

National Children's Alliance

Thriving Kids 2019

A National Report on Mental Health
Outcomes in Children's Advocacy Centers



NATIONAL
CHILDREN'S
ALLIANCE®



The Thriving Kids Initiative

NCA, along with our nationwide network of Children’s Advocacy Centers, State Chapters, and partners, have spent the last 10 years creating and executing a strategy to achieve one goal: to help kids thrive.

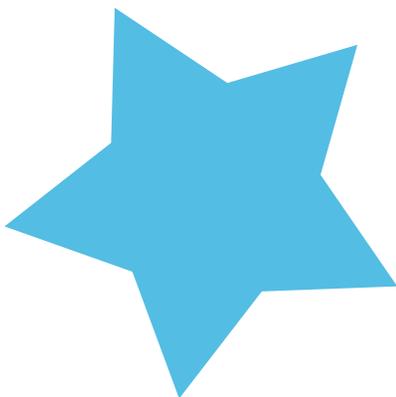
These efforts began in 2009, to help CACs not just deliver more mental health services to child victims of abuse, but also to improve the quality of service and to offer new, evidence-based treatments and assessments to ensure CACs are on the leading edge of science.

State by state, project by project, these efforts collectively became our Thriving Kids Initiative. Read on to see where we’ve been, how we got here, where we’re headed, and how we know this work works.

Our funding partners



Our clinical, training, & education partners



Thank you for helping us help kids thrive.

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How NCA is helping kids thrive

Evidence-based, trauma-focused mental health treatments help kids recover from the trauma of abuse and go on to thrive. In 2009, National Children's Alliance (NCA) recognized the need to develop the capacity of the entire Children's Advocacy Center (CAC) movement to deliver these science-backed services to kids across the nation. As the primary response to child abuse in the United States, CACs are well-positioned to deliver healing to kids nationwide, providing some 200,000 children each year with mental health services. Here are some highlights of our accomplishments over the past 10 years, achieved in partnership with CACs, State Chapters, Regional CACs, and the national stakeholders and institutions who have helped NCA create and spread groundbreaking mental health resources.

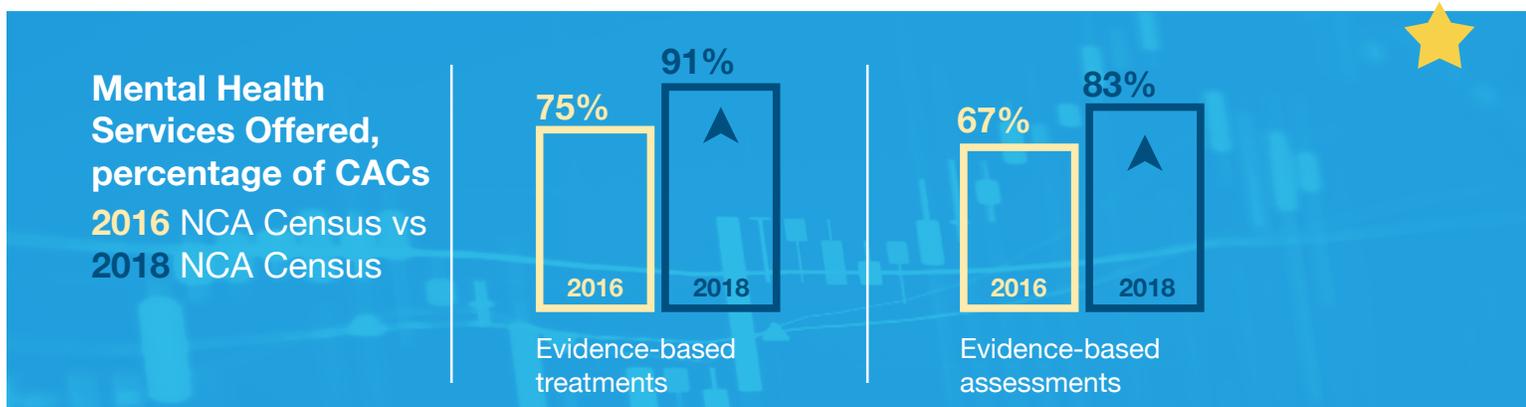
Our last 10 years

- NCA provided **millions of dollars** in mental health implementation grants, from both public and private sources, to CACs over a 10-year period to improve their practice.
- NCA members provided mental health services or referrals to **more than a million children** over **10 years**.
- NCA trained **112 clinicians** in **10 states** in evidence-based assessments to ensure that treatment is targeted to children's trauma symptoms. Through these projects, **clinicians have assessed nearly 1,000 children** and their caregivers so far.
- NCA trained **72 clinicians** across **four states** in Child and Family Traumatic Stress Intervention (CFTSI) as a way of expanding the range of evidence-based interventions available in CACs, and providing a short-course therapy to victims whose trauma happened recently, reducing wait times for treatment. So far, **899 children** have benefited from this pilot program.

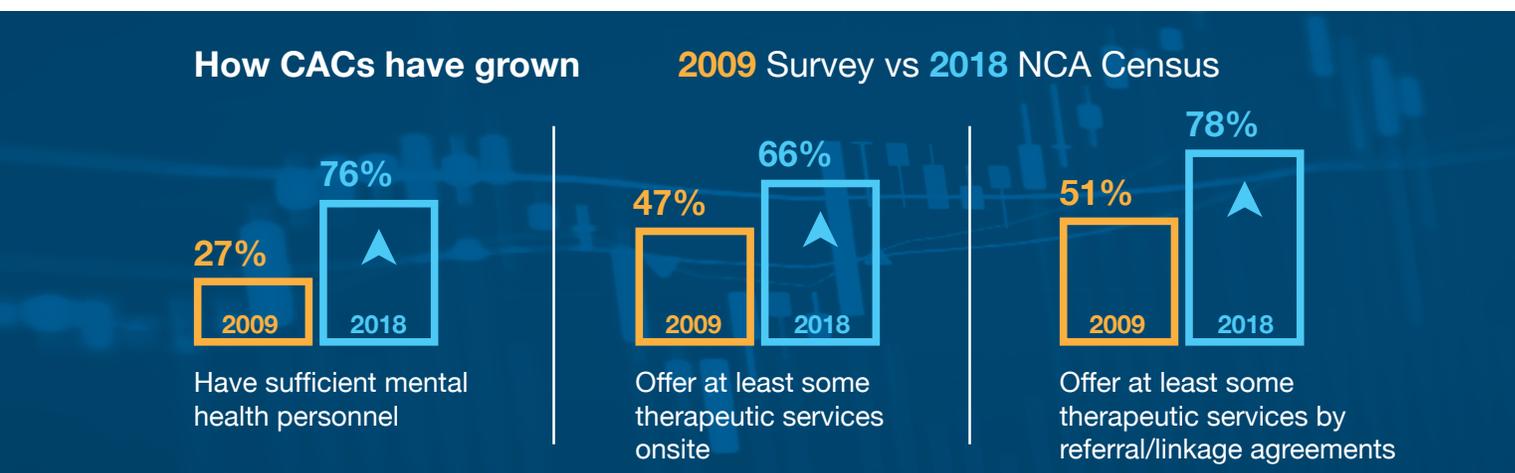


Mental health service delivery through CACs is growing

Even in the past two years, CACs have made dramatic strides in offering evidence-based mental health services. But these strides have been the effect of longer-term improvement trends at CACs.



Back in 2009, when Accredited and Associate Member CACs were surveyed about mental health care services, few reported having adequate mental health personnel, and only around half reported delivering mental health services either onsite or through referrals or linkage agreements. Thanks in part to Victims of Crime Act (VOCA) funding made available to CACs through NCA's federal advocacy efforts, fewer CACs than ever report mental health staffing shortages, and the CAC movement has shown dramatic growth in service delivery, both onsite and through referrals.



As you will see in this report, through the hard work of CAC leaders in partnership with NCA, not only has the system change been transformative for the mental health services offered in CACs, but more importantly, it has been transformative for children and their healing. The field has moved forward dramatically in the past decade. We look forward to building on that foundation until every child has the services he or she needs to not just heal from abuse but to thrive.

Why it matters



Child abuse and other forms of trauma can have lifelong effects on children, families, and communities.

Child trauma can last a lifetime

Many studies have shown the strong relationship between Adverse Childhood Experiences (ACEs), which include childhood trauma like abuse, and serious outcomes such as post-traumatic stress disorder (PTSD), depression, substance use, health problems, and even poverty and early death.

Possible risk outcomes

Behavior



Physical & Mental Health



Trauma is are both common and costly to society

How many children are we talking about? Nearly half of all U.S. children experience at least one type of childhood trauma.³ That exacts a toll on children, their caregivers, and their community, and our country as a whole also pays a price. Quite literally: In addition to the physical, emotional, and social costs of child abuse, it also carries economic costs.⁴

Abuse and other forms of trauma are common.



Nearly half of all U.S. children—some **34 million**—have experienced at least one type of childhood trauma, while **16 million** have experienced two or more types of trauma.

Abuse carries a heavy cost.

The lifetime cost for each victim is

\$210,012

Each year, total lifetime costs of new cases of child abuse reach approximately

\$124 billion

3 Bethell, C., Newacheck, P., Hawes, E., and Halfon, N. Adverse childhood experiences: assessing the impact on health and school engagement and the mitigating role of resilience. (2014) Health Affairs Dec; 33(12);210-2016.

4 Fang, X.; Brown, D., Florence, C., and Mercy, J. The economic burden of child maltreatment in the United States and implications for prevention. (2012) Child Abuse and Neglect, Volume 36, Issue 2, February 2012, pages 156-165.

Our 10-year strategy to address trauma

This success in serving kids didn't just come out of the blue. Here are specific actions we took together as a movement that led us to success and healing over the last 10 years:



Raised the bar in the [Standards for Accredited Members](#) for CACs to require the provision of trauma-focused, evidence-based mental health care for victims of abuse. First implemented in 2008 and a vital part of every edition since, this requirement laid the foundation for work to come over the next 10 years.



Launched a research-to-practice email series published every Monday morning that has shaped our field by sharing research and practical resources to address barriers to service.



Successfully advocated at the federal level to ensure that mental health care provided in CACs could be reimbursed through Victims of Crime Act funds.



Partnered with the National Child Traumatic Stress Network (NCTSN) to produce two editions of the [CAC Directors' Guide to Quality Mental Healthcare](#), a practical resource in implementing mental health programs in a CAC setting.



Upgraded NCAtrak, our proprietary case-management software platform, to help CACs track client mental health outcomes.



Produced educational materials for multidisciplinary team partners and [caregiver guides](#) to improve understanding of treatment, in partnership with institutions including University of Oklahoma's National Center on the Sexual Behavior of Youth and the U.S. Department of Justice.



Deployed the Outcome Measurement System to 762 CACs so far to obtain caregiver data on barriers to service and use that data to guide our improvement efforts.



Developed online training modules for providing care to specialized populations, such as [children with problematic sexual behaviors](#).



Since 2009, NCA has made more than \$90 million in grant funds available to CACs and their state chapters, and our federal advocacy work has made more than \$100 million in VOCA funds to support mental health services available to CACs each year.

Where we're going together



NCA has big plans to make our next 10 years as impactful as the last. Here's just the start of our current and future mental health projects, all part of the Thriving Kids Initiative.



NCA is collaborating with the University of Oklahoma's Health Sciences Center to produce an online training series on family engagement. Through this training series, victim advocates will help more children and caregivers receive the services they need to heal, as we teach CACs how to follow through, communicate why it is important for children and caregivers to receive services, and see cases through to the end. Learn more on **p. 12**

We're also collaborating with Baylor University and Dr. Jeffrey Wherry to provide EBA training to more than 1,000 clinicians over five years. The grant, from the Substance Abuse and Mental Health Services Administration and NCTSN, will purchase mental health assessments for 3,585 children, and NCA will work with CACs and our state chapters on options for them to purchase additional assessments and help even more children.

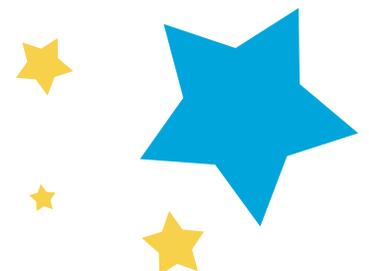


NCA is currently leading mental health training projects in Idaho, Utah, North Carolina, and South Carolina, training clinicians and equipping them with tools to help kids. Projects in Oregon and Washington state recently concluded, and we'll be planning projects to bring these tools to even more states in the coming years. See a map of our impact on **p. 10**

In five years, we expect that some 1,100 clinicians will be newly trained in EBAs, 45 will become trained trainers, and 75-100 graduate students will train in EBAs and Trauma-Focused Cognitive Behavioral Therapy.



We're continuing to improve NCAtrak, our online case management system, to make it even easier for NCA members to track cases and outcomes. The more data we have about what treatments CACs are using and how much progress clients make as a result, the more we can do to treat the trauma and inspire hope in children who have been victims of sexual abuse.

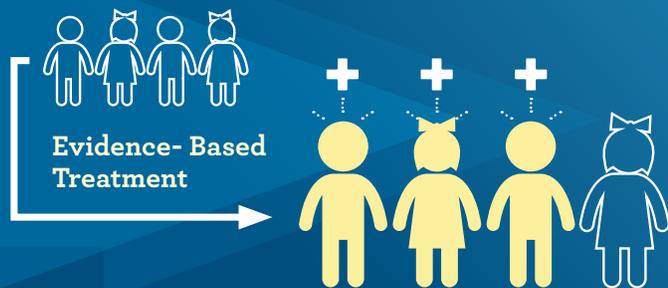


We're improving kids' lives (and caregivers' too). Here's proof.

Evidence-based treatments (EBTs) have been designed and tested for treatment of child trauma-related symptoms. It's through the use of those proven techniques that CACs are making a difference in kids' lives—and helping their caregivers, too. Learn more about different treatment models on p. 13

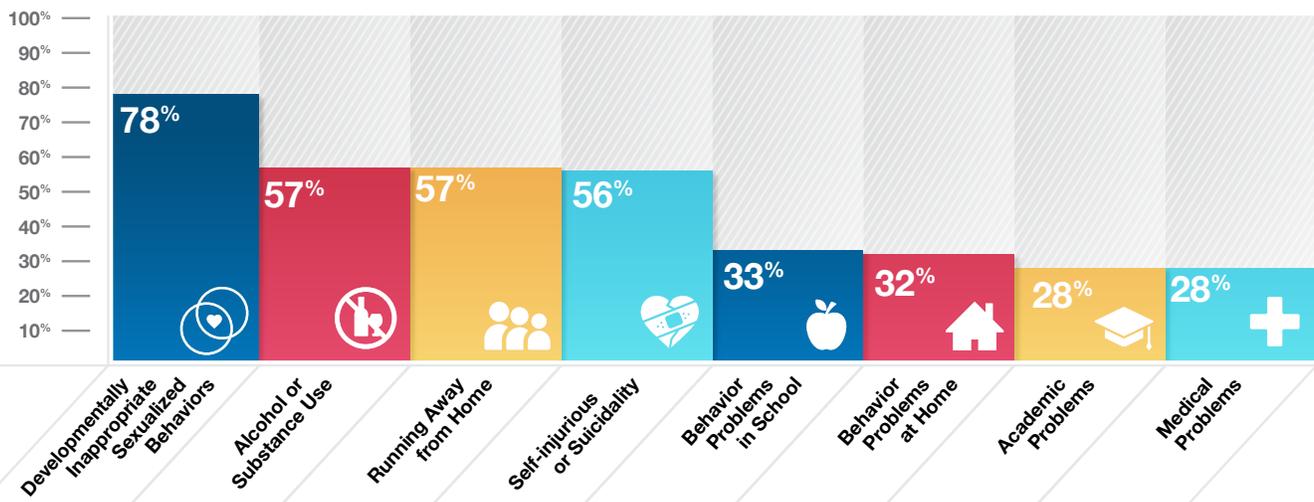
EBTs can help reduce trauma symptoms.

75% of children who had PTSD when they started treatment no longer had PTSD at their last follow-up



EBTs improve outcomes for children.

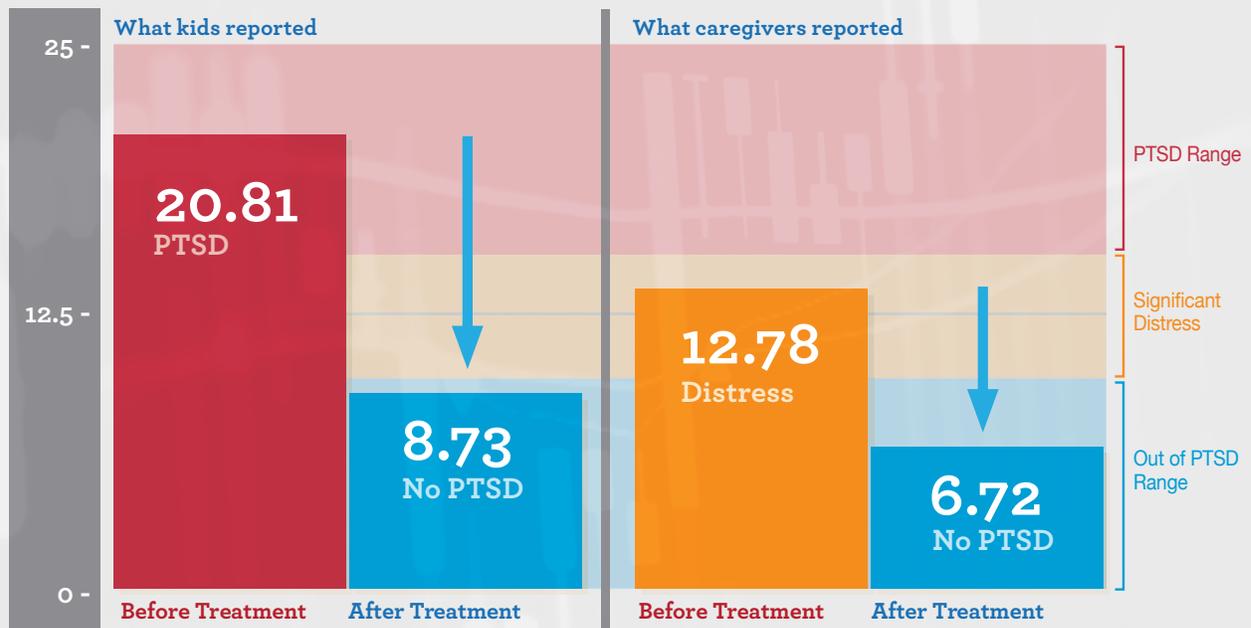
Below are percentages of children who **stopped experiencing** these major life problems after receiving EBTs.



A new treatment achieves rapid change

Child and Family Traumatic Symptom Intervention (CFTSI) is a new, short-term, early intervention treatment designed to reduce traumatic stress symptoms, reduce or interrupt PTSD, and help caregivers better support their child in coping with trauma. Starting in 2015, NCA collaborated with The Duke Endowment, Yale University, and CACs in the Carolinas to train mental health providers in CFTSI.

Children served during this project came in presenting high levels of PTSD symptoms, **such as nightmares, feeling scared, feeling worried, having trouble concentrating in school, feeling lonely, not wanting to play, and having intrusive thoughts.** The children’s level of symptoms were evaluated based on what the children reported themselves and what their caregivers reported about them. Scores of 11 or higher reflected significant distress, while scores above 15 indicate PTSD.



On average, before treatment began, children scored well within PTSD range based on their reported symptoms, and showed significant distress based on caregivers’ reports. After brief treatment, PTSD symptom scores reported by both children and caregivers fell significantly, bringing child victims out of PTSD range. The treatments healed their PTSD! Afterward, caregivers were asked about their experience with the CFTSI program:

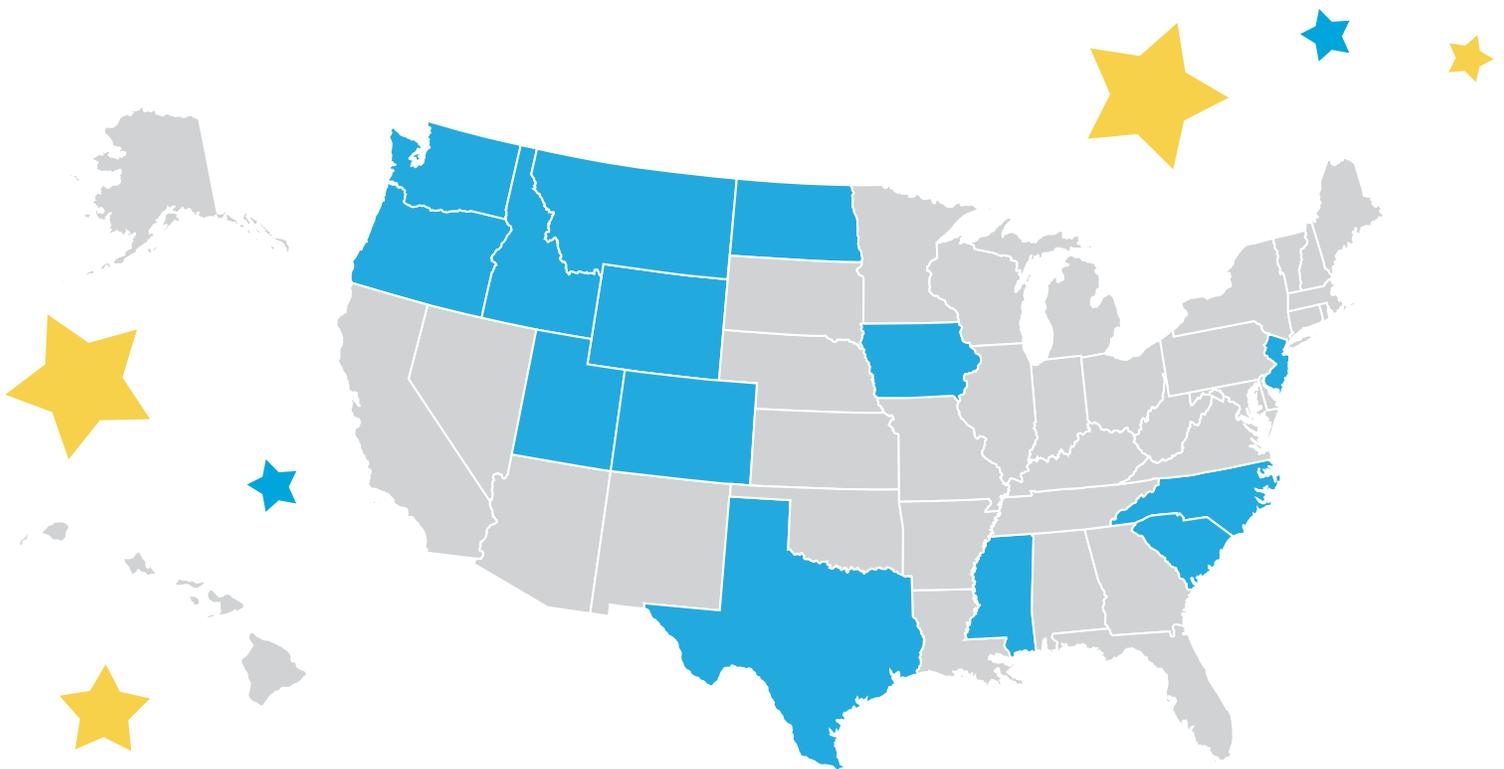
- ★ **100%** said they and their children learned ways/skills to help the child feel better and make the problems or reactions the child was having happen less often.
- ★ **99%** said CFTSI helped them be better able to assist their child after upsetting experiences.
- ★ **99%** said they’d suggest CFTSI to a friend dealing with a similar situation.

After our success in North and South Carolina, we also trained clinicians in Idaho and Utah. **So far 72 clinicians** have been trained and **899 children** have benefited from the program.

We're helping CACs expand—and know if it's working

Kids at CACs usually need evidence-based treatments. And, to plan the right treatment and make sure it's working for children and their caregivers, CACs need to use evidence-based assessments (EBAs). Since 2015, NCA has provided EBA training to **112 clinicians** from CACs in **10 states** and expanded services to many more.

States where NCA has expanded mental health services



Through these projects, clinicians **administered assessments to nearly 1,000 children and their caregivers**—a number that will continue to increase as those clinicians see more clients every year. In 2017, **more than 207,000 children** received evidence-based treatment or referrals to get it thanks to CACs. No single therapy is right for all children in all circumstances, so the more clinicians are trained in EBAs, the better they'll be able to ensure that children get the treatment they need.

We also extend our reach through a train-the-trainer program: Clinicians who have successfully completed the learning initiative can go on to learn how to share that knowledge with others. Currently, three clinicians have completed the program and started actively training other clinicians, and more are in the pipeline. We're also launching an Evidence-Based Assessment Video Training Series that will make training more accessible to clinicians around the country.

Non-clinicians need training too. That's why in 2017 we partnered with the National Child Traumatic Stress Network to launch the [CAC Directors' Guide to Quality Mental Healthcare](#). The free, online toolkit equips non-clinicians with the knowledge to manage, evaluate, and deliver quality mental health care to clients.



How we're working together to serve even more kids

Most caregivers are satisfied with the types of services available from CACs; when NCA members survey caregivers, **only six percent say they would like additional services for children**, for themselves, or for other caregivers.



⁵ Source: Healing, Justice, & Trust Outcome Measurement System National Report 2018. Figures not equal to total satisfaction percentage due to rounding.



Breaking down barriers

Although our data show that more children are being referred to mental health services, rates at which they actually use the services they were referred to have fallen, from 69 percent in 2014 to 64 percent in 2017.

To increase the mental health services that CACs provide, we must understand what the barriers to providing those services are. In the 2018 NCA Census, CACs cited these as the most common barriers to providing mental health services to kids and families:



44% cited funding as a problem



49% reported practical barriers for clients such as transportation



50% had other client barriers such as not following up on referrals or dropping out of treatment

Engaging with families to overcome barriers to treatment

The biggest single barrier is perceptual—many caregivers say they simply do not believe mental health services are necessary. Research shows that evidence-based mental health treatments do help children and their caregivers, so it's up to NCA and the CACs to get that message out to more families.

As part of a joint, multi-year project with the University of Oklahoma Health Sciences Center, NCA is producing an online training series on family engagement to help CACs communicate why it is important for children and caregivers to receive services. Starting with the first encounter, CACs must create a good working relationship with caregivers. CAC staff need to be able to explain not just what services are available but also how children and caregivers can benefit from those services. We are pleased to report that, in the past two years, the **number of family advocates employed at CACs grew by 29 percent**, increasing capacity to support non-offending caregivers through the investigative process and encourage them and their children to make use of services.





Emerging data: Onsite services help kids start and finish treatment

CACs offer a mix of providing mental health services in-house versus providing them by referral to community providers. While CACs with different resource levels, access to clinicians, and funding streams must determine what's best to serve their client population, emerging data is showing a clear advantage to providing onsite services to children.

ChicagoCAC recently studied the questions of engagement (children attending the first session of treatment) and retention (children continuing treatment for 90+ days or 10+ sessions) among children served by their own in-house clinicians. Compared against populations referred to outside therapists, children served onsite were 7 times more likely to attend the first session.¹

Additionally, more than three-quarters of children served at ChicagoCAC stayed in therapy for 90+ days or 10+ sessions.² Other research found that when treatments may be delivered elsewhere, similar low-income, urban, minority populations, like the one studied in Chicago, stop treatment, on average, after three or four sessions.



1 Walsh, Wendy, and Budde, Stephen. PATHH Collaboration: A CAC Based Initiative to Increase Engagement in Children's Mental Health Services Following Sexual Abuse Allegations. (2018) Urban CAC Forum presentation, October 16, 2018.

2 Budde, Stephen, and Waters, Jan. PATHH: Improving Access and Quality of Mental Health Services to Sexually Abused Children in Chicago. (2014) Pages 7-8. Available online at www.ChicagoCAC.org/PATHH-White-Paper.

The tools of healing

In order to facilitate healing, the NCA Accreditation Standards require that CACs offer children and families evidence-based treatments, which are those treatments that have strong scientific evidence that demonstrates effectiveness in treating symptoms. To be considered evidence-based, the treatments are to be used with the population for which they were studied; therefore, CACs should choose evidence-based treatments that have been proven **effective in treating trauma symptoms in the population served by CACs**. Here are some examples of EBTs that meet NCA's Standards for Accredited Members.

Five treatment types CACs offer



Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) is for caregivers who are emotionally or physically aggressive or abusive with their children; children who experience behavioral dysfunction, especially aggression, or trauma-related symptoms secondary to their exposure to physical discipline or abuse; and high conflict families that are at risk for these problems.



Child and Family Traumatic Stress Intervention (CFTSI) is for children ages 3-18 who have recently been exposed to a potentially traumatic event or who have recently disclosed physical or sexual abuse and report at least one symptom of post-traumatic stress. Developed at the Yale Child Study Center, CFTSI fills a gap between crisis intervention and longer-term treatments.



Parent-Child Interaction Therapy (PCIT) is for children ages 2-7 with behavior and parent-child relationship problems. The therapy can be conducted with parents, foster parents, or other caretakers.



Problematic Sexual Behaviors – Cognitive Behavioral Therapy (PSB-CBT) is for children with sexual behavior problems and their caregivers. It is a family oriented, psychoeducation, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems.



Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is for children ages 3-18 with a known trauma history who are experiencing significant PTSD symptoms. Children with depression, anxiety, or shame related to traumatic exposure and children experiencing Childhood Traumatic Grief can also benefit.

A chance to build the toolkit

While 92% of CACs offer TF-CBT—the gold-standard trauma-focused treatment that is appropriate for a wide range of cases and children—just like shoes, treatment for kids isn’t one-size-fits-all. Yet not every CAC has the resources to offer a broad menu of treatment models appropriate for different situations. That’s where our CACs, Chapters, expert partners, and private funders come in.

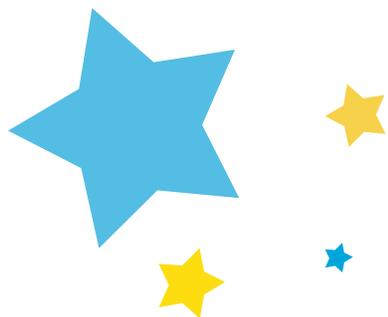
CACs are looking to expand their toolkits to include treatments specialized for serving specific population types, such as kids in certain age ranges or with specific problems. They’re also looking to expand their menu to include short-term treatments for kids in acute care. They also need access to new evidence-based assessments to understand, track, and heal kids facing a variety of different challenges. The five treatments we’ve shared are just part of the menu, but here’s a sample of the help CACs need to meet the needs of kids in their communities.

Number of CACs interested in offering key treatment models

2018 NCA Census



Hundreds of CACs serving tens of thousands of children each are ready right now to add specialized treatments to their menus and make kids’ lives better. One emerging area the CAC movement is addressing now is using tele-health platforms to deliver high-quality, evidence-based services to rural and underserved populations. As these treatments and delivery mechanisms become more common, interest from other CACs will only grow. Thanks for being a part of a bright future for thriving kids!



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