Mental Health Connections For Children's Advocacy Centers

A Newsletter for CAC staff who do not have a mental health background! - Early Winter 2012

"Get the Bad Guy AND Help my Child"

Most parents probably bring both of these expectations with them to the CAC. For CAC professionals, it can be a challenge to help parents (and sometimes MDT members) differentiate between the forensic process (Get the Bad Guy) and the mental health intervention (Help my Child). It is essential that CACs balance both of these priorities. This edition of Mental Health Connections contains articles and resources designed to help equip CACs to "Help the Child," meaning; navigate some of the complexities of providing mental health services within a forensic environment.

Got Questions?

About the provision of mental health services in your CAC?

Contact SRCAC!

www.srcac.org

1-800-747-8122

Inside this issue:

If you have topics or questions you would like covered in future editions of this newsletter, please email:

khangartner@nationalcac.org

SRCAC Core Training Schedule for 2012

TEAM FACILITATOR 101

May 23—25

This training is for Children's Advocacy Center staff/multidisciplinary team members wishing to enhance their skills as facilitators of team meetings as well as ongoing team communication and relationships. The three-day session will provide individuals charged with the responsibility for facilitation of their local multidisciplinary team with specific skills intended to enhance participatory discussion that involves all team members.

Registration fee: $49

CAC MANAGEMENT TRAINING

June 26—29

This training is designed to meet the specialized training needs of individuals who have primary responsibility for the day-to-day operation of a Children's Advocacy Center. Topics covered include *strategic planning, grant writing, financial management, legal and legislative issues,* and more.

Registration fee: $49

ACCREDITATION BOOT CAMP

August 14—15

This training is for CACs who are applying for accreditation and re-accreditation membership to the National Children's Alliance. The two day Boot Camp focuses on understanding the accreditation process, NCA standards, the accreditation packet, your role in the site visit.

Registration fee: $49

MEDICAL TRAINING ACADEMY

November 1—3

This training is specifically designed for medical professionals who have the responsibility for providing the medical evaluation for children who are suspected victims of child abuse. Topics to be covered include: *role of the medical provider, evaluation and diagnostic approach of child physical and sexual abuse, documentation and inter-pretation of findings, diagnostic dilemmas, testifying as the medical expert.*

Registration fee: $199

Go to www.srcac.org to register.

SRCAC may provide up to $300 in travel assistance for these core trainings for CACs in the southern region.

Trauma Assessments

Where do I find them?

The National Children's Alliance standards for accreditation requires specialized trauma-focused mental health services for the child client. These services include conducting trauma-specific assessment including a full trauma history and the use of standardized measures (assessment tools) initially and periodically. There are so many assessments out there with so many acronyms, how do you go about finding out if your mental health provider is using the appropriate tools that meet the standard? You go to CALiO! There is a fantastic article that clearly outlines what assessment tools are available, including target population, purpose, description, and psychometric properties. The citation for the article can be found below as well as a link to access the article.

Strand, V.C., Sarmiento, T.L. & Pasquale, L. E. (2005). Assessment and Screening Tools for Trauma in Children and Adolescents: A Review. *Trauma Violence Abuse 6:* 55-78.

http://libsys.uah.edu:7085/content/6/1/55.full.pdf+html

NOTE: The UCLA PTSD Index mentioned in the article is a FREE assessment tool!

The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study

Must Read Research Article

Great to pass on to your mental health provider, too!

This research project followed the lives of 84 sexually abused girls over a 23 year period and looked at the effect their abuse had on them at different points in their development. Of course, it can be found on CALiO.

Trickett, P.K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology. 23,* 453-476.

Contact the Child Abuse Library Online (CALiO)

National Children's Advocacy Center
210 Pratt Avenue
Huntsville, AL 35801
Email: library@nationalcac.org

Managing a Mental Health Component When You're Not a Tree-hugger

Dan Powers, LCSW
Sr. Vice President of Clinical Services
Children's Advocacy Center of Collin County
Plano, Texas

You don't need to be an CPA to ensure you have the right people paying the bills. You don't need to be a tree-hugger to manage a Mental Health component in your CAC. Most people understand that children who experience abuse need some type of "therapy" to combat the negative emotional and behavioral responses following abuse and other traumatic events. The CAC Director should have basic knowledge of trauma informed approach to treatment in order to provide administrative oversight to the mental health component of your CAC.

The CAC Director should have basic knowledge of trauma informed approach to treatment in order to provide administrative oversight to the mental health component of your CAC.

CAC directors are tasked with assuring resources can meet client needs. Externalizing mental health services is often kind to your budget, but you lose a considerable amount of control and they may not play nice with your team. Having an internal mental health component brings up budgetary, staffing and space challenges, but you gain control and the ability to assimilate them into the team.

Managing a mental health component changes the rules a bit. Licensed mental health providers (LPC, Social Work, Psychology) have their own rules and ethical standards. Confidentiality is the issue most discussed. Mental health providers can be a great resource to the team, but are often unable to freely share all information and records. Clients receiving mental health services require additional paper work and consent for services. When utilizing outside resources for mental health services an MOU (indicating that they agree to be part of the team) and standard client release of information would be needed so those clinicians can share information with the MDT. It is crucial that clients are aware of and agree to sharing mental health information with the team.

Mental health professionals that provide services to victims of child abuse should understand that the potential of going to court is part of the business. Agency's informed consent for services should outline that possibility. Subpoenas are handled differently in order to comply with state law and HIPPA requirements and CAC directors need to be aware of that. A court order may be necessary in order to release specific types of mental health information.

There are a lot of therapists out there. There are a lot of therapists out there who say they see kids. CAC directors that are familiar with evidence based, trauma focused treatment are better equipped to engage a treatment provider who has the experience and knowledge to be a member of the team. Even if you have a great therapist on staff, wellness and professional development of that therapist is dependent on good clinical supervision. Ensuring that any treatment provided includes an evaluative component will help a director monitor quality and effectiveness.

When considering a mental health program, a clinical supervisor will be the most important decision you can make. This can be a staff member or contracted consultant. The clinical supervisor will be responsible for clinical operations (policies and procedures). Supervision of mental health professionals takes on a different tone than that of other employees. It addresses administrative issues and the intense feeling often involved in treating traumatized children. Clinical supervision in an interactive process involving both process and FEELINGS! Regardless of your choice, this supervising clinician must have extensive knowledge of trauma informed therapy and develop a strong relationship with the CAC director.

When considering a mental health program, a clinical supervisor will be the most important decision you can make.

Elements of Supervision

So now, you not only have to broker correct trauma focused, evidence based mental health services, you have to find the right clinical supervisor too?! Does the "to do" list ever end for the ED of a CAC?

Sommer and Cox (2005) interviewed sexual violence counselors and suggested elements of supervision that were helpful such as:

- Talking about the effects of the work and addressing related personal feelings.
- The importance of directly addressing vicarious traumatization in supervision.

Additionally, participants in this study discussed issues related to supervision that were harmful including:

- Supervision not being a priority for the supervisor and the agency.
- The supervisor also being the "boss".
- Lack of instruction on self-care strategies.

Just food for thought and a topic for discussion with your mental health provider. Find the complete article on CALiO.

Sommer, C.J. & Cox, J.A. (2005). Elements of supervision in sexual violence counselors' narratives: A qualitative analysis. *Counselor Education and Supervision, 45(2),* 119-134.

Free Resources

CAC Directors Guide to Mental Health

Download FREE!

http://www.nationalcac.org/southern-regional-child-advocacy-center/about-srcac.html

National Child Traumatic Stress Network

The Promise of Trauma-focused Therapy for Childhood Sexual Abuse

A video which was developed to provide information about the impact of child sexual abuse, to emphasize the importance of including parents/caretakers in treatment, and to highlight the need for children in therapy to learn specific skills to deal with what has happened to them and to talk about the details of their sexually abusive experiences.

Additionally, NCTSN has lots of **FREE** fact sheets and information sheets about child sexual abuse.

http://www.nctsn.org/trauma-types/sexual-abuse

Don't Miss This!

The 28th National Symposium On Child Abuse
March 19-22, 2012
Huntsville, AL
www.nationalcac.org

The NCAC models, promotes, and delivers excellence in child abuse response and prevention through service, education, and leadership.

Protecting Our Children and Their Records

Chris Newlin, MS LPC
Executive Director
National Children's Advocacy Center
Huntsville, AL

The role of CACs is incredibly multifaceted depending on perspective, situation and need.

Will you interview my victim? Is there any medical evidence? What can we do to help this child? What services does this family need? Can you squeeze this case in for a second interview – I think more has happened? I need to add a case the MDT Meeting Agenda – can you help? How is my victim doing in therapy? Why isn't my victim attending therapy? Where is the most appropriate placement for this child? Can you give me a copy of the DVD or your records? The demands are endless and balancing the needs of the children and MDT can be precarious on the best of days!

The CAC model is brilliant in that it eliminates artificial barriers to our success, but this simplicity also creates challenges – we are consistently being pulled in a million directions in an effort to make the process child-friendly for our clients and user-friendly for our MDT members.

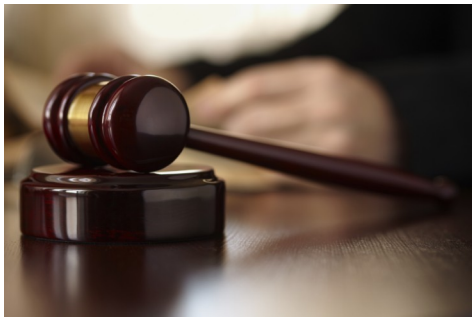
One way to organize our thinking is integral to Accreditation Standards – the separation of forensic from therapeutic services. This is important for both families and the professionals working with these families. For each, the expectations are different and can be boiled down to the simplest of approaches – "get the bad guy" and "help my child". You should be saying, "But everything we do is to help the child," and this is true; but the therapeutic aspects of the CAC model require special considerations.

Within the investigatory phase, all information which is developed is widely known amongst the MDT and eventually may become "public" if the case is prosecuted. This information is primarily evidentiary without necessarily considering the impact of these actions. However, once the child enters the therapeutic realm of the CAC model, the rules change. The MDT is not fully aware of the results of the child's trauma assessment, everything the child is saying in therapy, or how this child is progressing in therapy. We provide updates but not at the level of detail provided to all MDT members during the investigation phase. Why is this?

The therapist-client relationship is forged within the context of privileged communication - conversation that takes places within the context of a protected relationship. .

The therapist-client relationship is forged within the context of privileged communication - conversation that takes places within the context of a protected relationship, such as that between an attorney and client, a husband and wife, a priest and penitent, and a doctor and patient. As such, these records should be closely guarded and not shared with anyone unless the client has provided consent for their release.

How many of our families want this information released? Basically none. That means that requests for these documents will primarily come from entities outside of the context of the MDT – primarily defense attorneys who may have less than therapeutic interest in their contents.



It is important for all CACs to be fully aware of this potential and have structured their organizational policies and procedures to protect this confidential information. This will typically include efforts to separate investigatory files from the therapeutic records – oftentimes accomplished by having those with investigatory authority and responsibility to maintain the investigation records, and the provider of the therapeutic services to maintain these records.

This does not mean that the CAC cannot maintain records of who has come to the CAC – they just need to be sure this does not include extensive evidentiary information. Why? You can't choose what to release and what to keep privileged. Well, you can, but your chances are a bit more compromised, and it is easier to argue for a Motion to Quash a Subpoena if the only records included are of a therapeutic and demographic nature.

What if therapeutic services are provided outside of the CAC through a linkage agreement? There has been significant discussion over the last decade about the importance of utilizing evidence-based mental health services and how to determine whether third-parties may have this expertise with our specialized clientele. Beyond assuring they have this expertise, the CAC has an obligation to have clear discussions with these organizations to discuss the potential for records and staff being subpoenaed for either civil or criminal court. This may require a revision of certain policies and procedures, and potentially involve the reorganization of record-keeping within this third party mental health provider's organization. Additionally, it may be necessary to have the CAC's attorney consult with this organization's attorney to assure both are prepared to respond effectively to any subpoena.

We all play a role in the protection of children, and within the context of the therapeutic response to child abuse, the protection of children involves both providing evidence-based practice AND providing this in a manner which will limit any unnecessary disclosure of these confidential records.

Beyond preventive measures which may be taken to help protect the child and family receiving services, the mental health provider may need to revise the intake and informed consent process to address these issues – providing consent for release of information to the CAC and also informing the family of potential subpoenas for records and how safeguards have been put into place to help protect the child and family's privacy.

This is where the entire process comes full circle. At every turn in the CAC model and process, our focus is on doing what is best for the child. We all play a role in the protection of children, and within the context of the therapeutic response to child abuse, the protection of children involves both providing evidence-based practice AND providing this in a manner which will limit any unnecessary disclosure of these confidential records.

WHO WE ARE….

The U.S. Department of Justice established four Regional Children's Advocacy Centers in 1995 to provide information, consultation, training and technical assistance, helping to establish child-focused programs that facilitate and support coordination among agencies responding to child abuse.

Southern Regional
Children's Advocacy Center
210 Pratt Avenue
Huntsville, AL 35801
www.srcac.org

WHO WE SERVE. . .

SRCAC proudly serves:

Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

SRCAC Staff

Chris Newlin
Executive Director
cnewlin@nationalcac.org

Cym Doggett
Project Director
cdoggett@nationalcac.org

Karen Hangartner
Outreach Coordinator
khangartner@nationalcac.org

Missy Hanks
Communications & Data Coordinator
mhanks@nationalcac.org

Yvette Kubik
Outreach Coordinator
ykubik@nationalcac.org

Darlene Woodard
Training & Resource Coordinator
dwoodard@nationalcac.org

Visit our website at www.srcac.org

OJJDP

The Southern Regional Children's Advocacy Center is a project of the National Children's Advocacy Center, supported by Grant No. 2011-MU-MU-K008 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. We work collaboratively with the other Regional CAC's, NCA, and our Chapter Organizations in establishing and strengthening Children's Advocacy Centers. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.