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NCA Institute for Better Mental Health Outcomes®

Pilot Project

Improve and Increase CAC Data Collection on Mental Health Services for Children Served to Improve Mental Health Outcomes

The NCA Improving Mental Health Data Pilot Project

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Executive Summary

Tens of thousands of children are referred to and receive mental health services from Children's Advocacy Centers (CACs) each year. Understanding the effectiveness of mental health services referral processes and mental health treatment requires consistent and accurate data collection by CACs.

In line with its commitment to supporting CACs to collect and record comprehensive, accurate data, NCA launched the Improving Mental Health Data Pilot Project in 2023. The goals of this project were twofold. First, NCA sought to identify existing challenges, needs, strengths, and strategies related to mental health services data collection at CACs. Second, we examined what could be learned about access to and the completion of mental health services if mental health services data collection at CACs was strengthened.

Project approach

The pilot project engaged four CACs with a history of mental health services data collection. Pilot sites committed to collecting and documenting comprehensive data over a 15-month period between April 2024 – June 2025. Pilot sites also provided feedback to NCA about the strategies used to document data, the challenges encountered, and their recommendations regarding needed resources and support.

Executive Summary

Project findings

Feedback from pilot sites highlighted common challenges to consistent data collection and documentation. These included different definitions of the same data fields both within and across CACs, staff turnover and time constraints, and variation across staff in the comprehensiveness of data collection. Pilot sites also identified promising strategies for supporting more robust data collection, including identifying data "cheerleaders," setting aside designated time for data documentation ("data days"), and enhancing buy-in by engaging staff in exploring the ways that data can inform practice.

Encouragingly, the project yielded insight into the kinds of questions about mental health services that can be answered with robust data collection. These include but are not limited to rates of referral, wait times for services, and rates of service completion.

Conclusion and recommendations

The four pilot sites who donated their time to this project were committed to consistent and comprehensive mental health services data documentation. Even with the considerable time dedicated, these sites experienced data-related challenges, demonstrating both the difficulty of comprehensive mental health services tracking, and the need for robust data-related supports. Such support could include:

- The development of a field-wide data dictionary with clear, shared definitions for all mental health data fields,
- Standardized data training for new clinical staff,
- Training and technical assistance that helps CAC-based counseling programs to maximize use of their data in ways that demonstrate the benefits of data collection to clinical staff.

MH Pilot Project

Project background and introduction

Each year, about 285,000 children served by CACs need specialized mental health treatment–but about 80,000 of them don't get access to the services they need (NCA, 2023a). NCA's Mental Health Standard specifies that,

"Evidence-based, trauma-focused mental health services, designed to meet the unique needs of the child and caregivers, are consistently available as part of the multidisciplinary team response" (NCA, 2023b).

To close the services gap, the CAC field needs to better understand potential challenges in the pipeline of mental health services referral, initiation, and completion. To date, however, there are only six published CAC-specific studies that examine how often children start therapy, and only thirteen published CAC studies that examine how often children complete it (Walsh & Herbert, 2023). Aggregating findings across these studies, we can estimate that if 100 children were referred to therapy after going to a CAC, 56 children would start services and 30 children would complete mental health treatment.

There is insufficient research to fully identify the barriers to beginning and completing therapy after a mental health services referral from a CAC. Further, it is unclear whether mental health services data collected by CACs is consistent or comprehensive enough to document rates of service uptake and completion, or to identify the barriers to services.

The goals of this project were therefore twofold. **First**, NCA sought to identify existing challenges, needs, strengths, and strategies related to mental health services data collection at CACs. **Second**, we examined what kinds of things could be learned about access to and the completion of mental health services if mental health services data collection at CACs was strengthened. Ultimately, the purpose of the project was to identify strategies that could improve mental health services data collection across CACs in service of enhancing the field's understanding of how to improve rates of mental health services uptake and completion. To this end, we also hoped to illustrate how mental health data can be used to support and inform practice when this type of data is consistently entered.

Project approach

Four CACs with a history of and commitment to mental health services data collection were recruited for the pilot project. Characteristics of these centers are summarized in Table 1, below.

Table 1. Participating CACs

Region of CAC	Forensic interview/year	Mental health clinicians
Midwest	400	6
Northeast	250	5, few linkage
Northeast	250	3 linkage agreements
Midwest	1,800	6, few linkage

The pilot proceeded in four phases. Sites were recruited and oriented to data documentation requirements between the Fall of 2023 and Spring of 2024. CACs then began comprehensive data collection and recording for all children receiving therapy referrals in April of 2024. Abstraction and analysis of resulting data began in June, 2025 – this length of time was chosen to allow time for referred children to access and complete therapy. Feedback about pilot sites' processes, challenges encountered, and recommendations was elicited throughout the project.

The datapoints collected by CACs are summarized in Table 2, and were collectively designed to enable NCA to answer questions such as:

- When do children typically receive a therapy offer after a referral to a CAC?
- What is the duration of time between a therapy offer and attending the first counseling appointment?
- Are there differences between youth with problematic sexual behavior (PSB) and those without PSB in terms of accessing therapy?

For this project, these questions were selected as examples to serve as mechanisms for illuminating specific challenges associated with documenting information about the process of providing mental health services. Enhancing the degree to which these, and other questions can be answered with robust data set will ultimately help us learn what factors can contribute to healing. Thus, with this project, we also hope to convey to the field that entering mental health data is a critical part of providing an evidence-based trauma-focused quality mental health program.

Table 2. Data field summary

Domain	Data fields
Victim demographics	Date Case Received, Age, Sex, Race, Combined Maltreatment, YPSB Indicators
Offender Demographics	Age, Sex, Race, Relationship to Victim
Forensic Interview	Therapy Offered Date, FI Session Date, FI Session Status, FI Disclosure
MH Session Details	Session Date, Session Onsite, Session Location, Intervention, Session Status, Session Type
Provider Log Details	On Waiting List, Reason Therapy Ended, Therapy Accepted, Therapy Complete Date, Therapy Offer Date, Treatment Model
Assessment Details	Assessment Date, Instrument, Description, Score, Assessment Timing

Project findings

Goal 1: Identify existing state of play

The first goal of the data pilot project was to identify existing challenges, needs, strengths, and strategies related to mental health services data collection at CACs. More specifically, NCA assessed:

- How did sites get buy-in to enter mental health data?
- Who enters the data?
- What are barriers to consistent data collection?
- What facilitates consistent, accurate mental health data collection?

Getting buy-in

Pilot CACs reported using several strategies to increase commitment from staff charged with entering mental health data. These included engaging mental health department staff as partners in developing a plan for enhanced data collection, approaching staff with a "how can we" as opposed to a "thou shalt" approach, and identifying ways that increased data collection would be mutually beneficial to both the agency and to clinicians.

CACs also reported the importance of tangibly demonstrating how data could be used to highlight successes and to inform adjustments to practice. This was

accomplished through strategies such as showing clinicians data visualizations that helped to concretize the stories that data could tell. CACs also identified and communicated ways that more robust data collection would save time and energy in the long run, for example by eliminating the need to later hand-tabulate session counts or collate notes from disparate locations.

Who enters the data?

A wide range of staff roles were involved in data collection and documentation across the participating CACs. These included non-clinical staff such as advocates, administrative staff, interns and volunteers, as well as clinical staff such as therapists and student therapist interns. Across these roles, common reported challenges included staff transitions and the need to re-train new staff on the project, time constraints, and a lack of buy-in from some clinicians. Some CACs also engaged the assistant director or MDT coordinator in mental health data entry, with no major challenges reported for these roles.

What are the barriers to consistent data collection?

Over the course of the project, pilot sites noted a few challenges to consistently collecting and documenting mental health services data. Most prominent among these was staff turnover. Turnover in positions directly responsible for data entry, or for training staff in data entry led to gaps in data documentation, and in one case, to a CAC no longer being in a position to serve as a pilot site. Sites also noted that it was difficult to arrive at consistent, shared definitions for some data fields, and for data to be recorded in identical ways across staff. Even with extra focus on data collection, pilot sites also reported that some data fields continued to be difficult to consistently capture, resulting in missing data. Finally, some pilot sites noted that it was difficult to achieve buy-in among busy clinicians, contributing to some inconsistency in data collection.

What helps with data collection?

Finally, key themes for what helps with entering mental health data are summarized in Table 3. These included having a data champion, allocating time to run missing data reports, and finding ways to use the data to motivate more complete data entry. Even when CACs were committed to improving data entry, all CACs experienced challenges suggesting that it is important to educate staff that improving mental health data takes time.

Table 3. What helps with data collection?

Tactic	Details
Identify a cheerleader	Have a "cheerleader." Identify someone on the mental health team who is excited about and motivated to lead the team on entering data.
Identify a quality checker	Identify a specific person to regularly check if data is complete and to run missing data reports.
Institute “Data Days”	Set aside half or full days of protected staff time for data entry, reviewing fields for completeness, and back-entering missing data.
Include data in supervision	Include a review of data completeness and quality in supervisory meetings and employee goals.

Goal 2: Explore questions to answer with data

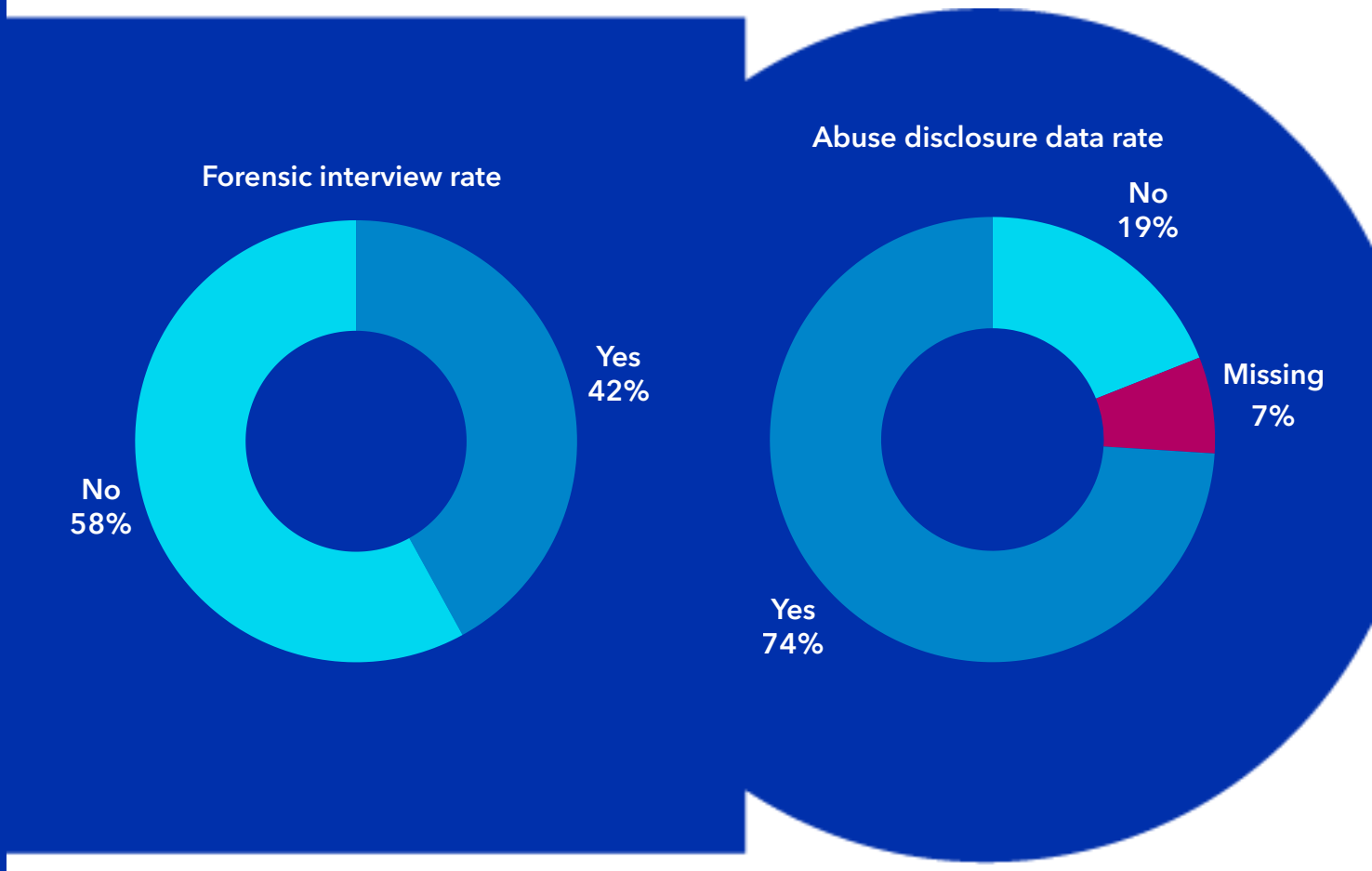
The second goal of the pilot project was to explore some of the kinds of questions that could be answered with enhanced mental health services data entry, and to examine how the process of data entry enhanced or foreclosed opportunities to use the data. In this section, we provide a summary of some of the data findings, exploring how the consistency of data collection contributed or detracted from the kinds of conclusions that can be drawn. This is not an exhaustive list of the kinds of analyses that mental health data can support; these data points were selected as illustrative examples. Specifically, we address the following example findings:

- What percentage of youth do a forensic interview, and what percentage subsequently disclose abuse?
- When do youth receive an offer for therapy relative to the referral to a CAC and relative to a forensic interview?
- What is the length of time between a therapy offer and initiating mental health services?
- Are there differences between youth with and without problematic sexual behaviors (PSB) with respect to referrals for therapy?

Q1: What percentage of youth have a forensic interview and disclose abuse?

This question can be addressed for youth without PSB only. Of the 569 youth without problematic sexual behaviors in the sample, the reason for referral to the CAC for most youth (72%) was an allegation of abuse. Missing data restricted a full analysis of this question; the reason for referral was missing for 21% of youth. As shown in Figure 1, 42% of youth had forensic interviews, and of those with a forensic interview (N=237), 74% disclosed abuse. Capturing this information alongside mental health data allows CACs to assess relationships between referral types, forensic interviews, and access to mental health services.

Figure 1. Rates of forensic interview and abuse disclosure



Q2: When do youth receive an offer for therapy?

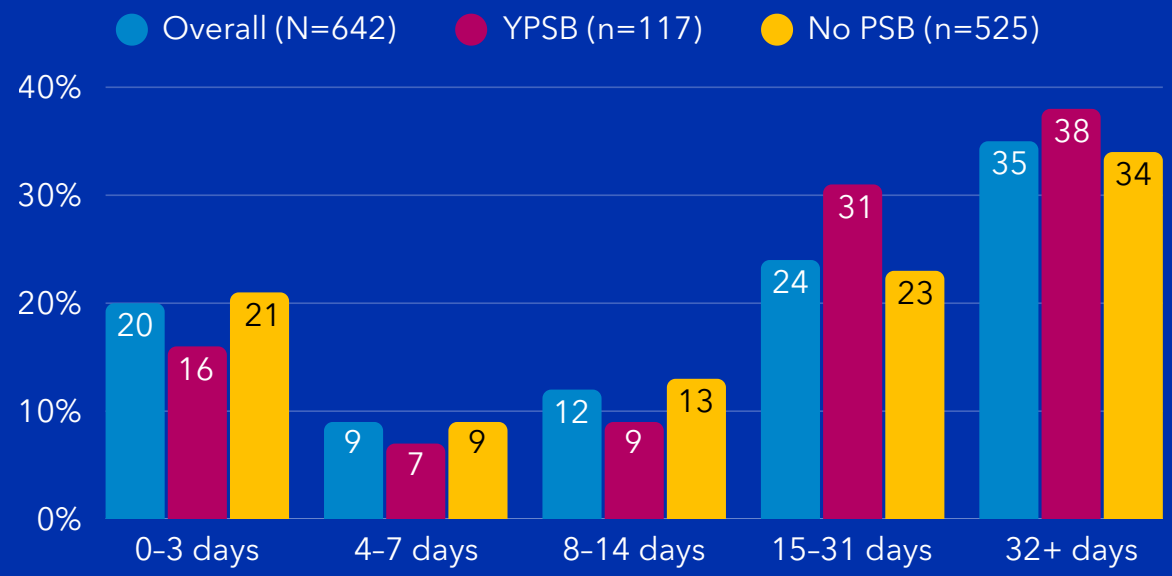
As depicted in Figure 2, some youth (20%) received an offer for therapy within 3 days after the CAC received their initial referral. For some youth, it took up to a month after the CAC received the initial referral to receive an offer for therapy (4 to 7 days for 9% of youth, 8 to 14 days for 12% of youth, and 15 to 31 days for 24% of youth). Approximately one-third of youth (35%) received a therapy offer more than one month after the CAC received the referral. There was no significant difference between when therapy was offered and problematic sexual behavior (PSB) status. Approximately 7% of cases were missing data about the timing of the therapy offer, making it one of the stronger data points to emerge from the pilot project.

When pegged to the date of a forensic interview, therapy offers were more timely. Just over half of youth (62%) received a therapy offer the same day as the forensic interview. About 1 in 10 youth (12%) received it between 1 to 14 days after forensic interview, 8% of youth received it between 15 and 31 days later, and 8% of youth received it month than 1 month later. This was missing for 10% of youth.

These findings suggest that there is some variability in the length of time it takes for a child to actually have access to a counseling appointment (a therapy offer), and that mental health wait times continue to be a challenge in some U.S.

communities. Consistently collecting data about the interval between visiting a CAC and receiving a therapy appointment offer would allow CACs to track trends in mental health services wait times, as well as the impact of any wait time mitigation strategies implemented by a CAC.

Figure 2. Timing of therapy offers relative to a referral to a CAC

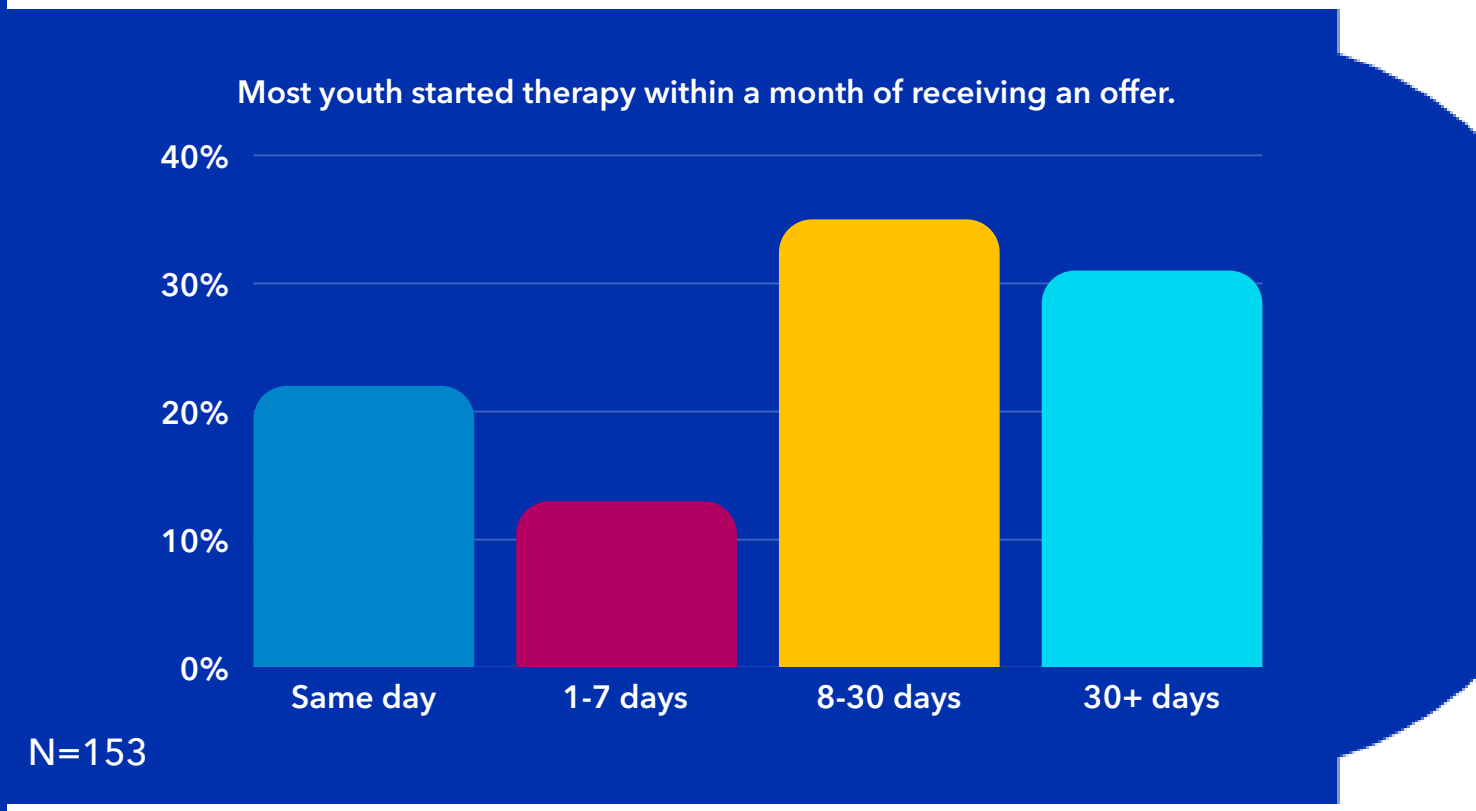


Q3: When do youth start therapy?

As depicted in Figure 3, data from the pilot sites showed that approximately 1 in 5 youth (22%) start therapy the same day it was first offered, 13% start between 1 and 7 days later, 35% start between 8 days and 1 month, and 31% start more than 1 month later. There was also a significant amount of missing data for this field. Pilot sites noted that they tracked therapy initiation via the date a treatment plan was established. However, some youth may have started therapy earlier than this date, and pilot sites noted that the treatment plan date was inconsistently recorded for others.

This is an example of both the challenge of operationalizing data points such as "therapy start date," and of implementing a consistent approach to measuring these data points. Still, consistent documentation of therapy start times can assist CACs to track attrition, and the reasons that therapy initiation may be delayed for some youth or not happen at all.

Figure 3. Therapy start times



Q4: How does access to mental health services differ for youth with and without problematic sexual behaviors (PSB)?

Although there was no difference between youth with and without PSB in terms of when they were offered mental health services, data from the pilot project showed that youth with PSB were significantly more likely to stop therapy before completion compared to youth without PSB. Specifically, 34% of youth with PSB stopped therapy prematurely by the end of the pilot project, compared to 19% of the youth without PSB. In contrast, at the end of the pilot project, a higher percentage of youth without PSB (56%) were still engaged in therapy, compared to 42% of youth with PSB. Consistently tracking these data points enables CACs to assess differential barriers to services, reasons for attrition, and different supports needed for subgroups within a center's mental health caseload.

Conclusion and recommendations

Given the fundamental importance of providing effective ways for children to heal from abuse, it is critical for CACs to track case and efficacy data about mental health services. This project helped to explore both the process of mental health data tracking, and the kinds of questions that can be answered when data is consistently collected.

NCA is extremely grateful to the four pilot sites who dedicated extra time to enhancing their mental health data collection and to providing recommendations about strategies to improve consistent data tracking. These sites noted that even during a period of committed data collection, they experienced challenges to consistently entering mental health data such as staff transitions, and lack of clinician buy in. CACs noted that things that helped improve data consistency were having a data cheerleader, allocating time to run missing data reports, and finding ways to use the data to motivate more complete data entry.

The lessons learned from the mental health data pilot project suggest the following strategies may be helpful for enhancing consistent, accurate mental health services data across the field as a whole:

- It is important to establish a field-wide data dictionary with clear, shared definitions for all mental health data points, and instructions for how to calculate and enter the information relevant to each data field.
- Designing standardized, evergreen data training for new clinical and data management staff can assist with mitigating the impact of CAC staff turnover on the consistency and accuracy of data collection.
- Pilot sites noted the importance of engaging relevant staff early in the data project and partnering to identify both the potential benefits of improved data collection, and strategies to support it.
- Setting aside designated time for data documentation and entering missing data, as well as including conversations about data in supervision meetings may enhance the consistency of data collection.
- CACs need training and technical assistance that support CAC-based counseling programs to maximize use of their data in ways that demonstrate the benefits of data collection to clinical staff.

When CACs have robust information about mental health services referrals, wait times, treatment initiation and treatment outcomes, this data can be used to highlight strengths, enhance services, address barriers, and advocate for additional funding. The generous CACs who served as pilot sites during this project demonstrated that robust mental health services data collection, while difficult, is possible and beneficial.

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