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# WRCAC ISSUE BRIEF



Western Regional  
CHILDREN'S ADVOCACY CENTER

## Task Sharing in a Children's Advocacy Center: The Role of Victim Advocates in Meeting the Mental Health Needs of Children & Families



**Background:** In September 2018, the Western Regional Children's Advocacy Center (WRCAC) convened a group of children's advocacy center (CAC) professionals, evidence-based treatment developers and purveyors, and experts in fields such as policy, technology, and licensing to explore strategies to improve access to high-quality mental health services for traumatized children served by children's advocacy centers (CACs) in rural and frontier communities. One potential pathway to improvement that the group identified was "mental health task sharing," which involves the pairing of paraprofessionals with mental health clinicians in ways that expand service delivery. This Issue Brief examines task sharing in the CAC context and promotes the active collaboration between the CAC victim advocate and the child's therapist as a task sharing team, especially in rural areas where the therapist may provide services remotely through tele-mental health.

### What is Mental Health Task Sharing?

Task sharing is the delegation of select tasks, that are often delivered by a licensed mental health provider, to a non-licensed colleague with relevant training, to expand the reach and depth of the services delivered by the licensed clinician. Through task sharing, the licensed professional can focus on activities that require advanced skill and licensure (e.g., clinical assessment, therapy, etc.) and utilize a paraprofessional partner for other tasks not requiring advanced education or licensing, (e.g., initial screening, client engagement, case management and advocacy). This arrangement allows more clients to be served effectively with a limited number of licensed professionals. Many mental health

organizations, from outpatient settings to psychiatric hospitals, are already using task sharing with their case managers, behavioral health aides, case aides, and psychiatric technicians in the paraprofessional role. Task sharing holds particular relevance for rural and frontier regions, where 20% of the US population resides (US Census Bureau, 2017) but where only 10% of the nation's licensed practitioners work (Ellis, 2009). For CACs, this imbalance is made more challenging by the shortage of licensed practitioners trained as specialized child trauma therapists in rural and frontier areas.

Research on adverse childhood experiences over the past three decades has made striking connections between a child's environment and their mental health, giving rise to a whole body of literature about the "social determinants of health" (CDC, 2021; Felitti, 1998, Larkin, 2014). Many contextual factors in a child's life must be addressed for a traumatized child to recover; such a response often requires the collaborative actions of more than one professional, well beyond what happens in a therapy session. Viewing the client or patient as a whole and not just as a cluster of symptoms may require a team approach that includes highly trained therapists along with other trained professionals (such as psychiatrists or primary care physicians) and paraprofessionals (such as case aides and advocates). Task sharing builds on the concept of a team approach in which the mental health of the patient or client is seen as the responsibility of a team who work together toward a common goal, much as the multi-disciplinary team (MDT) of a CAC does with the investigation of abuse allegations.

Task sharing can be especially successful when paraprofessionals from the same cultural frame as the family are involved. In that situation, the paraprofessional can offer a critical perspective to a licensed professional of a different cultural group or who is serving the child from afar through tele-mental health. Research suggests that task sharing partnerships with a paraprofessional of the same or similar culture as the client may play a vital role in initial engagement in mental health and substance abuse treatment (Allen, 2011). Research in Australia demonstrated the advantage of culturally attuned paraprofessionals in engaging aboriginal women in treatment (Hoeft, 2017). In the US, the Veterans Administration has long used local tribal member paraprofessionals as key task sharing partners in the delivery of tele-mental health treatment of Native American veterans experiencing post-traumatic stress disorder (Kaufmann, 2014).

## **Mental Health Task Sharing with Victim Advocates in a CAC**

The victim advocate position in a CAC is ready-made for a mental health task sharing role. In fact, many tasks victim advocates typically perform, such as providing psychoeducation about the effects of trauma on children, and addressing myths, cultural stigma, and other barriers to engaging in therapy, could easily be considered task sharing. Too often, however, victim advocacy in a CAC is not delivered in close collaboration with the mental health therapist.

At present, many therapists who serve CAC clients in rural areas, especially those providing services under a linkage agreement, work alone and not as part of a collaborative mental health team with the victim advocate. To fully support a child's recovery, however, a therapist acting in isolation must address a wide range of issues beyond therapy, from the child and family's understanding of and engagement in the therapeutic process at the point of referral to their understanding of the investigation and subsequent court actions, as well as ongoing safety planning. This is where the victim advocate comes in. When non-therapy related tasks are the responsibility of a victim advocate, it increases the team's capacity to provide quality mental health services to more children, and the families gains access to needed support. In fact, the opening paragraph of the "Victim Support and Advocacy" standard in the 2023 [National Standards of Accreditation for Children's Advocacy Centers](#) clearly links the victim advocate role to the mental health of the child in stating, "Research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members." (National Children's Alliance, 2021, p. 32). The rationale for that

standard goes on to encourage advocacy services that are coordinated with treatment, as well as with other aspects of the MDT response. Essential Component C, explicitly charges the advocate with the responsibility for "provision of referrals for trauma-focused, evidence-supported mental health." The standard assigns specific tasks to the victim advocate that, in their absence, would fall to a mental health professional, such as crisis intervention and assistance in "navigating the multiple systems involved with the CAC response."



Essential Component A of the "Victim Support and Advocacy" standard outlines training requirements for advocates, including multiple topics that might otherwise be the domain of the mental health clinician (or might be missed altogether): an understanding of the dynamics of abuse, trauma-informed services, crisis assessment and intervention, professional ethics and boundaries, court education and even understanding how to access protective orders, housing, public assistance, domestic violence intervention services, transportation, and financial assistance. All of these issues play a key role in the likelihood of success in therapy. The victim advocate helps ensure a family understands what is happening and helps them meet that. In his hierarchy of needs (Maslow, 1943), Maslow referred to physiological and safety needs (e.g., food, shelter, physical safety, psychological safety, etc.) as essential before a child and family can focus on higher-level needs necessary for healing, even when working with the most skilled therapist using the most appropriate evidence-based treatment.

## Going Beyond Accreditation Standards - Teamwork, Collaboration, and Communication

What separates a victim advocate who is exclusively aligned with the investigative team from a victim advocate who is also engaged in mental health task sharing is the degree of collaboration and teamwork that is built among the therapist, advocate, and other members of the MDT. Key to that teamwork is a sense of mental health team identity coupled with high levels of interdependence and trust among the mental health team members as well as strong communication within the team. The impact of the advocate's role as outlined in the National Children's Alliance (NCA) Accreditation Standards is multiplied when their efforts around education, crisis intervention, family support, engagement, and case management are all coordinated with what the mental health clinician is providing in therapy. When mental health is delivered in a collaborative or team environment, therapy is not only more efficient and impactful, the communication between the team members also reduces the risks of delivering mixed messages or uncoordinated activities that undermine the family's willingness to participate in therapy or cooperate with the investigation or court action. In fact, it is the nature of the communication and teamwork between the task sharing CAC staff and the therapist that elevates the treatment to a therapeutic system response that maximizes the potential for clinical success. The National Children's Alliance recently sponsored a series of "Enhance Early Engagement (E3)" trainings for advocates to learn effective engagement strategies to increase the percentage of families who actively participate in needed mental health services.

### ***Training to Integrate a Victim Advocate into the CAC Mental Health Team***

NCA partnered with the University of Oklahoma to develop [Enhance Early Engagement \(E3\): Engaging Families in Mental Health Treatment to Support Healing and Thriving](#), a training program designed to teach victim advocates the key roles of task sharing as part of a CAC mental health team. According to the National Children's Alliance, the E3 training was developed because "not all families served by CACs receive these critical [mental health] services. Through feedback from caregivers collected under NCA's national [Outcome Measurement System \(OMS\)](#), we know some families report never receiving information about mental health services for themselves or their children. Thankfully, that number is falling, but even more concerning is that many of the families who do report receiving information about treatment options for children and caregivers still fail to follow up on referrals to these essential services after visiting a CAC." (NCA, 2019) The E3 training guides victim advocates through the following:

- What family engagement is and why it is important
- The expanded role of the victim advocate to include family engagement in mental health treatment;
- The importance of building collaborative relationships with mental health providers; and
- How to collaborate with a mental health provider to monitor and track services and gather metrics to inform treatment progress.

[More information about the E3 training is available here](#)

## CAC Task Sharing Teams – the Roles of Clinicians and Victim Advocates

The sections that follow highlight several key task sharing roles paraprofessionals can fill to expand the delivery and impact of high-quality trauma mental health services in a CAC environment. Some are specifically addressed in the NCA victim advocacy standard discussed previously. Others go beyond the required elements of the standards. The victim advocate, especially in a smaller rural CAC, is likely to be the best-suited person to fulfill these task sharing roles.

### Crisis Assessment and Intervention

Child abuse and a subsequent investigation often throw a child and family into crisis, especially in the early stages of an investigation and at pivotal points such as an arrest, in the event of a financial crisis stemming from the incarceration of the one employed parent, or the anticipation of court testimony. Closely linked to mental health is the need to assess the child’s ongoing emotional state and associated risks when the child encounters highly distressing points in therapy or an abrupt change in living circumstances, such as placement in foster care or movement between foster homes.

Task Sharing Roles	
Clinician	Victim Advocate/Paraprofessional
While mental health clinicians are very qualified to assess crisis situations and intervene accordingly, crisis intervention need not be performed by licensed mental health providers.	A victim advocate can and should be prepared to step in as needed. Others such as forensic interviewers, nurses, child protective workers, and child abuse pediatricians may also be called upon to assess and respond to a crisis.

### Education/Psychoeducation

Trauma, especially sexual abuse-related trauma, is about a loss of control. Child victims feel powerless and out of control of even their own emotions. Providing education to the caregivers about how children, in general, respond to traumatic events and what to expect is a common role for a mental health provider but can also be delivered by a victim advocate working in concert with the MDT, even before a therapist has been identified for the child.

Task Sharing Roles	
Clinician	Victim Advocate/Paraprofessional
In therapy, clinicians, once matched and engaged in therapy, seek to restore to the child some sense of control, over their life and their own emotions.	A victim advocate or other staff person who is task sharing provides the child or family with a measure of control and choice, especially in the early stages of the case before a therapist is assigned, helps minimize

	<p>system-related trauma and demonstrates trauma-informed practice. The simple act, for example, of explaining the investigative process, as outlined in the “Victim Support and Advocacy” standard, gives the child and caregivers the power of knowledge and some sense of understanding, even as it relates to events, they cannot actually control such as arrests or decisions made about criminal charges.</p>
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**Screening**

While child abuse is stressful to all, not all children require immediate therapy. Some children and youth can manage the stress with their internal resources and/or supportive caregivers. It is advised, however, to screen all children served by the CAC at intake to determine who needs mental health services and which among them requires a trauma specialist (NCTSN, 2018). The 2020 NCA Member Census reports that nearly all CACs (95%) achieve this goal and provide mental health symptom screening (NCA, 2021). Screening can be accomplished using very brief screening tools (taking approximately 10-20 minutes at most to administer). Some measures are designed to screen for broad mental health needs and are [reviewed on the California Evidence-Based Clearinghouse](#), while trauma-specific measures are reviewed on the [National Child Trauma Stress Network \(NCTSN\) website](#).

<b>Task Sharing Roles</b>	
<b>Clinician</b>	<b>Victim Advocate/Paraprofessional</b>
<p>While all children generally benefit from an assessment by a skilled trauma therapist, most communities only have a limited supply of skilled trauma therapists. In these situations, it is important to hold trauma therapy openings for children who truly need trauma-specific services while at the same time accurately routing children who need a more general mental health intervention to a therapist skilled in the specific issues confronting the child.</p>	<p>While a mental health clinician can screen children so can a victim advocate or other non-mental health task sharing professionals such as a nurse.</p>

**Matching and Referral to Therapy**

Connecting a child to an appropriate therapist is not as simple as referring a child to anyone on a therapy list. Ideally the referring party has a working understanding of not only who has open therapy slots, what languages the therapists speak, what sources of payment they accept, or where is the shortest waitlist, but also who is best suited to meet the unique needs of this specific child and family. This may mean referring to a specific therapist, group of therapists, or agency because they are

trained and excel in the type of evidence-based or evidence-informed therapy the child needs, such as trauma-specific therapies (e.g., TF-CBT, CCP, EMDR, CFTSI, PSB-CBT, and AF-CBT) versus therapy for depression or ADHD. The person making the match and referral is exerting tremendous influence over the ultimate clinical outcome and should choose wisely.

<b>Task Sharing Roles</b>	
<b>Clinician</b>	<b>Victim Advocate/Paraprofessional</b>
<p>The clinician, once matched with a child, will conduct an assessment and then, based on the assessment and their repertoire of therapy approaches, select the most appropriate therapy model.</p>	<p>Once a determination is made that a child needs therapy the advocate (or in some centers the forensic interviewer or child welfare worker) will need to determine which therapeutic professional is best suited for the child. The selection of the therapist requires the victim advocate or other referring party to have a sense, from the screening process, as to generally what the child needs and a working understanding of what therapist or group is trained and skilled at what type of therapies.</p>

### Referral to Non-Clinical Community Supports

Anything the CAC can do to help caregivers address the problems that often come with a child abuse report and subsequent investigation and intervention will benefit the child’s recovery. These steps might include helping a family manage the loss of income from the offending parents or providing support to address the caregiver’s own mental health needs or substance use problems. The fact is that a child’s ability to progress successfully through therapy has a lot to do with their caregiver’s emotional state.

<b>Task Sharing Roles</b>	
<b>Clinician</b>	<b>Victim Advocate/Paraprofessional</b>
<p>While the need for referrals for non-clinical services may surface at any point throughout treatment, the immediate referrals necessary to stabilize a family is a responsibility that is shared with and primarily held by the victim advocate.</p>	<p>The victim advocate, or other MDT member responsible for case management, must determine what other, non-clinical services and supports are needed to stabilize the child and/or family and allow space to focus on healing. This is where referrals to other service systems such as income maintenance, food support, housing assistance, domestic violence intervention and/or other support services come into play.</p>

## Engagement in Therapy

As highlighted in the NCA report [Lighting the Way: The Broadening Path of Mental Health Services in CACs](#), families report perceptual barriers more commonly than practical barriers (such as transportation, waitlists, or scheduling) to participating in therapy (NCA, 2021). Many parents are skeptical of the value of mental health and hope their child will simply forget about the abuse and “get over it.” Others don’t fully appreciate the importance of selecting a therapist who can deliver an evidence-based treatment that is appropriate to their child’s needs. Through thoughtful interactions with caregivers about the need for and value of therapy, CAC team members are able to exert significant influence. If communicated effectively, a skeptical parent or one in denial will come to understand that, as hard as it is to talk about the abuse, that is exactly what many children need. An effective engagement strategy understands all children and families are unique and a child and family’s understanding of the events and its impact as well as their recognition of the need for help must be understood to help engage the family in the therapeutic process.

Task Sharing Roles	
Clinician	Victim Advocate/Paraprofessional
The therapist, once matched with a child, will help a child and family understand the benefits of therapy and how the process will work. Ultimately the skills of the therapist will have a significant impact on whether a child and family engage in and complete therapy.	Perhaps one of the most important task sharing roles a victim advocate can play in support of mental health response to child abuse is the vital action of engaging the family in the idea of therapy in the first place. The victim advocate must understand that families are often just coming to grips with what has happened and are in varying stages of denial and acceptance. The victim advocate will influence if a family even considers therapy in the first place or is willing to meet with the clinician to give it a try.

## Monitoring of Treatment

It is important for a designated professional to follow through with families to ensure an assessment is completed, therapy is initiated, and the child and caregivers are consistently participating until completion.

Task Sharing Roles	
Clinician	Victim Advocate/Paraprofessional
The clinician should continuously assess progress and can keep the victim advocate informed about general progress and barriers to continuing in therapy if they emerge.	The victim advocate is often that supportive person who earns the caregiver’s trust and can best help overcome any real or perceived barriers to remaining in therapy. The advocate has a continuing role as part of



	the mental health collaborative response in helping the child and family “maintain” or “sustain” the change and remain in therapy over the course of treatment until they have achieved their clinical goals.
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**Transportation**

For some children, in rural and urban areas alike, it may be impractical for them to attend weekly therapy sessions due to conflicts with caregiver work schedules and limited means of transportation. In these cases, the family would benefit from assistance navigating logistical barriers to full participation in treatment.

<b>Task Sharing Roles</b>	
<b>Clinician</b>	<b>Victim Advocate/Paraprofessional</b>
<p>The clinician and the victim advocate share responsibility for helping the caregiver develop a solution to transportation dilemmas, ranging from helping them navigate the public transportation system (which is often lacking in rural areas) or developing a plan to rely on friends, relatives or a supportive church. However, the relationship the advocate has with the family from the outset may put them in a better position to successfully address this challenge early as the family engages with therapy.</p>	<p>The victim advocate may be the best person to help the caregiver develop a solution to transportation challenges. In some cases, an advocate (or other CAC staff member or volunteer, if available), can provide transportation that makes it possible for the child to attend therapy. In those cases, the time spent in the car coming to and from therapy is often an important opportunity for the child to communicate about their life. In those moments, the staff providing the service really becomes part of the mental health team and should coordinate their part of the discussion with the treating therapist to use the opportunity to reinforce clinical goals.</p>

**Special Considerations for Rural and Frontier CACs**

As rural and frontier CACs previously grappled with the challenge of recruiting and maintaining a sufficient number of trauma-trained mental health therapists to live and work in their communities, some turned to tele-mental health strategies to fill that gap. With the onset of the COVID-19 pandemic, the percentage of communities embracing telemental health surged with the vast majority of CACs (rural and non-rural alike) currently offering at least some if not all mental health services virtually with plans to sustain these efforts as the pandemic recedes.

The concept of task sharing may be particularly relevant to rural and frontier CACs that have embraced telemental health and rely on trauma therapists who work a significant distance from the child’s community who provide their services via secure, web-based platforms. In those situations, the

local victim advocate becomes an indispensable part of the mental health team. The advocate has the opportunity for in-person contact with the child and family and familiarity with the community culture where they reside. In many rural areas, the victim advocate working with a remote tele-therapist may become the person with whom the child or parent is most comfortable and offers key advantages and opportunities as follows:

**Onsite Support:** A victim advocate (or other task sharing CAC staff) who is partnering with a remote therapist can be available to assist in routine tasks that the therapist cannot accomplish because of distance, including for example, assisting the family with intake forms, distributing agency iPads (if available), or answering questions about the videoconferencing system.

**Eyes and Ears of Distant Therapists:**

The local advocate can play a vital role of being the remote therapist’s eyes and ears about the realities of the child’s life in their home and community. They can explain to the therapist the nuances of the local culture, the meaning of words, names, and events that are unique to the community and answer the therapist’s questions about local developments that impact therapy.



**Liaison Between Remote Therapist and MDT and Local Stakeholders:** Especially when the therapist is distant from the community served by the CAC, the advocate or other task sharing staff or MDT member can also help share information between the MDT and therapist and for whom attendance at the case review may not be practical.

**Crisis Intervention and Immediate Safety Intervention:** Assessing risks is particularly complicated when the therapist is providing services via tele-mental health from hundreds of miles away. The advocate can assess ongoing risks and intervene in a clinical crisis, if needed, and in close consultation with the treating clinician. If the child physically comes to the CAC for therapy with a therapist who is delivering tele-treatment, the victim advocate or someone else at the CAC can and should be available to take immediate action in the event of unsafe behavior or threat of suicide. In these cases, the therapist, who would normally fulfill that role, must shift it to someone at the CAC. To that end, the victim advocate or other assigned staff needs to be trained how to intervene, and a failsafe plan to communicate the need for intervention must be in place.

## Victim Advocate as Task Sharing Member of the Mental Health Team Case Example

*Maria is 11 years old. Last week she finally got up the courage to tell her teacher about what her stepfather has been doing to her almost every Friday night when he comes home late and drunk. Maria lives on a farm 18 miles from the nearest small town. A children's advocacy center (CAC) is located in another small city, 45 miles away, and serves three large and sparsely populated counties in the eastern part of the state. Maria's teacher called the child protection hotline to report the abuse and the next thing Maria knew she was at the CAC for an interview and medical exam. Maria's mother arrived at the CAC upset, angry and crying. After the interview and exam, Maria is scared, anxious, feeling guilty, full of shame, and right now, more than anything, exhausted and wishing she had never said a thing.*

*Then Maria and her mother meet Sonya, the victim advocate at the CAC. While talking to Mom privately, Sonya asks Mom what she is most concerned about. Maria's mother does not know where to start or what is going to happen next. Sonya calmly explains the process and the roles of the various multi-disciplinary team (MDT) members. Mom is heartbroken to hear what her husband has been doing and acknowledges he has been violent with her as well. On a practical level, she is worried that if her husband is arrested, they will lose most of the income they depend on. Sonya problem-solves with Mom promising to connect her to domestic violence support services and, with the help of a local church, rental assistance for a few months. With Sonya's support, Mom is able to calm down a bit and feels a little more in control.*

*Sonya then explains she would like to talk with Maria for a few minutes to see how she is doing, and Mom agrees. Using two very brief screening measures, Sonya asks Maria a set of questions and learns Maria is not only confused and afraid today but she has been having nightmares and intrusive thoughts for months about the abuse and another horrible event she witnessed two years ago – the death of her uncle in a fight. Maria is now afraid her stepfather will hurt her, like what happened to her uncle. Sonya recognizes Maria needs a trauma-informed mental health response.*

*Sonya then meets with Mom and explains what she learned and what she thinks Maria needs. Mom's initial reaction is to decline saying she doesn't think Maria needs a counselor, assuring Sonya her child is strong and will get over it on her own – "you'll see, she will just forget, it's like all the other bad stuff." Sonya shares her belief that Maria can recover but she will need special help. She skillfully explains how trauma affects children*

*Maria's age and how what happens next could have a lifelong impact on Maria. Bit by bit, Sonya helps Mom understand the value of talking to a therapist.*

*Sonya then explains that the therapists at the nearby county mental health center need to treat all types of mental health issues in children and adults and don't specialize in what Maria needs. The good news, Sonya explains, is that the CAC has an arrangement with several trauma specialists who live and work in the state capital, 300 miles away, who can help Maria using what is called "tele-mental health."*

*Mom tells Sonya that she doesn't own a reliable car so getting Maria consistently to the mental health center or even the CAC for the tele-mental health session seems impossible. Sonya offers to explore arrangements with Sonya's school to have a private place for therapy there, or the CAC can loan the family an iPad with security features that allow it only to connect with the therapist and that way Maria can even participate in therapy from home. Mom agrees.*



*Sonya contacts the trauma therapists in the state network and connects Maria with a well-trained trauma therapist, Susan, on the other side of the state. Susan asks Sonya to help get all the authorizations signed, help file the Victims of Crime application that can pay for the therapy, and help Mom develop a plan for how Maria can have privacy in their home during therapy and who the therapist can alert in the*

*house and be immediately available in case of a crisis. Sonya informs Susan about the case and a little about the area of the county the child lives and about the school she attends so the therapist has a frame of reference about the child's culture and environment. Sonya teaches Mom and Maria how to use the iPad for the therapy sessions and promises to help them if they encounter problems. As therapy gets underway, Sonya and Susan stay in touch and when Maria misses a session a few weeks later, Susan alerts Sonya who is able to contact Mom and problem-solve the challenges she faces in ensuring Maria makes each session. Within six weeks Maria is reporting fewer nightmares and is able to increasingly manage her frightening memories. After a few more months of work with Susan, Maria completed her therapy successfully, and she and her mom feel she is better able to move forward in control of her thoughts and emotions.*

## References

- Allan, J., & Campbell, M. (2011). Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities. *Social Work in Health Care*, 50(6), 443–465. <https://doi.org/10.1080/00981389.2011.581745>
- Centers for Disease Control and Prevention (CDC). (2021). *Social Determinants of Health*. Retrieved August 25, 2021, from <https://www.cdc.gov/socialdeterminants/index.htm>
- Ellis, A. R., Konrad, T. R., Thomas, K. C., & Morrissey, J. P. (2009). County-Level Estimates of Mental Health Professional Supply in the United States. *Psychiatric Services*, 60(10), 1315–1322. <https://doi.org/10.1176/ps.2009.60.10.1315>
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4), 245–258. [https://doi.org/10.1016/s0749-3797\(98\)00017-8](https://doi.org/10.1016/s0749-3797(98)00017-8)
- Hoelt, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2017). Task-Sharing Approaches to Improve Mental Health Care in Rural and Other Low-Resource Settings: A Systematic Review. *The Journal of Rural Health*, 34(1), 48–62. <https://doi.org/10.1111/jrh.12229>
- Kaufmann, L. J., “Buck” Richardson, W. J., Floyd, J., & Shore, J. (2014). Tribal Veterans Representative (TVR) Training Program: The Effect of Community Outreach Workers on American Indian and Alaska Native Veterans Access to and Utilization of the Veterans Health Administration. *Journal of Community Health*, 39(5), 990–996. <https://doi.org/10.1007/s10900-014-9846-6>
- Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social Work and Adverse Childhood Experiences Research: Implications for Practice and Health Policy. *Social Work in Public Health*, 29(1), 1–16. <https://doi.org/10.1080/19371918.2011.619433>
- Maslow, A. H. (1943). The Authoritarian Character Structure. *The Journal of Social Psychology*, 18(2), 401–411. <https://doi.org/10.1080/00224545.1943.9918794>
- National Children’s Alliance. (2019). *Enhance Early Engagement (E3) Training for CAC Victim Advocates*. NCA Engage. <https://learn.nationalchildrensalliance.org/family-engagement-info>
- National Children’s Alliance. (2021). *2020 NCA Member Census: Key Takeaways for CACs*. [https://learn.nationalchildrensalliance.org/products/2020-nca-member-census-key-takeaways-for-cacs#tab-product\\_tab\\_contents\\_4](https://learn.nationalchildrensalliance.org/products/2020-nca-member-census-key-takeaways-for-cacs#tab-product_tab_contents_4)
- National Children’s Alliance. (2021). *Lighting the Way: The Broadening Path of Mental Health Services in CACs*. <https://4a3c9045adefb4cfdebb->

[852d241ed1c54e70582a59534f297e9f.ssl.cf2.rackcdn.com/ncalliance\\_d2ed9876fcd864b588bbdfcaf2e4d2c8.pdf](https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf)

National Children’s Alliance. (2021). *National Standards of Accreditation for Children’s Advocacy Centers 2023 Edition*. <https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf>

The National Child Traumatic Stress Network (NCTSN). (2018). *Child Advocacy Center (CAC) Directors’ Guide to Quality Mental Healthcare*. <https://www.nctsn.org/resources/child-advocacy-center-cac-directors-guide-quality-mental-healthcare>

U.S. Census Bureau. (2017, August 9). *One in Five Americans Live in Rural Areas*. *United States Census Bureau*. Retrieved August 25, 2021, from <https://www.census.gov/library/stories/2017/08/rural-america.html>

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CHILDREN'S ADVOCACY CENTER

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