

MENTAL HEALTH CONNECTIONS

A Newsletter for CAC Staff who do not have a mental health background!

FROM THE DIRECTOR'S DESK

Cym Doggett

Project Director, Southern Regional CAC

Sometimes the world around us moves so fast it is hard to keep up. Technology has increased the flow of information to such a degree, it often seems the changes in our field exceed our abilities to stay abreast of the latest research. How do we manage this flood of information? How do we make sure we know the latest advancements in prevention, investigations and treatment? Well, CALiO, of course!

The Child Abuse Library Online can help you work smarter and faster. CALiO provides a comprehensive collection of research literature, databases, statistical references, how-tos and much more in one easy-to-use location. My favourite tool in CALiO is the extensive collection of annotated bibliographies. For the topics listed below, the librarians have already done the research for you and have summarized the latest articles for your use! I often find myself going to these bibliographies when I need the latest information on a subject. Try it!

1. [Adverse Effects/Economic Impact of Child Maltreatment](#)
2. [Animal Abuse Co-occurring with Child Maltreatment](#)
3. [Animal Assistance: Research and Practice](#)
4. [Caregivers of Abused Children](#)
5. [Child Fatalities](#)
6. [Child Maltreatment and Links to Later Criminality](#)
7. [Child Maltreatment and Military Families](#)
8. [Child Maltreatment in Native American and Alaska Native Communities](#)
9. [Child Maltreatment in Sports](#)
10. [Child Maltreatment Victims with Disabilities](#)
11. [Child Maltreatment: Victim to Victimizer?](#)
12. [Child Poly-victimization and Multi-Type Maltreatment](#)
13. [Child Pornography: Victims, victimizers, and victimization](#)
14. [Child Sexual Abuse Allegations in Custody Cases](#)
15. [Children's Testimony-Issues and Concerns](#)
16. [Cordelia Anderson: Selected References](#)
17. [Cultural Competency](#)
18. [David Finkelhor Collection](#)
19. [Declining Rates of Child Sexual Abuse](#)
20. [Disclosure of Child Sexual Abuse](#)
21. [Domestic Violence Effects on Children](#)
22. [Effects of Interviewer Gender on Disclosure](#)
23. [Efficacy of Children's Advocacy Centers](#)
24. [Forensic Interviews at Trial](#)

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TF-CBT CERTIFICATION FOR THERAPISTS

The developers of TF-CBT have created a certification process for therapists who have been trained in TF-CBT. According to the Therapist Certification Program website, <https://rtfweb.wpahs.org/tfcbt/>, this process has been created to encourage and sustain successful implementation of the model.

You might be wondering if your therapist should pursue certification. If you contract with other agencies in your community for mental health services, should their therapists be certified? What are the benefits of certification?

We know from implementation science that a simple on-line or even one time in person training does not change practice. The process put in place by the developers of TF-CBT ensures that there has been sufficient training and supervision so that the intervention is implemented with fidelity to the model. When you hire or contract with a therapist who is certified in TF-CBT, you will know that professional has had the initial training and additional consultation/supervision to fully implement TF-CBT into their practice.

Criteria & Application

All eight steps must be met to achieve certification.

1. Master's degree or above in a mental health discipline;
2. Professional licensure in home state;
3. Completion of TF-CBTWeb;
4. Participation in a live TF-CBT training (two days) conducted by a **treatment developer** or an **approved national trainer** (graduate of our TF-CBT Train-the-Trainer Program);

OR

Live training in the context of an approved national, regional, or state TF-CBT Learning Collaborative of at least six months duration in which one of the treatment developers or a graduate of our TF-CBT Train-the Trainer (TTT) Program has been a lead faculty member;

5. Participation in follow-up consultation or supervision on a twice per month basis for at least six months or a once a month basis for at least twelve months. The candidate must participate in at least nine out of the twelve consultation or supervisory sessions. This consultation must be provided by one of the treatment developers or a graduate from out TTT program. Supervision may be provided by one of the treatment developers, a graduate of our TTT program, or a graduate of our TF-CBT Train-the-Supervisor (TTS) Program (In the latter instance, the supervisor must be employed at the same organization as the certification candidate);

OR

Active participation in at least ¾ of the required cluster/consultation calls in the context of an approved TF-CBT Learning Collaborative;

6. Completion of three separate TF-CBT treatment cases with three children or adolescents with at least two of the cases including the active participation of caretakers or another designated third party (e.g., direct care staff member in a residential treatment facility);
7. Use of at least one standardized instrument to assess TF-CBT treatment progress with each of the above cases;
8. Taking and passing TF-CBT therapist Certification Program Knowledge-Based Test.

For more information, you can visit the website <https://rtfweb.wpahs.org/tfcbt/>.

FOCUS ON WELLNESS

Sustaining our Passion for this Work

*Karen Hangartner
Outreach Coordinator, SRCAC*

If you have been in the CAC world for any length of time, you know that this work changes people. It changes the way we view the world, ourselves, and others. It changes our relationships with our partners, family and friends. This work challenges what we were taught growing up; how adults should treat children; how communities provide for the least among them. We quickly learn in the CAC world that “good” does not always defeat “evil” and often justice is not realized—we even begin to question our understanding of justice. We see the worst that society has to offer and are forced to struggle to make meaning of what we see on a daily basis in our centers. So why in the world do we willingly do this work?

I continue to be amazed and inspired by the professionals working in this field. People dedicated to removing children from harm’s way, providing support and treatment so families have the opportunity to survive and thrive in the wake of child abuse. It is imperative to create organizations that support the well-being of these professionals.

The question is HOW do we do that? Below are some things supervisors can do to support staff.

1. Provide information on vicarious trauma and secondary traumatic stress for all employees, including those who may not provide direct service. The good news is that there is a lot of great information on the internet. (See links below.)
2. Create an environment where it is OK to talk about how this work affects staff without fear of it negatively impacting performance appraisals.
3. Have employees complete the Professional Quality of Life Scale, a free assessment that measures compassion satisfaction, compassion fatigue, secondary trauma and burn out. http://www.proqol.org/Home_Page.php
4. Allow flexible work time.
5. Encourage staff to practice self-compassion.
6. Have discussions that remind staff why they chose this work. These discussions may help reconnect them with their passion and renew their energy for the work. Ask the following questions to start discussions:
 - ⇒ Why have you chosen to make helping children and families such a prominent part of your life?
 - ⇒ How have you changed since you began this work? How would your family and friends answer that question?
 - ⇒ Share an incident that produced that “I LOVE my job!” kind of feeling.

This is not an exhaustive list but offers some simple steps an organization can take to create work environments that support the well-being of staff. For more information, see the links below.

For more information go to these websites:

National Child Traumatic Stress Network: <http://www.nctsн.org/resources/topics/secondary-traumatic-stress>

Taking Charge of Your Health and Wellbeing: www.takingcharge.csh.umn.edu/

Professional Quality of Life: www.proqol.org/Home_Page.php

Green Cross Academy of Traumatology: www.greencross.org/

Compassion Fatigue Awareness Project: www.compassionfatigue.org/



It is imperative to create organizations that support the wellbeing of professionals.



As a Matter of fact

Maltreated Children: The High Risk of Poly-victimization

Poly-victimization (exposure to multiple forms of victimization) is highly correlated with indicators of traumatic stress in children. According to Finkelhor, Shattuck, Turner, Ormrod, and Hamby (2011), for these children, "victimization may be better thought of as a condition rather than an event." Practitioners should avoid organizing assessment of victimized children around a single form of maltreatment.^(2,9,12)

- 1** Poly-victimized children have lower self-esteem, higher incidences of risky sexualized behaviors, higher rates of self-harming attempts, higher instances of depressive behaviors, greater substance abuse issues, and have a significantly higher proportion of delinquency behaviors than children who suffer a single form of maltreatment.⁽¹⁻⁸⁾
- 2** There is often co-occurrence between sexual and physical abuse, and between witnessing domestic violence and experiencing physical and sexual abuse.^(1-2,13-15)
- 3** Emotional residues from maltreatment can create a "victim schema" that communicates vulnerability to peers and can invite bullying and peer violence.^(2,12,16,17)
- 4** Efforts to identify children, mitigate their circumstances, and disrupt their high vulnerability to ongoing victimization should be the goal of intervention. School staff and child welfare workers must pay particular attention when children report any type of victimization, including harassment by peers. These events may signal broader victimization vulnerability, and in responding to the child, the focus may need to extend beyond the specific report, to include an assessment of other forms of victimization.^(2,9-10,12-15,17)
- 5** Children suffering from multiple forms of victimization experience higher anxiety and psychological distress than children exposed to chronic victimization of a single type.^(1,10-13,15,18)
- 6** Significant associations exist between childhood physical and sexual abuse, and adolescent delinquency. Multiple types of adverse childhood experiences should be considered as significant risk factors for a spectrum of violence-related outcomes during adolescence.^(3-8,10)

Treatment Models for Poly-victimization

Summary of Key Points

Victoria Banyard, Sherry Hamby, and Heather Turner

Poly-victimization is defined as experiencing multiple, different types of victimization, such as physical abuse at home, bullying at school, and witnessing community assault. It is the strongest predictor of psychological symptoms in national studies. Adaptations of current trauma treatment models can help address poly-victimization.

Key components of a poly-victimization approach to treatment:

- Working with families rather than focusing only on children
 - ◊ Educate caregivers about poly-victimization and its effects. Work with caregivers to build strategies to support children who have experienced poly-victimization.
 - ◊ Consider that caregivers may be poly-victims themselves and may need assessment, safety planning, and their own interventions to support parenting strengths.
- Engaging and planning interventions across multiple contexts including schools
 - ◊ Educate school personnel and other youth professionals about poly-victimization.
 - ◊ Coordinate services and intervention strategies across different contexts in a child's life (connecting children to community resources, consulting with school professionals so that intervention plans are interconnected rather than separate).
- Multi-pronged treatment approaches may require a longer time frame and need to be developmentally specific.
 - ◊ Pervasive victimization is the hallmark of poly-victimization. Treatment models need to be tailored for children of different ages and linked across the lifespan.
- Looking ahead to prevention of future victimization
 - ◊ Work with other professionals on policies, resources, and programs to prevent further victimization.

Examples of treatment models that could be adapted to address poly-victimization

Child-Parent Psychotherapy (CPP)

Integrative Treatment of Complex Trauma

Trauma-Focused Cognitive Behavior Therapy

Structured Psychotherapy for Adolescents Responding to Chronic Stress

Conclusion

Children's Advocacy Centers (CACs), with their collaborative approach, are uniquely positioned to take next steps in developing treatments for poly-victims. Using existing models as a foundation, we need to find ways to work against traditional compartmentalization of services and their frequent focus on one type of victimization. CACs can work to develop treatment models that involve multiple settings and multiple relationships in a child's life.

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THE SMALLEST VICTIMS

HIGHLIGHTING THE RESEARCH OF DR. DEBRA NELSON-GARDELL

Reprinted from:

Miller, D. (March, 2014). The Smallest Victims. *RESEARCH Magazine*. Tuscaloosa, AL: The University of Alabama. <http://research.ua.edu/2014/03/the-smallest-victims/>

For therapists and forensic interviewers – specially-trained experts who conduct initial interviews with a child following reports of sexual abuse – getting a child to reveal all of the details of their abuse requires trust.

For the last 30 years, interviewers, therapists, judges and attorneys, along with researchers, have agreed that the forensic interview process should only be conducted once, in a video-recorded session so information can be shared with law enforcement officials, lawyers and therapists.

A one-interview format, the reasoning goes, lessens the possibility of re-traumatizing the victim by repeated interviews and eliminates the possibility of the victim's story changing if interviewed multiple times by different people who aren't trained to conduct interviews.

The reaction to this commonly-accepted practice seems – at least on the surface – a positive step toward ensuring a child is comfortable enough to share the story, while also safeguarding against inaccuracies that could taint a sexual abuse case. But others, including one University of Alabama social work professor, say there is a significant population of abused children whose stories are left incomplete because of today's standard practice.

Dr. Debra Nelson-Gardell, a professor in UA's School of Social Work, is researching the effectiveness of the current interviewing system. Nelson-Gardell, along with her UA colleague, Dr. Javonda Williams, and Dr. Kathleen Fowler, of the University of Michigan, and Dr. Mark Everson, of the University of North Carolina-Chapel Hill, are surveying therapists and child abuse professionals nationwide to gauge their attitudes of the effectiveness of the one-interview restrictions.

"Over time, I've come to believe it's not how many interviews that are troublesome," says Nelson-Gardell. "It's having more than one interviewer who is untrained in what they're doing. Dr. Everson has developed a measurement tool designed to tap into people's attitudes about whether they're more able or comfortable making sure we find all the victims we can."

"Sometimes this means using techniques that aren't the most forensically defensible interview techniques to increase the possibility that a child can tell about anything that might have happened, as opposed to being very invested in making sure no innocent adult is accused of the abuse. People find it difficult to agree upon how to balance these two imperatives."

There's a divide, Nelson-Gardell says, between those who think more than one interview pushes a child to tell something that isn't true and those who know some kids aren't ready to tell their stories in one interview. There's a general belief that around 20 percent of kids aren't ready to tell their story in one session, she says.



Nelson-Gardell has published more than a dozen manuscripts describing her research on forensic interviewing and the treatment of sexually abused children.

The child may be young and need more time to understand the adult's language, or the adult may need more time to understand the child's language, or they may have been threatened to not talk by the accused adult.

Though forensic interviewers are specially trained in what questions to ask and how to ask them, the child may suffer from separation anxiety. The case can be even more complex when the accused party is a family member, Nelson-Gardell says.

"It can be very challenging to determine the most effective forensic interviewing method because 'most effective' will change depending on the many different variables, including: the child's personality and temperament, cultural considerations, the child's abuse history, family situation, availability of resources, etc.," Williams says.

"But all of these things need to be taken into consideration and a plan of action developed based on what is in the best interest of the child."

Nelson-Gardell and Williams both worked as therapists, specializing in treating sexually-abused children who had already often been through the forensic interview process. Both recall cases when a child would recant previous statements about the abuse or even deny it despite physical evidence.

"When I was working in treatment, I worked with a girl who was around 11 who came in because there was semen found in her urethra," Nelson-Gardell says. "But she denied having any knowledge of being sexually abused. Trauma may have caused the disassociation from the memory, or she could have just been saying 'I'm not willing to tell.'

"Even when they were in treatment, the kids have a hard time talking about what happened to them," she adds. "Some kids come in, and they are ready and trust you." Others, Nelson-Gardell says, have had their trust disturbed by their victimization. "Therapy is about trust, and if the child doesn't trust the therapist, the child will have a hard time telling their story, even if they've already told it."

Nelson-Gardell, who worked as a therapist and supervisor in a sexual abuse treatment program while working on her doctoral degree at Florida State University, held therapy sessions at the FSU campus and consulted at 11 different sites around Florida.

She was initially drawn to UA, she says, because of its proximity to the National Children's Advocacy Center in Huntsville. The National CAC had a federal contract to be the national resource on child sexual abuse at the time, which helped Nelson-Gardell link with clinicians and begin her research. Since joining UA's faculty in 1995, Nelson-Gardell has published 14 manuscripts describing her research on forensic interviewing and the treatment of sexually abused children.

"The original research we did in the late '90s and published in early 2000s supported the notion kids need more than one interview," she says, "and, with more, they can give more info. That research has not been repeated. But there's increasing indication from data analysis and data gathered by other researchers of forensic interviewing that children give richer, more trustworthy details in more than one interview."

Nelson-Gardell's team is surveying professionals across the U.S. with differing views on extended assessments.

"It's important to note that this research goes both ways – the time needs to be there for the interviewer to find out what if the abuse didn't happen, too. Hopefully, it will contribute to a change in people's attitudes."



The one-interview format of child abuse victims sometimes generates incomplete stories, according to a UA social work professor.

FROM THE DIRECTOR'S DESK

Cym Doggett

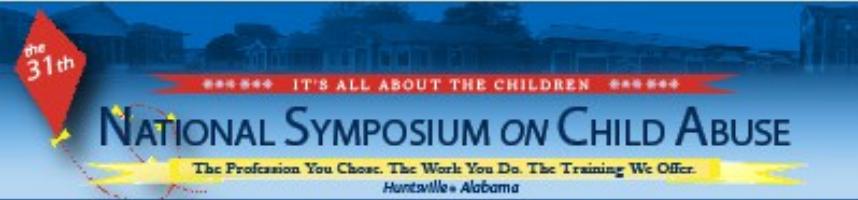
Project Director, Southern Regional CAC

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25. [Grooming of Victims of Child Sexual Abuse](#)
26. [Impact of Methamphetamine on Children](#)
27. [Interviewing Child Witnesses of Violent Crime](#)
28. [Mandatory Reporting of Child Maltreatment](#)
29. [Michael E. Lamb: A Selected Reference List](#)
30. [Multidisciplinary Teams](#)
31. [Play Therapy for Sexually Abused Children](#)
32. [Psychological Impact of Natural Disaster on Children](#)
33. [Recantation and False Allegations of Sexual Abuse](#)
34. [Resilience Among Victims of Child Maltreatment](#)
35. [Sandy Wurtele Collection](#)
36. [Secondary Trauma, Compassion Fatigue and Burnout among Professionals who Work with Maltreated Children](#)
37. [Temporal Aspects in Child Forensic Interviews](#)
38. [Tom Lyon Collection](#)
39. [Trafficking and Commercial Sexual Exploitation of Children](#)
40. [Truth-Lie Conversations in Forensic Interviews of Children](#)
41. [Use of Media in Forensic Interviews of Children](#)- Entire collection or each section accessible separately below.
 - a. [Use of Media in Forensic Interviews of Children: Human Figure Drawings](#)
 - b. [Use of Media in Forensic Interviews of Children: Dolls](#)
 - c. [Use of Media in Forensic Interviews of Children: Facilitative/Event Drawings](#)
 - d. [Use of Media in Forensic Interviews of Children: Props](#)



<http://www.nationalcac.org/calio-library/professional-bibliographies.html>



**Make Plans to Join us for the
31st National Symposium on Child Abuse
March 23-26, 2015
Huntsville, Alabama**

The *National Symposium on Child Abuse* is an informative and innovative multidisciplinary conference which offers more than 130 workshops presented by nationally-recognized experts from all facets of the child maltreatment field.



march 23-26
***** 2015 *****

National Children's Advocacy Center

National Training Center

2014 TRAINING DATES

Visit <http://www.nationalcac.org/ncac-training/ntc.html> for more information.

Extended Forensic Interview Training - This training introduces a model for a multi-session forensic interview of a child who is potentially a victim or witness of child abuse or other violent behaviors. An Extended Forensic Interview (EFI) is appropriate for children where the results of a single interview are inconclusive or where there are serious concerns about the child's ability to participate in a single-session interview. Such children might be the very young child, a child with developmental delays or cognitive disabilities, or an extremely traumatized child. Cultural considerations may indicate a need for an EFI, rather than a single-session interview.

April 22-24, Charlotte, NC

September 9-11, Salt Lake City, UT

Forensic Interviewing of Children Training - This comprehensive training teaches the nationally recognized NCAC Child Forensic Interview Structure, which is designed to gather the greatest amount of reliable information in a child-sensitive, developmentally-appropriate and legally-defensible manner. The NCAC Forensic Interviewing of Children Training immerses the participant in the most current research and evidence-based information in the field. Trainings held in Huntsville, AL.

April 7-11

June 9-13

July 28-August 1

September 29-October 3

December 8-12

Victim Advocacy Training - This training is designed for Victim Advocates who are working with children and families within a Child Advocacy Center setting and focuses on the knowledge, attitudes, and skills necessary for this important job. The training will include foundational sessions on understanding the criminal justice system, dynamics of child abuse, crisis development and resolution, effective listening techniques, the impact of trauma on a child, the rights of crime victims, cultural considerations and intervention strategies. Trainings held in Huntsville, AL.

May 6-8

November 4-6

Advanced Forensic Interviewing Training - This training will focus on challenging interviews. Challenges may arise from child factors (young age, developmental issues, cultural issues, impact of neglect or trauma on the child's abilities, and motivation to participate in the interview.) Additionally or alternatively, challenges may arise from case complications (trafficking, sexualized behaviors without verbal statements, multiple forms of victimization, or long-standing and violent abuse). Thorough case planning and investigation, as well as accommodations to the standard interview process are necessary. Attendees will be encouraged to bring recordings of challenging interviews or complicated case histories to share throughout the training.

June 17-19, Providence, RI

October 7-9, Kansas City, MO

Adapting the NICHD Forensic Interview Model to Special Populations—The first day of this two-day training will introduce the trainee to the important elements of the NICHD Forensic Interview Structure. This day of the training will be provided by Heather Stewart who has worked with and trained nationally and internationally on the NICHD protocol for 15 years. The second day of training will present adaptations of the NCAC Child Forensic Interview Structure for use with extremely reluctant, young, and/or cognitively/linguistically challenged children. Linda Cordisco Steele, NCAC Senior Trainer, will discuss how these adaptations may be useful for interviewers using the NICHD or NCAC protocol or another narrative interview approach.

August 5-6, Huntsville, AL

Southern Regional Children's Advocacy Center 2014 CORE TRAINING DATES

For more information

Visit <http://www.nationalcac.org/southern-regional-child-advocacy-center/srcac-train-core.html>

TEAM FACILITATOR 101: JULY 15-17

This training for Children's Advocacy Center staff/multi-disciplinary 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 insight into strategies for identifying system issues that impact cases and team dynamics as well as helping to promote collaborative decision-making and healthy, productive methods for addressing conflict.

Fee: \$49

CAC MANAGEMENT: JUNE 17-20

This training is designed to meet the specialized training needs of individuals who have primary responsibility for the day-to-day operations of a Children's Advocacy Center. The course is primarily geared to address the needs of newer CAC directors, but would also be beneficial to those with more experience who are seeking to enhance their management skills.

Fee: \$49

ACCREDITATION BOOT CAMP: AUGUST 26-27

This training is for CACs who are looking towards applying for accreditation or re-accreditation to the National Children's Alliance. The two-day Boot Camp focuses on understanding the accreditation process; NCA standards; the accreditation packet; and preparing for the site visit.

Fee: \$49

MEDICAL TRAINING ACADEMY: NOVEMBER 20-22

This training is designed specifically for healthcare providers who have the responsibility for providing the medical evaluation for children who are suspected victims of child abuse. This training is appropriate for physicians, nurse practitioners, SANE nurses, or other registered nurses with advanced training, and physician's assistants with less than 2 years of experience in this area of health care. **This training is not intended for nurses or other health care providers whose role is to assist an examiner.** CME credits are coordinated for this training.

Fee: \$199

Travel assistance available is available for SRCAC core trainings.

Visit SRCAC.org for more information.

QUESTIONS TO ASK WHEN BROKERING MENTAL HEALTH SERVICES

A national survey by Jackson (2004) study found that 42 % of 117 U.S. CACs provided on site mental health services to children, which means that a majority of CACs are working with other agencies in their community to meet the mental health needs of their clients. As with many issues in the CAC world, this means you are collaborating with other professionals to meet the NCA mental health standard. If you are not well versed in the mental health culture, it may be intimidating to approach an experienced clinician and explore what assessments and interventions they use with clients. Here are some questions and answers that might help guide the process.

Sample Questions:

1. What is your educational background?
2. What is your experience with children?
3. Are you licensed?
4. How soon can you get the children from our CAC into therapy?
5. What type of standardized assessments do you use?
6. How do you assess for trauma?
7. Do you do follow up assessments during the course of treatment and at the conclusion of treatment?
8. What interventions do you use with children?
9. How do you decide which interventions are appropriate for clients?
10. How do you know if therapy is working for a child?
11. What is the average length of time children are in therapy in your agency?
12. What percentage of your clients complete therapy?
13. Do you engage caregivers in the therapeutic process?
14. Do you receive supervision? How often? With whom?
15. What kind of ongoing training do you obtain?
16. What is your fee scale?
17. Does your agency have provisions for clients who do not have the ability to pay?
18. Are you reimbursed under Medicaid or other insurance programs?
19. Are you willing to comply with the training and continuing education requirements set forth by the National Children's Alliance?

You might be thinking "These are great questions! But how do I know if the answers they give are sufficient?" The resources listed below will provide guidance.

CAC Directors Guide to Mental Health

Download FREE!

http://www.nctsn.org/sites/default/files/assets/pdfs/CAC_Directors_Guide_Final.pdf

California Evidence-Based Clearinghouse for Child Welfare

Rating system for interventions.

<http://www.cebc4cw.org/>

Reference

Jackson, S.L. (2004). *A USA national survey of program services provided by children's advocacy centers*. *Child Abuse & Neglect*, 28(4), 411-421.

Southern Regional Children's Advocacy Center



A PROGRAM OF THE
NATIONAL CHILDREN'S ADVOCACY CENTER

www.SRCAC.org OJJDP



**Training and Technical Assistance for Communities
ESTABLISHING and STRENGTHENING
Children's Advocacy Centers**

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Visit our website at www.srcac.org

<https://www.facebook.com/SouthernRegionalChildrensAdvocacyCenter>



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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
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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.