National Children's Alliance®
The Force Behind Children's Advocacy Centers

Lighting the way

The broadening path of mental health services in CACs in the 21st century

National Children's Alliance (NCA) launched the Thriving Kids Initiative in 2009 to build up mental health services at Children's Advocacy Centers (CACs) into a core service dimension. Making it a requirement of accreditation was only part of the battle; building capacity and proficiency and expanding treatment menus has been the greater and more critical goal.

It worked. CACs are now known not just for providing justice for children, but also healing from trauma. CACs have increased not only in terms of the number simply offering services but also in offering an ever-broader treatment menu and hewing closer to best practices, like offering on-site therapy services. A look at the three most recent member surveys (known as the NCA Member Census or the CAC Census and conducted every two years), shows that this trend has continued—and even accelerated—in 2020 during the coronavirus pandemic and public health restrictions due to COVID-19:

CACs Offering Any CAC-Based Mental Health Services

In addition to 82% of CACs offering at least some mental health services themselves, in 2020, many CACs continue to offer key services through linkage agreements with outside therapists. In particular, that includes 53% of CACs offering evidence-based assessments and 58% offering evidence-based treatments through linkage agreements.

Types of Services Offered	CAC-Based Services	Linkage Agreement Services	Total
Crisis interventions	74%	43%	97%
Screenings	70%	42%	95%
Assessments	62%	53%	97%
Evidence-based treatments	59%	58%	98%
Support groups	38%	44%	73%

Additionally, the 2020 NCA Member Census shows:

- More CACs than ever before are offering evidence-based treatments to children. While CACs with different resource levels, access to clinicians, and funding streams must determine what's best to serve their client population, emerging data is showing a clear advantage to providing on-site services to children. See our *Thriving Kids 2019* report for more information.
- More CACs are beginning to use evidence-based assessments to figure out which kids should get therapy—and what type of therapy would be best.
- Family engagement in treatment continues to be a concern, though victim advocates (also known as family advocates) are perfectly positioned to encourage families to use mental health services.
- Telemental health was a powerful tool for CACs during the COVID-19 pandemic, enabling kids to stay connected to therapists when it wasn't safe to meet in person.
- Telemental health programs can help CACs in communities where children have trouble accessing services. A remote or rural community might not have a CAC nearby, and even families in urban areas can face access issues, such as a lack of reliable transportation to get to a CAC in another part of the city. We have a long way to go before not only all ZIP codes, but all kids have truly equal access to all CAC services.
- And, finally, more treatments are available for youth with problematic sexual behaviors, and more of these kids are being served by CACs, effectively reducing the risk that the behaviors will continue.

Building a menu of proven treatments

An evidence-based treatment (EBT) is one that has strong scientific evidence demonstrating its effectiveness in treating symptoms. To be considered evidence-based, the treatments must be used with the population in which they were studied—for CACs, that means using treatments that have been proven effective with child victims of abuse. Compared to the two most recent CAC Censuses, our 2020 data show that more CACs than ever before are offering EBTs:

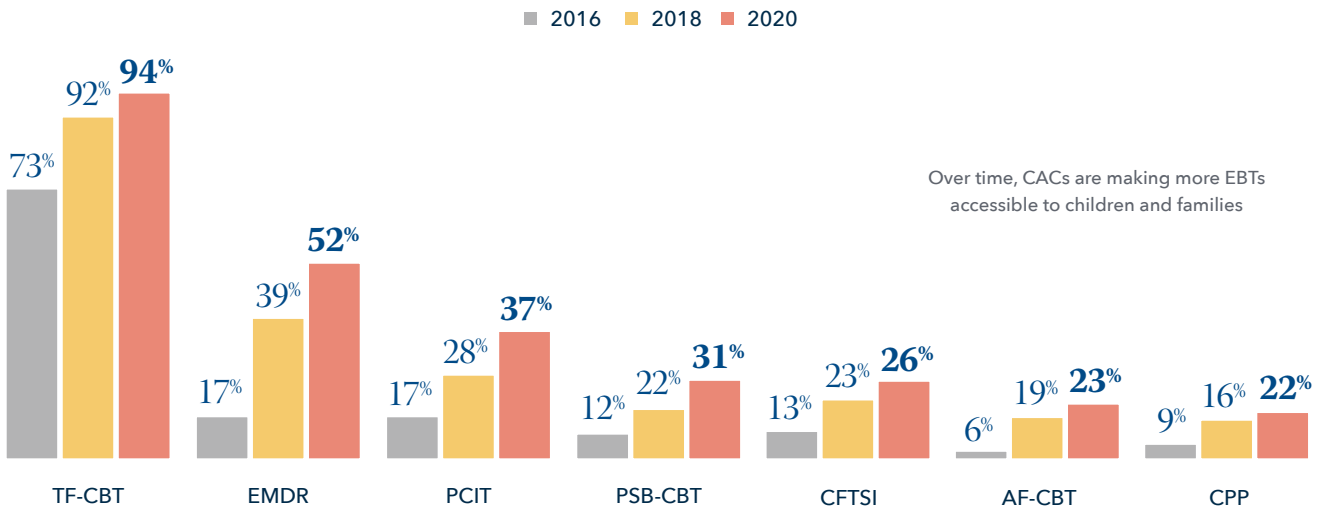
CACs Offering EBTs

No single therapy is right for all children in all situations. In our field, the following treatments have been proven effective:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is for children ages 3-18 with PTSD symptoms and their caregivers.
- Eye Movement Desensitization and Reprocessing (EMDR) is for children ages 2-17 with PTSD symptoms.

- Parent-Child Interaction Therapy (PCIT) coaches parents with children ages 2-7 with behavioral difficulties.
- Problematic Sexual Behavior - Cognitive Behavioral Therapy (PSB-CBT) is a family-based treatment for children ages 3-14 with problematic sexual behaviors.
- Child and Family Traumatic Stress Intervention (CFTSI) is an early intervention for children ages 7-18 dealing with acute stress; designed to reduce traumatic stress reactions and the onset of PTSD.
- Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) is designed to improve relationships between children ages 5-17 and caregivers in families dealing with physical abuse, conflict, or physical discipline.
- Child Parent Psychotherapy (CPP) is for children ages 0-5 with PTSD symptoms and their caregivers, helping families heal and grow after stressful experiences.

Evidence-Based Treatments Used at CACs



Over time, CACs are making more EBTs accessible to children and families

Over time, CACs are making more EBTs accessible to children and families, however, TF-CBT remains the most common treatment—at 94%, significantly more likely to be offered than any other type of EBT. Applications for specific and diverse demographics are available, such as TF-CBT for American Indian and Alaska Native children, and TF-CBT for children who have been the victims of commercial sexual exploitation.

Although CACs have made huge strides in expanding access to mental health services since we launched the Thriving Kid Initiative in 2009, demand for training remains very high: 78% of CACs still reported training needs for EBTs in 2020.

For an example of how this works, learn more about the research being done by Dr. Isha Metzger at the University of Georgia into applying TF-CBT for Black children and their families.

Assessing who needs treatment—and what kind

Before a child begins treatment, evidence-based assessments (EBAs) can help ensure that treatment is targeted to the child's trauma symptoms. The more clinicians are trained in EBAs, the more likely kids are to get the care that gives them the best chance of a brighter future.

CACs Offering Evidence-Based Assessments

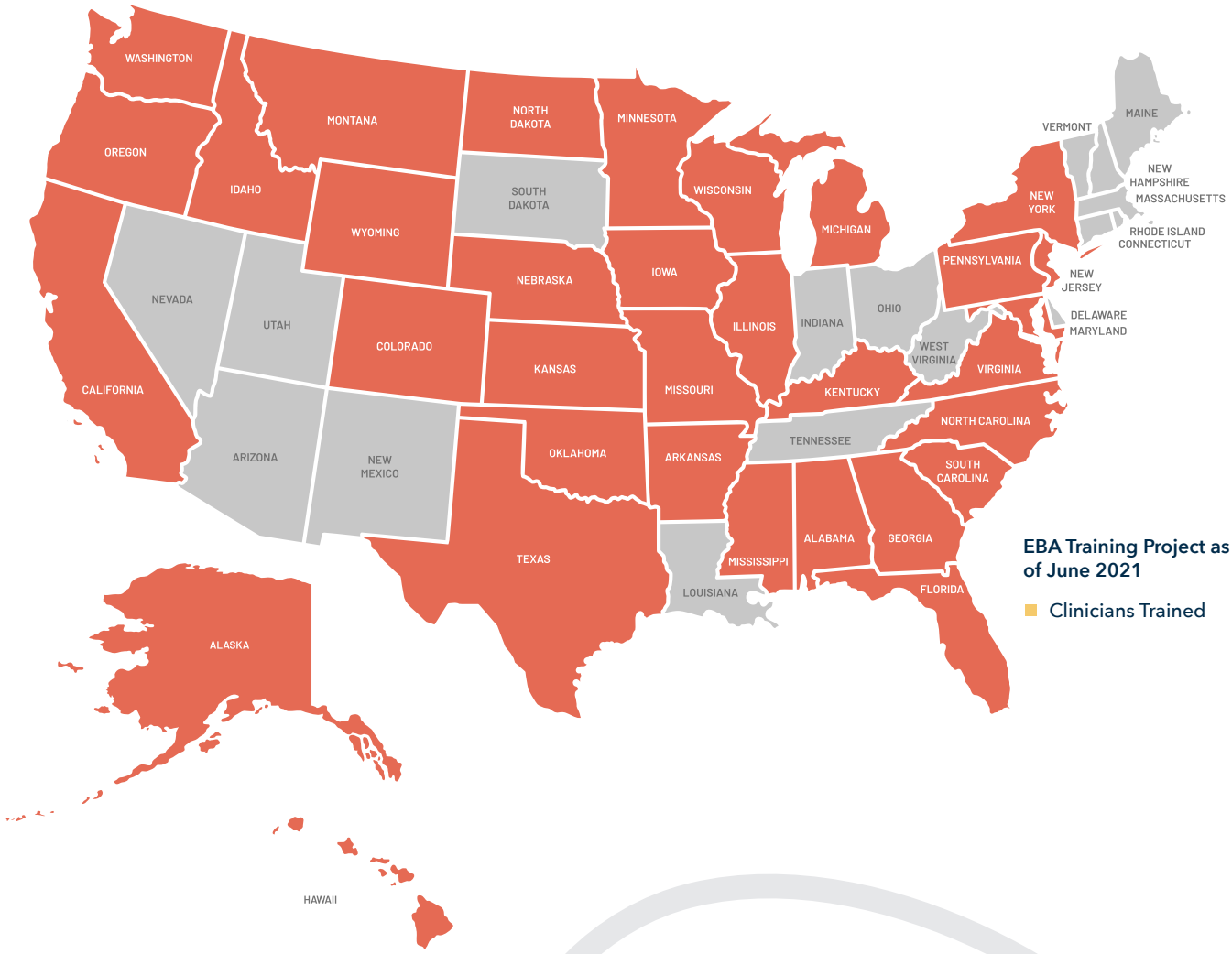
CACs may also use mental health screenings for early identification of the need for mental health services. Screenings are brief and narrow in scope and can be administered by non-clinicians as well as by clinicians. They're not meant to be diagnostic or definitive. Assessments, which are administered only by clinicians, provide a more complete picture and may be used to plan treatment.

CACs have multiple options to choose from for screenings and assessments to choose from. Just limiting our list to the ones used by at least 20% of CACs, we have:

Top Screenings Used in 2020	CAC-Based Services	Linkage Agreement Services	Total
Trauma Symptom Checklist for Children Screening Form (TSCC-SF)	25%	26%	45%
Trauma Symptom Checklist for Young Children Screening Form (TSCYC-SF)	22%	20%	38%
Child and Adolescent Trauma Screen (CATS)	21%	21%	37%

Top Assessments Used in 2020	CAC-Based Services	Linkage Agreement Services	Total
Trauma Symptom Checklist for Children (TSCC)	43%	32%	66%
Trauma Symptom Checklist for Young Children (TSCYC)	34%	26%	53%
Child PTSD Symptom Scale (CPSS)	22%	21%	38%
Child Sexual Behavior Inventory (CBSI)	20%	21%	36%

NCA is collaborating with Baylor University and the University of Texas project to train some 1,100 clinicians on EBAs. The project has so far reached clinicians in 31 states:



CACs and State Chapters that wish to learn more about the EBA project should contact Michelle Miller, Ph.D., LCSW, at mmiller@nca-online.org.

Removing barriers to treatment for families

In our 2019 *Thriving Kids* report and the 2019 *Healing, Justice, & Trust* report for NCA members (login required), we explored the fact that, although EBTs have been proven to help children recover from the trauma of abuse, many families do not take advantage of the mental health services offered at CACs. Why?

CACs most often cite **general barriers**, such as clients dropping out of treatment or caregivers not following up on referrals to services; **perceptual barriers** for clients, such as caregivers believing their children do not need services or not understanding the difference between treatment offered at a CAC and services received elsewhere; **concrete or practical barriers**, such as waitlists for treatment or transportation problems; **difficult finding qualified clinicians**; and **language barriers**.

Top Barriers to Mental Health Services as Reported by CACs

Type of Barrier	2016	2018	2020
Any barriers to mental health services	84%	88%	82%
General client barriers	36%	50%	60%
Perceptual barriers for clients	Not asked	45%	59%
Concrete/practical barriers for clients	41%	49%	57%
Difficulty finding qualified clinicians	29%	33%	37%
Language barriers	19%	22%	31%

When asked directly, however, families who do not access mental health services rarely report concrete/practical barriers. Instead, they tend to list perceptual barriers, such as: They don't feel that their child needs mental health treatment. Or they may prefer to go to an external provider of their own choosing, or make use of faith-based services. These other service providers may or may not offer evidence-based treatments proven to work for victims of child maltreatment, so we can't be sure if they are providing the best quality care for children served by CACs.

Concerned that we weren't reaching enough families with the message that the type of trauma-focused, evidence-based treatment offered by CACs could make a key difference in their child's recovery, NCA partnered with the University of Oklahoma Health Sciences Center (OUHSC) in offering Enhance Early Engagement (E3) Training for victim advocates and family advocates at CACs across the country. The project, which is supported by a National Institute of Mental Health grant to OUHSC, enlisted senior leaders and victim advocates at CACs to study the best methods of training advocates in brief mental health screening, evidence-based practice, identification and referrals, trauma responses, and evidence-based engagement skills, and then determining if that training helped get more children and families get screened and assessed for treatment needs and then start and, most importantly, complete treatment. In 2020, 66 CACs and 159 advocates participated in E3. After receiving feedback from the initial study and groups and incorporating it into the E3 program, we are now training a new group of CACs and will share results with the field when the project is complete.

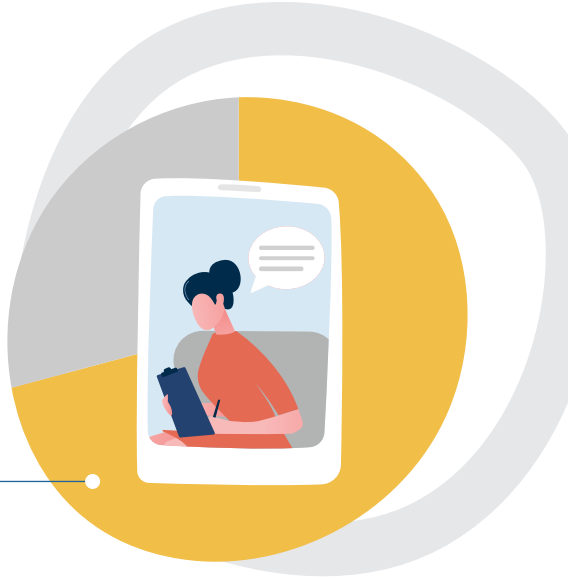
Even for CACs who have not yet participated in the E3 program, NCA has worked hard to educate the CAC field on the prevalence of perceptual barriers based on family feedback from OMS. This is reflected in the 2020 CAC Census through the sizable increase in the proportion of CACs recognizing perceptual barriers, which surpassed concrete/practical barriers for the first time since the Census began. By addressing the barriers that are most important to families, CACs can get more children on the path toward healing.

Telemental health: A bright spot in tough times

Amid a historically challenging year, telemental health—using technology to deliver mental health treatments—emerged as a tremendous asset for CACs striving to deliver crucial services to kids in the middle of a pandemic and long after. Of all the services CACs offer, mental health was the most likely to go remote in 2020.

Telemental health had for some time offered a promising solution to the problem of equitable access to high-quality treatment for kids. However, only a few CACs had such programs before the pandemic suddenly made adoption of telehealth services almost a requirement. Some 71% of NCA Member CACs offered telemental health services in 2020, and 95% of them cited COVID-19 as the reason.

Mental health services are also the teleservice most likely to be retained by CACs after the public health crisis is over, with about 65% of CACs that started such services due to COVID-19 planning to continue after the pandemic is over. The possibilities of delivering services to underserved, low-income, rural, and frontier communities through telehealth should and must make expansion and familiarity with this mode of service a staple for CACs for years to come.



71%
CACS OFFERING TELEMENTAL HEALTH SERVICES

*Data from 2020

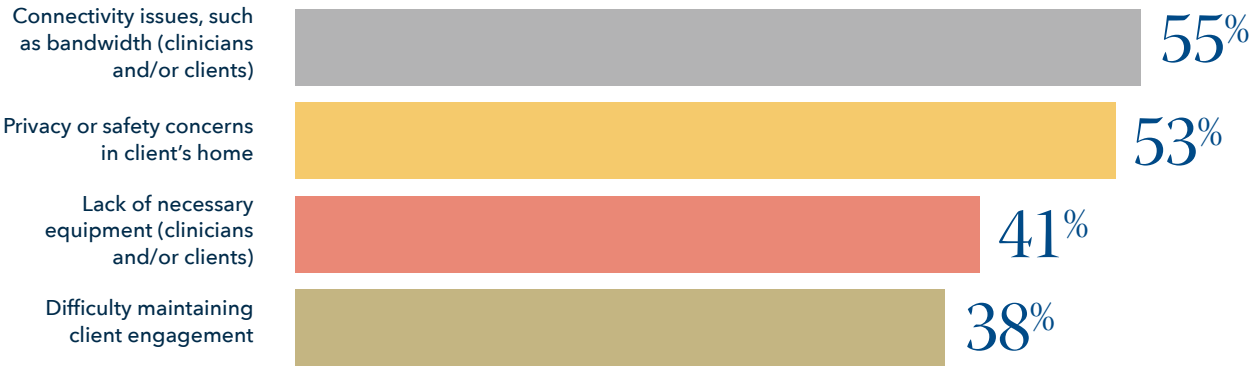
95%
OF THOSE OFFERING TELEMENTAL HEALTH, % CITING COVID-19 AS THE REASON

Breaking through walls with wires

Offering services remotely helped reduce some barriers to treatment. Anecdotally, clinicians told us more kids showed up for their appointments. No-show rates went down; it was easier to connect online than for caregivers to take time off work or get multiple kids out of the house to an appointment. And clinicians were happy with the results they were seeing children gain from the treatment. A recent study, "Feasibility and Effectiveness of a Telehealth Service Delivery Model for Treating Childhood Posttraumatic Stress: A Community-Based, Open Pilot Trial of Trauma-Focused Cognitive-Behavioral Therapy," looked at the effectiveness and feasibility of telehealth delivery of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In the pilot study, of the 70 youth who participated, nearly 89% completed a full course of TF-CBT, and close to 97% of these treatment completers no longer met diagnostic criteria for a trauma-related disorder at posttreatment.

But that doesn't mean technology clears away all barriers to treatment. In fact, in our 2020 Census, **only 14% of CACs that responded said that they had no barriers to telemental health services**.

Most Common Barriers to Telemental Health Services in 2020



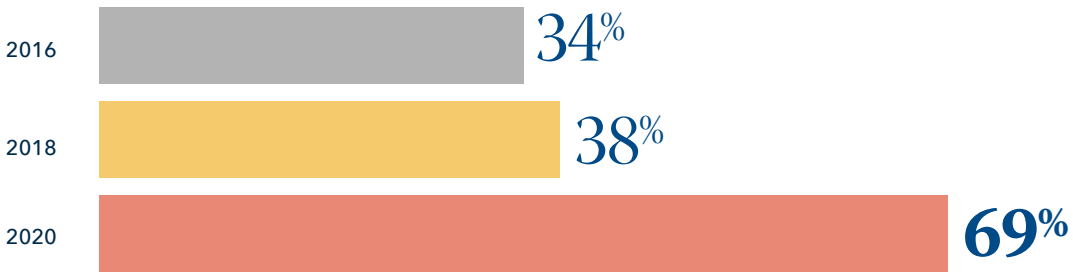
CACs needed assistance to implement telehealth programs—learning how to adapt treatments such as TF-CBT to telehealth delivery, what policies and procedures needed to be adapted, and what equipment and resources were needed to make it work. Some government rules and regulations had to be at least temporarily waived or loosened; for example, the federal government expanded allowable uses of Medicaid to cover telehealth. And, for many communities, access itself is a structural problem: Many very rural communities simply lack stable access to high-quality internet connections, and low-income clients often lack personal access to devices. Structural issues must be addressed comprehensively and creatively to meet the specific needs of the service population.

Moving forward, CACs will continue to need training on implementing and effectively delivering telemental health services. They'll need to learn to assess which kids are well-suited for telehealth treatments and which would be better off with in-person sessions. And other barriers—such as geographic restrictions on clinicians' licenses that can keep a client from a frontier community from connecting with an available therapist in a different state—remain to be addressed. Regardless, telemental health is here to stay.

Ending child-on-child abuse through treatment

Every year, 20-25% of the cases CACs handle involved a child acting out sexually against another child. Yet with proper treatment, as many as 98% of children stop these problematic sexual behaviors. To achieve their goals of healing, justice, and prevention, CACs are doing more than ever before to serve children and youth with problematic sexual behaviors and their families.

CACs Offering Mental Health Services to Youth with Problematic Sexual Behaviors



Many of these kids have their own trauma history to cope with—although clinicians must refrain from jumping to the conclusion that problematic behavior must mean that a child was sexually abused. CACs that serve this population should seek specialized training (such as Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT), which is currently offered by 37% of CACs) for their clinicians and, before implementing a program, consider other factors, such as how to keep the kids safe, and safely monitored, when they're in the building where other children who have been victimized are served.

Several evidence-based treatment models have been shown to make a significant difference in outcomes for kids with problematic sexual behaviors:

- Multisystemic Therapy (MST-PSB)
- Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT) School-Age Program
- Trauma-Focused Cognitive Behavioral Therapy for Problematic Sexual Behavior (TF-CBT-PSB)

Rural vs. Urban

One final note, about mental health services at rural CACs vs. urban. Both groups report similar overall rates for each type of service, with the exception of support groups, which are more likely in urban areas. Urban CACs are, however, more likely to offer services through the CAC (in person or via telehealth technology) while rural CACs are more likely to rely on linkage agreements with external providers.

Mental Health Services Offered & Location of Services	Rural	Urban	National
Crisis interventions	96%	98%	97%
CAC-based	68%	84%	74%
Linkage agreement	46%	38%	43%
Screenings	96%	95%	95%
CAC-based	67%	78%	70%
Linkage agreement	45%	34%	42%
Assessments	96%	99%	97%
CAC-based	57%	73%	62%
Linkage agreement	54%	50%	53%
Evidence-based treatments	98%	100%	98%
CAC-based	54%	71%	59%
Linkage agreement	59%	55%	58%
Support groups	66%	78%	73%
CAC-based	29%	50%	38%
Linkage agreement	44%	43%	44%

Rural CACs tend to have shorter waitlists for community-based services, but in other areas of concern, urban CACs have the advantage, such as in offering more diverse evidence-based treatment types. While both groups offer TF-CBT at similar rates, urban CACs are much more likely to offer CFTSI, PSB-CBT, and CPP, and are slightly more likely to offer PCIT, AF-CBT, and EMDR. Urban CACs are also more likely to base referral decisions on screenings and assessments. And rural CACs report more barriers to offering mental health services overall, except for language barriers, which are much higher in urban areas.

One unexpected difference is in terms of funding. Urban CACs have more diverse funding sources for on-site mental health services, likely due to them having larger donor bases. While one can hope that government funding sources might level the playing field for rural CACs, in practice urban CACs have far greater access to federal, state, and local funding.

Conclusions

In more than 70% of U.S. counties, CACs provide trauma-informed care to children who have experienced abuse. As the trauma experts, CACs are well-positioned to help kids heal using evidence-based mental health treatments. NCA supports and encourages centers to expand treatment menus, use evidence-based assessments, persuade families to participate in—and complete—mental health treatments as needed, and provide services to youth with problematic sexual behaviors. And CACs have risen to the challenge, offering more on-site mental health services than ever before. Finally, while we'll continue to explore which kids are best served by telemental health services and which would be better off meeting with their therapist in person, it's clear that the use of technology to deliver services remotely will play an important role in reaching our goal of making CAC services available to all children in need in the United States. Kids deserve a chance to heal and thrive, and NCA and our members have made it our mission to make sure kids get the expert care they deserve.

Resources for NCA Members

NCA's *Standards for Accredited Members* requires that evidence-based, trauma-focused mental health services, designed to meet the unique needs of the children and caregivers, are consistently available as part of the multidisciplinary team response. Therefore, we offer a range of trainings for members wishing to implement, expand, or improve on-site mental health services, as well as guidance on offering services using telehealth technology. Members can log in to NCA Engage and search the Learning Center Catalog for mental health resources such as the Evidence-Based Assessment training modules, and visit the Learning Center pages for resources on:

- Outcome Measurement System
- Enhance Early Engagement (E3)
- Telemental health
- Problematic sexual behaviors

Or contact Michelle Miller, Ph.D., LCSW, at mmiller@nca-online.org.

This project was supported by Grant #2020-CI-FX-K003 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Department of Justice.

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