Ensuring the

Well Being of Children

A Comprehensive Approach to Trauma-Informed Care for CACs

NATIONAL CHILDREN'S ALLIANCE®

northeast regional children's advocacy center

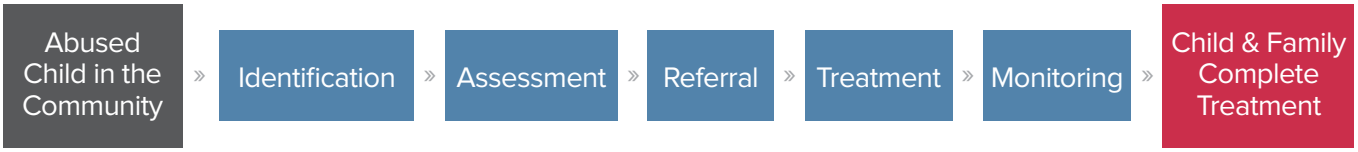
Service Delivery Pathway

Multidisciplinary team (MDT) partnerships are at the core of CAC activities. Just as CACs coordinate services among multiple MDT agencies working with investigation, child safety, and prosecution, it is equally important to coordinate the various agencies working to address children's mental health needs. Shared responsibility for the safety, permanency and well being of children within the child welfare system require each professional discipline to identify what they are willing to give and what they need to receive. One of the needs to create a process of shared responsibility is to describe and define the respective roles of each different discipline. Notably, the mental health representative on the MDT is not always the best team member to engage in all steps of the Coordinated Response Pathway, as each discipline demonstrates unique strengths and areas of expertise.

Brokers of mental health services, such as child welfare workers and CAC Family Advocates, are in an excellent position to identify children in need of further mental health assessment. In some communities, these members of the MDT also are trained to conduct mental health screening.

CAC Directors are in a position to consider what services are available in their communities, develop services in their communities, and work with leaders of their MDT partner agencies in order to reduce duplication and improve coordination across the steps of mental health service delivery.

Coordinated Response Pathway



Identification

The first step in responding to a child victim of abuse is identification. How do children who have been abused in your community come to the attention of your MDT members and CAC? Although various adults such as teachers and parents are in a position to recognize child victims, when a concern regarding the maltreatment of a child is identified, the following actions are used to determine specifics regarding that concern in order to rule it out or clarify the risk:

Child Protective Services is mandated to respond regarding child safety

•

Law Enforcement investigates to determine if a crime has been committed

A Forensic Interview, with MDT input, is conducted at a Children's Advocacy Center

•

The Multidisciplinary Team reviews the case to integrate gathered information and to make decisions regarding the allegation

When a child is identified as having been abused, the focus shifts from investigation to identifying services that address future safety, permanency and well-being of the child and family.

The Need for Comprehensive Screening & Assessment

TRAUMA SCREENING

Research tells us that single forms of child abuse, such as child sexual abuse, rarely occur in isolation. Instead, children who experience one type of abuse are at high risk for having experienced other types of traumatic events. One study shows that children served by a Children's Advocacy Center report an average of 4 different types of traumatic events. (Swiecicki et. al., 2011) As a result, a comprehensive screening for a history of other potentially traumatic events is helpful in identifying whether or not previous instances occurred, if those experiences play a role in the identified abuse, if they impact a child's response to that abuse, and what interventions may be needed as a result.

•

A traumatic event screen can be integrated into on-going treatment as an appropriate part of the history-taking that is critical to any assessment of risk. Child Protective Services workers and other brokers—such as family advocates or mental health professionals integrated into the CAC—are in an excellent position to conduct this screening as they are familiar with the child and family. The trauma screen involves asking both the child and caregiver about exposure to potentially traumatic events that include:

Abuse

•

Dynamics within the family including death, illness, and separation

Violence within the family or community

•

Natural disasters such as floods, fires, and hurricanes.

This information is critical to understanding family and child history and in assigning services needed through community response. Recommended trauma screening tools include the Harborview Trauma Screen *http://goo.gl/gVIPS2* (University of Washington Harborview Medical Center, 2012) and the Traumatic Events Screening Inventory-Child *http://goo.gl/5Ufgsh* (TESI-C; Ippen et al., 2002).

ASSESSMENT

When the child and or caregiver identify potentially traumatic events experienced by the child or family, the next step involves completing a mental health assessment to determine if those events did in fact result in trauma-related symptoms. Assessments are more comprehensive than screenings and, most often, are conducted by licensed mental health professionals.

•

Child maltreatment victims are at risk for a host of trauma-related emotional and behavioral problems. The most common symptoms usually fall into two categories: internalizing and externalizing. These include such problems as depression, anxiety, PTSD, behavior problems, nightmares, defiance, attention problems, and others. However, many child-serving professionals are surprised to learn that not all children who have experienced abuse develop symptoms. Traumatic experiences may be managed by a child due to their own resiliency and/or to the support they receive following the abuse.

•

The Quick Reference Guide to Evidence-Based Mental Health Treatments for Child Maltreatment Victims lists several standardized measures that are helpful for CACs and their teams in identifying the presence, severity, and form of post-trauma symptoms. Recommended symptom measures include:

Mood and Feelings Questionnaire (Angold & Costello, 1987)

•

Strengths and Difficulties Questionnaire (Goodman, 1997)

Child PTSD Symptom Scale (Foa et al., 2001)

•

UCLA PTSD Reaction Index (Pynoos et al., 2002)

Externalizing symptoms are more easily seen by others, such as behavior problems, aggression, defiance, and opposition. When these symptoms began or worsened after the child's trauma experience, they are considered to be "trauma-related symptoms."

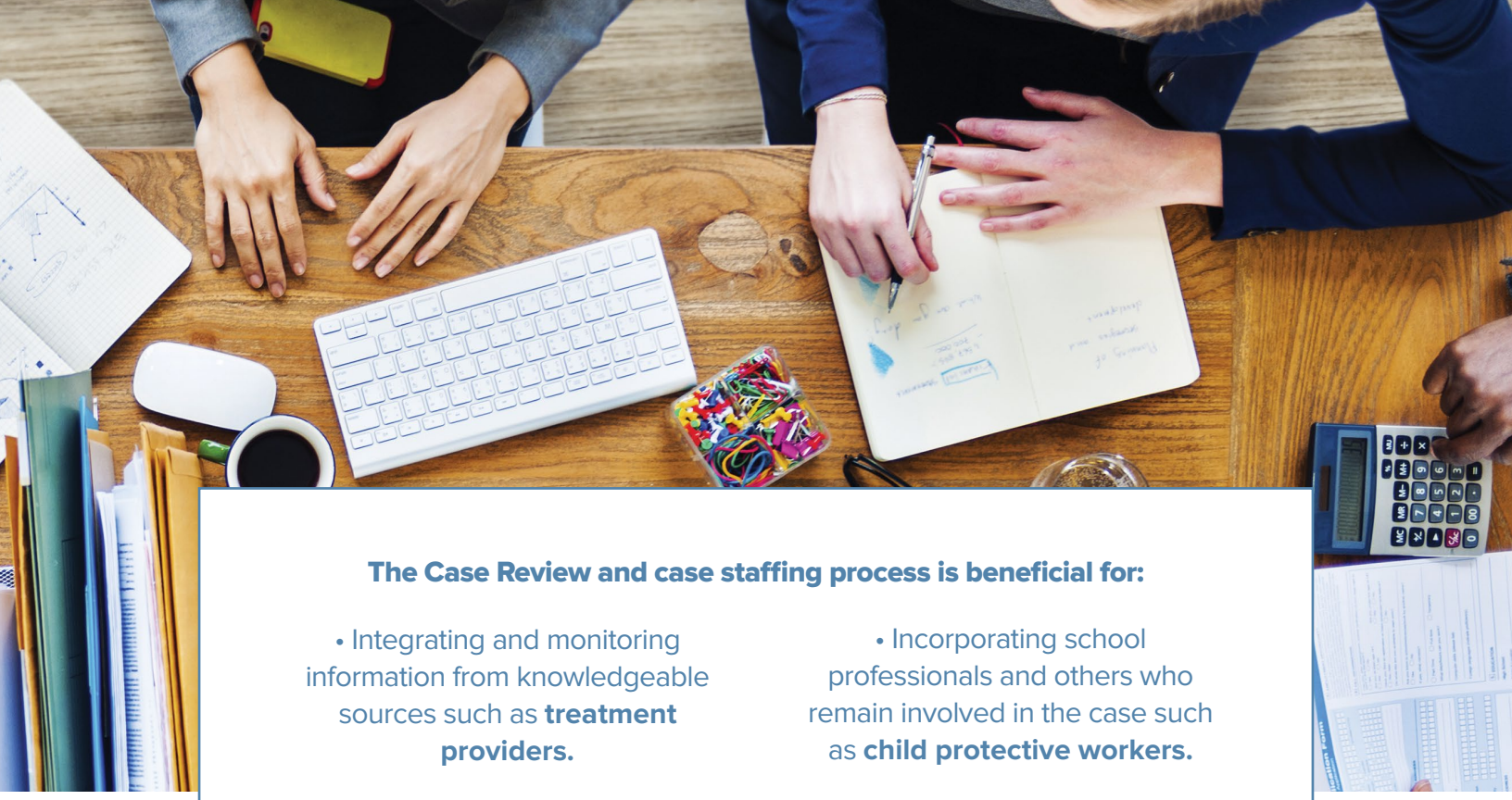
•

Internalizing symptoms are usually things that are harder for other people to see, such as sadness, nervousness, intrusive thoughts about the abuse, and fears.

Putting the Pieces Together:

Multidisciplinary Team Case Review & Staffing

Multiple community professionals are involved in gathering assessment information and family history. The core of the CAC remains multidisciplinary collaboration, and the sharing and integration of information related to children's mental health needs is best accomplished through a meeting of multidisciplinary professionals. As the MDT expands its focus to include the mental health treatment needs of the child, expansion of the MDT to include other relevant, knowledgeable professionals is necessary. In the early response phase, the Case Review can be a place for MDT members to share information about the child's history, symptoms, and needs of the family in order to make a referral to an evidence-based treatment, if this is appropriate.



The Case Review and case staffing process is beneficial for:

- Integrating and monitoring information from knowledgeable sources such as **treatment providers.**
- Incorporating school professionals and others who remain involved in the case such as **child protective workers.**

This integration and collaboration can be extremely helpful for achieving positive outcomes for the child and family.

The decision regarding which EBT to refer a child and family to is made based on a series of factors including:

The child's history

•

Symptoms

•

Referral criteria for treatment intervention.

•

Criteria often includes age, behavior and other factors determined to be most appropriate for the given treatment.

The MDT case review and case staffing process is helpful both for identifying appropriate treatment and as an ongoing mechanism for ensuring that treatment remains appropriate and the child is progressing through treatment.

What are Evidence-Based Treatments (EBTs)?

National Children's Alliance National Standards for Accreditation require that trauma-focused, evidence-based treatments (EBTs) are available to all CAC clients. In the field of mental health treatment research, "evidence-based treatments" are those therapies that have been extensively studied and repeatedly shown to be effective in reducing a specific symptom or behavior.

•

One might expect that all therapists provide evidence-based treatments, but there is a great deal of inconsistency in the use of treatments among community practitioners. Therefore, brokers are in a unique position to be informed consumers of services and to connect children with treatments that are proven to help with their specific symptoms.

Evidence-Based Treatments

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino & Deblinger, 2006), has the highest evidence base in reducing children's internalizing symptoms and has been shown to have moderate effectiveness in reducing children's externalizing 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. TF-CBT is appropriate for children ages 3-18 and their non-offending caregivers. It was first developed for children with histories of sexual abuse or of witnessing domestic violence, and has been extended for use with children with related trauma symptoms.

Parent-Child Interaction Therapy (PCIT; Eyberg, 2005) was developed for caregivers and children ages 2-7 who have disruptive behavior disorders. PCIT is an excellent treatment option for young children with predominantly externalizing symptoms. 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 caregiver abuse and risk for further abuse to occur.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT; Kolko et al. 2011) was developed for caregivers and children ages 6-adolescence who have a history of caregiver physical abuse or coercive parenting practices. Two randomized 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. Further, parents who receive AF-CBT demonstrate significantly greater decreases in the use of physical discipline and in anger at post-treatment as compared to those in routine community care.

Common Components of EBTs

The evidence-based treatments listed previously have several elements in common. It can be helpful for brokers to know these elements, and to know the training required for therapists to be proficient in them. This knowledge helps brokers ask questions to better understand a given therapist's use and adherence to an evidence-based treatment.

•

All of the described treatments include both children and caregivers in the treatment process. For TF-CBT and AF-CBT, children and caregivers have individual sessions, and some sessions are held jointly. For PCIT, most sessions involve both child and caregiver together.

•

Each of the three treatments involves skill building, or teaching the child and caregiver ways to manage symptoms. This can involve teaching skills for managing physical symptoms, distressing thoughts, or disruptive behaviors.

•

The treatments are structured and follow clear protocols. They typically include weekly sessions and last between 12 and 20 weeks. Therapists who are trained and proficient in these treatment models typically follow three steps:

1. Reading introductory material (or completing an introductory web course),
2. Attending a multi-day in-person training with a certified trainer in the model, and
3. Receiving ongoing case consultation in the model, typically for 6- to 12-months. Some treatments have additional requirements to become certified in the model, such as completing a knowledge test.

Monitoring Treatment Engagement and Progress

ENGAGEMENT

It is critical to involve the MDT and the family in identifying potential barriers to the successful engagement in, and completion of, the treatment interventions. Some barriers are tangible such as transportation and time. Other barriers may be more attitudinal or psychological, such as a history of unhelpful or unpleasant therapy. Whatever the barrier to success, the MDT is in an excellent position to resolve those barriers to engagement and participation. Creating a treatment plan that has too many requirements, or that is doomed to fail from the start due to tangible barriers, sets the family up for failure. Victim advocates at CACs are in an excellent position to assist and encourage engagement in treatment through connecting families with the resources of multiple agencies so that they may overcome tangible barriers to success.

TREATMENT PROGRESS AND COMPLETION

Once a plan has been developed, a referral is made, and the client is engaged in treatment, it is critical that the MDT professionals who are involved regularly collaborate to monitor participation and engagement in treatment and to examine and track progress in reducing the child's symptoms. This regular monitoring provides opportunities to identify and overcome new barriers to participation and to alter or change the plan as needed according to the responses of the child and family.

MDT's have effectively used the Case Review process in monitoring the investigative and prosecution process through Children's Advocacy Centers. This same process serves the goal of coordinating and monitoring the treatment process for clients and of providing the services and support needed for success. Similarly, the MDT Case Review is a place for the professionals involved in the case to learn about treatment completion. Just as the findings from Child Protective Services investigations and prosecution are reviewed at the MDT Case Review, a discussion of the treatments progress and results from pre- and post-treatment assessment measures can be helpful for closing out the mental health component of the MDT response for each child and family and for offering information to MDT partners who make decisions about placement and reunification.

Summary

When children have experienced abuse, their needs are multi-faceted. As multidisciplinary coordinators of child-serving professionals, CACs are uniquely positioned to help identify those children in need of treatment and make referrals to evidence-based treatments that are proven to reduce trauma symptoms.

Further, through the MDT Case Review process, CACs can track progress in treatment and target barriers that may interfere with treatment completion. When there is a concern for abuse of a child, CACs are resources in which children and families can receive answers to initial questions, as well receive the support needed to heal.