CRIMES AGAINST CHILDREN RESEARCH CENTER

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# Improving Access to Mental Health Services for Abused Children in NH: System Recommendations for CACs

## Summary Report

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The New Hampshire Endowment for Health awarded the University of New Hampshire a planning grant in 2008/2009 to identify ways that NH Child Advocacy Centers' (CACs) could increase their capacity to link child abuse victims and their families to evidence–based mental health services.

Child Advocacy Centers (CACs) are community partnerships designed to coordinate multidisciplinary investigations of child abuse and other child victim crimes. The CAC team typically includes law enforcement, the County Attorney's Office, the Division for Children, Youth and Families (DCYF), victim advocacy agencies and the medical and mental health communities. In addition to coordinating the forensic interview, CACs try to link the child and family to needed therapeutic and support services. There are currently ten CACs in New Hampshire.

As a part of this project, ten planning meetings were conducted with key stakeholders (i.e. CAC, DCYF, crisis center victim advocates, medical professionals and community mental health centers) across the state to discuss strengths and gaps in efforts to connect child abuse victims to needed mental health services in their community. A total of 67 participants attended. Below, we summarize the results and recommendations extending from this project.

## Strengths

The planning meetings identified several critical ways that CACs across NH communities are helping abused children access effective mental health treatments:

CACs have good connections with their local community mental health centers and therapists trained in evidence-based treatment for traumatic stress. All community mental health centers have access to training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) provided by Dr. Stanley Rosenberg's program through Dartmouth Hitchcock Medical Center (DHMC). This is an enormous benefit to the children of New Hampshire. TF-CBT has extensive and documented evidence of effectiveness in treating symptoms of traumatic stress. However, the number of trained therapists varies by region. Additionally, in several locations providers mentioned concerns that TF-CBT was only applicable to a small percentage of cases. There appears to be a need for: 1) more education about adapting TF-CBT in less-than-ideal cases; and 2) training in other evidence-based treatments appropriate for younger children and for multi-problem families with weaker caregiver support. New training efforts are currently being planned by DHMC.

It was also clear across the planning meetings that CACs have strong relationships with their community mental health centers, with some mental health centers triaging or "fast-tracking" referrals from the CAC. As part of these collaborations, some therapists mentioned that they appreciated how the court burden was mostly taken off their shoulders because they did not have to conduct forensic interviews. However, in other regions, the fear of the court process was described as a disincentive for therapists to work with child abuse cases, something that those CACs were struggling with.

CACs have strong partnerships with their local crisis centers. Nearly all the NH CACs have access to staff or volunteers from a partner crisis center who sit with the caregiver during the child interview to answer questions, assess concerns, and discuss service needs upon leaving the CAC. Some advocates provide follow-up with the families and will call the family if the family agrees. Advocates that provide follow-up services will help families to work through possible barriers to accessing mental health treatment as well as identify other services the family might benefit from. The state-wide relationship between the CACs and the victim advocacy agencies in New Hampshire is a unique and innovative model not commonly found in other parts of the country.

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## Innovative Practices

In addition to strengths that were common across NH communities, there were also some innovative practices that were in place or being set up in individual communities that could serve as models or examples to other regions:

Making a direct mental health referral for the family. The Strafford County CAC and Community Partners, the local community health center, have initiated an expedited referral process that allows the CAC staff to call with a referral, either with the family present or afterwards with their permission, to let the contact person know about the issues involved with the child and family. An intake appointment is set up and families are directly contacted by the mental health center within 1-3 business days to set up a first session. This process allows for outreach without requiring the caregiver to call the admissions line and take the first step.

At the Grafton/Sullivan CAC parents regularly sign a release of information form and the CAC helps make the referral for mental health services. The CAC will talk with the intake coordinators at the local community mental health center, West Central Services, who then calls the family to set up the appointment. The CAC also calls the family within two weeks to make sure they understand the process and see if they have any questions.

Finally, the Monadnock Region CAC also makes the first contact to the mental health center. The CAC will talk with the intake coordinator about scheduling. If the center has trouble getting in touch with the family, they may call the CAC to help. The CAC regularly gets releases from caregivers to talk about the case with the crisis center and other agencies and allows direct information sharing about cases.

Establishing a family advocate position. Beginning in September 2009, the Rockingham County CAC created a family advocate position. The family advocate provides crisis intervention and short-term case management to assist families in connecting with long-term supports such as mental health treatment. The position was funded by Sexual Assault Support Services (SASS), the area victim crisis center with input from a multidisciplinary group including representatives from the community mental health center, the local rape crisis center, medical professionals, and DCYF.

Providing free parent education groups. The Hillsborough County CAC has previously offered Family Education Sessions available to the community. These meetings were set up for any caregiver who has had a case come through the CAC, as well as interested parents from the community. The meetings were offered one time a month at the CAC. Parents who came to the CAC received a letter about it when they left the CAC and staff called them 1 week before the meeting to remind them about it and ask if they were coming. Flyers about the meetings were posted at Head Start and DCYF as well. The presentations consisted of a general information session about what parents can expect from children who have been abused, how to be on the lookout for abuse, and information about offenders and grooming behavior.

## Barriers and Gaps

In addition to strengths and innovative practices, the ten planning meetings also identified a number of critical gaps where more attention is needed to link victims to mental health services.

CACs and community mental health centers struggle to help parents overcome personal and emotional barriers to helping their children access treatment. Participants in nearly all the regional meetings identified that caregivers are a critical partner in getting children into mental health services. Caregivers often do not understand the process or benefits of therapy. The stigma of mental health treatment can be a problem as well. For some families, it is shameful to admit that someone in their family needs mental health services. It was also commonly reported that many of the parents were sexually abused themselves and may have not received adequate treatment or may have a false, negative perception of the mental health system.

Lack of case tracking and information sharing. Meeting participants also discussed the lack of data on which families follow through on obtaining and completing recommended mental health treatment. Because this information is not available, it is hard for many CACs to estimate the size or nature of the referral-service gap for their clients. In a few areas of the state, procedures for obtaining releases of information between the CAC and mental health provider have become routine, but in other areas such releases are less common.

In most communities there is limited follow-up with families to help facilitate connection with referrals and address barriers. The literature recommends having a professional assist families in making mental health appointments. This is thought to increase the likelihood that an intake appointment will be set up. CACs should consider ways in which this can be integrated into current CAC services and their relationship with partner mental health centers and providers.

The need for more evidence-based services specific to treating child sexual abuse victims and their families. Access to adequate numbers of therapists trained in TF-CBT varies greatly by region. Furthermore, many participants noted that this structured therapy requires both children and caregivers to participate and is therefore not appropriate for all children. Participants also mentioned the lack of available and affordable treatments and services for parents. If parents have unmet mental health needs, it makes it that much more difficult to address their children's mental health needs. A theme

across meetings was a shortage of services available that fit what parents and children need.

## System Recommendations

New Hampshire CACs, like service and non-profit agencies everywhere, struggle financially and need suggestions that will require few additional agency resources. We have included many such recommendations below. However, it is also recommended that CACs and their partner agencies consider more substantial efforts to improve children's mental health treatment as a component of planned organizational growth. We have therefore structured the recommendations stemming from this planning grant based on different levels of required resources.

### Few additional resources needed

1. Facilitate mental health referrals for parents. Many CACs seeking to improve the mental health referral linkage process for children and families have set up procedures where they initiate the referral for the family. A referral form or phone call is completed by the CAC and the mental health professional or agency then contacts the family to set up an intake. We recommend that this be a systematic process for as many families as possible.

2. Routinely obtain release of information from parents. In order to provide a comprehensive system response, team members need to have information about families' success in obtaining and complying with recommended treatments. We recommend that the CAC or the partner mental health agency develop procedures for routine release of information between the MDT and the mental health provider so that all agencies can fully share appropriate information by phone and at case review.

3. Set up triage agreements with mental health providers. Such agreements would allow children from the CAC to be prioritized and moved to the top of mental health agency waiting lists. Agreements could also specify a direct contact person at the mental health agency who could be relied on to help facilitate referrals.

4. Help educate MDT members about the importance and availability of evidence-based mental health treatment. The chances of children and families connecting with services are increased when multiple members of the team are checking in about mental health needs and are aware of evidence-based treatments available in the community. There are different ways that CACs could increase team members' knowledge about mental health treatment including discussions, articles, trainings, memos, and websites.

5. Initiate and improve case tracking efforts. Although CACs have a case tracking system in place that has the capacity to collect detailed data on mental health referrals and access, there is minimal use of the system for this purpose. This can partly be attributed to limited resources, but some changes in procedures and better interagency communication would also improve use of the data-tracking system. Such data provide information about which children and families are falling through the cracks and not obtaining needed services, important information both at the case-level and for informing program development.

### Moderate resources needed

1.) Develop practices and programs to educate caregivers and community professionals about trauma and mental health treatment. Because parents often have a difficult time dealing with the alleged abuse of their child, more help is needed to help parents handle the perceived stigma as well as their own mental health issues. Most CACs provide parents with informational packets and there may be ways to draw on mental health partners' knowledge to improve these. CACs or crisis centers could provide psycho-educational or support groups to help inform parents about some of the symptoms their children may be having. CACs could also partner with schools to help educate parents and professionals about trauma in children in general.

2.) Follow-up with families to problem-solve barriers to services Many of the NH CACs and/or crisis centers make an effort to follow-up with families 1-2 weeks after they have been to the CAC. However, due partly to resource limitations, most families are missed or can't be reached and phone messages are left. Families would likely benefit from extended efforts to make sure all families are reached by phone and a brief protocol followed to assess parent and child functioning, and emphasize the importance of following up on mental health referrals.

3.) Help to minimize barriers for parents to access educational, support and mental health services. This could include gas cards, transportation to services, playroom with supervision for other children, and payment for adult mental health services.

### Substantial resources needed

1.) Increase the number of mental health providers trained in evidence-based mental health treatments for child abuse victims and innovative ways of delivering such services. While NH has benefitted substantially from the efforts of Dr. Rosenberg to increase the number of providers of TF-CBT, more work is needed to increase the number of treatment providers of this and other evidence-based therapies in each community. CACs can partner with mental health agencies and DCYF to identify and promote additional evidence-based treatment models, for example, treatments appropriate for younger children, or treatments for children in chaotic and minimally supportive home environments. They can also support ways to establish evidence-based treatment programs in

non-clinical settings, such as schools.

2.) Increase mental health treatment options for non-offending caregivers. Many parents of child sexual victims are often dealing with their own mental health issues, including trauma histories. However, health insurance will not always pay for parents' mental health services and typically parent treatment options are limited. More services are needed to help parents address their own mental health needs.

3.) A family advocate to provide care coordination for CAC children. Many CACs nationally have a family advocate or other care coordination staff position to follow-up with families after they have been to the CAC, provide education and support after some of the immediate crisis of disclosure has passed, and work with parents to navigate the barriers to obtaining mental health treatment for their children or themselves.

4.) A mental health professional on-site or funded through the CAC. A mental health professional at the CAC could administer clinical screening and assessment tools, provide short-term crisis treatment, and administer comprehensive referral protocols for long-term services or treatment.

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