to identify if there is a need for a referral to a mental health provider to determine the need for mental health treatment for a child. As not all children who experience maltreatment or trauma develop symptoms that require mental health treatment, the use of the screener can serve as a method for triaging those children who need treatment services and those who are not. The results of the screener determine if there is a need for a referral for a comprehensive mental health assessment including the assessment of the impact of the trauma of maltreatment.

To address the potential mental health needs of the children served by the CAC, the CAC will implement the following screening protocol:

The Victim Advocate or other designated and trained CAC staff member will administer the (name of screener) to each caregiver and/or child following the completion of the Forensic Interview. The administration of the screener including the scoring will take place during the child's Forensic Interview and prior to the family leaving the CAC following the Forensic Interview. This is because the screener may identify risk to the child that needs to be addressed immediately, i.e., suicide feelings/thoughts, use of drugs and/or alcohol or the risk of problematic sexual behaviors.

CAC Response to Risk identified through the Screener. (Implement the CAC Crisis Response Protocol)

1. Identify the required response.
2. Consult your CAC Crisis Response Protocol
3. Consult with a Mental Health provider.

a. Is it safe for the child to go home?
b. Is Mental Health referral sufficient?
c. Will a safety plan be sufficient?
d. Is a mental health assessment needed?
e. Should a crisis referral be made?
f. Is an immediate psychiatric evaluation needed through the ER?
g. What is the response of the caregiver to this risk?

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The Screening Process and the NCA MH Accreditation Standard:

Remember, the screening is the first step in determining the need for a comprehensive mental health assessment by a mental health professional. When the score on the screener does not indicate a need for further assessment, that information is shared with the caregiver with a request from the VA to follow-up in two to four weeks with the caregiver as the need for services may occur over time.

When the score on the screener indicates a need for further MH assessment, the VA will share this information with the caregiver, as well as information about the need for and purpose of the MH assessment to ensure that it is consistent with component C of the 2023 MH Standard: 1. Trauma-specific assessment including traumatic events and abuse-related trauma symptoms and; 2 Use of standardized assessment measures initially to inform treatment, (determine the need for MH treatment and the most appropriate treatment)

The VA then identifies a mental health professional who is trained and experienced in providing a standardized mental health assessment and who is willing to collaborate with the CAC on identifying any treatment needs for the child and family.

The VA then shares information about the mental health assessment with the caregiver and/or child as well as information about the training, experience and competency of the mental health providers being referred to.

The VA also helps the caregiver and/or child identify any questions he or she wants to ask the MH provider when they meet.

The VA explains the need for the caregiver to sign a release of information so that the results of the screener can be shared between the mental health professional and the CAC to support the need for collaboration regarding the needs of the family and services provided.
The VA then makes a face-to-face referral for the caregiver and/or child to the MH provider and facilitates the caregiver and/or child getting answers to their questions.

The VA shares a copy of the release of information signed by the caregiver and a copy of the screener with the MH professional and secures a commitment from the MH professional for collaboration regarding the outcome of the assessment and recommendation regarding services needed and provided to the family.

To ensure consistency with the 2023 MH standard, when the MH assessment indicates a need for mental health treatment the results of the assessment are used by the MH professional to collaborate in the development of a 3. Individualized treatment plan and 4. Individualized, evidence-supported treatment appropriate for the child client and other family members based on assessments that are periodically reassessed.

Documentation and follow up of the Screener.

Mental Health Screening will be documented in NCA Trak or (another case monitoring system)

1. Advocacy Tab – Services Log – Emotional Support Screening Tools
2. Mental Health Tab – Assessment - Add New Assessment
3. Hard copy of the Screener will be filed in child folder.
4. If screener indicates a need for a comprehensive Mental Health Assessment, the screener should be shared with the MH provider identified to administer the MH Assessment

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DESK CARD (10)
Comprehensive Mental Health Assessment (including an Assessment of Trauma)

Child maltreatment victims are at risk for a host of emotional and behavioral problems, though some child victims do not develop these symptoms.

A Mental Health Trauma specific assessment administered by Mental Health professions is designed to identify what impact the maltreatment has had on a given child.

Of the children who develop problems those symptoms fall into two categories:

- Internalizing Symptoms that may be difficult for others to see and identify and include depression, anxiety, Post-Traumatic Stress, nervousness, intrusive thoughts and about the abuse and fear.
- Externalizing Symptoms are usually more easily observed and identified and include nightmares, defiance, aggression, attention problems and opposition (behavioral acting out).

When a child has experienced some form of maltreatment a Screener may indicate the need for a comprehensive assessment that includes a trauma specific assessment and involves the use of standardized mental health assessment instruments may be indicated.

The assessment is completed prior to the start of treatment as the information gathered from the assessment is used to determine if the child needs treatment and if symptoms are identified, to determine the most appropriate Evidence Based Mental Health Treatment (EBT).

The assessment is given again during the course of treatment to determine progress and again at the end of treatment to help determine if treatment was successful.

Commonly used standardized assessment screening tools include:

Mood and Feelings Questionnaire
Strengths and Difficulties Questionnaire
Child PTSD Symptom Scale
UCLA PTSD Reaction Index

Additional standardized assessment tools are continually in development.

Refer to the NCTSN Website https://www.nctsn.org/ and the California Evidence-Based Clearinghouse for Child Welfare https://www.cebc4cw.org/ for up-to-date information on evidence-based assessments and treatment.

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DESK CARD (11)

Developing and implementing an individualized treatment plan based on the assessment results that include Measurable Behavioral Treatment Outcome Goals

The mental health assessment outcome helps determine treatment goals as they relate to symptoms or behavioral issues. These goals need to be behavioral in nature and measurable, i.e., if a child's symptom is nightly nightmares that interfere with sleep and then lack of sleep leads to sleepiness in class that impact ability to be successful one goals would be to reduce the number of nights the child has nightmares. The goal can be measured by having a parent report on the occurrence of nightmares the child experiences. The goal might be reducing the number of nights from 6 to 3. This is easily measured and provides a measure for treatment success from 6 nights to no more than 3.

Developing the MH Treatment Plan for an individual client

The treatment plan is then developed considering what evidence based mental health treatment model offers the best opportunity to be successful in meeting the treatment goal/s. In this example, TF-CBT would be the treatment of choice.

Identifying an appropriate Mental Health Provider

Once the treatment goal/s have been determined and the best EBT identified, the next step is to identify a mental health professional who provides treatment to CAC clients and who meets the criteria of education, training and supervision required by the 2023 NCA MH Accreditation Standard. This information should be available through the linkage agreements with community mental health providers and through the curriculum vitae of the mental health professionals working at the CACs. Reaching out to the potential MH provider to determine timeliness availability and willingness is the next step prior to making a referral for treatment.

Making a Warm Referral (Face-to-face or virtually) to introduce the client to the Mental Health Provider

Prior to the actual referral, the CAC staff can share information with the client regarding the provider and can help the client identify questions he or she may want to ask the provider. Having developed a collaborative relationship with the provider helps with this step as the client can learn about the providers experience, expertise, and relationship with the CAC. Prior

to the referral, a signed release from the client allows the CAC staff to share information with the MH provider to support their role in the treatment of the client.

Identifying and Removing Barriers

It is the responsibility of the CAC and MDT to identify and help resolve any barriers to the family's engagement in mental health treatment. This is an on-going process that begins with the client's first appointment and continues through the successful completion of treatment. Collaboration with the MH provider, the family and the client are required for this task.

Monitor Treatment Progress

Regularly examine the goals related to the treatment plan and alter, change, or end the treatment plan according to the responses of the child and family. The CAC needs to have in place a system for documenting the metrics regarding client participation and progress in the treatment plan. This includes tracking information about the treatment goals/plan, the referral for treatment, attendance at the initial and subsequent sessions, barriers identified and how reduced/removed and finally the treatment outcome including early termination and treatment completion. This monitoring and tracking process documents the services provided, the response of the client/family and the outcome and is necessary for the CAC to determine if children seen at the CAC have benefited from the CAC services designed to help them heal from any negative consequences of their maltreatment. Monitoring provides the CAC information to determine if children seen at a CAC get better as a result of the CACs services.

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DESK CARD (12)
What is Family Engagement?

Family engagement involves the process of identifying, enrolling, and retaining families in needed treatment services. Because caregivers play a crucial role in the physical and emotional development of their children, it is critical that parents are also involved in their child's mental health treatment. While attendance is important, true engagement is motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing things for the better.

Why is family engagement so important to helping children heal?

Evidence-based practices for children exposed to trauma frequently involve treatment for both the child and their primary caregivers. Research has identified that involving caregivers in treatment services significantly increases the likelihood of positive outcomes for children. Engaged caregivers aid the treatment process by ensuring the child's attendance and participation in treatment to completion. Further, as the experts regarding their children, caregivers can aid clinicians in identifying treatment needs and goals, increasing treatment compliance and the practice of skills learned during treatment at home. Engaged caregivers provide their children with additional support that significantly increases their likelihood of success.

What are potential barriers to the child and caregiver being engaged in treatment?

Barriers can impede family engagement in mental health child trauma services. Caregivers may face internal barriers such as personal mental health issues, medical problems, limited cognitive capacity, substance abuse, or emotional dependency. Further, a caregiver's own fears, past negative experiences with mental health treatment, believing that their child does not need treatment or a cultural belief system that prevents them from valuing or utilizing mental health treatment may contribute to their decreased engagement. External barriers such as scheduling conflicts, financial and economic struggles, lack of access to transportation or childcare, and family stressors may complicate this issue further.

Whatever barriers families face, it is critical that the CAC/MDT recognizes and works to identify family and community resources that can aid in decreasing these barriers, allowing families to successfully engage and benefit from treatment.

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What specific strategies can be used to enhance family engagement?

Research has identified strategies that can be used to enhance family engagement in the Mental Health treatment process. Prior to the onset of services, MDT partners should strive to identify barriers that may arise for each family. Upon first contact with the caregiver, the treatment process should be explained, and a foundation should be established for a collaborative working relationship. Service providers may use this time to build positive expectations for therapy by emphasizing the evidence supporting treatment as well as a brief rationale for the services. Following meeting with the family, providers should strive to focus on immediate, practical concerns of the family such as barriers to transportation or scheduling conflicts. Personal barriers such as struggling to meet basic needs, negative beliefs about mental health treatment or significant family life stressors should also be discussed at this time. Services can be modified as necessary to support the families' success in treatment. MDT partners should work collaboratively to overcome these barriers by identifying community resources and providing necessary education. Progress and barriers should be monitored and reassessed throughout the course of treatment and praise should be used frequently to encourage continued engagement in the treatment process.

How can all MDT partners be involved in providing support to enhance family engagement?

While it is likely that not all MDT partners will have a strong background in providing trauma-informed care, there are certainly ways that MDT members can enhance family engagement in treatment. MDT members should first strive to gain an understanding of how trauma impacts the entire family (become trauma informed) as well as the valuable role of treatment and accept that healing from the impact of maltreatment is a victim's right. Once accomplished, MDT partners can support family engagement directly through contact with the family and through coordination and collaboration, assessment, service plan development, reducing barriers to treatment success and monitoring of treatment interventions.

Partners can enhance the engagement process by utilizing their specific backgrounds and skill sets. For example, Law Enforcement can provide information to the court system regarding the need and option for mental health treatment following the investigation process. Child Protective Services can utilize trauma screening and assessment to identify treatment needs of the children in their caseload, monitor treatment progress, and make recommendations regarding safety and placement based on the treatment needs and the outcome of treatment for the child and caregiver. Mental Health partners can advocate for the benefits of treatment,

provide detailed information on treatment options, collaborate with other professions as allowed through signed releases and monitor families' engagement through completion of treatment services. Lastly, Victim Advocates can support the family by promoting the benefits of treatment and advocating for each families' unique needs to eliminate barriers to treatment completion before they begin and throughout the treatment process.

NCTSN Child Welfare Collaborative Group | June 2017 The National Child Traumatic Stress Network www.NCTSN.org

Engagement is what keeps families working in the long and sometimes slow process of positive change (Steib, 2004) Family Engagement emphasizes the families' level of participation, collaboration, and partnerships with service providers (Funchess, Spencer, and Niarhos, 2014)

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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DESK CARD (13)
Types of Potential Barriers to Family Engagement

Concrete/Tangible Barriers

- Transportation
- Child Care
- Finances
- Time from work
- Child out of class
- Hierarchy of basic needs critical to survival (food, housing, etc.)
- Other, identify.

Other Perceptual/Attitudinal Barriers

- Cultural beliefs
- Fear of the consequences of engagement
- Past negative history with mental health and "helpers"
- Trauma triggers
- Poor therapeutic alliance
- Perceived need for treatment
- Expectations of therapy
- Beliefs about the therapeutic process
- Fear of labels
- Stigma associated with mental health.
- Lack of knowledge about the effectiveness of services available
- Lack of knowledge regarding the potential impact of trauma on the child and on the caregiver
- Relationship between the caregiver and their child

Other System Barriers

- Financial cost of services
- Waiting lists
- Service criteria
- Lack of cultural or ethnic sensitivity or representation
- Distance for services
- Lack of public transportation
- Lack of access to Evidence Based treatments

Lack of trauma informed and trauma sensitive services

Professional Barriers

Secondary Traumatic stress
Own unresolved history of abuse/trauma
Implicit and explicit biases
Resistance to change
Other

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DESK CARD (14)

Steps for Building Positive Expectation for Mental Health Treatment with a Child and Caregiver

Remember to ask permission to provide information and reflect the concerns shared by the child/caregiver to keep the focus on their role as the expert about their family and their needs.

"I have some information about some services that we have available to help you help your child manage the issues you identified as problematic. Is it okay if I share these with you?"

1. Explain the **need for treatment**.
2. Explain the **treatment process**.
3. Explain the **effectiveness of the treatment**.
4. Describe the **training, expertise, and effectiveness** of the therapist.
5. Explain the need for a **Release of Information** and the role of collaboration and help guardian in signing that release.
6. Help the family identify **questions** they want to ask the therapist
7. Explain the need to **attend** regularly and to **participate**.
8. Identify barriers to treatment engagement.
9. Problem-solve **concrete barriers**.
10. Explore and problem-solve **perceptual barriers**.
11. Help the caregiver identify question he or she wants to ask the mental health treatment provider regarding the treatment, their training, the process etc.

12. Make a **Warm handoff** to a mental health professional and facilitate the caregiver asking the questions you have helped them formulate.

13. **Follow-up** with the MH provider on each referral to confirm engagement.

14. Engage in On-going **Collaboration** with the family and the mental health provider to identify and resolve barriers to treatment engagement.

15. Collaborate with MH professional to **Track** treatment progress.

16. For families who do not progress or complete treatment, identify barriers and attempt to re-engage.

17. Celebrate treatment completion with the child, family, and MDT.

Adapted from 2009 National Crime Victims Research and Treatment Center, Medical University of South Carolina and the Dee Norton Child Advocacy Center.

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DESK CARD (15)
TIES Evidence-Based Family Engagement Strategies

FAMILY ENGAGEMENT IS A KEY TO SUCCESSFUL TREATMENT

- Barriers can reside with the family, the provider, and/or the system in which the provider works.
- Triple threat: poverty, single parent status, stress
- Concrete obstacles: time, competing priorities, transportation, childcare.
- Perceptual obstacles: attitudes about mental health, stigma, negative experiences, parents' own stress and needs.
- Not all barriers are "equal."
- Perceptual barriers (e.g., stigma) and prior negative experiences have been shown to have the greatest influence on initial and ongoing engagement.
- Addressing perceptual barriers may be more important than focusing only on concrete obstacles.

Many families make a call for a child mental health intake appointment yet never attend.

- Rates of no-shows for initial intake appointments have been found to range from 48% to 56% in prior studies.
- The crisis: Children with mental health difficulties often never come through the door of the service system.

FAMILY ENGAGEMENT (TIES) STRATEGIES: FIRST CONTACT

Client satisfaction at the time of the first visit predicts retention in treatment.

- If families are dissatisfied with treatment at first appointment, they are not likely to return.
- Clarify the need for mental health care --- Determine why child and family want help from a provider.

- Engage child and family in a helping process.
- Increase caregiver investment and efficacy.
- Identify attitudes about previous experiences with mental health care and institutions.
- Problem-solve around concrete obstacles to care.

1. Clarify the Need
   - Why are they here?
   - Why now?
   - What does the family need?
   - What are the family's strengths (or resources)?
   - Whose idea is mental health care for the child?
   - Does the parent agree with the referral?
   - In a parent's own words, what does the child need?

2. Increase Caregiver Investment and Efficacy
   - Reinforce what the parents have done well and empower them on the phone.
   - Remember that this call sets the tone for treatment, so start by reinforcing the parents for their hard work.
   - Mobilize resources.

3. Identify Attitudes about Previous Mental Health Care Experiences
   - Help parents' express concerns about seeking mental health care for their child.
   - Ask about previous attempts to seek treatment.
   - Help parents convey expectations and hopes for this encounter.

4. Problem Solve Around Concrete Barriers
   - Address concrete barriers and find ways to problem-solve around transportation, childcare, time, and other issues.
   - Address barriers from within your setting (e.g., difficulties with parking, offices that can be hard to find).

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CONCLUDING THE INITIAL CONTACT

- Be sure caller has date and time of the appointment, as well as directions by car, bus, and subway (if applicable).
- Be sure caller understands what he or she needs to bring (past reports, insurance card, identification, list of medications, etc.).
- Explain timeline of first appointment (orientation to clinic, paperwork, questions/topics for first appointment, etc.).
- Follow up with caller by phone or mail with an appointment reminder.

SUMMARY

- Help parents clarify the need for mental health care.
- Increase caregiver investment and efficacy by validating their attempts to seek help.
- Identify attitudes about previous experiences with mental health care and institutions, as well as expectations for this experience.
- Problem-solve around concrete obstacles to care.
- Tell parents what to expect for the first appointment and answer any questions.

FOUR CRITICAL ELEMENTS OF THE ENGAGEMENT PROCESS

1. Clarify the helping process for the client by:
   - Introducing the process and key players
   - Allowing time to build trust.
   - Providing accurate information about services
   - Addressing expectations

2. Develop foundation for a collaborative working relationship by:
   - Balancing the need to obtain intake information with helping the child and family "tell their own story" about why they have come.
   - Framing agency-required information in a client-centered way
   - Commit to partnership every step of the way.

3. Focus on immediate, practical concerns by:
   - Being prepared to schedule a second appointment sooner than the following week/month if needed.
   - Helping parents negotiate with other "systems" (e.g., school)
   - Responding to parents' concerns

4. Identify and problem-solve around barriers to help seeking by:
   - Exploring potential barriers families may face in obtaining ongoing services.
   - Addressing concrete barriers families may face, such as time limitations and transportation challenges.
   - Recognizing perceptual barriers families may face.
   - Help parents' problem-solve ways they can overcome barriers
   - Help parents identify resources they need to overcome barriers and how to access those resources.

SUMMARY:

- Discuss the helping process with families, including family expectations and concerns.
- Include families as equal partners in treatment planning and decision- making.
- Start with issues that are most urgent to the family.
- Talk with families about barriers to care and help identify resources to
- overcome barriers.

EMPOWER PARENTS

Empower parents to explore new strategies and develop problem-solving skills by:

- Helping parents identify barriers to implementing change within the home and other settings.
- Working with families to problem-solve around these barriers.
- Providing positive feedback to parents
- Establish goals for success from the beginning and focus treatment plan on meeting these goals.
- Continually assess status to determine progress toward success.

- Make changes as needed to ensure progress.
- Stay involved and engage families through to treatment success and identify if additional services are indicated.

GOALS OF RETAINING FAMILIES

- Validate families and take the time to understand each member's perspective.
- Remind families of their appointments.
- Identify barriers to ongoing involvement.
- Identify barriers to implementing change.
- Empower parents to attempt new strategies and problem-solving skills.
- Keep families involved in the treatment process and continue to seek feedback on treatment progress and treatment goals:
- Partner with family support or advocate resources to encourage ongoing involvement in mental health care.
- Therapeutic alliance and quality of parent-provider relationship are strong predictors of treatment success and retention.
- Help parents track treatment goals and progress toward goals.
- Collaborate with school and other agencies involved in caring for the child.

TIES Sources:

1. McKay MM, McCadam K, Gonzales JJ. Addressing the barriers to mental health services for inner city children and their caretakers. Community Mental Health Journal. 1996a;32:353–361. [PubMed] [Google Scholar]
2. McKay M, Nudelman R, McCadam K. Involving inner-city families in mental health services: First interview engagement skills. Research on Social Work Practice. 1996b;6:462–472. [Google Scholar]
3. McKay MM, Stoewe J, McCadam K, Gonzales J. Increasing access to child mental health services. Health and Social Work. 1998;23:9–16. [PubMed] [Google Scholar

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DESK CARD (16)
Cheat Sheet (Script) for Initial Contact Core Engagement Components

1. *Clarify the helping process*:

Purpose: Let them listen, relax, catch their breath, and get a sense of who you are while you do the talking.

- *You talk first*. Introduce the agency – describe the mission, services, the physical setting, who works there, etc.
- *Introduce yourself*. Share something personal that they can relate to (your experience, history working with children, something about you as a parent (of you are one), something that makes you human).
- Explain the purpose of this first session – justify any paperwork that must be done in a way that is *meaningful* & *tied to engagement* (e.g., not, "we have to do this so that we can get paid"). Make sure they understand the importance of any information you have to collect or papers that have to be signed (e.g., "getting this waiver signed means I can talk to your child teacher, and we can coordinate on how to help him").

5 minutes

2. *Develop the basis for a collaborative working relationship:*

Purpose: To make it clear that you want to team up and work with the foster parent--their participation will be crucial. Gain their interest in that collaboration, praise their importance.

- Reassure them that your job is to help the caregiver as much as it is to help the child – let them know that you want to hear the story—what is difficult about this child, what is making things challenging at home.
- Remind them that, as the expert on the child, their participation each week will be crucial. Having them come to sessions and *work with you individually each week* will have a lot to do with how quickly and how much the child's symptoms and behaviors improve.
- Continue preview of TF-CBT including the role of the caregiver and *weekly practice assignments at home*.

- Explain why weekly practices and Caregiver involvement are key to helping the child.
- Make sure you talk about the structure and short-term nature of TF-CBT.
- Like on the phone call, tell them you want to know immediately if they feel therapy isn't working.
- Problem solve around any perceptual barriers to their engagement (e.g., fears it won't work, feeling like the last therapist didn't listen to them). *Bring up what you think they might not*.

2-3 minutes

3. *Focus on immediate, practical concerns:*

Purpose: Begin active treatment: Convey the idea that this can be helpful, effective, and responsive to their needs.

- Pick one thing that they identified as a problem (ideally, from the first phone call) and provide something tangible: a handout or make a phone call with them (e.g., if need help reaching caseworker or teacher).
- Spend 2-3 minutes talking with the foster parent about the handout or phone call plan.
- Discuss any "systems" issues that have come up– school, child welfare, outside agencies, etc. – Offer your support in navigation of these systems and working to improve communication.

2-3 minute

4. *Identify and problem solve any concrete barriers to participation in counseling (if needed):*

Purpose: To get barriers out on the table immediately and find ways to work around them.

- Discuss options for childcare, bus routes, flexible appointment scheduling, etc.

1-2 minutes

5. *Find out if the Caregiver wants to come back!*

- "There are always some things that sound good to people about this therapy, some that don't sound so great. What are those things for you?" *Discuss and Clarify*
- "Given what we've talked about today and TF-CBT, do you think you'd want to come back next week? Do you think this could be helpful for your child, for you?"

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DESK CARD (17)
Motivational Interviewing: (OARS)
Open-ended question, Affirmations, Reflection, Summaries

OARS is a motivational interviewing technique used to encourage caregivers to tell their stories. It is non-judgmental and through open-ended questions, reflections, and affirmations, it encourages caregivers to be active in the conversation.

Open-ended questions – elicits information from caregiver on their story which includes reluctance to change. Look for discrepancies e.g., this is how it is now, and this is how I would like things to be.

Examples:

- *What has your experience been with mental health?*
- *What are the strengths of your family?*
- *What concerns do you have for yourself (or your child)?*
- *How can I help you today?*
- *What would you like to be different?*

Affirmations – conveys that you are paying attention to their story and acknowledges client strengths.

Examples:

- *Thank you for sharing concerns about your schedule. It does seem that you have a lot on your plate right now and have done a very good job of managing it.*
- *I appreciate you sharing your concerns about the mental health system. Even though you haven't been impressed in the past, you are willing to try again for your son.*
- *It sounds like things have been stressful, and despite that, you continue to do what you can to help your son.*

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Reflection - Listening to the caregiver and reflecting what you heard them say. In addition to content, pay attention to tone of voice and body language. AIM for a ratio of 2 reflections for every question.

Examples:

- *You are concerned about your son's behavior at school, and he isn't sleeping well at night. You wonder if medication will help.*
- *You are concerned that your daughter has been breaking rules and think she is making poor choices with her current friends.*
- *You aren't sure how to tell your other children about what happened to their sister. You are worried that if you tell them, it might scare them.*
- *Your son doesn't want to go to therapy so you fear that you will have a difficult time getting him there***.**

Summaries – a form of reflection that summarizes what the client told you. Listen for change statements from the client.

- *You shared some really important information with me. You are interested in getting your son into therapy though you are concerned that he will refuse, and you are also concerned that because of the trauma, he is acting out at school and his grades are dropping. You are hopeful that therapy will help with this situation.*
- **Change Statement: Interested in getting son in therapy though concerned he will refuse.**

- *You have a lot that you are managing right now with the other kids at home and your work schedule. You think that counseling for yourself may offer some support, but you are not sure that you can make it work with your schedule.*
- **Change statement: she thinks counseling may offer support.**

- Your daughter is wetting the bed again and she is having nightmares which is making sleep difficult in the house for everyone. You tried therapy before, and it didn't work so you are not interested in going down that road again.

- **Change statement: Not present rather presenting with Sustain talk.**

REMEMBER - **Client is the expert and is the only one who can decide to change and what to change.**

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DESK CARD (18)

Some ways to initiate a discussion about perceptual barriers with a caregiver or older child

"Thank you for taking the time to help me understand more about you and your family. It sounds as though life has been stressful for you lately. Can you tell me a little more about what you're hoping to accomplish during treatment?" [Prompt for references to mental health difficulties.]

"I hear what you are saying about [child's name] and his/her difficulties with [paraphrase the presenting problem]. In your description, I noticed that you [paraphrase perceptual barriers noted, i.e., stigma, reluctance to attribute difficulties to mental health, fear about treatment, concern that treatment will not help]. Can we talk a little more about that?

Explore perceptual barriers by pointing out your observations and gently inquiring as to how parents formulated those beliefs. Be careful not to "correct" parent beliefs, as this may lead to resistance.

Ask permission to provide families with information and support to normalize the help-seeking process, ensure family members have the information they need about their child's mental health diagnosis/treatment, and help families feel that they are doing the right thing for their child. Empower families to make changes at home to benefit their child, so families take ownership for the healing process.

Some things to say to support engagement.

AGAIN….Ask permission from the family to provide information and to ask questions.

"It would be helpful to me to know something about you and your family. Is it okay for me to ask some questions? If I ask a question, you do not want to answer, just tell me you aren't comfortable answering that question."

"If someone asked me to tell a stranger about me and about my family, I would want to know something about that person. What would you like to know about me? "

"Other families have told me that a concern about their child that involves abuse is one of the hardest things they have ever had to deal with. I really appreciate your willingness to come here, and it is my job to learn from you how we can be helpful to you and your child."

"I see (or hear) how hard it is for you to be here. As we sit together what can I do that would be helpful to you?" "What could I do that would be helpful to your child?"

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DESK CARD (19)
Opportunities for Family Engagement Roadmap

Initial Face to Face Contact including Screening.

- Express empathy for the concern that brought them to the CAC.
- Ask for permission to provide information regarding what the family can expect from their involvement with the CAC.
- Ask permission to ask them questions to help you understand how to be helpful to them.
- Invite them to share their greatest concern, hear what they identify and ask what would be helpful to them right now as they deal with this concern.
- Be patient and understand that taking in new information during a crisis is difficult and may require repeating concerns and information.
- Gather information about potentially traumatic events and the families concern about the impact of those events.
- Ask permission to provide information regarding trauma and the potential impact of trauma on them and on their child.
- Explain how the screening tool can help the parent identify trauma issues that may be impacting their child.
- Ask to have the caregiver answer the questions in the Screening tool to gather further information regarding the family history and any impact of trauma on the child and family.
- Address any critical items endorsed during the Screening prior to the family leaving the CAC as it may be difficult to get the family back for a second appointment.
- Ask to share feedback from the screening/assessment.
- If symptoms are identified, reinforce the caregiver's concerns regarding problems/needs of their child/family.
- If the Screening Tool identifies a need for a referral to a Mental Health professional for a Mental Health Assessment, ask permission to describe the purpose of a mental health assessment, answer any questions and identify any barriers to engaging in the assessment.
- If barriers are identified, provide a supportive and empathetic response as you help the family identify ways to reduce or remove those barriers.

Mental Health Assessment

- Provide information about your knowledge of the Mental Health professional who will be conducting the assessment including their training and expertise and location.
- Ask for questions and answer any questions the family might have.
- Help the family identify questions they may want to ask the Mental Health professional.

- Provide a collaborative face-to-face referral to that MH professional and facilitate any questions from the family.

Following the successful completion of the Assessment and collaborative communication with the Mental Health Professionals

- Invite the family to discuss and to ask questions regarding the outcome of the assessment.
- If the assessment indicates a need for treatment, ask to share and describe the value of EBTs to address that need. (EBT DESK CARD)
- Have family sign release to share information.
- Identify and address any barriers to the family engaging in MH treatment.
- If the treating MH professional is different from the assessing professional, provide the family with the training, experience, and expertise of the MH professional and make a face-to-face collaborative referral.
- Identify questions the family may have for the MH treatment professional and offer to facilitate that process if warranted.
- Collaborate with the family regarding the desired treatment goals and how to achieve those goals.
- Continue with on-going family collaboration during treatment to identify and overcome barriers to the family's engagement in treatment to completion.
- Monitor treatment engagement and progress through collaboration with the Mental Health provider and track and document treatment progress.
- And Celebrate treatment success with the family and the MDT.

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DESK CARD (20)
Identifying and Delivering Evidence-Based Mental Health Treatment for Children Served by Children's Advocacy Centers

1. Engagement and Screening

   The initial and on-going task when delivering mental health services is engaging the caregiver and child. This involves using engagement strategies that help the child/family feel safe in sharing information and to agree to having information provided to them. Engagement may also require the identification and overcoming of barriers the family has to participating and collaborating with CAC staff. Administering the screener provides staff with an opportunity to use engagement strategies to help the caregiver/child share information about concerning issues/problems they may have. The Screener is administered to the caregiver and/or child to gather their input regarding issues or problems that may warrant further mental health services. The outcome/score of the Screening process completed by the CAC will indicates if there is a need for a comprehensive mental health assessment. The screener provides information for the VA/CAC to triage referrals for MH services which can help reduce wait lists for MH services.

2. Referral to a MH professional for a MH Assessment

   When the outcome of the screener indicates specific symptoms or behavioral issues, a warm referral to a mental health professional for a comprehensive mental health assessment is then made. In support of making this referral and being able to share the results of the screener and to collaborate with the MH professional regarding the child and caregiver the VA must have the child's legal guardian sign a release of information.

   The warm referral for the MH assessment can be made face to face or virtually. Helping the caregiver identify questions or information they want to get from the

MH professional and then supporting that caregiver in asking for that information during the face-to-face referral can reinforce treatment engagement.

3. Mental Health Comprehensive Assessment

   The outcome of the MH assessment determines if there is a need for treatment to reduce identified problems. When further treatment is indicated, behavioral and measurable treatment goals are developed to reduce or resolve the identified symptoms/problems. An example: if a child's symptom is nightly nightmares that interfere with sleep and then lack of sleep leads to sleepiness in class that impact ability to be successful academically, one goal would be to reduce the number of nights the child has nightmares. The goal can be measured by having a parent report on the occurrence of nightmares the child experiences. The outcome goal might be reducing the number of nights from 6 to 3. This is easily counted and provides a measure for treatment success from 6 nights to no more than 3. When measurable/behavioral treatment goals are identified the next step is to develop a treatment plan with the MH provider, and the caregiver/child. This treatment planning process can be completed and/or shared with the MDT during the Case Review process.

4. Developing the MH Treatment Plan for an individual client

   The treatment plan is then developed considering what evidence based mental health treatment model offers the best opportunity to be successful in meeting the behavioral and measurable treatment goal/s. In this example, TF-CBT would be the treatment of choice as it provides psycho education and stress management skills for both the child and the caregiver.

5. Identifying an appropriate Mental Health Provider

   Once the treatment goal/s have been determined and the best EBT identified, the next step is to identify a mental health professional who provides treatment to CAC clients and who meets the criteria of education, training and supervision required by the NCA MH Accreditation Standard. This information should be available through the linkage agreements with community mental health providers and through the curriculum vitae of the mental health professionals

working at the CACs. Reaching out to the potential MH provider to determine timeliness availability and willingness is the next step prior to making a referral for treatment.

6. Warm Referral (Face-to-face or virtually) to introduce the client to the Provider.
   If the treatment provider is different from the MH professional who completed the MH assessment, prior to the actual referral, the CAC staff can share information with the client regarding the provider and can help the client identify questions he or she may want to ask the provider. Having developed a collaborative relationship with the provider helps with this step as the client can learn about the providers experience, expertise and relationship with the CAC. Prior to the referral, a signed release from the client allows the CAC staff to share information between the CAC Victim Advocate and the MH provider to support collaboration regarding treatment engagement and progress. The purpose of this release and the importance of collaboration needs to have been communicated to the child's guardian who will need to sign the release.

7. Identifying and Removing Barriers
   It is the responsibility of the CAC and MDT to identify and help resolve any barriers to the family's engagement in mental health treatment to completion. This is an on-going process that begins with the client's first appointment and continues through the successful completion of treatment. Collaboration with the MH provider, the family, and the client to identify and remove barriers is required for this task to be successful.

8. Monitor Treatment Progress
   Regularly examine the goals related to the treatment plan and alter, change, or end the treatment plan according to the responses of the child and family. The CAC needs to have in place a system for documenting the metrics regarding the client's participation and progress in the treatment plan. This includes tracking information about the treatment goals/plan, the referral for treatment, attendance at the initial and subsequent sessions, barriers identified and how reduced/removed and finally the treatment outcome including early termination

and treatment completion. This monitoring and tracking process documents the services provided, the response of the client/family and the outcome. This tracking is necessary for the CAC to have data to inform the need for change in their process. Of equal importance, tracking provides data to determine if children seen at the CAC have benefited from the CAC services designed to help them heal from any negative consequences of their maltreatment. Monitoring provides the CAC information to determine if children seen at a CAC get better because of the services provided by and through the CAC.

9. Celebrate Treatment Success and/or consider other needs of the child/caregiver. CAC Staff and MDT partners are exposed to the traumatic experiences of children and families served by the CAC and by their own community organizations. Celebrating positives and successes of the children and families served can serve as an antidote to some of that stress. Sharing the positives of success with the family also reinforces the positives of community services and collaboration in support of positive outcomes for child victims and their families.

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DESK CARD (21)

The Importance of CAC and MDT Data to Answer the Question "Do Children at Our CAC Get Better"?

Child Advocacy Centers and their MDT partners respond to hundreds of thousands of children yearly who are alleged to be victims of maltreatment. Historically CACs have gathered information (data) about the number of children and their caregivers served. This data describes how much or how many services they provide (output data). This output data provides important information about the number of services CACs provide and the number of child victims and their families who participate in these services. This provision of services historically focused on supporting the successful investigation and prosecution of those who sexually abused a child. One goal of gathering this data was to identify how these services impacted the outcome of the investigation and prosecution of child sexual abuse. Unfortunately, in most CAC jurisdictions this outcome data has not been available. There are multiple barriers such as a lack of common definitions of crimes, the tracking of "cases" by offenders by law enforcement, tracking by victims of Child Welfare and CACs. Also, the gathering of data requires collaboration, a willingness, and a method for sharing by MDT members that does not exist across all CAC and MDT partners. This has left most CACs with the "outcome" question, "does the CAC model of coordination and collaboration between CACs and their MDT partners increase the successful investigation and prosecution of child sexual abuse cases?

Data and research have identified effective MH treatment interventions that reduce the potentially negative impact of child maltreatment. Based on this data and research NCA expanded the mission of CACs beyond the focus on the investigation and prosecution to include the healing of child victims. In support of this expanded mission, NCA, through their MH Accreditation Standard requires that all CACs provide evidence-based mental health services to the children they serve. This standard defines the MH process for CACs as they identify the mental health treatment needs and coordinate and collaborate with their MDT to implement, monitor, and track MH services to completion.

Based on this standard, CACs have an opportunity to expand their data collection to include the response (outcome) to the impact of maltreatment on a given child, the services provided to help that child heal from that identified impact and the outcome of those services with the goal of healing. This data is critical to being able to answer the question, Do the children seen at your CAC get better?

The data gathered through this MH process to the goal of healing include the Screening completed and the score of that screener; the Mental Health Assessment completed and any symptoms identified through that assessment: the behavioral and measurable treatment goals; the evidence-based MH treatment provided; the monitoring of the attendance and participation of the child/caregiver in that treatment and finally, the outcome of that treatment as measured by re-administering the MH assessment to identify any reduction in symptoms. By accurately documenting each of these data points of services delivered (outputs), the CAC will be able to identify the impact of the MH interventions on the (outcome) goal of victim healing.

Another important and evolving role for CACs in terms of the collection and documentation of accurate data is the fact that CACs are often the primary community-based organization that serves child victims and their families, and NCA is the national organization that supports these local services. NCA uses data to inform their policies and programs. It is data that allowed NCA to expand the mission of CAC to include victim healing from the identified impact of maltreatment. CACs have the opportunity and the responsibility to use data to inform their practice and to use research to improve the outcomes of the children they serve. CACs are also in a very strong position to create research opportunities and to collaborate with others in research efforts to inform and improve outcomes for those they serve.

The Adverse Childhood Experience (ACE) study has provided us with the results of research regarding the potential negative impact of traumatic experiences including child maltreatment.

This research has significantly impacted the child abuse field and supported the increase in attention to the need to provide services to help victims learn positive and healthy coping skills. Data and research have also given us MH treatments with evidence of reducing the negative impact of the experience of maltreatment.

CAC, through accurate data collection regarding services and service outcomes can contribute to research to inform and improve the response to children and their families who experience the potential trauma of maltreatment.

CACs need to have a commitment to and a system for data collection and for ensuring the accuracy of the data entered. This will provide CACs the ability to document MH services and to track the outcome of those services. As research and learning regarding the potential impact of child maltreatment and of services to reduce that potential impact expand, CACs need to understand and contribute to this learning. We cannot be satisfied with what we do and how much of if we do. We need to expand our vision to include the impact (outcome) of what we do and to deliver research and data informed services to the children and families that we serve.

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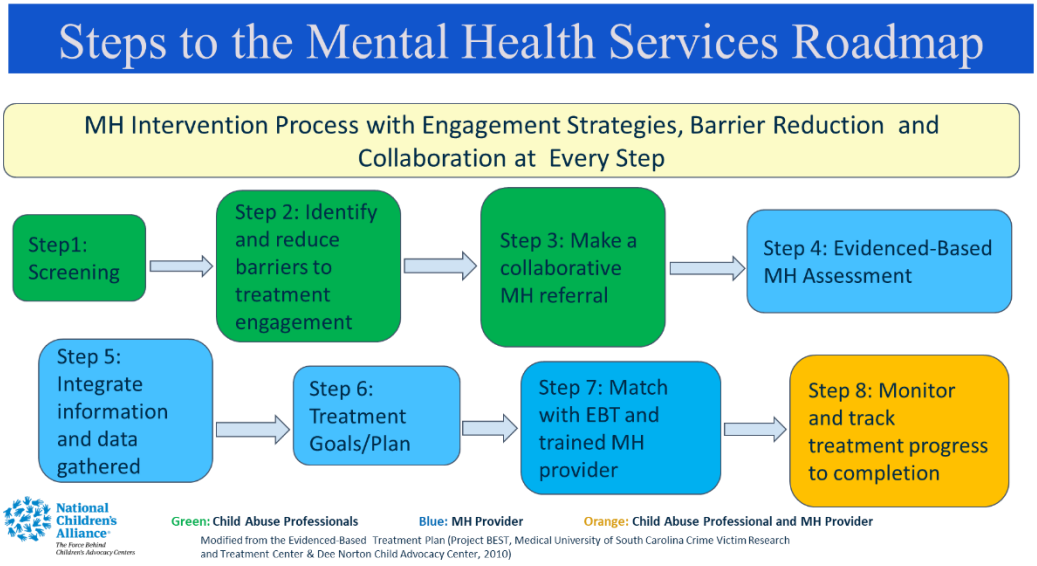
DESK CARD (22)

Mental Health Standard Implementation Roadmap

Steps in the process for delivering mental health services.



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DESK CARD (23)
CAC Mental Health Linkage Agreement Sample

Sample Interagency Linkage Agreement for
Mental Health MDT Participation, Referral, Assessment and Treatment

( ) Children's Advocacy Center (CAC) and ( ) Mental Health Provider agree to collaboratively provide mental health services to child victims of maltreatment to support a trauma informed response and trauma focused evidence-based mental health services for all children and their caregivers served by the CAC.

This linkage agreement is consistent with the NCA Mental Health Accreditation Standard (attached) and outlines the following:

The mental health agency or individual professional will provide documentation that each individual professional seeing clients of the CAC meets the education, training and supervision requirements as outlined in the attached MH accreditation standard and includes:

- Master's degree, licensed or supervised by a licensed mental health professional
- Student Intern in an accredited mental health related graduate program and supervised by a licensed/certified mental health professional
- Has completed 40 contact hours from specific EBT for trauma training
- Clinical supervision by a licensed clinical supervisor
- Complete a minimum of 8 contact hours of continuing education in the field of child abuse every two years.

The MH provider/agency will provide training and input regarding issues that impact child victims of maltreatment and their caregivers to help the MDT understand the responses of the child and of the caregiver served by the CAC.

The MH provider/agency will provide information regarding the potentially positive impact that participation in Evidence-Based Mental Health treatment can have on a child's ability to maintain their disclosure of abuse and to testify in court regarding that experience.

The MH provider will participate as a community partner on the Multidisciplinary Team and in MDT meetings/case reviews to provide mental health input regarding issues pertinent to each child and caregiver staffed.

The MH provider will protect confidentiality of clients referred by the CAC as required by law, their licensure and the policies of their own agency including a release of information signed by the guardian of each child seen for services.

The MH provider will administer a comprehensive mental health standardized assessment for each child referred to determine the need for mental health treatment.

In consultation with the CAC and as appropriate with the child's caregiver:

the MH provider will recommend mental health treatment goals as indicated through the assessment process and identify the most appropriate evidence based mental health treatment to meet those goals.

the MH provider will give input regarding the most appropriate treatment provider with the requisite training in the identified EBT.

The MH provider will prioritize CAC referrals by providing timely appointments (within two weeks)

The MH provider will collaborate with the CAC Victim Advocates or other designated staff as needed regarding:

- Referrals for MH assessment
- Meet with the Victim Advocate and Caregiver/client face to face or virtually to facilitate referrals for and engagement in Evidence Based Mental Health treatment
- Use Evidence-based Family Engagement strategies such as TIES and Motivational Interviewing to support treatment participation and successful treatment completion
- The Identification and reduction of barriers to treatment engagement
- Monitoring of treatment engagement and progress by sharing attendance and participation/engagement level.
- Immediately notify the CAC Victim Advocate if a family is a no show or terminates treatment
- Modification of treatment plan as required for success
- Tracking of treatment progress and outcome through use of a mental health assessment pre/during and post treatment
- Provide no less than monthly treatment updates at Case Review

The MH provider and his or her agency will share research and Mental Health practice updates with the CAC/MDT and will provide accurate and timely data to inform practice improvements.

The MH provider will share information regarding the outcome scores of the initial pre-treatment assessment, and of the post treatment assessment.

The MH provider will collaborate with the CAC is sharing data regarding treatment progress, identified barriers to treatment, treatment completion and outcome of treatment.

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DESK CARD (24)
Template for CAC Mental Health Screening Policy Procedure

NOTE: This a template – please customize to your CAC

CAC Mental Health Screening Policy and Protocol

The National Children's Alliance Mental Health Accreditation Standard defines the mental health services required to be delivered to children seen at CAC for a CAC to be accredited.

The MH Standard component C requires the provision of "Evidence-supported, trauma-focused mental health services for the child client are consistently available and include:

1. Trauma-specific screening/assessment including traumatic events and abuse-related trauma symptoms

2. Use of standardized assessment measures initially to inform treatment, and periodically to assess progress and outcome

3. Individualized treatment plan based on assessments that are periodically reassessed

4. Individualized, evidence-supported treatment appropriate for the child client and other family members

5. Child and caregiver engagement in treatment

6. Referral to other community services as needed.

Purpose of the Mental Health Screening: To identify which children coming through the CAC would benefit from a more comprehensive trauma-informed mental health assessment to identify the potential effect of the trauma experience. The Screening is the first step in the CAC response to the provision of MH services. There are a number of MH screeners available that are appropriate for use by CACs.

NCA Institute for Better Mental Health Outcomes℠

Guidelines for Administering and Scoring Mental Health Screeners;

- Age Range: All children over the age of three coming through the CAC will be screened when the child is seen for an interview or a medical exam.
- (Identify the screener or screeners that will be used in a given CAC)
- (Name of the person or positions who) will administer the screening and consult with mental health providers, when needed.

The screener is administered by a non-mental health professional and is most often administered by the CAC Victim Advocate The Victim Advocate should be well trained in the use of the screener including how to introduce the screener to the caregiver, how to administer the screener, how to score and how to share the results with the caregiver. This screening process offers the Victim Advocate an opportunity to strengthen the engagement of the caregiver in any mental health services identified as needed.

The purpose of the screener is to identify a need for a referral to a mental health provider for a mental health assessment to determine the need for mental health treatment for a child. As not all children who experience maltreatment or trauma develop symptoms that require mental health treatment, the use of the screener can serve as a method for triaging those children who are in need of an assessment to determine the need for treatment services and those who do not need MH services. The results of the screener determine the need for a referral for a comprehensive mental health assessment including the assessment of the impact of the trauma of maltreatment.

In order to address the potential mental health needs of the children served by the CAC, the CAC will implement the following screening protocol:

The Victim Advocate or other designated and trained CAC staff member will administer the (name of screener) to each caregiver and/or child following the completion of the Forensic Interview. The administration of the screener including the scoring will take place prior to the family leaving the CAC following the Forensic Interview. This is due to the fact that the screener may identify risk to the child that needs to be addressed immediately, i.e. suicide feelings/thoughts, use of drugs and/or alcohol or the risk of problematic sexual behaviors.

CAC Response to Risk identified through the Screener. (Implement the CAC Crisis Response Protocol)

1. Identify the required response.

2. Consult your CAC Crisis Response Protocol.
3. Consult with a Mental Health provider
   a. Is it safe for the child to go home?
   b. Is a Mental Health referral sufficient?
   c. Will a safety plan be sufficient?
   d. Is a mental health assessment needed?
   e. Should a crisis referral be made?
   f. Is an immediate psychiatric evaluation needed through the ER?
   g. What is the response of the caregiver to this risk?

The Screening Process and the NCA MH Accreditation Standard:

Remember, the screening is the first step in determining the need for a comprehensive mental health assessment by a mental health professional. When the score on the screener does not indicate a need for further assessment that information is shared with the caregiver with a request from the VA to follow-up in two to four weeks with the caregiver as the need for services may occur over time.

When the score on the screener indicates a need for further MH assessment, the VA will share this information with the caregiver, as well as information about the need for and purpose of the MH assessment as defined under component C of the MH Standard; 1. Trauma-specific assessment including traumatic events and abuse-related trauma symptoms and; 2. Use of standardized assessment measures initially to inform treatment, (determine the need for MH treatment and the most appropriate treatment)

The VA then identifies a mental health professional who is trained and experienced in providing a standardized mental health assessment and who is willing to collaborate with the CAC on identifying any treatment needs for the child and family.

The VA then shares information about the mental health assessment with the caregiver and/or child as well as information about the training, experience and competency of the mental health providers being referred to.
The VA also helps the caregiver and/or child identify any questions he or she wants to ask the MH provider when they meet.

The VA explains the need for the caregiver to sign a release of information so that the results of the screener can be shared between the mental health professional and the CAC to support the need for collaboration regarding the needs of the family and services provided.

The VA then makes a face to face referral for the caregiver and/or child to the MH provider and facilitates the caregiver and/or child getting answers to their questions.

The VA shares a copy of the release of information signed by the caregiver and a copy of the screener with the MH professional and secures a commitment from the MH professional for collaboration regarding the outcome of the assessment and recommendation regarding services needed and provided to the family.

When the MH assessment indicates a need for mental health treatment the results of the assessment are used by the MH professional to collaborate in the development of a 3. Individualized treatment plan and 4. Individualized, evidence-supported treatment appropriate for the child client and other family members based on assessments that are periodically reassessed.

Documentation and follow up of the Screener

Mental Health Screening will be documented in NCA Trak or (another case monitoring system)

1. Advocacy Tab – Services Log – Emotional Support Screening Tools
2. Mental Health Tab – Assessment - Add New Assessment
3. Hard copy of the Screener will be filed in child folder
4. If screener indicates a need for a comprehensive Mental Health Assessment, a release needs to be signed by the child's legal guardian and the screener should be shared with the MH provider identified to administer the MH Assessment