



PATHH: Improving Access and Quality of Mental Health Services to Sexually Abused Children in Chicago

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The Providing Access Toward Hope and Healing (PATHH) Collaboration was developed by Chicago Children’s Advocacy Center, mental health providers, and private and public funders to address the considerable unmet mental health needs of children in Chicago who have been victims of sexual abuse. Over the last five years, in response to concerns about long waiting lists and consequent delays in providing mental health treatment, PATHH has developed and refined a robust set of systemic and practice strategies focused on two ambitious long-term objectives – to increase treatment capacity and to improve referral and linkage processes in order to more effectively engage and retain children in trauma informed treatment. The ultimate goal and purpose of these efforts is to reduce the harmful effects of trauma and increase the well-being of children who have been sexually abused.

PATHH provides an exemplar of innovative system of care efforts to use a Children’s Advocacy Center as a hub for identifying and engaging a hard to reach target population of mostly inner city minority children who have experienced trauma and are in need of mental health services. Children’s Advocacy Centers (CACs) investigate a sizable number and proportion of sexual abuse allegations, serving more than 294,000 children nationally in 2013 (National Children’s Alliance 2013 National Statistics). Given the large number of traumatized children served by CACs and their historical emphasis on professionals working collaboratively to respond to the needs of children and families, there has been a growing recognition of the important role CACs can play in improving systems of care, including linking children and families to mental health services (e.g., Cross et al, 2008; Jones & Walsh, 2010). This is particularly important when viewed in the broader context of children’s mental health services research, which documents that many inner city children with mental health problems are unlikely to be referred to or start mental health services, and most that participate at all tend to stop treatment within a few sessions (see review by Gopalan et al, 2010).

Below we describe the early development of PATHH, key PATHH strategies, overall evaluation findings, achievements, challenges, and replication opportunities.

IN THE BEGINNING

Several elements of the pre-existing ecology provided a fertile context for the growth and development of PATHH. ChicagoCAC had a strong and reliably funded Family Advocacy program designed to provide support and information to nonoffending caregivers and children during the sexual abuse investigation, and to refer the children for mental health treatment. In addition, ChicagoCAC already received funding from multiple private foundations and public sources for a range of treatment, advocacy, and investigative services. Finally, a diverse group (network) of mental health treatment providers had been meeting formally and regularly since 2001, and they have continued to provide the bulk of services to children referred by PATHH and to participate in the ongoing collaborative planning and refinement efforts of PATHH.

Three characteristics of the pre-existing network of providers and service ecology appear to have shaped the conceptualization and development of PATHH.¹ First, ChicagoCAC took a leadership role in coordinating the network while also promoting a collaborative process. Previous efforts to improve systems of mental health care at the network level have recognized the need for a strong lead agency or hub to effectively coordinate service delivery given high levels of existing fragmentation of services (Morrissey et al, 1994). ChicagoCAC was able to assume an essential leadership role in PATHH of promoting what in implementation science are called *organizational drivers* (related to systems) and *competency drivers* (related to practice) of implementation efforts to improve performance and outcomes (Fixsen et al, 2014). Second, providers coalesced primarily around their shared commitment to address the unmet needs of child sexual abuse victims prior to any hint that additional funds might be available. The focus on shared values is essential to the early stages of efforts to improve systems of care (Hodges, Ferreira, & Israel, 2012). Finally, funding sources for existing treatment services varied widely, which, while it reflects the high level of fragmentation of mental health services, also may have reduced the potential competitiveness among providers.

From the beginning, PATHH faced and embraced the need to understand and address a startling array of challenges related to increasing treatment capacity and implementing coherent and thoughtful referral and linkage procedures to more effectively engage nonoffending caregivers in bringing children to treatment. These challenges included:

- Long waiting lists for treatment for children who have been sexually abused, highlighting the lack of available and accessible treatment slots;
- Inadequate numbers of Spanish speaking therapists relative to the population served at ChicagoCAC;
- A diverse network of mental health treatment providers that varied widely in terms of location of services, intake and case closing procedures, funding sources, eligibility requirements, payment and insurance options, funding for transportation, and approach to treatment;
- Lack of capacity to provide trauma informed treatment;
- Inability to assess and identify different levels of need for mental health services and to prioritize the use of limited treatment resources based on the level of need;
- An inefficient referral system which involved families being referred to multiple service providers and waiting on multiple wait lists;
- Lack of reliable and timely data on issues of great importance, including treatment utilization and capacity issues (e.g., waiting list size, length of time waiting for services, how many slots were available) or on rates of engagement and retention.

These problems and needs, along with a strong commitment to evaluation and quality improvement, were clearly and passionately articulated by ChicagoCAC and the network of treatment providers. Two prominent Chicago-based foundations responded and helped to engage

¹ It is important to clarify that the network level-functioning of the PATHH providers was not formally evaluated. These inferences are based on the anecdotal observations and past experience of the evaluator.

additional local foundations. Eventually, PATHH was able to receive multi-year funding from a national foundation to continue and expand. Overall, funding for PATHH has been used to promote collaboration and coordination (including staff capacity and technical infrastructure), to provide additional direct services (including more therapy slots, Hope & Healing groups, and Intensive Case Management), to support evaluation and quality improvement activities and capacity, and to provide professional development within the network through clinical training and consultation.

KEY PATHH STRATEGIES

PATHH has developed a robust set of practice, program, and network level strategies that address the concerns that prompted the project and aim to improve child engagement in treatment and child well-being and functioning outcomes, and serve more victims of child sexual abuse. PATHH strategies that were planned or developed near the beginning of the initiative and refined over time include systematic assessment (including screening for domestic violence exposure and mental health crises), triage, referral, and follow-up procedures; a centralized waiting list connected to a referral database and tracking system; and training for frontline ChicagoCAC staff on psychosocial assessment and motivational interviewing. Over time, additional funding enabled PATHH to further increase staffing to support and sustain implementation, to add treatment capacity through a new psychoeducational group intervention (*Hope and Healing* Groups modeled on existing evidence-based group interventions, but adapted for PATHH participants), and to create dedicated child therapy slots at four agencies specifically for PATHH referrals. At the network level, PATHH has developed a set of strategies (training in evidence based treatment approaches, dedicated treatment slots, expanded provider membership) to increase the capacity of the network to provide evidence-based treatment and essential ancillary services (e.g., domestic violence interventions).

There are several features of the PATHH strategies that reflect the comprehensive and ambitious nature of PATHH. First, PATHH strategies address the experiences and needs of children and nonoffending parents over time, specifically during three sequential time periods—the investigation, the process of referral and linkage to child mental health services, and after treatment starts. An integrated set of assessment, referral and linkage procedures, emotional and concrete support, and motivational interview techniques are used to help families at each step of the process, and in making the sometimes difficult transitions to the next step and the next relationship with a professional. Further, the rigorously maintained referral and tracking logs increasingly allow us to track and study case characteristics and longitudinal outcomes (initial engagement in treatment, retention in treatment, client functioning).

Second, PATHH strategies aim to improve both the quality and the quantity of services and supports to better meet the needs of children and families. That is, while undertaking the considerable challenge of trying to improve existing services and client outcomes, PATHH also

aims to increase capacity to serve more victimized vulnerable children and families. This latter goal involves working collaboratively with other treatment providers to build the mental health services network (e.g., by funding additional treatment slots dedicated to PATHH and by adding new providers to the network) and securing additional and sustainable funding. Third, given limited resources, PATHH explicitly aims to improve efficiency, for example, by including prioritizing (through triage assessment) individual mental health treatment for high risk cases, targeting Hope and Healing groups to moderate risk cases, and efficient use of project resources (e.g., not placing disinterested parents on the waiting list, but working with them via advocacy staff follow up).

In addition, since the beginning, PATHH has maintained a commitment to continuous quality improvement--refining or changing strategies over time based on systematic and frequent feedback from rigorous and regular monitoring and tracking of implementation and case status, feedback and ideas from partners, and evaluation findings. Formal strategies for evaluating PATHH to date include in depth qualitative interviews (N=10) and a survey (N=57) of parents and caregivers, analysis of initial treatment engagement (i.e., attending a first session) rates and predictors (using data from the PATHH referral and tracking log) for 1,586 children who were referred to PATHH providers, and retention in treatment for children (e.g., attending 10 or more treatment sessions) referred to ChicagoCAC's own mental health program (N=139).

PATHH ACHIEVEMENTS

1. *Highly valued Family Advocacy services.* ChicagoCAC is one of very few CACs with a fully staffed cadre of Family Advocates (FAs) that provide emotional and concrete support to nonoffending caregivers and children during the sexual abuse investigation at the CAC. Survey evidence suggests that most caregivers have high levels of satisfaction with this support. In qualitative interviews, a small sample of mothers gave compelling accounts of positive relationship experiences with FAs that helped them feel more comfortable during a significant crisis. Advocates provided detailed information and answered questions (especially about the investigative process) that helped mothers know what to expect and reduced their considerable uncertainty and anxiety. These interactions were all the more meaningful because they contrasted sharply with some mothers' negative expectations about how they would be treated at ChicagoCAC given what they viewed as harsh or unfair treatment from DCFS or the police regarding the allegation.
2. *Professionalization of Family Advocacy.* PATHH was able to professionalize the role of the Family Advocates through ongoing training, supervision, and support--building their capacity to implement a detailed Family Screening tool and motivational interviewing techniques in the course of their interactions with families. They now use the screening tool to systematically collect critical assessment data, including items used for triaging, a mental health crisis assessment, and information about concrete needs and childhood

adversities. The motivational interviewing strategies help Advocates move beyond purely supportive responses to parents and engage in potentially more therapeutic interactions such as discussing parental ambivalence about pursuing mental health services for their child, and nurturing parental motivation to seek these services. To support Family Advocates in implementing Motivational Interviewing Techniques with families, an observation process was developed where supervisors observe Family Advocate's interaction with families and provide feedback to the advocates regarding their use of the techniques.

3. *Increasingly integrated referral and linkage (to mental health services) processes.* As a result of considerable reflection, in April 2012, PATHH fundamentally changed key procedures related to referring and linking children to mental health services. A new Resource Team (RT) now manages referral and linkage procedures through a Centralized Wait List (CWL). While FAs still provide information about mental health services, they no longer make referrals for mental health services on the day of the investigation. Instead, referrals are made during subsequent follow up calls and the direct referral is made by the RT. This change reflected increased understanding from evaluation findings and clinical observations that most parents were narrowly focused on the investigation when they came to the CAC, and not on securing mental health services for their child. The FAs role in supporting new families and the high volume of cases coming to the Center also made it difficult for them to consistently follow-up with families on subsequent mental health services referrals.

With funding to support staffing of essential coordination functions, the Resource Team has been able to develop procedures and practice strategies to more effectively manage a large waiting list and the complex referral and linkage tasks involved in matching children with accessible service providers and open treatment slots. As a result, the referral and linkage system is now more integrated in two ways. First, consistent with research illustrating the importance of managing each step of the referral process (e.g., McKay et al, 1998), the RT now has clear procedures for managing regular communications about mental health services with both nonoffending parents and providers throughout the entire process, from the time parents come to ChicagoCAC until the child starts treatment. In fact, the Resource Team continues to check in with the parent after the first session to see if they are satisfied with services and will only close someone out from the wait list when they affirm that they are engaged and are happy with the provider. Second, similar to the FAs, RT staff are trained in motivational interviewing (Miller & Rollnick, 1991). Consistent with research findings (McCourt & Peel, 1998), staff provide non-offending parents a non-judgmental space in which they can tell their story about the abuse allegation (McCourt & Peel, 1998). Family Advocates and Resource Team staff also attempt to nurture the parent's motivation to seek mental health services for the child while also considering that some families are not interested in mental health services (they are always offered the opportunity to seek treatment in the future). Theory and research on transtheoretical stages of change (Prochaska, Norcross, & DiClemente, 1994) is paired with motivational interviewing practice.

4. *Improved targeting of scarce mental health services.* Prior to PATHH, there was no systematic way to prioritize the allocation of scarce treatment slots to the children most in need. With the guidance of PATHH member, LaRabida Children's Hospital, PATHH developed a triage system to identify high priority cases from among the children coming to ChicagoCAC. A total triage score is computed from assessment scores for three factors—whether the sexual abuse was either chronic and/or perpetrated by a caregiver (both of which increase concern about harm to the child), history of exposure to multiple other adversities/trauma (e.g., exposure to domestic violence or parent with a mental health problem), and the severity of the child's symptoms. Thus, by definition, children in high priority cases are significantly more likely to have been exposed to domestic violence and other types of adversities. Evaluation findings show that the percentage of children engaging in (i.e., starting) treatment is significantly higher for high priority (vs. medium and low priority) cases, providing evidence that the priority levels are actually influencing service allocation.

5. *Increasingly efficient referral and linkage processes.* In addition to improved targeting, more consistent and realistic assessments of parental motivation to seek mental health services for the child have led to dramatic improvements in efficiency. Since the implementation of the CWL, lack of genuine or ongoing interest has been detected more often. As a result, fewer children have gone on the waiting list. Thus, Resource Team staff can focus their energies on cases where motivation is higher. The new system is also much more efficient for providers. The Resource Team matches identified openings at provider agencies with the family's availability, only referring families that are available to take identified open slots. The dramatic increases in efficiency are illustrated by two interrelated findings derived from the tracking database. The number of cases referred/assigned to a specific provider declined by over 50% between FY12 (545 cases assigned) and FY13 (266 cases assigned), while the rate at which these children engaged in treatment increased from 36% in FY12 to 63% in FY13. Similarly, of the 291 high priority cases put on the CWL, 47% of the children dropped off the wait list prior to a formal referral being made.

Implementation of the CWL and attending procedures was undertaken through the leadership of ChicagoCAC, collaboration with partners, and funding for ChicagoCAC staff to manage improved referral and linkage procedures. In the context of a fragmented system and limited resources, the procedural changes and staffing have led to more reliable and focused communication with parents and providers, and to more systematic and efficient tracking of motivation to seek treatment while on the waiting list, available treatment slots and parental responses to openings across the city, and initial engagement in mental health treatment with a PATHH provider.

Given the goals and ideals of PATHH, it can be heart-wrenching to remove children in need, especially in high priority cases, from waiting lists because of lack of parental motivation to seek treatment. Unfortunately, in the context of long waiting lists and voluntary services, this appears to be a reasonable strategy.

6. *PATHH strategies increase the likelihood of children engaging in (i.e., starting) mental health services.* Even when controlling for multiple other factors, two strategies developed by PATHH significantly increased the likelihood that children would actually start mental health services. First, children referred to these Expanded Capacity slots available through four different providers were significantly more likely to engage in treatment. These treatment slots are funded by PATHH and dedicated solely to serving children referred through PATHH. The frequent communication providers are required to have with the Resource Team about these slots likely contributes to better information exchange with the Resource Team and the parent. In some cases, the Expanded Capacity slots are assigned to one designated therapist at an agency, which appears to simplify coordination and improve communication and collaboration between therapists and the Resource Team. Decreased complexity and improved communication in the referral and linkage processes both likely contribute to increasing engagement. Second, if families participated in the Hope and Healing groups developed by PATHH, they are also more likely to subsequently start treatment. This evidence suggests that these groups serve at least one of their intended purposes of providing support to families while children are waiting for individual treatment.

7. *“Internal” referrals increase the likelihood of children engaging in (i.e., starting) mental health services.* Children referred “internally” to ChicagoCAC’s own mental health program were consistently and significantly more likely to start treatment than children referred to other providers. We have identified numerous plausible reasons for this finding, and multiple factors may be involved. Consistent with the above explanations of the positive impact of expanded capacity slots, the physical proximity of the Resource Team and ChicagoCAC clinical staff may make coordination and communication easier. They may also have formed closer working relationships within the agency. Third, anecdotal data suggest that ChicagoCAC clinical staff do a very good job of handling initial contact with the nonoffending parents and children. Fourth, ChicagoCAC has leveraged funding to provide transportation and child care assistance. It is the only PATHH provider program that offers to pick children and parents up at their home and bring them to therapy appointments. Given that the population served is predominately low-income and that lack of transportation and the location of services were two of the most common reasons parents declined referrals, it is highly likely that these concrete supports contribute to the higher engagement rates for ChicagoCAC. Finally, it is quite possible that the positive experiences most nonoffending parents report having with the Family Advocates contribute to increased trust or comfort with other people and/or services at ChicagoCAC. Conversely, negative experiences with the FAs or the lack of supports from FAs (e.g., for a CAC that doesn’t have FAs) could decrease the likelihood of engagement.

8. *High levels of treatment retention for clients served at ChicagoCAC.* Although data on participation and retention in treatment were reliably available only for ChicagoCAC’s own program, the high levels of retention found for this fairly large sample (N = 141) are

compelling. Over three-quarters of children referred by PATHH stayed in treatment at ChicagoCAC for at least 90 days (81%) and attended 10 or more sessions (76%). While there are several studies of initial engagement of child sexual abuse victims in treatment, we have not yet identified any research on retention in treatment for this sample. Studies in the broader mental health research literature suggest that children from urban low-income communities that start mental health services commonly attend an average of only 3-4 treatment sessions before dropping out (McKay et al, 2002).

9. *Increased exposure of mental health professionals to theory and skills involved in providing evidence based, trauma informed treatment to children who have experienced sexual abuse.* From its inception, the network of treatment providers has offered high quality trainings on topics relevant to mental health therapists working with children who have experienced sexual abuse and complex trauma. Over the past several years, trainings for clinicians at PATHH agencies have been held every other month and addressed a wide range of clinical issues, including working with difficult attachment patterns, developmental trauma, incest, and mindfulness. PATHH also has sponsored symposia twice a year on clinical topics such as working with various important populations, including children with disabilities, Latino families, African American families, and LGBTQ clients. One of the most extensive professional development ventures for PATHH was a year-long learning collaborative on an innovative way of conceptualizing cases and approaching treatment of children with complex trauma-- the Attachment, self-Regulation, and Competency (ARC) model. Over 40 clinicians from 11 PATHH agencies regularly attended monthly training and consultation sessions that were provided free of charge. The trainings and their impact on actual practice have not been systematically evaluated to date. However, anecdotal responses to the ARC learning collaborative were positive with clinicians commenting that it was particularly helpful to learn a common language and framework for conceptualizing and articulating their work in therapy which has helped improve internal agency communications in supervision and consultation groups.

10. *Conceptualization and Implementation of Hope and Healing Groups.* Hope and Healing groups were designed to enhance the treatment capacity of PATHH in several interrelated ways, including by: a) increasing the number of children who receive services, b) adding a service and much needed support for caregivers while children were on the wait list; and c) offering a less intensive type of service that might appeal to some parents and children more than psychotherapy. The groups were also viewed as a strategy for increasing engagement in child therapy. In 2010, ChicagoCAC contracted with a clinical psychologist from PATHH partner, Ann and Robert H. Lurie Children's Hospital, experienced in group work, to develop the curriculum for a psychoeducational group for families. Initially, the group had three clinical goals; a) reduce stigma associated with sexual abuse and mental health services, b) build coping skills and resilience among children and caregivers, and c) increase caregiver support for children following sexual abuse.

The group was designed as a six-session, drop-in style group. The curriculum was based on the Cognitive Behavioral Intervention for Trauma in Schools (CBITS, n. d.) and other empirically-supported interventions. The program was piloted in January 2011 with two cycles of the group held at two PATHH partner agencies. Nearly 30 clinicians from five PATHH agencies were trained to lead the groups by the curriculum developer (Raviv, 2011) in August 2011 and a group schedule was created. During the first year after the pilot, 29 group cycles were held at five PATHH agencies with a total of 174 group meetings. A total of 77 families attended at least one group. During year two, a total of 108 group sessions were held with 59 families attending. Families that attend one group tend attend more than once. In the first year, 26% of families attended all six group sessions and 65% of the families attended three to six group sessions. Feedback on satisfaction surveys from families regarding the group was very positive, and as noted above, participation was predictive of the child subsequently starting individual treatment.

OVERALL EVALUATION FINDINGS

1. *Large numbers of children were successfully linked to mental health services.* Over the course of three years (2011 thru 2013), 519 children who were referred for mental health treatment through PATHH started mental health services with a PATHH provider committed to providing trauma informed treatment.
2. *Increases in PATHH treatment capacity as measured by caseload size.* Monthly tracking data from April of 2012 thru January 2014 show evidence that monthly counts of the number of children receiving treatment through PATHH increased modestly. Given that there are seasonal patterns, it is important to compare annual changes using the same month. For the month of April, the only month with three years of data, treatment slots filled increased from 218 in 2012 to 235 in 2013 and 245 in 2014. This is a 12% increase between 2012 and 2014. These increases appear to result primarily from increased funding through PATHH for *expanded capacity* (i.e., dedicated) treatment slots. To date, only a small number of children are being served by agencies that have recently joined the PATHH network of providers.

These positive findings are tempered by the fact that there were no substantial annual differences between 2012 and 2013 during the months of August and December, highlighting the need to follow capacity trends through 2014 and beyond. In addition, trends for other quantitative indicators of treatment capacity raised concerns, such as longer wait times before starting treatment and lower numbers of children starting treatment. These and related issues are discussed in the *challenges* section below.

3. *Lower than hoped for rates at which children engaged in (i.e., started) mental health services, with some small improvements in rates over time.* Of 1,576 children that entered the potential referral pool, 30% attended an initial treatment session with a PATHH mental

health provider. Engagement rates were significantly higher for the High Priority cases (37% vs. 25% for Medium or Low Priority) targeted by PATHH. Thus, the 37% engagement rate for High Priority cases is probably the most reasonable single measure of initial engagement outcomes in PATHH. While it is difficult to directly compare engagement rates across studies, and the measurement strategy used (e.g., counting only children who started treatment with PATHH providers) is a very conservative estimate of engagement rates, these findings remain somewhat disappointing. Challenges of and strategies for increasing initial engagement rates are discussed below.

CHALLENGES

One attribute of PATHH has been the steadfast commitment of participating organizations and professionals to understanding and articulating the challenges that need to be addressed to improve services. PATHH holds a strong belief that we should not avoid identifying and facing the considerable challenges that inhibit efforts to improve the mental health system of care for child sexual abuse victims, but should openly and collaboratively discuss and explore them. Below, we provide lessons learned about the challenges and complexities of increasing treatment capacity and increasing the rates of initial engagement of children in mental health services.

Treatment Capacity and Utilization Challenges

There was a wish in some quarters, as in many areas of human services, to view the expansion of treatment capacity to serve more children referred by PATHH as a relatively straight forward objective that could be addressed quite directly by well-planned strategies to increase services. Given the notable though modest increases in the monthly counts of the number of children receiving services, there is some truth to this. At the same time, many factors affect capacity over time, the quantitative dimensions of treatment capacity can be measured in multiple ways, and there were important barriers to fully implementing planned strategies to increase capacity. While our measure of the point in time counts of children served through PATHH is an excellent indicator, it is a global measure for one type of service, and there are other indicators of “capacity” that are relevant to PATHH. For example, other capacity related concerns of PATHH from the beginning of the initiative related to long waiting lists, the lack of Spanish speaking therapists, and the need for a broader continuum of mental health services that included less intensive forms of intervention for some children and support for parents. Here we address some of the lessons learned about these treatment capacity challenges.

1. *Contextual factors and implementation challenges inhibited larger increases in PATHH caseload counts.* Above, we reported an increase of 12% (27 children) in monthly counts of PATHH children in treatment between April of 2012 (218 served) and April of 2014 (245). Given that expanded capacity slots were supposed to add

approximately 50 children to existing caseloads and several new providers were added to the PATHH network and had made commitments to serving approximately 20 additional clients, it is reasonable to wonder why caseloads did not increase more. Just picking the months of April 2012 and April 2014, examination of the expanded capacity providers reveals that three were fairly close to planned (higher) levels of utilization and one remained at the same level of utilization that existed prior to “expansion.”

Closer examination revealed that monthly capacity numbers for the system were highly variable across providers from month to month. For one major provider, there was a major and sustained decline in utilization since the summer of 2012. This included persistently lower utilization (e.g., lower by 11 children in April 2014 relative to two years earlier) and consistently low utilization during 2013 and to date in 2014. This decline partly counteracted the increases that were noticeable in other agencies.

With regard to the implementation of strategies to increase capacity, careful tracking enabled PATHH to see that one expanded capacity provider did not actually expand capacity when given additional funds. Discussion of these issues led to improved definitions of who was counted as being served (e.g., if no services were provided for a certain period, the child could not be counted on the caseload) and clearer expectations about the need to use funding to add slots to existing capacity. But it is also important to note that there was considerable variability the number of children served over time by all major PATHH providers, including those with both expanded capacity and “regular” slots availability. Significantly, this variability included short term reductions in capacity that likely resulted from turnover or organizational capacity issues unrelated to seasonal issues (e.g., interns leaving).

While this volatility within and across programs is not surprising from a program standpoint, given there is turnover of staff, entries and exits of cases, and interns coming and going, it illustrates that capacity and utilization are dynamic. Overall, funding “expanded capacity” slots appears to have had a positive net effect on serving more children at a given point in time, but gains have been muted to some extent by contextual factors that affect all providers and by the challenges of implementing this PATHH strategy.

PATHH was successful in recruiting 5 new treatment providers since the fall of 2012, even though no funding was directly available. New providers signed MOUs developed by PATHH and have participated actively in clinical training opportunities in PATHH. However, the referral and utilization tracking data and feedback from the Resource Team converged to highlight lower than planned utilization (e.g., only 7 children receiving services with new providers in April 2014) and that referral and linkage processes were not well-coordinated. As is the case with most PATHH providers, PATHH is only one of multiple sources of referrals to the new mental health providers, which may make it harder for agencies to follow the referral procedures specifically used in PATHH. The utilization findings, implementation challenges and potential changes

are being openly discussed, and PATHH has worked hard with partner providers to address referral challenges. Nonetheless, the findings serve to highlight the considerable challenges of significantly increasing the availability and utilization of treatment slots without direct funding for services for children and families referred by PATHH.

2. *While the number of children served at a given point in time increased, the number starting treatment declined and wait times increased—how can that be?* There are different ways to measure treatment capacity and utilization. In addition to PATHH caseload counts, we examined the number of children who started treatment with a PATHH provider. Analysis of the total number of children starting treatment per year shows some negative trends. After increasing from 161 in 2011 to 210 in 2012, the number of child treatment starts decreased markedly to 148 in 2013. It is very important to consider the possible reasons for the apparent incongruity between the decrease in treatment starts in 2013 and the modestly higher numbers of children in treatment (rather than *starting* treatment) during parts of 2013. The declines in treatment starts can result from longer stays in treatment or contextual factors that are very important to understand and consider when interpreting these findings.

The number of available treatment slots in a system of care is affected by how long children stay in treatment. If children begin to stay in treatment for longer periods of time, there will be fewer available slots for children who needed to start treatment. If treatment providers are actually improving their ability to provide evidence informed treatment (an important goal of the PATHH Learning Collaborative) that is long term in nature (as most of the recognized approaches), this could increase the average length of treatment and reduce premature terminations, thereby also limiting the number of treatment slots available to PATHH. Conversely, if, hypothetically, more children were to drop out of treatment prematurely, PATHH would have more available slots and would be able to serve more children. While we cannot yet measure length of stay system wide because PATHH is still working toward being able to gather reliable discharge dates, there is some modest evidence of longer stays in ChicagoCAC's own treatment program. Children who started treatment in 2013 at ChicagoCAC were somewhat more likely to stay in treatment 180 days or more in 2013 (73%) than those who started in 2012 (64%). We cite this to illustrate how caseload dynamics could potentially affect the number of children served.

The length of time children have to wait before starting treatment is another indicator of PATHH treatment capacity. Unfortunately, children who started mental health services with a PATHH provider have had to wait much longer before starting treatment since the CWL was implemented in April of 2012—an average of 116 days compared to an average of 71 days before the CWL, along with a similar increase in the percentage of children waiting 90 days or more (58% vs. 31% before the CWL). While improved tracking (and measurement of wait times) may account for some of this difference, the longer wait times are generally consistent with the lower numbers of children starting treatment over time, and the possible explanations offered above are equally relevant. In addition, anecdotal observations suggest

that some parents may have been willing to have the child stay on the waiting list longer due to the systematic contact procedures that have been developed by the Resource Team since implementing the CWL and the more trusting relationship that developed.

3. *Utilization rates show that many treatment slots that are available to PATHH are not filled.* One might easily assume, given the long wait times and large waiting lists that all possible treatment slots that are available would be filled right away. That is not the case. In July of 2013, PATHH began to systematically track the number of slots that were available to PATHH each month. This allows PATHH to estimate the amount of treatment capacity that is utilized (vs. unfilled). Through April of 2014, between 76% and 93% of slots per month have been filled to date—83% overall, with a range of 17 to 61 slots not being filled. These findings suggest that some children are waiting for the right match of provider (see below). Tracking these *utilization rates* over time will enable PATHH to examine seasonal trends and track progress on this important indicator of treatment capacity and utilization. PATHH has used this information to inform quality improvement, including efforts to recruit providers in underserved communities. For example, after the presentation of PATHH findings to providers and funders in August 2013, several PATHH providers identified additional locations that their agencies had in underserved areas and offered to provide services to ChicagoCAC clients in those additional locations. Recent discussion of these utilization rates revealed that some slots that are technically *unfilled* at a given point in time have actually been offered to families, and providers are attempting to engage the family. Future tracking efforts will distinguish between unfilled slots that have been offered vs. those that are available.

As with the other indicators, interpreting the findings and trends requires careful analysis. For example, the highest utilization rate (93%) tracked to date occurred in July 2013. Interestingly, this occurred even though the number of children in treatment that month was relatively low. The main reason for the high utilization rate that month was that interns left many providers, thereby reducing the number of available slots (and the denominator used to compute this percentage).

4. *Limited Family Participation in Hope & Healing Groups.* Although feedback regarding Hope and Healing groups has been very positive, engaging families in attending groups has proved extremely challenging. Group attendance has been much lower than hoped—2.6 families per group in the first year and, despite numerous efforts to boost attendance, 2.4 in the second year. Attendance was highest at groups held at ChicagoCAC (4.0 families per group compared to the 2.4 average). This is in keeping with consistent feedback from families that they prefer to attend services at ChicagoCAC, the utility of providing transportation to the clinic, and with the higher rates of engagement in individual therapy for children referred there.

Consistently, approximately 50% of families referred to Hope and Healing groups attend the group. A systemic concern has been related to low levels of initial referrals. Anecdotal

information revealed that family advocates had some confusion regarding group schedules and eligibility which may have hampered the referral process. Attempts have been made to increase communication in this regard. Additionally, ChicagoCAC plans to have all family advocates trained in the curriculum to further help their understanding of potential benefits for families and help them to find ways to present the curriculum to families.

Attendance at Hope and Healing groups was particularly sparse at south side locations which are located primarily in African American neighborhoods. This is in keeping with the lower engagement rates reported relative to individual therapy for African-American clients. The agencies involved at these sites have held several meetings to strategize ideas for improving attendance at these sites, but supportive interventions attempted thus far have not improved group attendance at these locations.

Overall, Hope & Healing groups appear to mark an increase in the continuum and quality of services available through PATHH, and they appear to promote participation in child therapy. However, the groups have had only a modest impact in terms of the numbers of families receiving services, highlighting the significant challenges of organizing and implementing groups in clinic based settings.

Thus, PATHH has made some modest gains in increasing utilization of individual therapy services and newly developed group services, but the gains have been and are likely to continue to be inhibited by contextual factors that are hard to predict and by stubborn program implementation challenges. The experience of PATHH also shows that measuring capacity and utilization for a complex system involving hundreds of children throughout Chicago, a waiting list, and a diverse network of treatment providers requires careful tracking of multiple indicators of treatment utilization and strategies, along with equally careful interpretation of trends over time for multiple indicators. Applying a narrow “outcome driven” perspective that simply examines whether certain goals are met will not yield adequate understanding of the possible interactions between indicators or the complex factors that affect trends and that need to be addressed.

Challenges of and Strategies for Increasing Initial Engagement in Trauma-Informed Treatment

There is clearly room for improvement in the initial rates of engagement in treatment in PATHH, so it is particularly important to articulate lessons learned about the challenges of increasing the likelihood that nonoffending caregivers will take their child(ren) for needed mental health treatment. These challenges relate to treatment availability and capacity issues, the context of a sexual abuse investigation, parental ambivalence, and racial/ethnic considerations.

1. *Matching a child with the right provider.* Matching a client to an open therapy slot is a challenging task that involves understanding the services and funding options for various providing agencies, as well as the needs of the family. A number of factors

influence an agency's ability to provide services to a specific client including insurance, language, location, availability, and eligibility requirements. Furthermore, each PATHH provider has a unique set of factors that determine eligibility for services. Some of these factors are determined by the types of insurance that the agency accepts. Within the state of Illinois there are a variety of HMO options available for people who receive Medicaid. Different agencies have arrangements with different HMO providers and many only accept certain types of Medicaid HMO plans. Approximately 25% of the children referred through PATHH require services in Spanish because either the child or the parent or both speak Spanish. Yet, of the 17 agencies, only six are currently able to provide services in Spanish. PATHH tracks the reasons parents give for declining referrals to specific providers — by far the most common reasons relate to problems with scheduling and location, with issues of insurance (i.e., payment) being the third most cited issue.

Agency location and accessibility are often the first factors considered. Families with limited resources lack the ability to travel to engage in services. ChicagoCAC is the only PATHH provider that provides transportation to therapy appointments in the form of a fleet of vans and drivers. Through the data tracking system, PATHH has been able to identify service gaps in certain areas of the city, and efforts are being made to recruit providers in or near these areas. With regard to scheduling therapy, only two of the 17 agencies provide services on Saturdays when most families can attend. There is a limited service time window for children who attend school and have early bedtimes and, therefore, therapy slots fill in quickly. PATHH referrals compete with other referral sources, including those that might provide better payment options, for prime therapy slots. Three PATHH agencies provide additional flexibility by offering therapy services in schools. However, this practice has its own problems including lack of ability to involve parents in services, difficulty with finding an appropriate, private space for therapy, and problems related to pulling children out of class to attend therapy.

Restrictive eligibility requirements often reduce the treatment options available to the child and family. Some agencies specializing in treatment of trauma require that the child must have disclosed in the investigatory interview. Other agencies will not provide services to children who engage in sexually problematic behavior (a common symptom for children who have experienced sexual abuse) or children whose parents are involved in a custody dispute. Different agencies have different age ranges for the various programs that they offer. While some agencies are able to provide services to an entire family, including parents with mental health issues and siblings, other PATHH providers only have services for kids or only services for kids who have experienced trauma.

All of these factors make the matching of a client from the wait list to a specific open time slot with a specific provider agency a very complex process. While the improved communication with providers and parents fostered by the RT staff has dramatically improved the quality and timeliness of the information that is available to inform matching

efforts, these diverse challenges and complexities still often limit treatment options and increase the time children spend on waiting lists.

2. *The availability of treatment slots affects initial engagement in (starting) mental health treatment.* One of the most important conclusions of the evaluation to date is that indicators related to availability affect the likelihood of initial engagement. In statistical analyses that control for multiple other factors, high priority children who stay on the waiting list for only 45 days or less were more likely to engage in treatment. In addition, children who were referred during the months of April thru September, which would put them on the waiting lists when psychology and social work interns arrived at multiple providers in late summer were also significantly more likely to start treatment. These effects were separate from (i.e., independent of) the effects of the length of time on the waiting list. Convergent evidence in support of the latter finding comes from analyses of monthly trends in the number of children per month starting treatment. There were clear seasonal trends, with the largest numbers of children starting treatment in August, September, and October every year, specifically when the interns are starting. Thus, increased availability within the system of care clearly increased the likelihood of case level engagement.

Reductions in the availability of Spanish speaking therapy slots (which are not yet tracked regularly) may also have contributed to a marked decline in engagement rates observed for High Priority children needing Spanish speaking therapists—from 50% before the CWL to 35% since the implementation of the CWL. Evidence of declining availability includes the fact that wait times increased much more for Spanish speaking families (from an average of 70 days before the CWL to 154 days) than for English speaking Latino families (from 56 to 93 days) and African American families (from 76 to 112 days), and similarly larger declines over time in the numbers of children from Spanish speaking families starting treatment in 2013 (vs. 2012). Furthermore, these declines paralleled the reductions in therapy slots used and treatment starts per month by a major provider (due to staff turnover) of Spanish speaking treatment services.

From a system of care perspective, the lack of available treatment slots for many children on the waiting list essentially places downward pressure on initial engagement rates. Other things being equal, this downward pressure is reduced to some degree when available capacity is increased.

There are two studies of initial engagement in mental health treatment focusing on samples of children referred through CACs that report initial engagement rates (52-54%) that are higher than the overall rates for high priority cases in PATHH (Lippert et al, 2008; McPherson et al, 2011). These rates are virtually identical to the engagement rates for referrals to ChicagoCAC's internal treatment program. However, it is also important to note that there is no evidence in these studies that children and families had to wait for any significant period of time before starting treatment services.

3. *Reflections on why waiting lists are problematic.* While it is obvious that making traumatized children wait for treatment is problematic, we want to give voice to the perspectives of parents about waiting lists and highlight how having a waiting list necessarily decreases the likelihood of engagement by increasing the complexity and the number of relational transitions in the referral process. In in-depth qualitative interviews (Budde, 2011), mothers made numerous comments about their experiences of waiting list. Especially after hearing from Family Advocates how important mental health services are, mothers' comments highlight their painful experiences and negative views of having their traumatized child put on waiting lists. They remind us that their children really need services right now. As one mother said: *"I just think that it's not fast enough. The situation is so frustrating to understand the seriousness about what was going on with my daughter, and then to be told over and over again that the wait was 3 months or 6 months is just so, so frustrating. I was incredibly angry about it."* This comment conveys that being on the waiting list can represent a significant loss for children and their families. For children, lack of prompt services can convey, albeit inadvertently, that they do not deserve to receive services quickly. In some instances, this experience can indirectly support the common belief among victimized children that they were to blame for the abuse.

From a relational perspective, we can think about the referral and linkage process in terms of relational transitions, for example from the parent and child's relationship with a referring professional or agency to new relationships with a therapist. From a trauma-informed practice perspective, we also know that any type of transition (e.g., changing classrooms, changing schools), with multiple accompanying uncertainties about what will happen next, are likely to be highly stressful for children and adults who have experienced trauma. Further, for the many parents who are interested but ambivalent about seeking treatment for their child or who have competing priorities, being put on or having to stay on a waiting list for treatment could easily tilt decision making in the direction of not seeking treatment at some point.

While the Resource Team cannot reduce the wait time, follow-up and referral procedures have aimed to improve communication with parents whose children are on the waiting list. Training and procedures for Resource Team staff (as well as advocates) have incorporated ways of talking with parents that acknowledge the loss of being put on a waiting list (after being encouraged to seek counseling), avoid insensitive and clinically inappropriate comments (e.g., *there are 45 people ahead of you*), describe a specific plan for communicating while the parent is on the waiting list (when, how often, with whom) and offer specific services (e.g., groups) or resources (e.g., pamphlets on how to talk with your child). Also, clear "handoff" procedures to providers (e.g., referrals are not offered to a parent until a specific opening is available) dramatically reduce the uncertainty and delays that parents and children experience following learning of a provider.

Nonetheless, even when waiting lists are run sensitively and responsively, it is still important to fully recognize that they cause a structural impediment to engagement by adding an

extra relational transition to the referral and accompanying stress. Put in probabilistic terms, adding a transition increases complexity in communications and increases the likelihood that the parent will drop out of the process. Like the game of *telephone*, each transition increases the likelihood of problems.

4. *CACs and sexual abuse investigations are a coercive context in which to make mental health referrals.* A common challenge in developing mental health systems of care involves identifying and reaching high risk children and families. From this vantage point, by virtue of their investigative role, CACs have the distinct advantage of both identifying and intervening with a large population of children who may be victims of sexual abuse and who may have significant mental health needs. At the same time, referring children for mental health treatment within the context of an investigation of alleged sexual abuse also poses significant challenges for engaging parents and children in child treatment. The effects of coercive contexts on engagement outcomes when parents receive referrals for voluntary services are rarely considered or examined (Budde et al, 2011). While service providers tend to think of services as voluntary, given that a large majority of nonoffending parents are not actively seeking treatment for the child when they come to the CAC, it is more accurate to think of them as either *nonvoluntary* or *involuntary* participants (see Rooney, 2009). Accordingly, recommendations by professionals in this context are likely to be viewed (probably accurately in some instances) as involving some element of coercion to participate.

The investigative context of referral may make some parents more likely and other parents (probably a much larger group) less likely to actually pursue mental health treatment for their child. For example, a subset of nonoffending parents who may want to get help for the child may also worry about what therapists might learn about other incidents or family problems that the parent prefers to remain hidden.

The coercive context of the investigation is also likely to increase socially desirable responses on the part of many nonoffending parents, which make it challenging for practitioners to assess their actual interest and motivation. To illustrate, we found that in over 600 high priority cases, 70% of nonoffending parents conveyed a *high* level of interest in child treatment to the Family Advocate, but only 39% of children in these cases actually started mental health services. These findings strongly suggest that nonoffending parents often give compliant responses to Advocates that do not reflect their actual ambivalence. These findings spurred training for FAs on motivational interviewing and the importance of welcoming the parent's ambivalence and attempting to assess true readiness to change. Nonetheless, the coercive context of the investigation will push some parents to give socially desirable responses regarding child treatment.

5. *Many parents report a range of concerns and ideas about why and whether their child needed treatment.* The likelihood that children will start and continue mental health services is clearly determined largely by parents and caregivers, specifically their

willingness and ability to bring the child in for treatment. A wide range of parental attitudes, perceptions, relationships (e.g., with the child and the alleged perpetrator), and stress may affect engagement (e.g., Lippert et al, 2008). As noted above, nonoffending parents tend to be focused more on the investigation than on obtaining mental health services and they are likely more ambivalent about mental health services than is readily apparent in this context. Another key finding from the PATHH evaluation illustrates very directly the impact of the perspective of the nonoffending parent on bringing children to treatment—even controlling for multiple other factors, children whose parent believed the allegation of sexual abuse were significantly more likely to start treatment than the 30% of children whose parents did not appear to believe the allegation.

Additional findings from the PATHH evaluation, even among non-random samples of parents who reported positive experiences with advocates, also suggested that perceptual and motivational barriers to seeking treatment for the child are common. In qualitative interviews, mothers raised a range of questions about whether therapy was needed or potentially helpful given, for example, the absence of observable symptoms, having a young children (how would therapy work?), or that children should talk with their mothers when they have problems. In the parent/caregiver survey, over 60% of respondents reported one or more views of child therapy that reflected either ambivalence about child treatment, motives for treatment unrelated to the trauma per se (which is what PATHH emphasizes), or lack of knowledge about trauma treatment or the effects of trauma. These responses were scattered across a wide range of survey questions, such as that children were not in counseling because the abuser was out of the home (21%), their child was too young (9%), not wanting to remind the child of the abuse (9%), or not wanting to attend (15%) as reasons the child wasn't in counseling. In addition, almost one-quarter (24%) of parents with children not in treatment disagreed with a statement that the child needed someone other than the parent to talk to about her feelings.

The findings highlight the need for FAs and Resource Team staff to seek out and respond to how nonoffending parents perceive the allegation, the need for treatment, and any concerns or questions they may have. PATHH professionals also help nurture parental motivation to seek treatment by connecting their concerns to the child's reactions to trauma and the need for trauma-informed treatment. Note that the interviews and survey were also likely affected by social desirability biases to some degree, so it is unlikely that parental ambivalence was fully measured.

6. *Hard to engage populations.* Of the High Priority cases, about half are African American and slightly less than half are Latino. Many of these families are low income—for example 41% of families need transportation assistance in order to attend therapy. In the broader children's mental health research literature, there is considerable evidence that children from low income families and non-Caucasian children (e.g., Garland et al, 2005) are less likely to start mental health services and more likely to prematurely drop out of treatment

after receiving very few sessions (e.g., Harrison, McKay et al, 2004). Thus, while a wide range of factors may contribute to these findings, we highlight them here to illustrate that, irrespective of the context of a sexual abuse investigation, the families that come to the CAC tend to be relatively hard to engage in mental health services.

7. *Low initial engagement rates for African Americans.* African American children, who make up a slight majority of the children referred, are significantly less likely than either Latino or non-Hispanic White children to start mental health treatment. Among high priority cases, even with shorter (though still long) periods spent on the wait list, only 30% of African American children in the referral pool started treatment with PATHH providers compared to 40% of Latino children. In statistical analyses, when controlling for other factors, Latino and non-Hispanic White children were over two times more likely than African American children to start treatment. Lippert et al (2008) similarly found that the odds of children referred by a CAC entering therapy were over two times higher for non-Black children (White: Latino and non-Latino) than for African American children. Racial/Ethnic differences in treatment engagement in PATHH could be affected by differences in perceptions of mental health services, responses to the coercive context of investigation, child factors (African Americans were more likely to be younger and male), family factors (e.g., access to transportation, levels of family support), or provider factors (e.g., accessibility factors, capacity to engage). We have found recently that lower African American engagement rates (compared with Latinos) are evident only for a couple of PATHH providers. These findings are being considered. In addition to efforts to improve culturally sensitive practices, a subcommittee of PATHH is working on community level efforts aimed at promoting awareness of and de-stigmatizing recognition of trauma and the need for mental health services for children in the African American community.

Promisingly, following major changes in referral and linkage procedures initiated in April 2012, the initial rates for African American children rose from 24% (before the CWL) to 30% (since the CWL), including increases from 26% to 33% for High Priority cases. The reason for these improvements is unclear, but it is certainly the case that supervision and training for both FAs and RT staff addressed this concern and attempted to improve practice with African American parents. Systematic follow-up procedures implemented by the RT may also have been helpful. It is also important to note and consider that prior to the CWL, FAs made the mental health referrals. In order to have bilingual FAs available, over 80% of FAs were Latina. During that time period, African Americans who had a Latina FA (compared to White or African American FA) were significantly less likely to engage in treatment, suggesting that specific cross-cultural differences may have impeded engagement. Since the RT staff (who are not primarily Latinas) took over making the referrals, these differences have vanished, suggesting the possibility of that African American parents may tend to feel more comfortable in some way with RT staff.

Even after starting treatment, there continue to be racial/ethnic differences. Among the children who started treatment at ChicagoCAC, African Americans also had significantly

lower rates of attending at least 10 treatment sessions (66% vs. 85% for Latino children). There is also tentative evidence that augmenting therapy with intensive case management (and concrete services) increases retention rates overall, including for African American children.

Thus, PATHH is attempting to engage a population that is relatively disinclined to start mental health services. Parents are offered services for their child in a coercive context of a sexual abuse investigation that complicates the assessment of the child's needs and their motivations. Then, if they are interested, the child and family are put on a waiting list, often for more than three months. When services become available, they may or may not be a good fit in terms of scheduling, location, language, or financing. In this context, almost remarkably, 37% of children in High Priority cases still start treatment with a PATHH provider.

The lessons learned suggest key factors that are likely to increase initial engagement rates in mental health treatment for children who have experienced trauma:

- Listening to and responding supportively to the parent's concerns and questions from the beginning of their time at ChicagoCAC;
- Identifying parents who have no real interest in treatment for their child;
- Identifying and supporting the parent's own motivations to seek treatment for the child;
- Maintaining a supportive relationship with the family while they are on the waiting list and providing supportive services (e.g., Hope & Healing groups) during this time;
- Having a clear set of procedures for managing and tracking communication with providers and families to facilitate timely and comprehensive information to guide matching discussions;
- Internal referrals to ChicagoCACs own program;
- Concrete support when needed, especially actual transportation to therapy sessions;
- The combination of funded dedicated capacity slots plus close communication and collaboration with a single therapist (committed to PATHH) that characterize some "expanded capacity" slots;
- Having an available and accessible treatment slot right away (shorter wait times).

We believe that these are useful and exciting lessons. At the same time, it is important to remember that resource scarcity (i.e., lack of available or accessible slots) relative to need (i.e., the supply of treatment) will always put downward pressure on engagement rates (as well as on the number of people who can be served).

REPLICATION AND APPLICATION OF PATHH

Rather than thinking of PATHH as a total package or model that can be replicated elsewhere, it is more useful to think more about how and in what contexts *the Products and Lessons Learned from the PATHH Collaboration might be applicable and replicable*. Important

questions include: What could be most useful to other CACs vs. other types of mental health systems? What investments are necessary and what could be done with minimal amounts of new funding?

It appears from our vantage point that many of the well-articulated practice approaches and procedures, as well as the related data collection and tracking systems that follow children and families from the point of contact through to linkage to a mental health provider are well-suited to CACs. In particular, the Family Advocacy services at ChicagoCAC are more extensive and more professionalized than is found in most CACs. Family Advocates provide essential information and emotional support to children and nonoffending parents during the highly stressful investigation, and their work in completing the Family Screening tool provides critical assessment data (e.g., domestic violence and crisis assessment) and specific results from the triage instrument that inform next steps in efforts to help children and support the family. The Centralized Wait list, as well as detailed and thoughtful referral, linkage, and follow-up procedures facilitate improved communication with parents and providers. Interconnected databases track each step of the process at the case level, including activities of staff and the responses of families, providing systematic data for management, supervision, quality improvement, and evaluation purposes. Rigorous training and ongoing monitoring, supervision, and support for Family Advocates and Resource Team staff in applying motivational interviewing techniques and assessing motivation to change provide an integrated, relationship-based approach to working with families. These PATHH products and procedures offer a solid programmatic infrastructure for CACs that are interested in improving supports for families and linkage to mental health services for traumatized children.

While these strategies and products form an integrated whole in PATHH, many of the single strategies can be useful to CACs, other types of systems of care, or specific mental health providers. For example, PATHH's rigorous application of motivational interviewing and motivation to change assessments to the initial engagement process in mental health services is relevant to virtually any program or network targeting (Rooney, 2009) clients that are not actively seeking treatment, especially in children's mental health, where parents largely determine the use of mental health services by their children. Examples of such nonvoluntary target populations include children referred through psychiatric crisis services funded by Medicaid and early intervention projects aimed at engaging foster parents and biological parents in dyadic interventions. The databases, tracking strategies, and indicators of initial engagement and retention utilized by PATHH also offer easily adapted stand-alone products for a wide range of mental health programs or individual providers.

At the level of a mental health provider network, PATHH offers useful products and strategies for improving systems of care in CACs. Specific products of potential use within CACs or other types of provider networks include provider MOUs that articulate both the benefits and expectations of becoming a member of a network. For partner providers who receive specific funding to add to the treatment capacity of PATHH, these procedures are more detailed and have higher expectations (e.g., in terms of data collection and communication with ChicagoCAC)

in order to provide greater accountability for the use of funding. A complete curriculum and training for conducting Hope and Healing groups is another well-articulated product that PATHH can offer that has the potential to expand the range of services and supports for children and families. The Learning Collaborative that PATHH has developed offers a model for engaging and training and supporting professionals in providing more effective trauma-informed treatment approaches.

Ultimately, the partnerships that have developed amongst ChicagoCAC, treatment providers, and funders that make up the PATHH collaboration are grounded in an enduring commitment to improving and expanding supports and mental health service to child sexual abuse victims and their families. This commitment is exemplified by the many specific strategies described, the investment made to support these strategies, and the truly continuous quality improvement efforts that are informed by systematically collected and analyzed data. PATHH can help others who share this commitment and these ideals to develop more responsive and efficient systems of care for children and families.

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