CAC Directors Guide to Mental Health Services for Abused Children

A Joint Project of

The National Child Traumatic Stress Network

&

The National Children's Alliance

With Support from SAMHSA and
The National Center of Child Traumatic Stress

NCTSN The National Child Traumatic Stress Network

National Child Traumatic Stress Network - Mission

To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

One of the key functions of the NCTSN is transferring research and learning to practice

NCA Standards for Accreditation

- Standard 1: Child-Appropriate/Child Friendly Facility (psychological safety)
- Standard 2: Multidisciplinary Team
- A multidisciplinary team for response to child abuse allegations includes representation from the following: law enforcement, child protective services, prosecution, mental health, medical, victim advocacy, and children's advocacy center staff.

NCA Standards for Accreditation

- <u>Standard 3: Organizational Capacity</u>

  A designated legal entity responsible for program and fiscal operations has been established and implements basic <u>sound administrative practices</u>.

- <u>Standard 4: Cultural Competency and Diversity</u>

  Culturally sensitive treatment interventions

NCA Standards for Accreditation

- **Standard 5: Forensic Interviews**

  The CAC promotes forensic interviews which are legally sound, are of a neutral, fact finding nature, and are coordinated to avoid duplicative interviewing (developmental issues, mental health history)

- **Standard 6: Medical evaluation**

  (input regarding medical or psychiatric conditions that might impact behavior and require treatment)

NCA Standards for Accreditation

- **Standard 7: Therapeutic Intervention**
  Specialized mental health services must be made available as part of the team response, either at the children's advocacy center or through coordination with other treatment providers.
- **Standard 8: Victim Support/Advocacy**
  Victim support and advocacy are to be available throughout the investigation and prosecution (and supportive of treatment)

NCA Standards for Accreditation

- **Standard 9: Case Review**

  Team discussion and information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis. (cross training/treatment planning)
- **Standard 10: Case tracking**

  CACs must develop and implement a system for monitoring case progress and tracking case outcomes for all team members (MH interventions and outcomes)

Implementing the Standard

- Provision of mental health services to child victims and their families is a CAC standard for accreditation
- A Partnership between CACs and the NCTSN is in the best interest of abused children and their families and is in the best interest of our communities

NCA Mental Health Standard

- The primary form of trauma experienced by children is child abuse.
- But these children may have very complex trauma histories beyond child abuse
- CACs serve child victims of abuse and their families.

Mental Health Interventions (CAC on site or by referral)

- Establish a sense of safety for the child
- Assess the impact of the abuse, physically, emotionally, socially, educationally and psychologically.
- Reduce any negative effects identified through the assessment.

Responsibility of the CAC (on site or by referral)

- Help the child integrate the traumatic events psychologically
- Address and reduce any negative effects on behavior and development
- Provide support and guidance to the child's family

Why Best Practices Have Not Spread Widely in CACs

- Child victims have not been the tradition client of public mental health
- CACs have focused interventions on investigation vs. mental health treatment
- CACs have not fully integrated mental health into their MDT
- NCA standards do not address the quality of services provided

Barriers to Recovery/Evidence Based Mental Health Services in or through CACs

- Initial focus of CACs was investigation.
- Lack of attention to mental health issues and interventions
- Impact of the legal focus of the CAC on treatment decisions in <u>some</u> centers
  - Potential Conflict- Therapy vs. Prosecution
- Impact of the court process on child's recovery
  - Juvenile Court-testimony, visits, placement reunification, changes in schools
  - Criminal Court-reinterviews, testimony, timing
  - Conflicts in timing of different courts

Barriers to Evidence Based Mental Health services in or through CACs

- Disconnection between the problems presented by traumatized children (and their families) and the interventions used by therapists.
- Disconnection between current scientific knowledge and practice in the field.

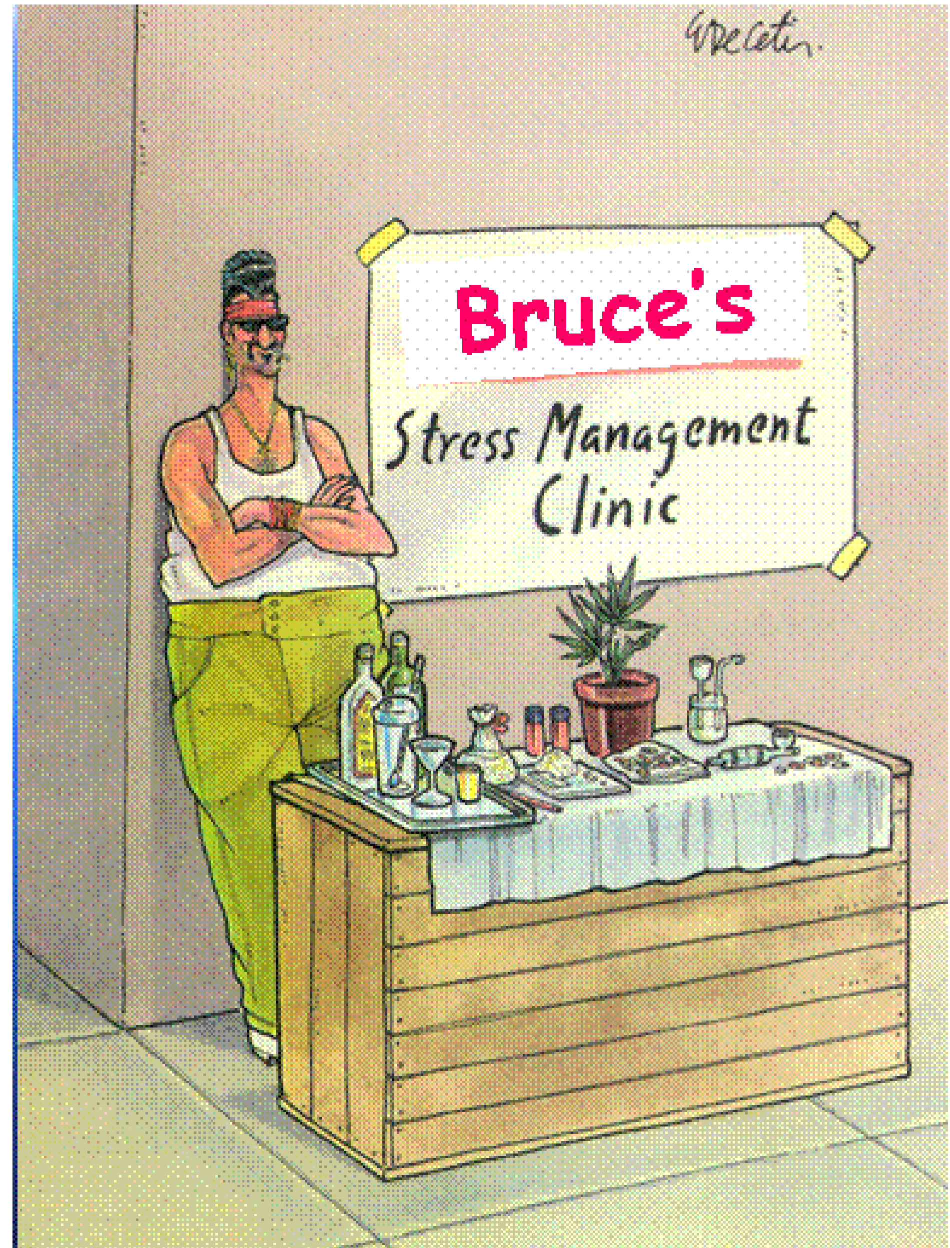
Barriers to Evidence Based Mental Health services in or through CACs

- Providing available treatment vs. appropriate trauma focused treatment
- Poor communication between treatment providers and treatment brokers.
- Mental health providers do not have access to or knowledge of best practices in child abuse interventions

This Reflects Problems in Wider Behavioral Science World

- Empirical evidence of efficacy has not been a common criteria for treatment selection in the many places.
- Lack of outcome research for many commonly used interventions.
- Poor dissemination of the significant clinical outcome research that has been done.
- Naturally self-limiting dissemination models for empirically supported practices
- Ready willingness among some to use, embrace, promote, and staunchly defend practices that have no evidence for their efficacy and questionable theoretical bases.

All sorts of "treatments" are available out there.



Thought Field Therapy

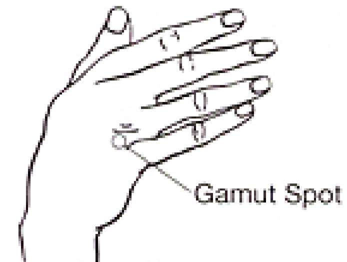
All Things Considered, March **29, 2006 ·**

“In the wake of Hurricane Katrina, ….. some mental health workers are using untested therapies -- and that is prompting concern. One controversial treatment is thought field therapy, which is being used to aid victims of Katrina in New Orleans.”

“According to psychologist Roger Callahan, the creator of thought field therapy, major problems like depression can be cured quickly with this method. He says post-traumatic stress disorder is easily dispatched in 15 minutes, and even the most serious cases of anxiety, addiction and phobias are likewise subject to quarter-hour cures.”

The 9 Gamut Treatment Sequence

1. Eyes Open
2. Eyes Closed
3. Eyes open down to right
4. Eyes open down to left
5. Eyes in a circle
6. Eyes in a circle–opposite direction
7. Hum a tune outloud
8. Count to five outloud
9. Hum a tune outloud



Tap 10 times at each of the following locations:

Outside edge of eyebrow

Under eye

Under arm

Collarbone

Proceed to 9 Gamut treatment (tap continuously on the spot marked below while following treatment steps)

Why worry about doing Best Practice?

The Post and Courier

Therapist gets jail in 'rebirthing' death

Woman receives minimum 16-year prison sentence

Associated Press

GOLDEN, COLO.—A therapist was sentenced to 16 years in prison Monday in the death of a 10-year-old girl who suffocated while wrapped in blankets during a "rebirthing" session.

Connell Watkins, 54, received the minimum sentence for the death of Candace Newmaker. The therapist could have gotten 48 years behind bars.

"I failed Candace and I failed her mother," Watkins told Judge Jane Tidball. "I failed to keep Candace out of harm's way."

The girl was covered in blankets and pillows meant to simulate the womb and was encouraged to push her way out during the April 2000 session. Therapists hoped she would emerge "reborn" to bond with her adoptive mother.

A jury convicted Watkins of reckless child abuse in April. A second therapist, Julie Ponder, who led the session in Watkins' home, was convicted of the same charge and awaited sentencing later Monday.

Prosecutor Steve Jensen argued for the maximum sentence, saying Watkins had shown little remorse. He called the therapy "torturous cruelty of a sickening and depraved nature."

But the judge noted that Watkins had no criminal record and said there was no indication she had ever meant to hurt Candace.

Tidball said the sentence would send a powerful message to other therapists.

A videotape of the 70-minute therapy session was shown to the jury.

Four adults leaned on Candace with pillows, applying several hundred pounds of pressure.

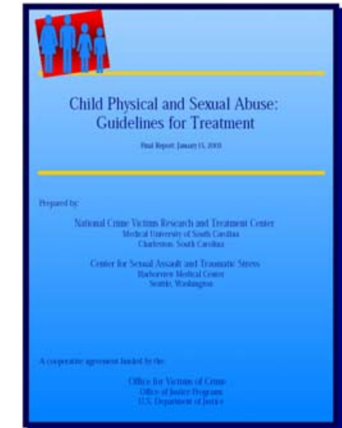
The girl had been diagnosed with attachment disorder, in which children resist forming loving relationships and are violent and unmanageable.

Colorado has since outlawed the New Age form of therapy.

Candace's adoptive mother, Jeane Newmaker, is scheduled to go on trial in November on charges of criminally negligent child abuse.

Watkins' office manager and an intern await trial in September.

Questions to ask of any Practice or Treatment

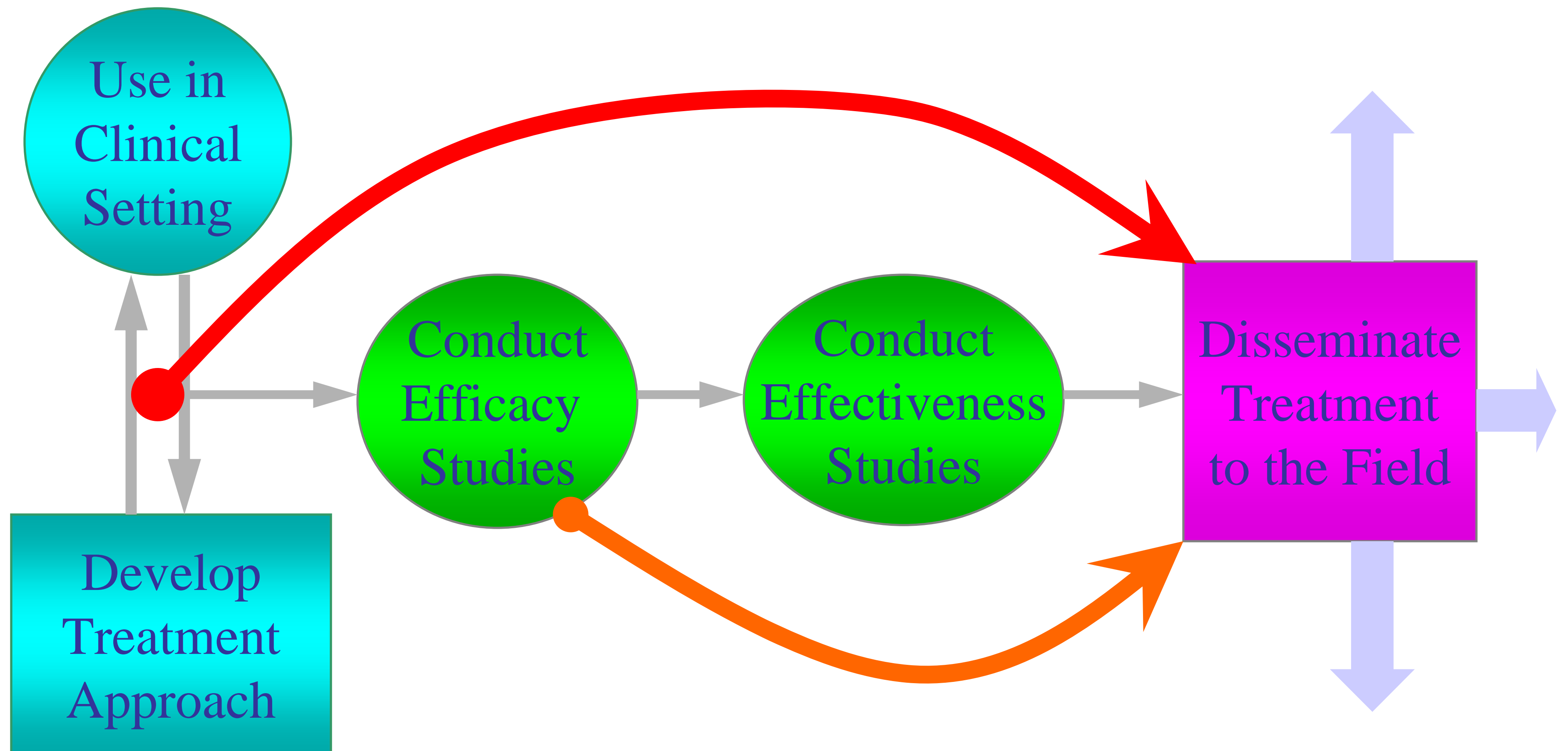


- **Is it based on a solid conceptual and theoretical framework?**
  - Is the theory upon which it is based widely accepted?
  - Is there a logic model that makes sense?
- **How well is it supported by practice experience?**
- **Does is have an acceptable benefit vs. risk for harm ratio?**

www.musc.edu/cvc

- **Can it be used by the average provider?**
  - Are books, practice manuals, and procedure descriptions available?
  - Is training, supervision, and consultation available?
  - Is there any reason the practice cannot be used with the clients you work with?
- **How well is it supported by scientific research?**
  - How many evaluations have been conducted?
  - How rigorous were the research designs? How strong are the results?
  - How relevant are the results to your clients?

The Ideal Clinical Science Process



CAC Directors Guide to Mental Health Services for Abused Children

1) Overview of Trauma
2) Trauma and the Investigative Process
3) Trauma Assessment
4) Trauma Informed-Evidence Supported Treatments
5) Parental/Caregiver Engagement and Motivation
6) Mental Health Treatment for the Juvenile/Criminal Justice Systems
7) Mental Health Treatment and the Team
8) Securing Quality Trauma Mental Health Services in the Community
9) Supervising a Mental Health Component When You are Not a Mental Health Practitioner
10) Securing Financial Support for Trauma Treatment

Traumatic Events

"Traumatic events often produce great emotional stress. This stress often manifests itself in destructive and maladaptive ways that can impair the child's ability to relate to others, to succeed in school and to control his or her emotions and behaviors. Trauma related stress has been linked to a host of short and long term adverse outcomes.

We have an obligation to prevent these adverse consequences if we can."

It is important to remember that not all adverse events that children experience should be qualified as traumatic. The child's response to the event determines if it is appropriately categorized as traumatic.

How do children react to Trauma?

A number of factors influence how a child reacts to a specific traumatic event including:

- Severity of the trauma
- Extent of exposure to the event
- History of or presence of other stressors
- Multiple episodes of abuse or exposure to violence
- Proximity to the trauma
- Preexisting psychopathology
- Personal significance of the trauma
- Separation from a caregiver during the trauma
- Extent of disruption in support systems during and after the trauma
- Parental psychopathology and parent distress
- Support available from family members
- Presence of supportive role models in the child's life
- Genetic predisposition

Differences in Responses to Trauma

Some children appear to have a natural resilience and show little outward effect. Other children react strongly and meet full criteria PTSD and still many others show only some post traumatic symptoms or react in other ways from depression to acting out.

A child's response to trauma often is influenced by their developmental level:

- **Preschool Children**
- **Elementary School Aged Children**
- **Adolescents**

Trauma and the Investigative Process

a) How trauma affects children's ability to recount events.

Memory Loss

Details of Abuse

Fantastic Statements

b) How some normal trauma derived behaviors may confuse investigators

Children Wanting to be with Abuser

Children Attached to the Abuser

Children with No Emotional Reaction

Considerations in Meeting CAC Mental Health Standards

- In House-CAC therapist
  - Staff
  - Clinical Supervision
  - QA
- Community referral
  - Community agency
  - QA
  - Feedback
- Hybrid

Considerations to Enhance the Quality of CAC Mental Health Services

- What assessments do we do on all children seen?
- Are treatment plans related to assessment?
- Are the treatment outcome goals consistent with the goals of the child protection system?

Trauma-Informed, Evidence-Supported Treatments

Determine what approach the clinician/agency uses with children and families. Regardless if a person uses an evidenced based model, a therapist should be able to discuss the following core issues:

- How they build a strong therapeutic relationship
- What constitutes psycho-education about normal responses to trauma
- How parent support/conjoint therapy or parent training is offered
- Techniques for assisting with:
- Affect expression and regulation skills
- Anxiety management/relaxation skills
- Cognitive processing/reframing
- Construction of a coherent trauma narrative
- Strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
- Personal safety/empowerment activities
- Resiliency and closure

Questions to Ask Providers

1. Is your treatment based on comprehensive trauma assessments?
2. Does your treatment have measurable outcomes?
3. Do you have specialized training and supervision to address trauma symptoms common in child abuse victims?
4. Are you willing to participate in case reviews at the CAC with your clients consent?
5. Is your treatment plan consistent with the court ordered plan?
6. How do you regularly evaluate the efficacy of your services?

Administrative supervision includes

- Staffing issues, including background checks
- Defining the scope of care including specific populations to be served
- Setting Productivity Standards and tools to track productivity performance
- Development of policies and procedures
- Legal considerations
- Financial viability/ relationships with a variety of funding sources
- Relationships with community partners
- Evaluating outcomes of treatment
- Creating linkages between the mental health and other components within the CAC
- Malpractice insurance
- Other liability issues

Clinical supervision includes the following components:

- Developing a procedure for screening referrals to ensure that clients accepted fit within the CAC's Scope of Care
- Establishing clinical policies and procedures
- Establishing a defendable clinical record of every client served
- Maintaining confidentiality of all clinical information consistent with state and federal regulations
- Identify a HIPPA compliance officer
- Developing procedures that consider how the treatment of family members is coordinated within the CAC
- Developing and maintaining a trauma assessment procedure
- Ensuring quality services through training on evidence based practices
- Providing individual and group supervision for CAC therapists
- Providing clinical case consultation
- Creating an atmosphere in which countertransference issues can be explored
- Providing oversight functions for high risk clinical issues
- Overseeing a Quality Assurance or Continuous Quality Improvement process for therapy cases.

Considerations to enhance the Quality of CAC Mental Health Services In Your Community

- **Have we identified the standards of practice in our community for child victims, for caregivers and for offenders?**

- **How can we raise the bar in our community in support of best mental health practices and positive intervention outcomes for child victims and their families?**

- **Advocate for services for child victims/families**

- **Advocate for Evidence Based Services**

What is Post Traumatic Stress Disorder?

Post Traumatic Stress Disorder (PTSD) is a mental disorder listed in the Diagnostic Statistical Manual IV (DSM IV). To meet full diagnostic criteria for PTSD in the following must be present:

A. **Traumatic event in which both of the following were present:**

1. Actual/threatened death or serious injury, or a threat to their physical integrity

2. Intense fear, helplessness, or horror.

B. **Re-experience of trauma** such as recurrent and intrusive distressing recollections, recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring, intense psychological distress when confronted with trauma triggers, and physiological reactivity on exposure to internal or external cues.

PTSD (con't)

C. **Persistent avoidance of stimuli** (indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
2. Efforts to avoid activities, places, or people that trigger recollections
3. Inability to recall an important aspect of the trauma;
4. Markedly diminished interest or participation in significant activities;
5. Feeling of detachment or estrangement from others;
6. Restricted range of affect (e.g. unable to have loving feelings);
7. Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

PTSD (con’t)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:

1. Difficulty falling or staying asleep;
2. Irritability or outbursts of anger;
3. Difficulty concentrating;
4. Hypervigilance;
5. Exaggerated startle response.

E. The symptoms on Criteria B, C, and D last for more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.