Task Sharing in a Children's Advocacy Center: Expanding the Reach of Mental Health Services

In 2018, the Western Regional Children's Advocacy Center (WRCAC) developed a strategic plan for improving access to high-quality, trauma-focused mental health services for children served by children's advocacy centers (CACs) in rural and frontier communities. One promising pathway that emerged was "**mental health task sharing**," which involves pairing mental health clinicians with paraprofessionals and intentionally delegating tasks in ways that expand the reach of mental health services. In CACs, task sharing allows a licensed clinician to focus on activities that require advanced skill and licensure (e.g., clinical assessment, evidence-based treatment, etc.) and utilizes a paraprofessional partner (typically a victim advocate) for other important tasks that do not require advanced education or licensing, (e.g., initial screening, client engagement, case management and advocacy). Through this task sharing collaboration, more clients are effectively served with a limited number of licensed professionals. Task sharing is particularly relevant for rural regions, which make up 86% of the US land area, but contain less than 20% of the US population.[1] The low population density and geographic isolation of rural areas make it challenging for residents to access mental health services.[2] Additionally, approximately 66% of federally designated "mental health professional shortage areas" in the US are rural or partially rural.[3] For CACs, this workforce gap is exacerbated further by the shortage of licensed practitioners trained as specialized child trauma therapists in rural and frontier regions.

In a children's advocacy center (CAC), the victim advocate often serves in a mental health task sharing role, as the tasks they perform are critical to the family's engagement in mental health services. Essential Component C of the Victim Support and Advocacy standard in the National Children's Alliance (NCA) 2023 National Standards of Accreditation for Children's Advocacy Centers outlines the constellation of services advocates must provide, many of which would fall to a mental health professional in the advocate's absence, such as crisis intervention and assistance in procuring concrete services (such as housing, food, or transportation). The rationale for the standard also states that "parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members" and encourages the coordination of advocacy services with treatment.

While collaboration is core to the CAC model, task sharing requires even more intentional and ongoing coordination that deepens the impact on the client. Perhaps one of the most important tasks sharing roles a victim advocate can play is helping a family get comfortable with the idea of therapy in the first place. Some parents are skeptical of mental health services; the victim advocate can address these perceptional barriers through thoughtful interactions with caregivers about the need for and value of therapy. Ultimately, the skills of the clinician will have a significant impact on whether a child and family engage in or complete therapy, but the advocate, who is often well-trusted by the family, has a continuing role to play. If the clinician keeps the victim advocate informed about the family's progress, together they can overcome barriers as they emerge, ensure the family's continued participation in therapy, and achieve their clinical goals.

For clinicians serving CAC clients in rural areas, especially those providing services under a linkage agreement, this coordination is critical to ensure the clinician is not working in isolation but as a part of a collaborative mental health team. Task sharing may be particularly useful in rural and frontier CACs that rely on trauma therapists who work a significant distance from the community and provide services via telemental health. In these situations, the local advocate has in-person contact with the family and thus can perform on-site tasks the remote therapist cannot, such as assisting the family with intake forms and distributing agency iPads. In addition, the on-site advocate is familiar with and able to provide the remote therapist with insight on the local culture, the meaning of words, names, and events that are unique to the community, and updates on local developments that may impact therapy. When mental health is delivered as part of a collaborative effort, families are more likely to engage in services and therapy is more efficient and impactful.

In 2020, WRCAC launched a telemental health pilot project in collaboration with Children's Advocacy Center of Washington and Children's Alliance of Montana with the following goals: (1) ensure all CAC clients have access to high-quality, appropriate mental health treatment regardless of where they live; (2) build state capacity to meet identified needs of rural CAC clients; and (3) expand access to necessary support systems for children to heal from trauma. Through this project, WRCAC has learned just how valuable a task sharing model is for increasing access to mental health services in rural and frontier communities. Victim advocates (or similar paraprofessionals) in the state networks serve as a key link between clients and clinicians. Participating clinicians are trained on tele-delivery of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and at the same time, paraprofessionals are trained on the benefits of telemental health via TF-CBT and their role in screening, referring, and engaging CAC families in telemental health services. As a result, the paraprofessionals are better equipped to facilitate client access to trauma-trained clinicians who deliver services via telemental health. In Washington, the trained paraprofessionals include CAC and community-based victim advocates who provide case management and family engagement services, while in Montana, those roles are filled by a variety of child serving professionals, including child protective service workers, who broker services for families.

"Truly inspiring, comforting, and reassuring to see a path forming from those needing help to those providing help." - Feedback from a participant in the TMH Pilot Project training "Harnessing the Power of Victim Advocates, CPS Workers and other Child Serving Professionals in Telehealth"

You can read more about task sharing in the December 2021 WRCAC Issue Brief **"Task Sharing in a Children's Advocacy Center: The Role of Victim Advocates in Meeting the Mental Health Needs of Children & Families".**

The following resources and training opportunities are available to support clinicians and victim advocates in delivering a collaborative mental health response:

- Clinical resources for engaging children in telemental health services are available on the engagement page of the Telemental Health Resource Center.
- NCA created a fact sheet for CAC staff and multi-disciplinary teams called "Help Families Heal: Engaging Families in Mental Health Treatment" that highlights the role of the victim advocate in supporting family engagement in mental health treatment.
- Clinicians serving CAC clients are invited to join quarterly Mental Health Peer Consultation Forums hosted by WRCAC and NCA to connect with other clinicians and seek guidance on issues of importance. The next forum will be on Tuesday, May 3rd and the topic will be telemental health. Registration will open in April 2022.
- WRCAC collaborates with the other three Regional Children's Advocacy Centers to offer a quarterly, virtual training, The Advocate's Role in the Multidisciplinary Response to Child Abuse, which fulfills the 24 hours of core training for victim advocates required for NCA accreditation. Applications for the next cohort will open in April 2022.

If you have questions about mental health task sharing in a CAC, please reach out to Charles Wilson at cwilson@rchsd.org. If you have questions regarding the victim advocate's role in the MDT response to child abuse, please contact Salli Kerr at skerr@rchsd.org.

[1] U.S. Health Resources & Services Administration. 2021. "Defining Rural Population." https://www.hrsa.gov/rural-health/about-us/definition/index.html.

[2] Morales, Dawn A., Crystal L. Barksdale, and Andrea C. Beckel-Mitchener. 2020. "A Call to Action to Address Rural Mental Health Disparities." Journal of Clinical and Translational Science 4 (5): 1–20. https://doi.org/10.1017/cts.2020.42.

[3] Health Resources and Services Administration. 2022. "Designated Health Professional Shortage Areas Statistics." https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

Madison Stark
Training & Communications Coordinator
Western Regional Children's Advocacy Center
mstark@rchsd.org

Madison Stark served two years with AmeriCorps after graduating with a bachelor's in biology in 2017, implementing programs targeted towards youth who have experienced adversity. A passion for trauma-informed practices and public health led her to the Chadwick Center in 2019, where she serves as a Training & Communications Coordinator on the WRCAC team. Madison brings her experience in grants, technology, and non-profit communications to this role to facilitate outreach and logistics for WRCAC trainings and events. Madison is currently pursuing her Master of Social Work degree while working part-time to support the Rural Mental Health Project.

WRCAC is funded through the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Grant #2019-CI-FX-K002