Enhancing Canadian Child Advocacy Centers With A Mental Health Component

Tomisin Iwajomo, MPH

University of Saskatchewan
School of Public Health

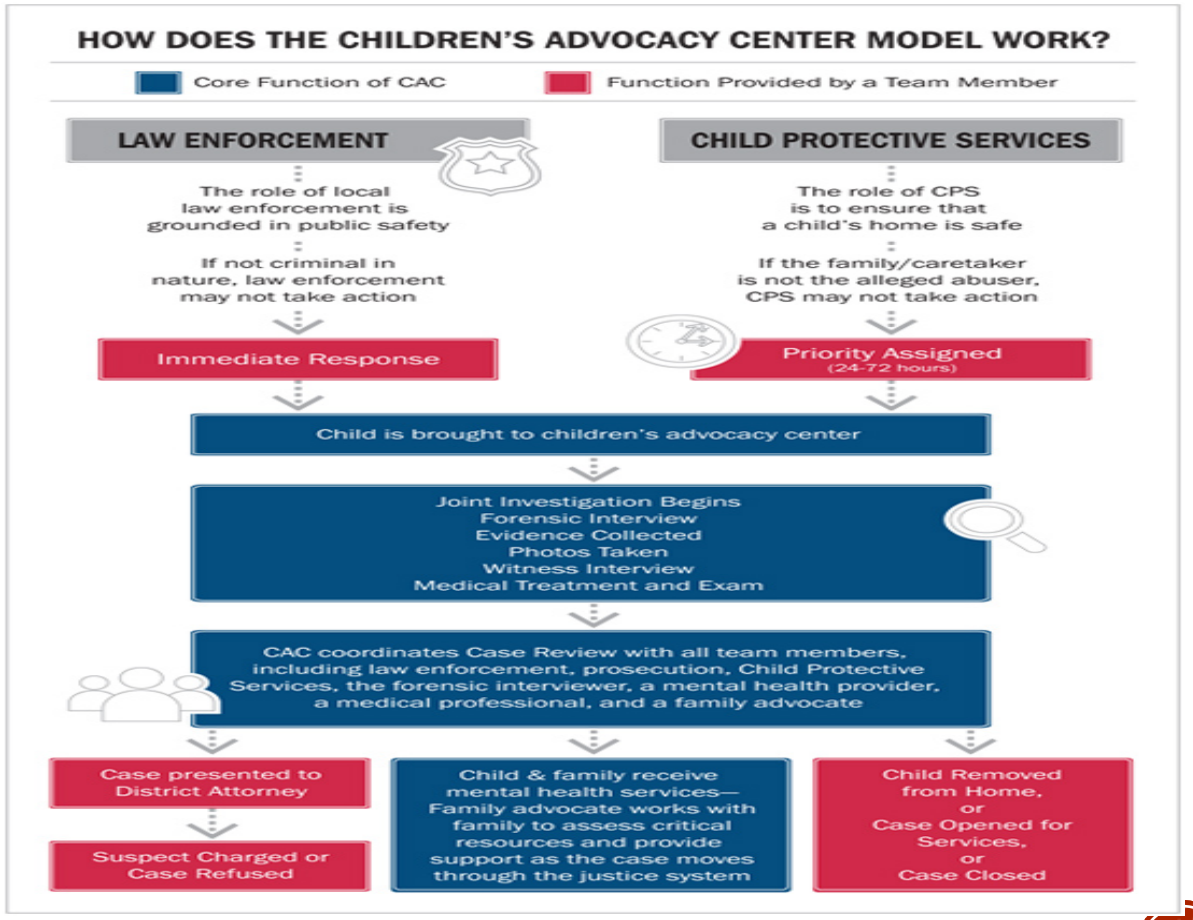
Saskatoon Health Region

BACKGROUND/INTRODUCTION

- **Child abuse and maltreatment has been identified as a risk factor for varying mental health, emotional and developmental disorders, behaviours and outcomes.**
- It is a complex phenomenon that requires a multidisciplinary response; as victims of crime and their non-offending families usually require a combination of services including medical, legal, therapy/counseling support.
- Delay in receiving therapy is detrimental to the child's health and results in trauma; this has lifelong health consequences for survivors of abuse.
- Child Advocacy Center's (CACs) were developed to provide services to reduce trauma, harm and discomfort faced by child victims/witnesses of abuse and their families all with a coordinated approach.

BACKGROUND/INTRODUCTION

- However, few child centers in Canada fully incorporate the CAC model, thus creating a gap in services available for children impacted by abuse; in addition to the unspoken court process policy.
- The Saskatoon Centre for Children's Justice (SCCJ) partnered with the Mental Health and Addictions service (MHAS) of the health region.
- The aim was to become a full CAC; enhance present services with the addition of two dedicated mental health positions and help reduce harm and trauma suffered by children impacted by abuse.



METHODS

Literature and Document Review

- Case notes; therapy intervention tracking forms

Satisfaction Survey

- Qualitative and quantitative

Child and Adolescent Functional Assessment Scale (CAFAS)

- Standardized clinical outcome measure

Process and Outcome Evaluation

- Utilized Information collected from the therapy intervention forms and data analysis to determine process changes and outcome
- Created a logic model depicting the inputs, activities/resources and the impacts/outcomes

METHODS

Survey Themes:

Survey data were analyzed based on the following six themes:

- Education, Collaboration and enhanced services
- Timely and accommodating Service
- Family Centered Care
- Clinician Knowledge and Skills
- Knowledge and awareness of Parents role
- Valuable and Positive Outcomes

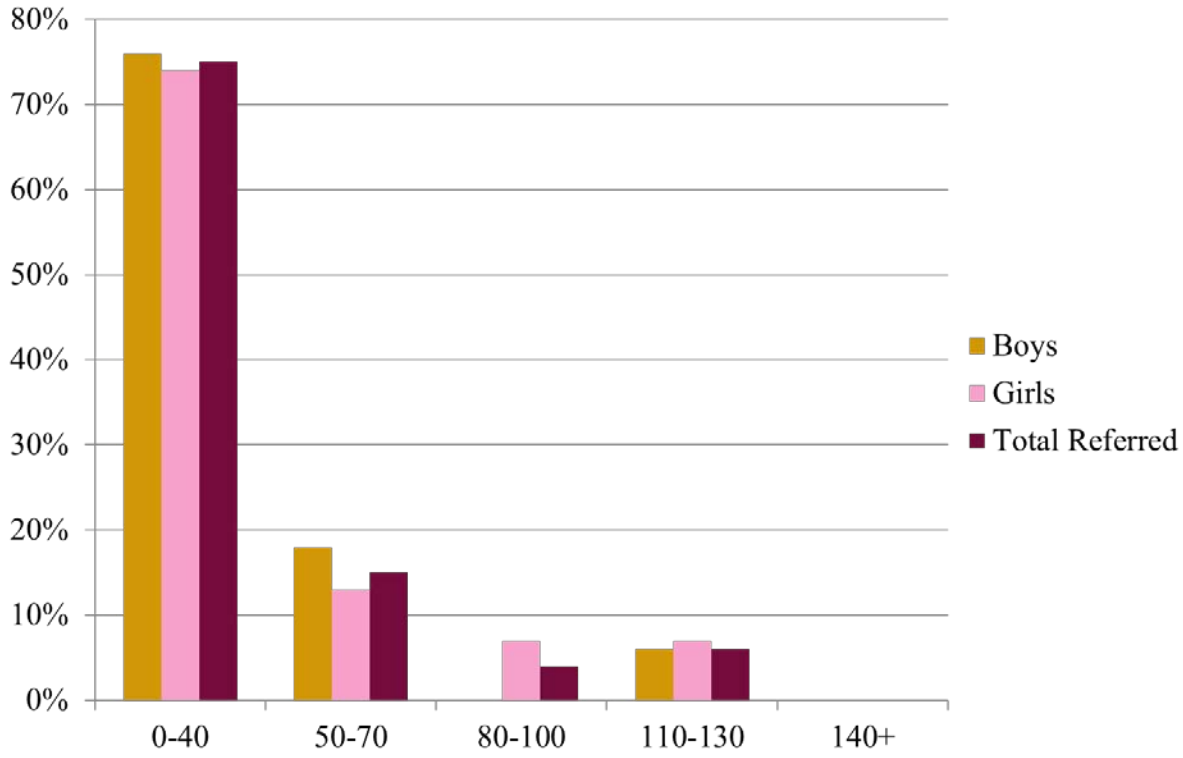
MEASUREMENT INDICATORS

- Has the program being successful in attaining the anticipated implementation objectives?
- Were the services or training which were initially planned for implementation actually implemented?
- Did we reach the intended target population and the intended number of participants?
- Are we developing the planned collaborative relationships?
- Was the program delivered as designed?

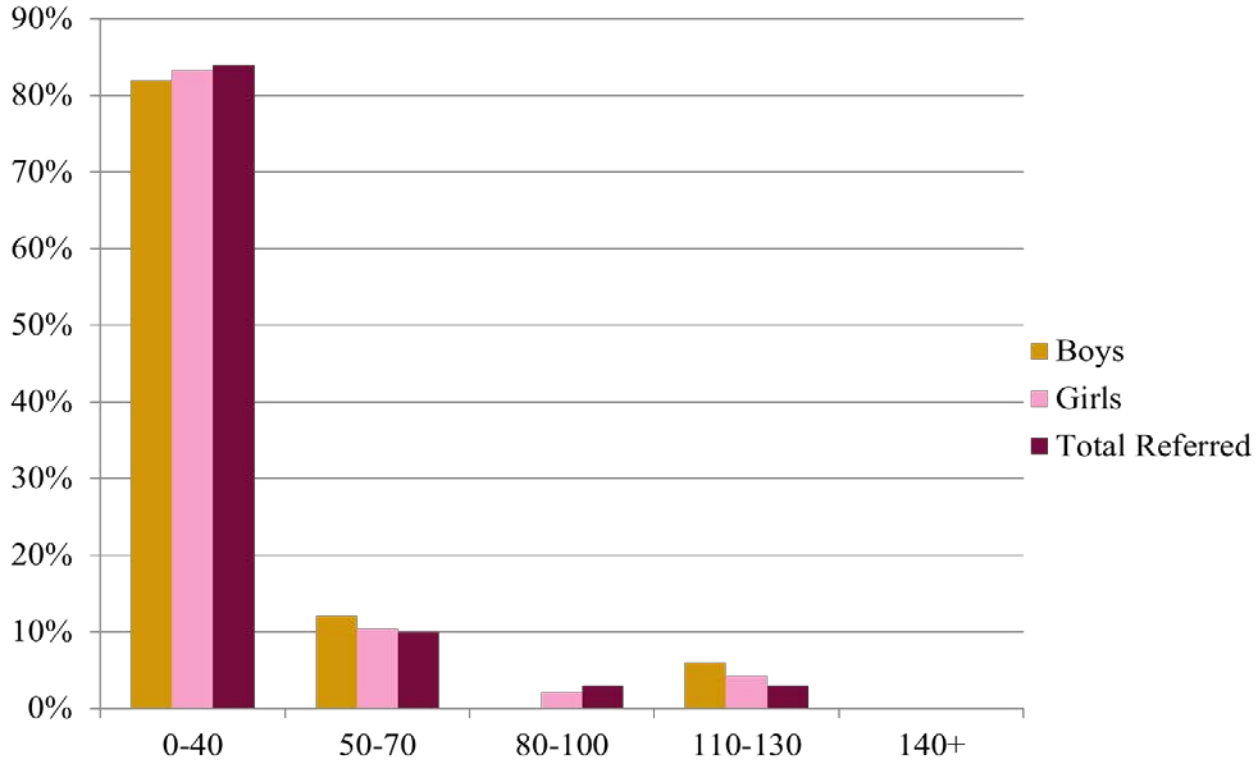
RESULTS

- Organization survey achieved a response rate of 100%.
- The client surveys achieved a response rate of 50%.
- Mental health functioning of the clients largely improved (CAFAS scores, subscales, clinical markers and tiers, including initial and exit scores).
- Based on the theme valuable and positive outcomes; 77% of respondents were able to move past the trauma and be supportive for their children, whilst 23% were neutral.
- Largely based on the survey alone, there was evidence of improvement in child's functioning separate from the CAFAS Scale.

RESULTS

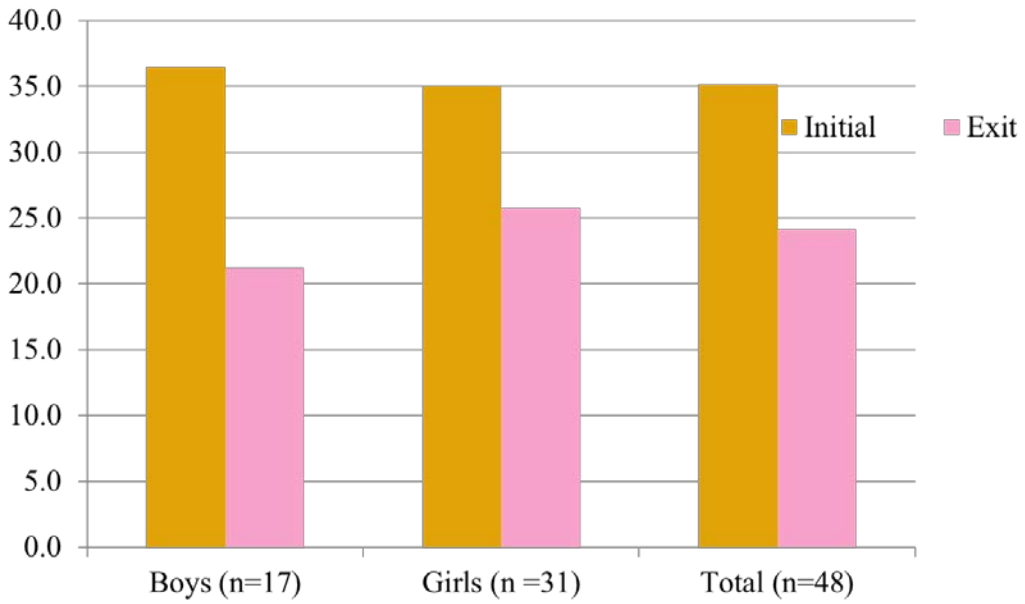


CAFAS scores by severity interval on entry

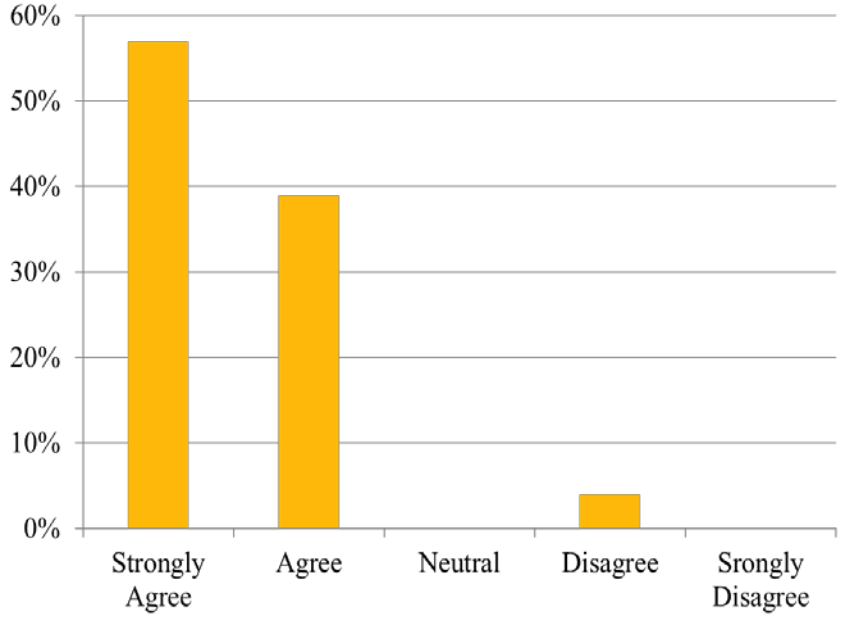


CAFAS scores by severity interval on exit

RESULTS



Mean CAFAS total score on entry and exit

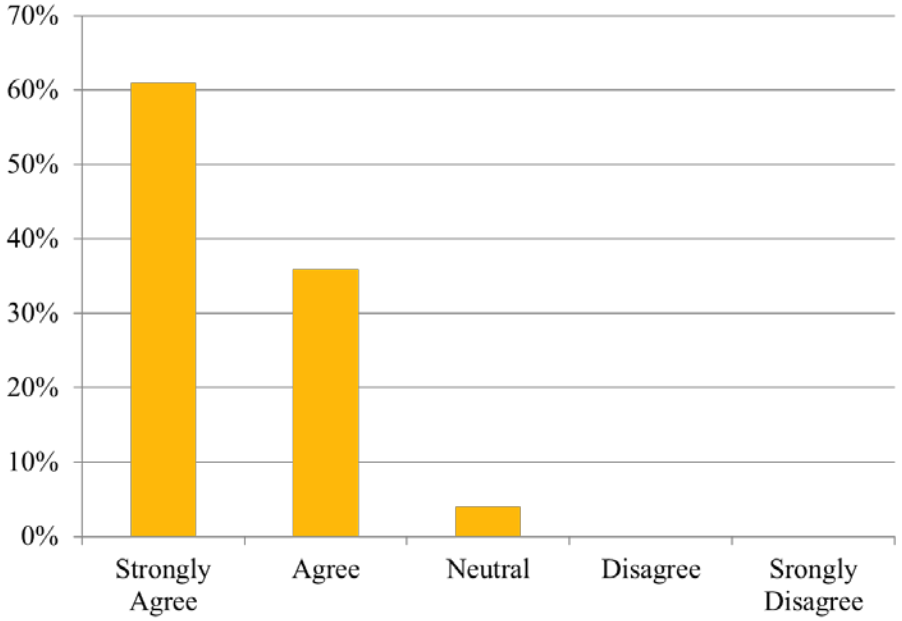


My child's behaviour has improved since we started seeing our clinician

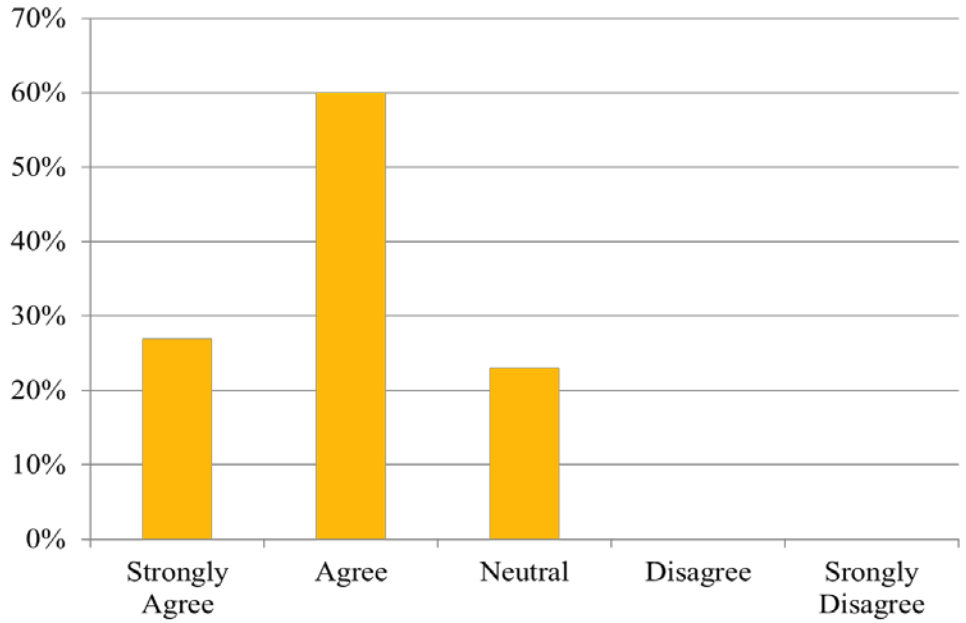
RESULTS

- Timely and accommodating service is essential to the success of the CAC model
- Results showed an improvement in average wait times, compared to standard entry to the mental health service (shortest wait time was 1 week, the longest was 5.5, this was an outlier).
- There was a significant decrease in barriers to service access with transportation support and other outreach services.
- Other themes represented here are education, collaboration and enhanced services and family centered care.

RESULTS

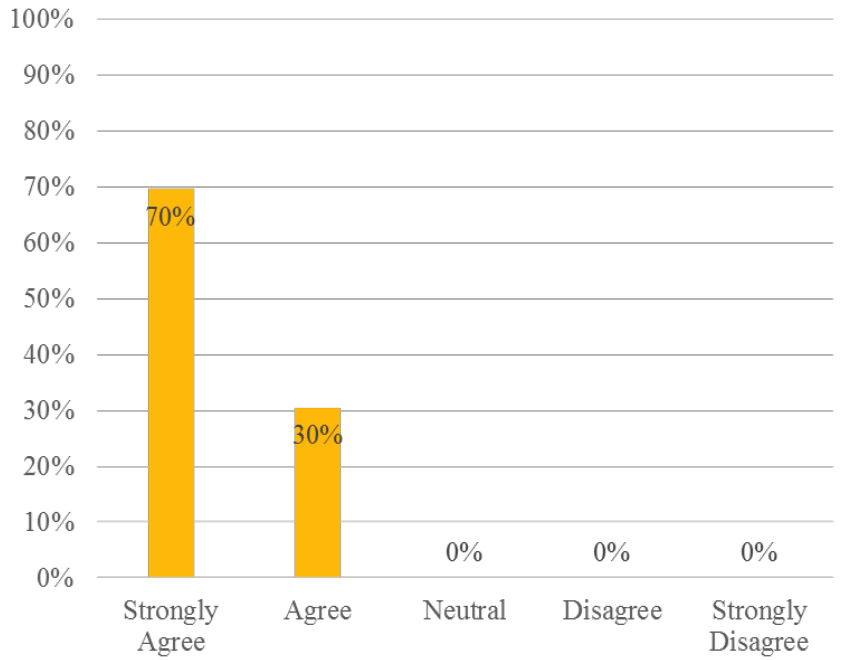


A clinician contacted our family in a timely fashion

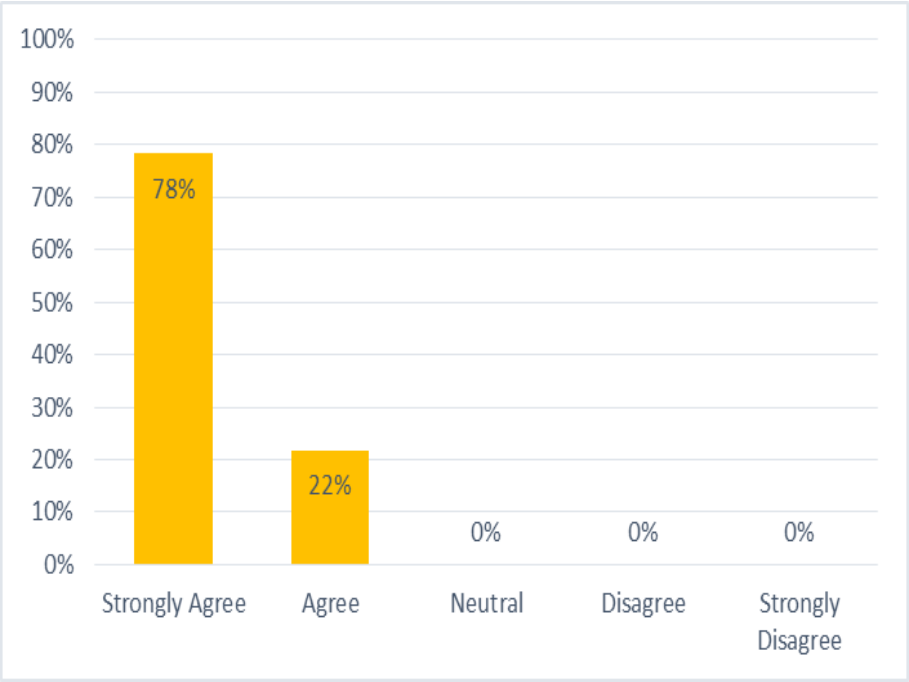


Our clinician helped me handle my own feelings about what happened to my child

RESULTS



our family found the referral from SCCJ/Victim Services to be helpful



Our clinician seemed sensitive to the needs of my child/family

DISCUSSION

- Increase in positive feedback from partners and clients compared to the previous funding period(wait times improving 100%; mean wait times decreased from 30 to 15 days; timely and immediate access to service).
- New partnerships and collaborations were developed between the SCCJ, and MHAS(increased consultation hours).
- Children and their families received more service and intervention than they did previously.
- Mental health functioning generally improved, with a reduction in the mean total entry score at exit; change in total score; and number of clients with less impairments.

RECOMMENDATIONS

- Establish continued support for the present CAC model
- Increased collaboration with the Judicial System
- Specialized training in evidence based therapy and treatment with focus on traumatic experiences.
- Funding should include a parent component

CONCLUSION'S

- In conclusion, the program achieved a reduction in barriers to service and increased support for families with complex issues; we were able to validate therapy methods and interventions and achieve an increase in referrals.
- This evaluation demonstrated the need for continued support and funding for the position of a dedicated mental health position to improve the mental health status of children impacted by abuse.
- This partnership created more service and access to timely interventions for children and their families.

ACKNOWLEDGEMENTS

- Children's Mental Health Service and Youth Resource Centre, Saskatoon Health Region
- Ms. Deanne Kaar
- Ms. Karen Bassingthwaite
- Ms. Barb Afseth
- Saskatoon Centre for Children's Justice
- Victim Services, Saskatoon Police Service
- School of Public Health, University of Saskatchewan
- Dr. Michael Szafron
- Ms. Karen Ruston

REFERENCES

- Butchart, A., Harvey, A. P., Mian, M., & Furniss, T. (2006). Preventing child maltreatment: A guide to taking action and generating evidence.
- Christian, C. W., & Schwarz, D. F. (2011). Child maltreatment and the transition to adult-based medical and mental health care. Pediatrics, 127(1), 139-145.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents* Guilford Press.
- Hodges, K. (2005). Child and adolescent functional assessment scale (CAFAS). *In T. Grisso, G. Vincent, & D. Seagrave (Eds.), Mental Health Screening and Assessment for Youth & Adolescent Justice,* (123-136), 123-136.
- Jones, L. M., Cross, T. P., Walsh, W. A., & Simone, M. (2007). Do Children's Advocacy Centers improve families' experiences of child sexual abuse investigations?. Child Abuse & Neglect, 31(10), 1069-1085.
- McDonald, S., Scrim, K., & Rooney, L. (2013). Building our capacity: Children's advocacy centres in Canada. *Victims of Crime Research Digest,* (6), 2. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd6-rr6/p2.html
- National Children's Alliance; http://www.nationalchildrensalliance.org/