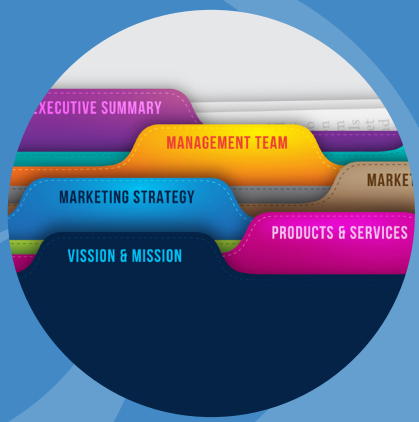
northeast regional
children's advocacy center

MDT Orientation Manual



2020

Table of Contents

northeast regional children's advocacy center

This project was supported by Grant 2016-CI-FX-K003, CFDA#16.758 awarded by the Office of Juvenile Justice and Delinquency, Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions expressed in this manual do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

northeast regional children's advocacy center

Purpose of this Manual

OVERVIEW

Multidisciplinary Team Orientation Manual is offered by Northeast Regional Children's Advocacy Center to provide training information and resources to Children's Advocacy Centers (CACs) to assist with on-boarding of new multidisciplinary team (MDT) members. The materials within this manual have been created to accompany CAC plans for onboarding new team members and discipline-specific shadowing opportunities. Some CACs provide annual training for new MDT members and a draft agenda is included in this manual (Attachment 1). Other CACs provide onboarding on a rotating basis, when there are a number of new professionals joining the team. CAC Directors and/or MDT Facilitators often take the lead in creating a process to share CAC overview and operations. A Checklist for MDT Orientation is included as Attachment 2.

Onboarding for new MDT members

- Addresses FAQs
- Spells out acronyms
- Points to key documents
- Sets a foundation for the culture and expectations you'll build with your team

Each chapter of this manual includes:

1. Overview of the topic
2. Available resources
3. Research
4. Other suggestions for onboarding team members to your CAC

Most of the resources below are links that you can click on. The document can be found at www.nrcac.org/resources/multidisciplinary-team-resources/.

The Children's Advocacy Center (CAC) Model

OVERVIEW

A Children's Advocacy Center (CAC) is a child-focused program in which representatives from core disciplines – law enforcement, child protection, prosecution, mental health, medical, and victim advocacy – collaborate to investigate child abuse reports, conduct forensic interviews, determine and provide evidence-based interventions, and assess cases for prosecution. As community-based programs, CACs are designed to meet the unique needs of the communities they serve and, as such, no two CACs look or operate exactly alike. They are founded on a shared belief that child abuse is a multifaceted community problem and no single agency, individual, or discipline has the necessary knowledge, skills, or resources to serve the needs of all children and their families. This unique model was established in 1985 in Huntsville, Alabama under the direction of District Attorney Bud Cramer. CACs offer a coordinated multidisciplinary response to child abuse cases with the goal to minimize trauma to child victims and their caregivers. The CAC model was initially created to address child sexual abuse cases, however, the model has also evolved to include severe physical abuse, neglect, witness to violence, commercially sexually exploited children, youth with problematic sexual behavior, etc.

The National Children's Alliance (NCA) is the national association and accrediting body for Children's Advocacy Centers (CACs). NCA opened in 1994 and has created standards for accreditation, with member CACs across the country and state chapter organizations in all 50 states.

AVAILABLE RESOURCES

Videos

1. CAC of Suffolk County, Boston
2. CAC Video, CAC of Kennebec and Somerset Counties
3. Massachusetts Children's Alliance Video, Child Abuse: Stars in the Field
4. Video Gallery – Children's Advocacy Centers of Texas
5. What is a CAC? National Children's Alliance explainer video

Additional Resources

1. Better Together: Children's Advocacy Centers – a publication of the Association of Prosecuting Attorneys, Child Abuse Prosecution Project, Les Enfants, Quarterly Newsletter, Winter 2018
2. CAC Effectiveness infographic from National Children's Advocacy Center
3. Changing the Child Abuse System: Robin's story
4. Healing, Justice, and Trust: A National Report on Outcomes for Children's Advocacy Centers, 2018
5. National Children's Policy Brief

RESEARCH

Cramer Jr, R. E. (1986). A community approach to child sexual abuse: The role of the office of the district attorney. *Response*, 9(4), 10-13.

Cross, T. P., Jones, L. M., Walsh, W. A., Simone, M., Kolko, D. J., Szczepanski, J., Lippert, T., Davison, K., Cryns, A., Sosnowski, P., Shadoin, A., & Magnuson, S. (2008). Evaluating Children's Advocacy Centers' response to child sexual abuse. *Juvenile Justice Bulletin*. No. 218530. Washington, DC: U.S. Department of Justice. Office of Juvenile Justice and Delinquency Prevention.

Jones, L.M., Cross, T.E., Walsh, W.A., & Simone, M. (2007). Do children's advocacy centers improve families' experiences of child sexual abuse investigations? *Child Abuse and Neglect*, 31, 1069- 1085

Miller, A., & Rubin, D. (2009). The contribution of children's advocacy centers to felony prosecutions of child sexual abuse. *Child Abuse and Neglect*, 33, 12-18.

National Children's Advocacy Center. (2018). Children's Advocacy Centers – The Literature: A bibliography arranged by topic. Huntsville, AL: Author.

National Children's Advocacy Center (2010). Efficacy of Children's Advocacy Centers: A Selected Bibliography. Huntsville, AL: Author.

Shadoin, A. L., Magnuson, S. N., Overman, L. B., Formby, J. P., & Shao, L. (2005). Cost-Benefit analysis of community responses to child maltreatment: A comparison of communities with and without child advocacy centers. Huntsville, AL: National Children's Advocacy Center.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Provide a tour of the CAC and meeting of CAC staff/board
2. Provide the Mission/Vision/Values for the CAC and for the team, if there are separate ones
3. Provide an organizational chart of the CAC
4. The Child First Doctrine is the foundation for CACs:
    - The child is our first priority
    - Not the needs of the family
    - Not the child's "story"
    - Not the evidence
    - Not the needs of the court
    - Not the needs of the police, child protection, or attorneys, etc.

Being part of a Multi-Disciplinary Team (MDT)

OVERVIEW

A collaborative multidisciplinary response to child abuse cases has been found to be effective in reducing trauma to children, promoting successful legal intervention, and ensuring the availability of appropriate follow-up services for children and their families. A high-performing multidisciplinary team (MDT) is at the core of every Children's Advocacy Center that serves as the neutral, child-focused site within which coordinated investigation, intervention and case management can be accomplished.

Protocols or operational guidelines are the mechanisms that prescribe the collaborative response among core members of the MDT, including law enforcement, child protection, prosecution, medical, mental health, victim advocacy and Children's Advocacy Center professionals.

The purpose of written protocols/guidelines is to:

- Establish case criteria (ex. age, abuse type[s], geographical area[s])
- Clarify the roles of each discipline
- Coordinate the activities of each agency
- Reduce duplication of effort
- Focus activities on the needs of the child to reduce trauma and promote healing

Operational guidelines should be developed collaboratively to promote respect for the rights, mandates, and obligations of each agency that is a core member of the MDT, and should be detailed enough to guide an investigation that includes multiple agencies and disciplines so coordination and cooperation is maximized. You can contact your Regional CAC for assistance with protocol development. An outline of MDT Roles and Responsibilites is included as Attachment 3.

The Role of the Team Facilitator

The Team Facilitator is a key member of the multidisciplinary team and plays a multitude of roles to ensure the children and their supportive caregivers receive the best possible services for healing and justice. These roles include; advocator, challenger, mediator, motivator, organizer, team builder, and visionary to name a few. Team Facilitators are seen as leaders in the case review process, protocol development, and system's advocacy. It is with the Team Facilitator's leadership that teams come together in an atmosphere of trust and safety to partner for success in child abuse cases.

AVAILABLE RESOURCES

1. Maine MDT Orientation Video
2. MDT Team Functioning and Case Review Part I
3. MDT Team Functioning and Case Review Part II
4. What is an MDT, Day One CAC

RESEARCH

Herbert, J. L., & Bromfield, L. (2017). Better together? A review of evidence for multi-disciplinary teams responding to physical and sexual child abuse. *Trauma, Violence, & Abuse*.

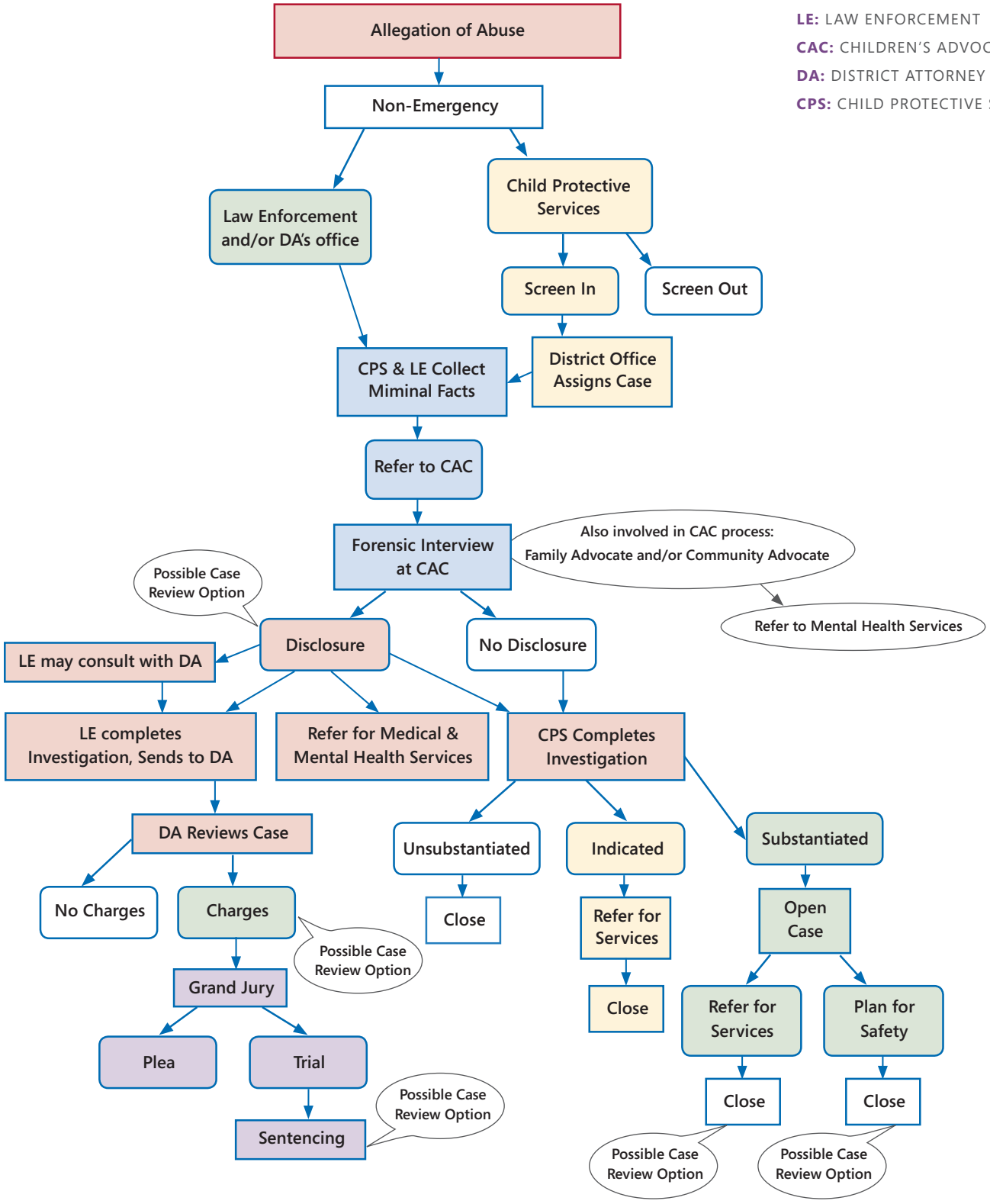
National Children's Advocacy Center. (2018). Multidisciplinary teams and collaboration in child abuse investigations: A selected bibliography. Huntsville, AL: Author.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Discuss your CAC's referral process and criteria
2. Review your Case Flow Chart (see example on following page)

MDT Case Flow Chart

LE: LAW ENFORCEMENT
CAC: CHILDREN'S ADVOCACY CENTER
DA: DISTRICT ATTORNEY
CPS: CHILD PROTECTIVE SERVICES



Cultural Considerations Throughout the CAC Process

OVERVIEW

Cultural considerations should be integrated into the daily operations and protocol development of the CAC. The CAC needs to review policies and procedures for services to families throughout the life of the case, not just at the forensic interview. Developing a culturally-informed plan is essential in determining how advocates communicate with families throughout an investigation and what mental health and medical services are available in your community that serve the diverse populations within it.

CACs should conduct a community assessment, at a minimum every three years, of the demographics of your community in order to identify un-served or under-served populations.

Questions to consider for your community include:

- How does the CAC provide an experience that is welcoming and respectful of all members of the community?
- What type of outreach is needed and planned to engage different parts of the community?
- What steps are taken to ensure the MDT, staff, volunteers and board of the CAC reflect the larger community?

Demographics should include:

- race
- ethnicity
- gender
- disability status
- sexual orientation
- socio economic status
- rural v. urban
- religion
- primary language
- family structure (i.e., single parent, grandparents, same sex couples)

AVAILABLE RESOURCES

1. 2016 Community Assesment Template, created by Midwest Regional CAC
2. Child Welfare Information Gateway, Cultural Competence: Child Abuse & Neglect
3. Child Welfare Information Gateway, Resources for Families of LGBTQ Youth
4. Child Welfare Information Gateway, Statistics on abuse and neglect of children with disabilities
5. Indian County Criminal Jurisdictional Chart 2017
6. NASW Standards & Indicators for Cultural Competence in Social Work Practice, 2015
7. Native American Children's Alliance, (NACA)
8. NCAC's online training: Collaboration, Consistency and Cultural Competency
9. NCAC's online training: Cultural Competency: Plays Well with Other
10. NCAC's online training: Memories Hold Hands: Understanding Historical Trauma and Unresolved Historical Grief in American Indian/Alaska Native Communities
11. NRCAC Guidelines for Working with Interpreters, 2018
12. Sites, J., & South, G. (2019). Listen and Learn: A Process for Initiating Collaboration between Tribal Communities and Children's Advocacy Centers. Huntsville, AL: Southern Regional Children's Advocacy Center
13. The CAC Accessibility Toolkit, created by the Children's Advocacy Center of North Dakota
14. The Indian Child Welfare Act (ICWA)
15. The Indian Country Child Trauma Center (ICCTC)

RESEARCH

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosure of child sexual abuse. *Journal of Child Sexual Abuse*, 19(5), 491-518.

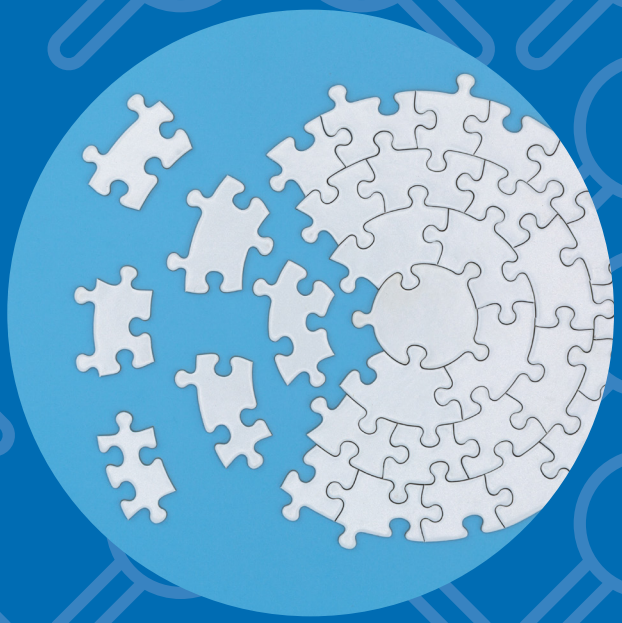
Fontes, Lisa (2008). Child Abuse & Culture: Working with Diverse Families.

National Children's Advocacy Center. (2018). Cultural Competency: A Bibliography. Huntsville, AL: Author.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review your CAC's current community assessment and/or cultural competency plan, if available
2. Outline the CAC plan for working with children who have limited English proficiency or are hard of hearing

Forensic Interviewing: Best Practices



OVERVIEW

Forensic interviewers conduct legally-sound, developmentally-appropriate, culturally-competent, neutral, fact-finding interviews of children (and sometimes adults with disabilities) in accordance with CAC referral policy. Forensic interviews are provided at CACs across the country as part of the multidisciplinary team response. Interviews are coordinated with the multidisciplinary team to avoid duplicative interviewing and minimize trauma to those being interviewed. Forensic interviewers are trained in a national or state recognized specialized training of at least 32 hours that includes practice interviews. Forensic interviewers should participate in peer review on a regular basis to receive feedback on interviews conducted, share general practice with peers and review relevant and updated research in the area of forensic interviewing. There is research to support the specialized training and background of those professionals conducting forensic interviews (see references below).

Children are usually referred to the CAC for forensic interviews by child protective services and/or law enforcement. Interviews are coordinated with all parties involved to include, at a minimum, child protection, law enforcement and victim advocacy. Prosecutors, mental health and medical personnel may or may not be present at forensic interviews, depending on the capacity of the CAC. On the day of the interview, pre and post meetings will take place with the forensic interviewer and the team members present to discuss case details. The family will also meet with the team after the interview to discuss the next steps in

the investigation. Each CAC should have a protocol that outlines who has custody of the digital recordings and where they will be stored.

The CAC Forensic Interview Protocol should outline:

- Where will joint forensic interviews routinely take place?
- How does a referral get made for a forensic interview?
- What information is collected prior to the interview and shared among investigative team members?
- Who is expected to be at the forensic interview? How are they notified?
- How does the team select an appropriate, trained interviewer?
- What training is required for forensic interviewers?
- Does the interview space allow for team members to observe the interview?
- Are the interviews audio and/or video-recorded? How is the recording shared to eliminate duplicate interviewing?
- Who attends the pre and post meetings?
- How do observers communicate questions or concerns to the interviewer during breaks in the interview process, "bug" in the ear, etc?
- How does the MDT promote cultural competence (i.e., needs of distinct cultural groups, etc.)?
- What provisions are made for non-English-speaking children and family members throughout the case?
- What specialized services are made available for children with disabilities?

AVAILABLE RESOURCES

1. A Multidisciplinary Team Approach To The Investigation and Prosecution of Child Abuse Cases Involving Recantation
2. Child Forensic Interviewing: Best Practices, September 2015, OJJDP
3. Considerations for the MDT/CAC Approach to Recantation-Infographic
4. Forensic Interview Peer Review Form, MRCAC
5. Forensic Interviewing: What Every Prosecutor Needs to Know
6. National Children's Advocacy Center's Child Abuse Library Online, Forensic Interviewing Bibliographies
7. NCA Approved list of Forensic Interviewing Training
8. Outline of the National Children's Advocacy Center Forensic Interview Structure
9. Position paper on the Introduction of Evidence in Forensic Interviews of Children. National Children's Advocacy Center (2013).

RESEARCH

Cross, T.P., Jones, L.M., Walsh, W.A., Simone, M., & Kolko, D.J. (2007). Child forensic interviewing in children's advocacy centers: Empirical data on a practice model. *Child Abuse and Neglect*, 31, 1031-1052.

Perona, A. R., Bottoms, B. L., & Sorenson, E. (2005). Research-based guidelines for child forensic interviews. *Journal of Aggression, Maltreatment & Trauma*, 12(3-4), 81-130.

Rivard, J. R., & Schreiber Compo, N. (2017). Self-reported current practices in child forensic interviewing: Training, tools, and pre-interview preparation. *Behavioral Sciences & the Law*, 35(3), 253-268.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Invite them to observe a forensic interview or watch a recording
2. Review the forensic interview protocol, if any
3. Share research about disclosure process, your chosen interview training model(s) and peer review

The Investigative Team: Child Protective Services, Law Enforcement, and Prosecution

OVERVIEW

The role of child protection on the MDT is to provide referrals for child abuse cases that meet the community-specific case acceptance criteria (sexual abuse, physical abuse, neglect, commercial sexual exploitation of children, witness to violence, and youth with problematic sexual behavior, etc.) to the CAC for forensic interviews, observe the forensic interview, communicate with the MDT about the status of the case and participate in case review.

Child Protective Services (CPS) investigates reports of child abuse and neglect and provides services to children who have been abused or neglected by a person responsible for a child's care, custody or welfare. The focus of CPS is the protection of children and to act in the children's best interest. The decisions made concerning the protection of the child will be based upon the professional judgment of the CPS staff in compliance with CPS policy, statutory law and placement factors. Participation in the MDT does not take precedence over CPS policies and procedures. CPS is called different things in different states, such as Department of Children and Families, Department of Human Services, etc.

Law Enforcement (LE) attends the forensic interview at the CAC, investigates criminal activity and files criminal charges when there is enough evidence to do so. Participation in the MDT does not take precedence over law enforcement investigative policies.

Prosecution evaluates the forensic interview, reviews statements of any witnesses, suspects and any other corroborative evidence to make decisions about criminal prosecution. Charging decisions shall be based upon the professional judgment of the prosecutor's office. If a case goes to criminal court, the prosecutor and victim advocate are responsible for maintaining contact with the family about the status of the case, providing information about victim rights and preparing children and families for court.

AVAILABLE RESOURCES

1. Indian Child Welfare Act of 1978
2. Mandatory Reporting Statutes

RESEARCH

Duron, J. F. (2018). Legal decision–making in child sexual abuse investigations: A mixed–methods study of factors that influence prosecution. *Child Abuse & Neglect*, 79, 302-314.

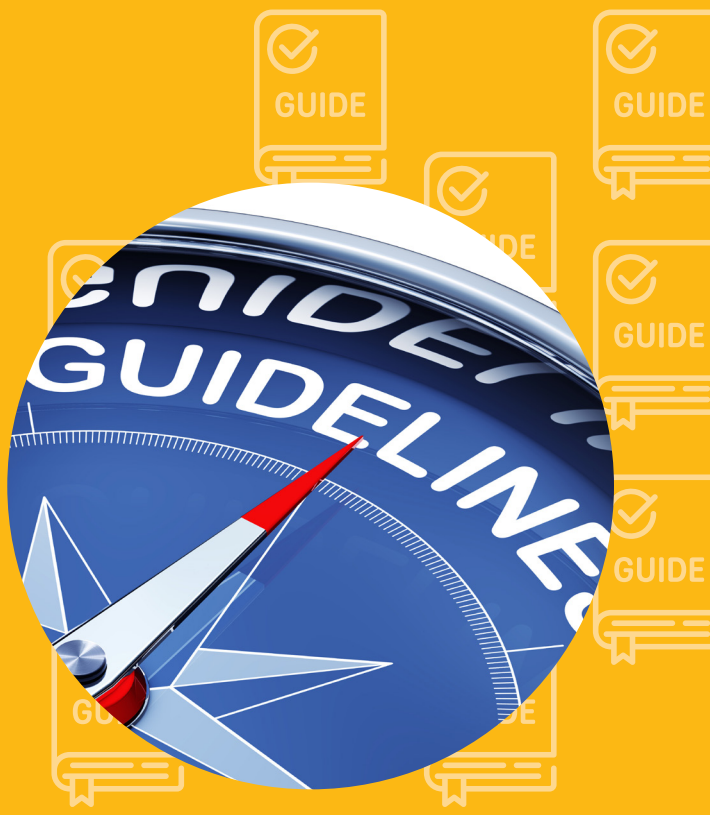
Miller, A., & Rubin, D. (2009). The contribution of children's advocacy centers to felony prosecutions of child sexual abuse. *Child Abuse & Neglect*, 33(1), 12-18.

Newman, B. S., & Dannenfelser, P. L. (2005). Children's protective services and law enforcement: Fostering partnerships in investigations of child abuse. *Journal of Child Sexual Abuse*, 14(2), 97-111.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Meet with investigative team members to ask questions about child protection policies and procedures; law enforcement investigations, and the court system
2. Observe a court proceeding, such as an arraignment, bail hearing, motions, trial

Minimal Facts Guidelines for Law Enforcement, Child Protection, & Other First Responders



OVERVIEW

Upon a report of child abuse allegations, both law enforcement and child protection have initial responsibilities to ensure child safety and assess the situation before referring to the CAC for a forensic interview. Child protection has a timeframe (see state-specific timeframes) when they need to see the child/family to assess safety and respond to family needs. The initial child contact must be completed within child protection policy timeframe, but may not require a full interview of the child within this initial timeframe. In many cases, general information necessary to ensure child safety may be gathered from guardians/other referral sources, if they are protective of the child. However, if first responders need to talk with the child to assess the child's safety, emotional state and physical condition, some tips are outlined below:

Minimal facts interviews with children include gathering basic information regarding:

1. the alleged perpetrators
2. witnesses and /or fellow victims
3. Where on the child's body did the abuse take place and what happened
4. When the abuse happened (last time, frequency)
5. Location where abuse occurred (establish jurisdiction)
6. Necessary steps to assure the safety of the child and other potential victims (siblings or others to whom perpetrator has access)?

7. Whether immediate medical attention is necessary – if abuse has taken place within 72 hours for pre-pubescent children and 120 hours for adolescents, a medical exam is necessary to gather evidence (timeframes for evidence collection may vary by state)

It is understood that all investigations differ in some respect and the approach to the minimal facts interviews must be flexible and permit the responding officer or child protection investigator to use their on-the-scene judgement. These guidelines do not supersede investigative needs if it is an emergency situation, safety is at risk, or an immediate arrest of the perpetrator is possible. In addition, if the child volunteers detailed information, that information should be written down, or otherwise recorded, and a report should reflect the circumstances under which the child made the disclosure(s). On the other hand, if the child is not volunteering information, questioning – particularly leading questions – should be avoided and "minimal facts" should be developed from other sources whenever possible. If a guardian or another adult can tell you what the child has disclosed, there should be no reason to question the child at this point.

Once minimal facts have been established and a decision has been made to make a referral for a forensic interview at the CAC, the caregiver should be advised that an in-depth interview will take place at the Children's Advocacy Center, where all agencies will be represented and trauma to the child minimized. First responders should give detailed information to caregivers about the CAC process including, where it will be, how interviews are conducted, and who will observe.

AVAILABLE RESOURCES

1. NRCAC Minimal Facts Guidelines, 2019
2. NCAC's online training: Law Enforcement's Initial Response to Child Maltreatment

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Discuss child protection and law enforcement timelines for investigations
2. Talk with law enforcement and prosecution on the benefits and limitations of minimal facts interviews
3. Talk with advocates on how best to support families during this initial investigative process

Victim Advocacy Through the CAC Process

OVERVIEW

Victim advocacy services are essential to support the child victim and the caregiver in the aftermath of an allegation of abuse. Research shows that a supportive caregiver is a critical piece in the healing and recovery for children. A victim/family advocate is present at the time of the forensic interview to meet with the MDT during the pre-meeting to discuss and share information with the MDT. The advocate then meets with the caregiver during the forensic interview to provide support and information that includes a brochure about the visit to the CAC, the forensic interview, medical exam options, mental health services, Victim Compensation information, names and contact information of all team members, referrals for follow up services and any other appropriate materials for the caregiver. The advocate will participate in the post-meeting with the MDT to discuss the outcome of the interview and the next steps before bringing in the caregiver for the post-meeting. Ideally, another CAC staff member/volunteer will sit with the child during this time as it is essential that children in the CAC receive adult supervision at all times.

Multiple Advocates (See Victim Advocacy Flow Chart)

More than one victim advocate may perform these functions at different points throughout a case to ensure continuity and consistency in service delivery. Several examples are:

- The CAC advocate may work with the child and family at the time of the forensic interview to provide information, support, crisis intervention, referrals and follow up calls/meetings.

- The CAC advocate may refer the child/family to a sexual assault advocate from a community agency.
- The sexual assault advocate may continue with advocacy and crisis intervention for a period of time and then transition to the prosecutor advocate if the case proceeds to court.
- The prosecutor advocate (sometimes referred to as a victim witness coordinator) is responsible for provision of updates to the family on case status, continuances, dispositions, sentencing, inmate status notification (including offender release from custody), provision of court education and courthouse/ courtroom tours, support, and court accompaniment.

AVAILABLE RESOURCES

1. A Courtroom for All: Creating Child- and Adolescent-Fair Courtrooms, National District Attorney's Association, 2013
2. Caring for Kids: What parents need to know about sexual abuse
3. Field Guide to Victim Advocacy
4. Role of the Victim Advocate, NRCAC video 2020
5. Supervisor Manual for the Field Guide to Victim Advocacy
6. The Advocate's Guide: Working with Parents of Children Who Have Been Sexually Assaulted, National Sexual Violence Resource Center, 2015
7. Victim Advocate Case Flow Chart
8. Victim Advocacy Guidelines, 2020
9. Victim Rights Law by State

RESEARCH

Bolen, R. and Lamb, L. Child Maltreatment. (2007). Can Nonoffending Mothers of Sexually Abused Children Be Both Ambivalent and Supportive?

Bonach, K., Mabry, J. B., & Potts-Henry, C. (2010). Exploring nonoffending caregiver satisfaction with a Children's Advocacy Center. *Journal of Child Sexual Abuse*, 19(6), 687-708.

Jones, L. M., Cross, T. P., Walsh, W. A., & Simone, M. (2007). Do Children's Advocacy Centers improve families' experiences of child sexual abuse investigations? *Child Abuse & Neglect*, 31(10), 1069-1085.

Kouyoumdjian, H., Perry, A. R., & Hansen, D. J. (2009). Nonoffending parent expectations of sexually abused children: Predictive factors and influence on children's recovery. *Journal of Child Sexual Abuse*, 18(1), 40-60.

National Children's Advocacy Center. (2019). Victim Advocacy: A Bibliography. Huntsville, AL: Author.

National Children's Advocacy Center. (2018). Caregivers of Abused Children: A Selected Bibliography. Huntsville, AL: Author.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Shadow a victim advocate
2. Observe court proceedings with an advocate (motions, bail hearing, trial etc.)
3. Speak with other disciplines on their experience working with victim advocates and how victims and families are supported

Evidence-Based Mental Health Services

OVERVIEW

CACs provide trauma informed, evidence-based mental health services on-site or refer to community agencies that provide these services for child abuse victims and their families. Quality mental health services are critical for the long-term well-being and healing of children victimized by abuse. Trauma-informed mental health care is a specialized clinical process designed to assess and mitigate the long-term adverse impacts of trauma or other diagnosable mental health conditions.

Research has shown that childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs), see resources below.

The role of Mental Health Provider

The role of mental health provider on the MDT and at Case Review is to (1) provide clinical information regarding clients (if HIPPA release authorized); (2) provide information about trauma-informed, evidence-based treatment modalities; (3) discuss impact of trauma on child victims and their caregivers; (4) answer any questions from the MDT.

Evidence-based, trauma-informed mental health treatments for child abuse victims are listed below and additional information can be found at National Traumatic Stress Network or The California Evidence-Based Clearinghouse for Child Welfare.

Trauma-Focused, Cognitive Behavioral Therapy (TF-CBT): The goal of TF-CBT is to help address the biopsychosocial needs of children, with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

Child Family Traumatic Stress Intervention: CFTSI is a brief (5-8 session), evidence based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD.

Parent-Child Interaction Therapy (PCIT): PCIT is an evidence-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. Generally, the therapist provides the coaching from behind a one-way mirror. The emphasis is on changing negative parent/caregiver and child interaction patterns.

Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT): AF-CBT represents an approach to working with physically abused children and their offending caregivers that incorporates therapeutic principles/procedures from several areas, including learning/behavioral theory, family-systems, cognitive therapy, and developmental victimology.

Eye Movement Desensitization and Reprocessing (EMDR): Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. Adaptive Information Processing model posits that EMDR therapy facilitates the accessing and processing of traumatic memories and other adverse life experience to bring these to an adaptive resolution. After successful treatment with EMDR therapy, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced.

Child-Parent Psychotherapy (CPP): CPP integrates a focus on the way the trauma has affected the parent-child relationship and the family's connection to their culture and cultural beliefs, spirituality, intergenerational transmission of trauma, historical trauma, immigration experiences, parenting practices, and traditional cultural values.

AVAILABLE RESOURCES

1. Adverse Childhood Experience(s), ACE Study
2. Adverse Childhood Experiences Study video
3. CAC Directors' Guide to Mental Health Services for Abused Children, 2008
4. CAC Director's Guide to Quality Mental Healthcare NCTSN Elearning course & resources
5. California Evidence-Based Clearinghouse for Child Welfare
6. NCA/NRCAC Mental Health Brochures
   - Ensuring Well Being of Children; A Comprehensive Approach to Trauma-Informed Care for CACs
   - Evidence-Based Mental Health Treatments for Child Abuse Victims
   - Helping your Child Heal from Abuse
7. Tele-mental health webinars, WRCAC, 2019
8. Thriving Kids 2019: A National Report on Mental Health Outcomes in Children's Advocacy Centers

RESEARCH

Batzer, S., Berg, T., Godinet, M. T., & Stotzer, R. L. (2018). Efficacy or chaos? Parent–child interaction therapy in maltreating populations: A review of research. *Trauma, Violence, & Abuse*, 19(1), 3-19.

Berkowitz, S. J., Stover, C. S., & Marans, S. R. (2011). The child and family traumatic stress intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*, 52(6), 676-685.

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, 36(6), 528–541.

National Children's Advocacy Center. (2018). Issues affecting utilization of mental health treatment by victims of child sexual abuse and their caregivers: A bibliography. Huntsville, AL: Author.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review Mental Health Guidelines from your CAC, if any
2. Meet with a mental health team members to discuss the referral process and therapeutic protocols
3. Discuss importance of evidence-based, trauma-informed treatment

Medical Exams in Child Abuse Cases: What MDT Partners Need to Know

OVERVIEW

All children who are suspected victims of child sexual abuse are entitled to a medical exam conducted by a specialized medical provider. CACs/MDTs can share with families and partner agencies, the reason a medical exam is important:

- To ensure the health and well-being of the child
- To reassure the child that everything is okay with their body
- To diagnose and treat medical conditions that may be related to sexual abuse
- To document any possible physical and forensic findings
- To allow for collection of evidence that may be present on the child's body or clothing (within 72 hours for pre-pubescent children/120 hours for adolescents, although time frames may differ among states)

It is also important for CACs/MDTs to share with families and partner agencies that most medical exams (over 90%) have normal findings, but that does not mean sexual abuse did not occur. Medical professionals are able to explain "why normal is normal" in court if needed. The medical exam is not painful and assures children and their caregivers that their body is okay in spite of what has happened to them.

The role of the medical provider on the MDT is to:

1. explain the results of medical exams conducted

2. explain what happens during a medical exam is conducted and when it is recommended
3. discuss why a normal exam does not mean abuse did not happen
4. discuss who should conduct a medical exam and
5. answer any questions from the MDT

Draft Medical Guidelines

- Who determines if a medical exam is needed for the child victim? When is it recommended?
- What is the purpose of the medical exam?
- Are medical evaluations offered to all child victims?
- How are MDT members trained and by whom regarding the purpose of the medical exam? How and by whom, are children/families educated regarding the medical evaluation?
- Who conducts the medical exam? Do the medical providers have pediatric or child abuse expertise?
- Where are the medical exams conducted? How are emergency situations addressed?
- What information will be shared with the medical provider prior to the exam and by whom? How is duplicative information gathering prevented?
- How is the medical evaluation made available?
- How are multiple exams avoided?
- What are the procedures for forensic documentation and collection/preservation of evidence?
- How is the medical evaluation coordinated with the MDT in order to avoid duplication of interviewing and history-taking?
- If the MDT is responding to physical abuse and/or maltreatment cases, what are the procedures for medical intervention?
- How are the medical findings shared with investigators and prosecutors on the MDT in a routine and timely manner?
- How does the MDT ensure access to appropriate medical evaluation and treatment for all child victims regardless of ability to pay?

AVAILABLE RESOURCES

1. CAC Director Resource for Orienting Medical Providers
2. Medical Aspects of Child Abuse for the Multidisciplinary Team
3. Medical Issues in Child Abuse Resources
4. NRCAC Medical Fact Sheet, 2018
5. RCAC Medical Linkage agreement
6. The Medical Exam in Child Sexual Abuse Cases: What MDT Partners need to know, NRCAC video 2018
7. Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused

RESEARCH

Adams, Joyce, Harper, Katherine, Knudson, Sandra, Reville, Juliette. (1994) Examination Findings in Legally Confirmed Child Sexual Abuse: Its Normal To Be Normal.

Finkel, M. A., & Alexander, R. A. (2011). Conducting the medical history. *Journal of Child Sexual Abuse*, 20(5), 486-504.

Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2018

International Association of Forensic Nurses, Sexual Assault Nurse Examiner (SANE) Education Guidelines, 2015.

Leventhal, J. M., Murphy, J. L., & Asnes, A. G. (2010). Evaluations of child sexual abuse: Recognition of overt and latent family concerns. *Child Abuse & Neglect*, 34(5), 289-295.

Walsh, W.A., Lippert, T., Cross, T.E., Maurice, D.M., & Davison, K.S. (2008). Which sexual abuse victims receive a forensic medical examination? The impact of Children's Advocacy Centers. *Child Abuse and Neglect*, 31, 1053-1068.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review Medical Guidelines from your CAC, if any
2. Discuss the medical component, role and responsibility of medical provider on team and at case review

Building A Better Case Review Together

OVERVIEW

Case Review is the formal process through which professionals share facts and observations that inform team decisions and assist participating professionals to make decisions about cases. Case review is a core standard of an accredited member CAC program. Case review allows the CAC to monitor cases and bring the expertise of the team members together. Through case review, the efforts of all team members are maximized because knowledge is shared and cooperation is built among the participating agencies. Case review presents an opportunity for each professional to share their unique knowledge and skill with the other team members and allows for full discussion on determining the optimum case plan and next steps.

Each CAC determines, with their multidisciplinary team, the criteria for case review – deciding whether all cases will be reviewed or just identified/complex cases. The more complicated cases are usually reviewed on an ongoing basis until all efforts on the case have taken place and the case is closed.

Case review should present opportunities to:

- Evaluate the child's interview
- Discuss, plan and monitor the progress of the investigation, including what has been done and what still needs to be done on the case
- Review the findings from the medical examination

- Discuss protection issues, if needed, and provide input into the decision about removal of the child from the family
- Discuss support issues for caregivers and other family members
- Discuss cultural considerations of child and caregivers
- Provide input into the decision about prosecution
- Provide an opportunity to discuss the treatment issues/needs for the child and other family members
- Review the family's viewpoint about prosecution
- Review criminal and civil case proceedings
- Promote joint decision making on case management issues
- Determine appropriate time frames to accomplish tasks
- Provide an opportunity for formal and informal communication among all responsible agencies
- Discuss the important child development issues relevant to interviewing the child, assessing their ability to participate in court, and preparing them for court
- Provide support to the professionals who work the child abuse cases to prevent burnout
- Build trust and support among team members
- Provide cross-training opportunities for team members.

In addition to the opportunities listed above, case review has many benefits:

- Provides an opportunity for new agency personnel to become acquainted with other team members and the case review process
- Allows each team member to retain their agency identity/mandate while becoming familiar with the other systems involved with abused children and their families
- Helps prevent cases from "falling through the cracks" in the system by enabling team members to identify gaps in resources and conflicts in service provision
- Ensures pro-active planning and case coordination in the best interest of the child and family

At case review, all agencies or professionals who have information about a case should be present. Each agency should be present so all issues pertinent to the case can be discussed, decision making can occur, and appropriate referrals made. Some agencies send the ongoing caseworker/detective, while others send the supervisors with the latest case updates. Each CAC should have a policy about confidentiality of case review information and all those in attendance at case review must be bound by the CAC policies on confidentiality.

The following team members are designated to participate in regular formal case review:

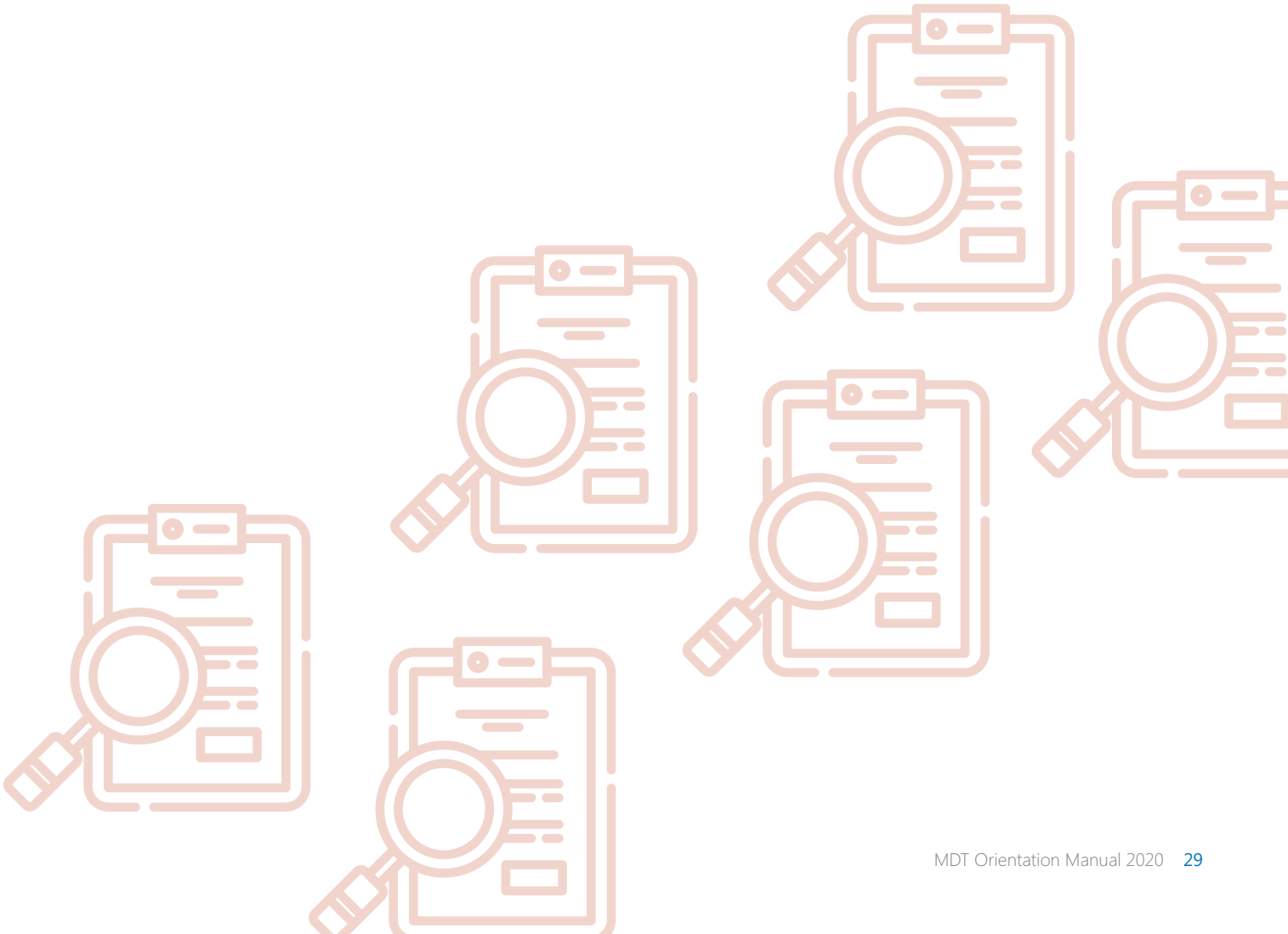
Law Enforcement	**Child Protection**	**MDT Coordinator**
Mental Health	**Victim Advocacy**	**Medical**
Forensic Interviewer	**Prosecution**	**CAC Staff**

AVAILABLE RESOURCES

1. Building a Better Case Review Together, NRCAC Guidelines
2. Building a Better Case Review Together NRCAC video 2020
3. MRCAC Case Review Checklist

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review Case Review Guidelines from your CAC, if any
2. Observe a case review with a colleague to then ask questions about roles and responsibilities of each member



Case Tracking

OVERVIEW

Tracking child abuse cases throughout the investigation and prosecution, if any, is critical for MDT members to know the outcome of cases they were involved in. CACs use different databases or Excel spreadsheets to track outcomes in each discipline. CACs need to outline case tracking criteria and procedures to ensure that cases are routinely tracked while the case is pending in the child protective and criminal justice systems. NCA Trak is available, at a cost, from National Children's Alliance for CAC members to utilize. There are also other individual or state-specific databases that have been created to track CAC cases.

Some questions to ask include:

1. What mechanisms does the CAC have in place to track and retrieve the following information?
   - Client demographics (including age, race, ethnicity, disability, and gender)
   - MDT involvement and case outcomes for CPS, LE and Prosecution
   - Status/follow-up on medical and mental health services
   - National Children's Alliance statistical information
   - Other information as appropriate
2. Who is identified to implement the case tracking process?
3. How do team members get access to tracking information?

4. Who is the keeper of the records?
5. What are the procedures to maintain the confidentiality of files, records, and reports?
6. How is client and/or caretaker feedback obtained

Client feedback is important for CACs to incorporate into their program. Outcome Measurement System (OMS) is available, at no charge, to accredited members of National Children's Alliance. OMS allows CACs to gather information from families and also from MDT members.

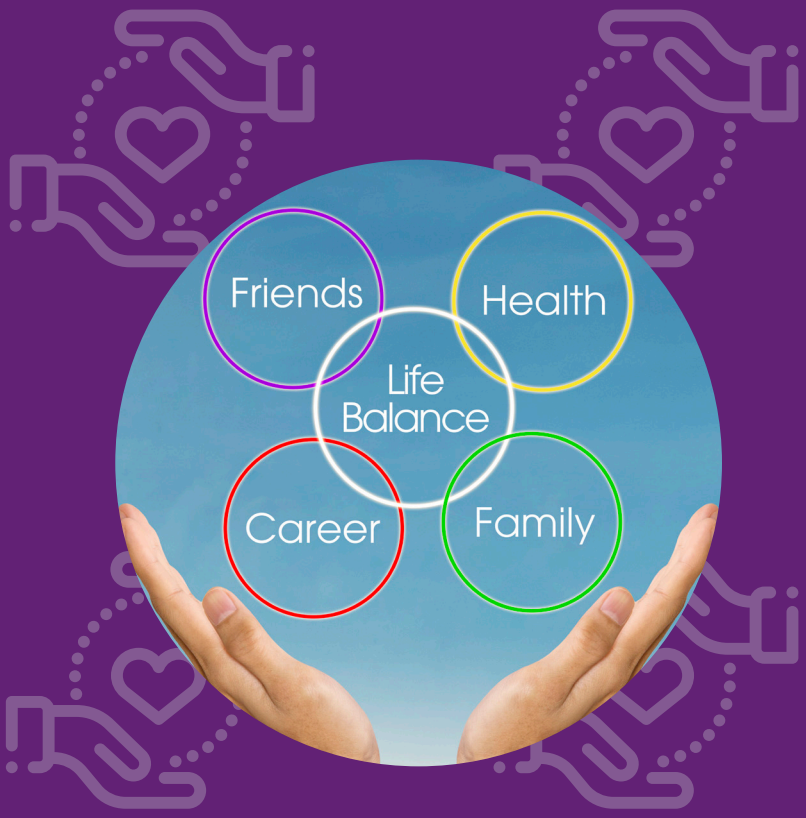
AVAILABLE RESOURCES

1. NCA Trak
2. Outcome Measurement System

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review case tracking database, including annual statistics report, if available
2. Review OMS survey results, for clients and MDT members

Vicarious Trauma/ Building Resiliency for Child Abuse Professionals



OVERVIEW

It is essential for CACs and MDTs to discuss the emotional, mental, and physical toll from working in the field of child abuse. Individual staff should have the opportunity to evaluate their own resilience and learn strategies to combat vicarious trauma/compassion fatigue and burnout. We need to educate new team members, as well as seasoned employees, to understand the impact, identify any physical, emotional and behavioral symptoms, to then address ways to build resilience.

1. Vicarious Trauma - Profound shift that workers experience in their world view when they work with clients who have experienced trauma.
2. Compassion Fatigue - Profound physical and emotional exhaustion that helping professionals can develop over the course of their career as helpers.
3. Secondary Traumatic Stress - Emotional toll of listening to trauma stories. Impact of indirect trauma exposure and hearing stories of firsthand experiences of others could lead to PTSD symptoms for the MDT professional.
4. Burnout - Feelings of physical and emotional exhaustion associated with job dissatisfaction, feelings of powerlessness and overwhelmed at work.
5. Compassion Satisfaction - Positive feelings from work as a trauma professional.

Organizational Strategies

In addition, it is critical for organizations to look at the impact of the work on their employees and MDT and seek to address from a systemic lens. The five most important things to address within your organization include: (Vicarious Trauma Toolkit, OVC, 2016).

Leadership and Mission

To address the impact of vicarious trauma, leaders in vicarious trauma-informed organizations proactively integrate strategies into workplace values, operations, and practices; maintain a clear vision that supports and articulates the agency's mission; and regularly model and promote open and respectful communication.

Management and Supervision

To fulfill their obligation to lessen the impact of vicarious trauma, managers and supervisors in vicarious trauma-informed organizations foster supportive relationships based on inclusivity, mutual respect, and trust; promote policies and practices that lessen the negative impact of the work; seek out and support staff following critical or acute incidents; and conduct performance evaluations that include discussions of vicarious trauma.

Employee Empowerment and Work Environment

To promote and maintain a healthy work environment, vicarious trauma-informed organizations foster teamwork; encourage collaboration both within and outside the organization; create formal and informal opportunities for staff to connect with one another; and offer opportunities to diversify job tasks.

Training and Professional Development

To strive for professional competency, capacity, and staff retention, vicarious trauma-informed organizations promote continuing education, professional development, and networking opportunities; provide thorough orientation and ongoing training; enable access to resources; and support staff participation in on- and offsite learning opportunities.

Staff Health and Wellness

To maintain the health and wellness of their staff, vicarious trauma-informed organizations recognize links between health/wellness and staff satisfaction and productivity; devote time and resources to promoting staff well-being; encourage and provide health and wellness activities; and incorporate wellness into policies and practices.

AVAILABLE RESOURCES

1. Building Resiliency in Child Abuse Organizations, Office of Victims of Crime
2. Secondary Traumatic Stress in Child Welfare Practice: Trauma-informed Guidelines for Organizations, Chadwick Center for Children and Families, 2016
3. Trauma Stewardship Ted Talk
4. Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision, NCTSN
5. Understanding Secondary Traumatic Stress for CAC Workers, National Traumatic Stress Network (NCTSN)
6. Vicarious Trauma Plan Guide, SRCAC, 2018
7. Vicarious Trauma Toolkit, OVC, 2016

RESEARCH

Figley, Charles (1995). Compassion Fatigue: Secondary Traumatic Stress Disorders from Treating the Traumatized. New York: Brunner/Mazel.

Fisher, P. (2015). Building resilient teams: Facilitating workplace wellness and organizational health in trauma exposed environments.

Gilmartin, Kevin (2002). Emotional Survival for Law Enforcement: A Guide for Officers and their Families. E-S Press.

Mathieu, Francois. (2012). The Compassion Fatigue Workbook. New York: Taylor & Francis Group LLC.

Richardson, Cheryl (1999). Take Time for Your Life: A Personal Coach's 7-Step Program for Creating the Life You Want. Broadway Books.

Van der Kolk, Bessel (2015). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma.

Van Dernoot Lipsky, L. & Burk, C. (2009). Trauma stewardship: An everyday guide to caring for self while caring for others.

Van Dernoot Lipsky, L (2018). The Age of Overwhelm: Strategies for the Long Haul. Berrett-Koehler Publishers.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Review vicarious trauma training/activities done at your CAC, if any

Standards for Accreditation with the National Children's Alliance

(www.nationalchildrensalliance.org)

OVERVIEW

The National Children's Alliance (NCA) is the national association and accrediting body for Children's Advocacy Centers (CACs). NCA opened in 1994 and has created standards for accreditation, with member CACs across the country and state chapter organizations in all 50 states. There are three levels of membership, Accredited, Associate and Affiliate, with different requirements for each level.

Accredited member

CACs must meet standards for Accreditation. These standards ensure that child abuse victims throughout the country receive effective, efficient and compassionate services. The following program components are necessary for accredited membership in National Children's Alliance:

1. **Multidisciplinary Team (MDT):** A multidisciplinary team for response to child abuse allegations includes representation from the following:
   - Law enforcement
   - Child protective services
   - Prosecution
   - Medical
   - Mental health

- Victim advocacy
- Children's advocacy center.

2. **Cultural Competency and Diversity:** Culturally competent services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

3. **Forensic Interviews:** Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact finding nature, and are coordinated to avoid duplicative interviewing.

4. **Victim Support/Advocacy:** Victim support and advocacy services are routinely made available to all CAC clients and their non-offending family members as part of the multidisciplinary team response.

5. **Medical Evaluation:** Specialized medical evaluation and treatment services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

6. **Mental Health:** Specialized trauma-focused mental health services, designed to meet the unique needs of the children and non-offending family members, are routinely made available as part of the multidisciplinary team response.

7. **Case Review:** A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis.

8. **Case Tracking:** Children's advocacy centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.

9. **Organizational Capacity:** A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.

10. **Child-Focused Setting:** The child-focused setting is comfortable, private, and both physically and psychologically safe for diverse populations of children and their non-offending family members.

Associate/Developing Members

Associate/Developing Members must provide documentation of the following requirements:

- a functioning MDT with representation from Law Enforcement, Child Protective Services, Prosecution, Medical, Mental Health and Victim Advocacy
- a signed interagency agreement and MDT protocols
- a facility designated for interviews of children

- working toward implementing all standards for Accreditation
- MDT case review which is conducted on a regularly scheduled basis, and attended by all MDT representative disciplines
- a letter of recommendation from the Chapter in their jurisdiction (if applicable)

Affiliate Members

Affiliate Members must provide documentation of the following:

- a functioning MDT with representation from Law Enforcement, Child Protective Services, and Prosecution
- a signed interagency agreement and MDT protocols
- a letter of recommendation from the Chapter in their jurisdiction (if applicable)
- MDT case review which is conducted on a regularly scheduled basis, and attended by all MDT representative disciplines
- child forensic interviews are conducted in a neutral and child-focused setting

AVAILABLE RESOURCES

1. NCA Putting Standards Into Practice, 2017
2. NCA Standards for Accreditation, 2017

RESEARCH

National Children's Alliance (2011). Annotated Bibliography of the Empirical and Scholarly Literature Supporting the Ten Standards for Accreditation by the National Children's Alliance. Washington, DC: Author.

OTHER SUGGESTIONS FOR ONBOARDING TEAM MEMBERS TO YOUR CAC

1. Share your next site review date with team members, along with expectations regarding their participation in the process
2. Review Standards together with a specific focus on the standards most applicable to that team member's role/discipline

Acronyms

AG	Attorney General
ADA	Assistant District Attorney
AP	Assistant Prosecutor
CAC	Children's Advocacy Center
CASA	Court Appointed Special Advocate
CALiO	Child Abuse Library Online
CPS	Child Protective Services
CSEC	Commercial Sexual Exploitation of Children
DV(S)	Domestic Violence (Specialist)
EBPs	Evidence Based Practices
FI	Forensic Interview
ICAC	Internet Crimes Against Children
MDT	Multidisciplinary Team
MRCAC	Midwest Regional Children's Advocacy Center
MOU	Memorandum of Understanding
NCA	National Children's Alliance
NCAC	National Children's Advocacy Center
NCJTC	National Criminal Justice Training Center
NCMEC	National Center for Missing and Exploited Children
NCTSN	National Child Traumatic Stress Network
NRCAC	Northeast Regional Children's Advocacy Center
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OMS	Outcome Measurement Services

SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
SCR	State Central Registry
SRCAC	Southern Regional Children's Advocacy Center
STI	Sexually Transmitted Infection
STS	Secondary Traumatic Stress
VOCAA	Victims of Child Abuse Act
VT	Vicarious Trauma
VOCA	Victims of Crime Act
WRCAC	Western Regional Children's Advocacy Center
YPSB	Youth with Problematic Sexual Behavior

National/Regional Resources

National Children's Alliance

516 C Street NE, Washington DC 20002

(202) 548-0090

www.nca-online.org

Midwest Regional Children's Advocacy Center

5901 Lincoln Drive, Edina, MN 55436

(952) 994-5277

www.mrcac.org

Northeast Regional Children's Advocacy Center

300 East Hunting Park Ave, Philadelphia, PA 19124

(215) 387-9500

www.nrcac.org

Southern Regional Children's Advocacy Center

210 Pratt Ave., Huntsville, AL35801

(800) 747-8122

www.srcac.org

Western Regional Children's Advocacy Center

Chadwick Center for Children and Families,

Rady Children's Hospital San Diego

MC 5016, 3020 Children's Way, San Diego, CA 92123

(858) 966-1700 ex 6581

www.westernregionalcac.org

National Children's Advocacy Center

210 Pratt Ave., Huntsville, AL 35801

(256) 533-5437

www.nationalcac.org / www.ncacvtc.org

NCA Engage

A professional networking and learning tool designed to connect National Children's Alliance members and partners. NCA Engage provides instant access to a community of your peers, useful and informative document libraries, access online training, and allows users to engage in focused online discussions.

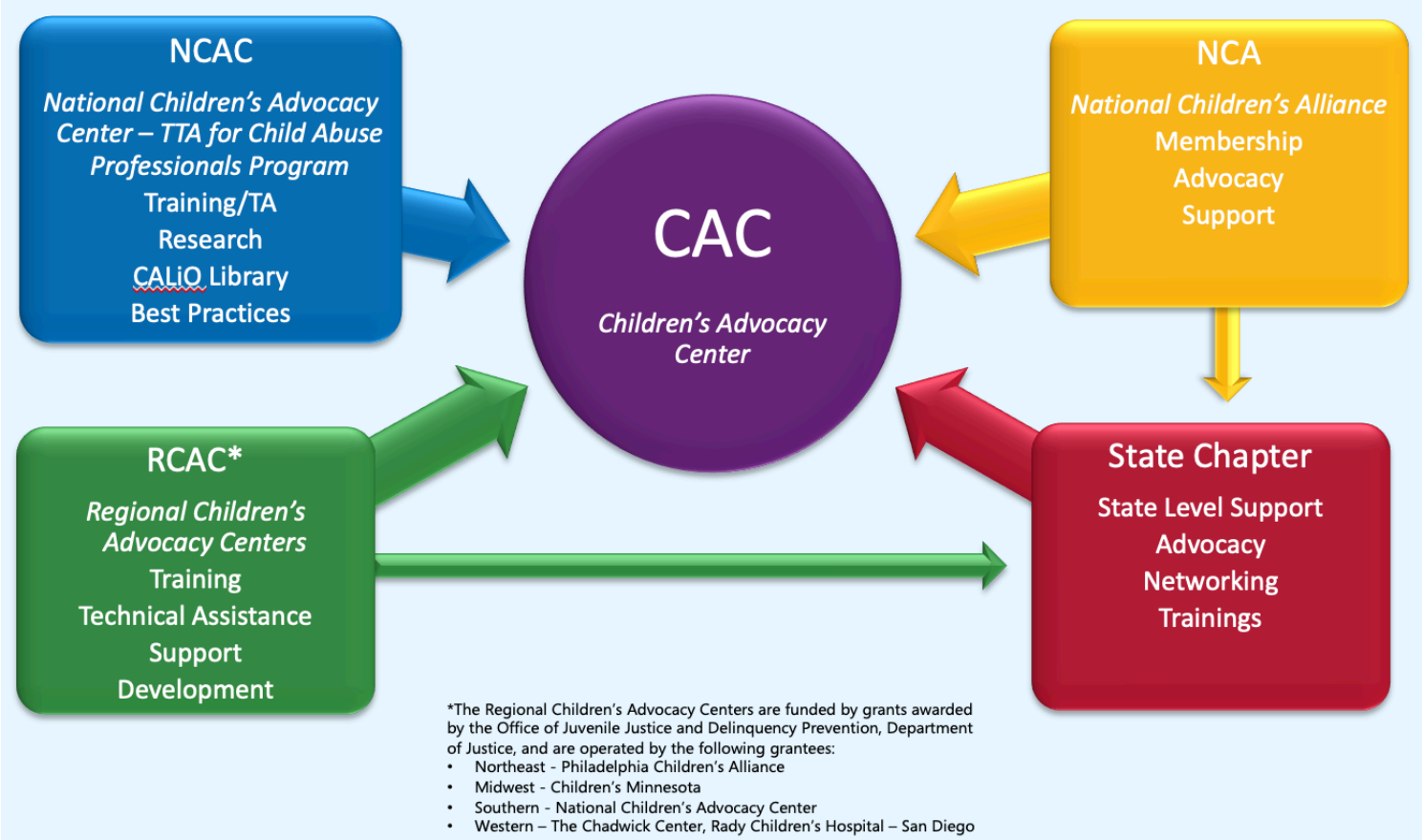
engage.nationalchildrensalliance.org

Child Abuse Library Online (CALiO)

A service of National Children's Advocacy Center developed as a resource collection for professionals working in fields associated with child abuse.

calio.org

National CAC Support Structure



northeast regional children's advocacy center

MDT Training Agenda

ORIENTATION FOR NEW CAC STAFF/MDT MEMBERS
DRAFT TRAINING AGENDA (CAN BE MODIFIED TO MEET YOUR CAC NEEDS)

Annual or Bi-Annual Training	Presenter	Content
Welcome & Introductions	CAC Director	Share history of your CAC; state legislation regarding CACs; state chapter infomation
Overview of National Children's Alliance and Regional CACs	CAC Director	Show NCA explainer video, What is a CAC?; Share Changing the Child Abuse System: Robin's story, Review NCA Standards for Accreditation, 2017
Forensic Interviews	FI	Review Forensic Interview guidelines and case acceptance criteria, describe FI process, explain training for FIs
Role of Child Protective Services	CPS	Describe the process of CPS investigations, including state specific time-frames
Role of Law Enforcement	LE	Review the number of police departments involved with your CAC – local, state, sheriff's office; Provide an overview of a criminal investigation and what it takes to make an arrest/ obtain a complaint
Role of Victim Advocacy	VA	Describe the role of the advocate during the forensic interview and follow up, including if there are multiple advocates involved
Role of Medical	MD/Pedi-SANE	Describe specialized medical services (on site or off site); Discuss the difference between...*(cont'd)*

MDT Training Agenda *(cont'd)*

ORIENTATION FOR NEW CAC STAFF/MDT MEMBERS DRAFT TRAINING AGENDA (CAN BE MODIFIED TO MEET YOUR CAC NEEDS)		
Annual or Bi-Annual Training	Presenter	Content
		(cont'd)...emrgency department and specialized medical provider; Explain benefits of exam and clarify why "normal is normal"
Role of Mental Health	MH	Describe mental health services on-site or linkage agreements with community agencies; Review evidence-based trauma-informed mental health services
Commercial Sexual Exploitation of Children (CSEC)	CAC Director or other	Describe CSEC services (if relevant)
Other Services	Education, Development, Nonprofit Board	Describe additional services and/or organizational structure information

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW MDT MEMBERS

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Agency Tour and CAC Staff Orientation		Organizational chart; Agency mission/vision
Review CAC Employee Handbook Discuss time sheets, travel reimbursement, etc.		Employee Handbook & other personnel policies & forms
CAC Overview: History, benefits, philosophy, different models 1. CAC Videos CAC of Suffolk County, Boston 2. CAC Video, CAC of Kennebec and Somerset Counties 3. Video Gallery – Children's Advocacy Centers of Texas 4. Massachusetts Children's Alliance Video, Child Abuse: Stars in the Field		Changing the Child Abuse System: Robin's story CAC Effectiveness infographic from National Children's Advocacy Center
State/Local specific information		State chapter website
Child Sexual Abuse Statistics & Dynamics of Abuse		NCTSN Child Sexual Abuse Fact Sheet Child Welfare Information Gateway statistics National Center for Victims of Crime statistics

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW MDT MEMBERS (CONT'D)

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Review NCA, Regional and National CAC materials: National Children's Alliance Northeast Regional Children's Advocacy Center Midwest Regional Children's Advocacy Center Western Regional Children's Advocacy Center Southern Regional Children's Advocacy Center National Children's Advocacy Center		Standards for Accreditation, 2017 Putting Standards Into Practice
CAC Referral Process (child sexual abuse, physical abuse, witness to violence, commercial sexual exploitation of children)		MOU/Interagency Agreement; Case Flow Chart
Meeting/Shadow with Reception/Intake Cover answering phones, doors, overall CAC operation day to day and review of individual volunteers (training, coordination, etc)		Intake forms

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW MDT MEMBERS (CONT'D)

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Meeting/Shadow with Victim Advocacy Cover working with children and families during their initial visit and beyond, role definition, and responsibilities. Discuss protocol and role of multiple advocates (if relevant) and caregiver survey		Field Guide to Victim Advocacy Victim Advocacy Guidelines, 2017 NRCAC Victim Advocate Case Flow Chart
Meeting/Shadow with Forensic Interviewer Discuss protocol, child abuse dynamics, disclosure process, interview training model and peer review.		Child Forensic Interviewing: Best Practices Forensic Interview Guidelines for your CAC
Observe a live forensic interview. Discuss interview process from referral to pre/post meeting MDT only & with caregiver/MDT		Folder of information for caregiver
Meeting/Shadow with Medical Provider(s) Discuss medical component, role and responsibility on team along with benefit to children and families		The Medical Exam in Child Sexual Abuse Cases: What MDT Partners need to know, NRCAC video 2018 NRCAC Medical Fact Sheet

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW MDT MEMBERS (CONT'D)

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Meeting/Shadow with Mental Health Provider(s) Meet with MH team member to discuss component's referral process and therapeutic protocols and methods used. Discuss importance of evidence based, trauma informed treatment – TF-CBT, CFTSI, ARC etc		Mental Health Guidelines (from your CAC) CAC Director's Guide to Quality Mental Healthcare NCTSN
Meeting/Shadow with CPS Meet with a CPS investigator to discuss their role and responsibility on the team, if possible shadow for a period of time (PS cases, safety plans, etc)		Mandated reporting law for your state NRCAC Minimal Facts Guidelines
Meeting/Shadow with LE Meet with a LE detective to discuss their role and responsibility on the team, if possible shadow for a period of time		NRCAC Minimal Facts Guidelines
Meeting/Shadow with Prosecution Meet with a prosecutor and/or victim witness coordinator to discuss their role/responsibility, shadow if possible		Overview of the criminal justice system for your state

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW MDT MEMBERS (CONT'D)

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Meeting/Shadow with Education Department (if applicable) Cover CAC's training capabilities, explore opportunities for individual involvement with providing training/education		Education overview or guidelines
Observe a live training conducted by CAC staff (if applicable)		
Meeting/Shadow with Development (if applicable) Cover events, fundraising and group volunteer opportunities as well as the components purpose and role within the CAC		
Review NCAtrak database (or other data tracking system)		NCA Trak
Meet with MDT Coordinator to discuss importance and value of MDT, case review meetings, etc.		Building a Better Case Review Together, NRCAC video and guidelines MRCAC Case Review Checklist

northeast regional children's advocacy center

MDT Orientation Checklist

ORIENTATION FOR NEW CAC STAFF/MDT MEMBERS (CONT'D)

CHECKLIST CAN BE ADAPTED TO YOUR CAC'S NEEDS

Training Checklist	Date Completed	Documents to Review
Review Cultural Competency plans		Community Assessment materials
Meet the CAC Board of Directors (if relevant)		Board materials (as relevant)
Review the issue of vicarious trauma & importance of self care		Trauma Stewardship (book and Ted Talk)
Read the Adverse Childhood Experiences Study, watch video		ACES video

northeast regional children's advocacy center

MDT Roles & Responsibilities

I. REFERRAL PROCESS		
Discipline	Roles	Responsibilities
Law Enforcement	Refer cases where there are allegations of sexual abuse/assault of anyone under 18 (or add your age limit here) and adults with developmental disabilities (if applicable)	• Call the CAC • Provide case information and your availability • Respond to confirmation date/time of the forensic interview
Child Protection	Refer cases where there are allegations of sexual abuse/assault of anyone under 18 or adults with developmental disabilities.	• Call the CAC • Provide case information to the CAC • Provide availability • Confirm date/time of the forensic interview
Prosecutor's Office	Consult with CAC and law enforcement regarding referrals to the CAC	• Work with law enforcement & CAC regarding referrals • Confirm date/time of the forensic interview
All Other MDT Members	Make a Mandated Report to the Child Abuse Hotline	• Call the Child Abuse Hotline in your state to report any suspicion of child abuse or neglect 1-800------

northeast regional children's advocacy center

MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW

Discipline	Roles	Responsibilities
Law Enforcement	Observe interview to gather information to investigate criminal acts	• Arrive 15 minutes prior to the interview • Participate in pre-interview meeting with other MDT members and the caregiver • Share information about any prior knowledge of victim or family or suspect • Provide feedback to the forensic interviewer and participate in the interview process • Participate in the post-interview meeting with the MDT
Child Protection	Observe interview to gather information to investigate abuse and neglect	• Arrive 15 minutes prior to the interview • Participate in pre-interview meeting with other MDT members and the caregiver • Share information about victim or family or suspect • Provide feedback to the forensic interviewer regarding child protection while observing the interview • Participate in the post-interview meeting with the MDT

MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW (CONT'D)

Discipline	Roles	Responsibilities
Victim/Family Advocate	Provide support to the caregiver	• Attend pre-and post-interview meetings with the MDT • Provide support to the caregiver while child is interviewed • Provide information and referrals to trauma informed mental health services and other community resources, as needed • Offer OMS survey to caregivers at the end of the appointment
Prosecutor's Office (If attending)	Observe interview to gather information regarding prosecution of criminal acts	• Arrive 15 minutes prior to the interview • Participate in pre-interview meeting with other MDT members and the caregiver • Provide feedback to the forensic interviewer regarding legal issues while observing the interview • Participate in the post-interview meeting with the MDT and caregiver

MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW (CONT'D)

Discipline	Roles	Responsibilities
Medical Provider (If attending)	Provide information and consultation regarding medical care for child abuse victims	• Arrive 15 minutes prior to the interview • Participate in pre-interview meeting with other MDT members and the caregiver • Provide feedback to the forensic interviewer regarding medical issues while observing the interview • Participate in the post-interview meeting with the MDT and caregiver
Mental Health (If attending)	Provide consultation to the team regarding mental health issues related to trauma and child development	• Arrive 15 minutes prior to the interview • Participate in pre-interview meeting with other MDT members and the caregiver • Attend the forensic interview to provide expertise on a mental health issues related to the child/family • Provide referrals to trauma-informed, evidence-based mental health treatment • Participate in the post-interview meeting with the MDT

MDT Roles & Responsibilities

III. ROLES AND RESPONSIBILITIES AFTER THE FORENSIC INTERVIEW

Discipline	Roles	Responsibilities
Law Enforcement	Investigate criminal acts based on information obtained at forensic interview	• Interview witnesses & suspect(s) • Discussion with prosecutor • Arrest or summons • Communicate with CAC/MDT regarding status of investigation • Participate in case review
Child Protection	Determine outcome of child protection investigation	• Make investigation determination (supported or unsupported- use your state language) • Communicate with family and CAC/MDT regarding decision to open/close case • Participate in case review
Victim/Family Advocate	Support the caregiver through the investigation process and prosecution, if any	• Follow up with family on a regular basis post interview to confirm resources secured • Provide support during ongoing investigation and prosecution • Liaison with MDT partners regarding case status • Participate in case review

MDT Roles & Responsibilities

III. ROLES AND RESPONSIBILITIES AFTER THE FORENSIC INTERVIEW (CONT'D)

Discipline	Roles	Responsibilities
Prosecutor's Office	Make decisions regarding prosecution of criminal acts	• Communicate with law enforcement regarding investigation • Discuss charging options • Prosecute charged cases • Participate in case review
Medical Provider	Provide consultation regarding medical care	• Provide specialized medical exams • Provide medical information to MDT members at forensic interview and case review • Participate in case review
Mental Health	Provide consultation regarding mental health treatment	• Provide specialized mental health care to victims and their caregivers • Coordinate linkage agreements with community agencies providing mental health services • Participate in case review