2009 Mental Health Practices in Children's Advocacy Center Survey
EXECUTIVE SUMMARY

In late 2008 and early in 2009, under the leadership of Drs. Sandra Hewitt and Elizabeth Ralston and the direction of the Midwest Regional Children's Advocacy Center, a survey of accredited and associate member children's advocacy centers was conducted to ascertain the scope of therapeutic services available to children and families within the membership of National Children's Alliance. The results, in full, are available in the members-only section of the NCA website at www.nca-online.org. There were 382 respondents to the survey, an impressive 47% response rate.

Of those responding, the demographics were roughly representative of the national disbursement of CACs and generally matched national statistics in organizational model, location, and community make up:

- Location of Responding CACs:
  - 41.4% Southern Region
  - 27% Midwest Region
  - 20.9% Western Region
  - 20% Northeast Region
- Organizational Structure
  - Independent Not-for-Profit 70.6%
  - Hospital Based CAC 12.2%
  - Government Based CAC 13.5%
  - Co-located CAC 4%
- Community Size
  - 42.8% Rural
  - 39.6% Midsize or Suburban
  - 17.8% Urban

Respondents were closely split between those who provide therapeutic services by referral (50.6%) and those who provide on-site services (46.6%). Of concern, 2.8% indicate that they provide no such services. The overwhelming majority of providers (80.9%) of mental health providers were practitioners at the Master's level. The credentials of those providing services were primarily MS and MSW.

We were pleased to see that 69.8% of children's advocacy centers indicated that they refer to therapists with documented skills in child abuse. In addition, 64.4% of children's advocacy centers refer to therapists with specialized training in evidence based assessment and treatment. While, of course, we will continue to work to ensure that those numbers continue to trend upward, it is positive that children's advocacy centers are working to ensure that children and families receive specialized care that has been demonstrated to be efficacious. Given the requirement for specialized care in the revised standards for accreditation that will go into effect in January 1, 2010, we have some challenges remaining to support this level of care in the roughly 1/3 of centers yet to achieve that level of service provision. Of more concern, however, given the revised

standards is the absence of written linkage agreements with providers. Fifty-nine percent of children's advocacy centers indicated that they lacked these formalized agreements. Centers, working by referral, lacking such agreements will want to begin working on those in anticipation of the revised standards implementation.

Children's Advocacy Centers are significant brokers of a range of care for children and families. Ninety-four percent indicated that they provide (either onsite or through referral) treatment of the child. Other services include: trauma assessments (58.3%); family/child work (89.1%); child assessment interview (47.1%); and family reunification work (35.9%). Positively, the majority (60.2%) are using standardized measures to gather caregiver input to assess child behaviors. Of course, we would like to see that number continue to trend upward.

Likewise, centers are brokering services to non-offending caregivers. Of those surveyed, 91.9% offered mental health services to non-offending caregivers. Of concern, however, is the effect that the age of the child victim seems to have upon whether or not services are offered. For example, while services are offered to non-offending caregivers 91% of the time when the child victim is older than 13 years of age, that percentage drops to a concerning 61% at age 3 years. This is particularly concerning for three reasons: 1)research clearly indicates that the greatest long-term predictive factor in child wellbeing is the level of emotional support they receive from the non-offending caregiver; 2) that largely derives from the level of support the non-offending caregiver receives from both informal and formal support systems (of which mental health intervention is one source); and 3)those young children, most reliant on non-offending caregiver support, are less likely to receive ongoing services through the CAC—particularly if they are unable developmentally to complete a forensic interview.

Another area requiring additional inquiry relates to what happens when a child does not make a clear disclosure of abuse during the forensic interview. Thankfully, in 86% of responding CACs, the therapist provides additional services. However, children's advocacy centers seem unclear about how to provide services to very young children. Developmentally, children ages 3 years and younger cannot complete a forensic interview. And, children age four are certainly challenging in this regard, with many developmentally incapable of doing so. Yet, when surveyed, 37% of surveyed centers were attempting to complete forensic interviews with children under age three, 57% were attempting to do so with three year olds. This may be because children's advocacy centers are understandably concerned about these children—as is National Children's Alliance—but may not be aware of other child abuse protection and intervention protocols that forgo an unlikely prosecution but secure safety for the child. When asked what happens to children three years of age or younger when there is a concern of abuse, there were 13 pages of responses. Unfortunately, many of these responses were unlikely to yield increased child safety or protection. National Children's Alliance will continue to explore this as an area of concern for system improvement.

Challenges and barriers to mental health service provision were noted by survey respondents. Primarily these were noted as cost, transportation, and willingness of family

to participate in treatment. Survey respondents also indicated that more mental health personnel are needed (73.1%), and that more training for mental health professionals is needed (71.1%). On a positive note, however, 95.9% of respondents stated that their mental health providers would be interested in further education and peer review/journal club (76.6%).

In summary, Children's Advocacy Centers both provide services directly and act as significant brokers for a comprehensive range of mental health services. The majority of such providers have specialized child abuse experience and training in evidence-based treatment modalities. Furthermore, our centers encourage and provide caregiver support. However, gaps in services—particularly to very young children—exist. And, barriers to services include both difficult systemic problems such as transportation and cost and a perceived lack of training for providers. National Children's Alliance is committed to continue to encourage better practice in mental health service provision through its grant-making and training partnership with NCTSN. Centers may wish to access the extensive training resources available through the National Traumatic Stress Network at www.nctsn.org. In addition, they will want to consult the recently published "CAC Director's Guide to Mental Health Services for Abused Children" available on the NCA website at www.nca-online.org in the members-only section for suggested guidelines for implementation of better practices. Requirements for mental health service provision under the Revised National Standards for Accreditation are likewise available on the NCA website.

To view the survey click here