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National Children's Alliance®
The Force Behind Children's Advocacy Centers

Rural Putting Standards into Practice

A Guide for Implementing the 2023 National Standards of Accreditation for Children's Advocacy Centers

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HOW TO USE THIS MANUAL

This manual is a technical assistance tool for new and existing Children's Advocacy Centers (CACs) seeking National Children's Alliance (NCA) accreditation or reaccreditation. It provides the foundation for understanding how the Standards for Accredited Members support NCA's mission and ensures the integrity of the CAC model of response to reports of abuse. This manual also enables users to conduct an analysis of accreditation readiness and stimulates strategic program planning aimed at delivering comprehensive, evidence-based services.

NCA sets minimum standards that inform and strengthen professional practice and are consistent and updated with the state of the field. These standards were developed with consideration of the vast array of communities in which CACs operate. As a national organization, NCA recognizes and values the variety of ways in which the standards are implemented based on a particular locale's unique needs and resources. By virtue of the multidisciplinary, interagency nature of CAC work, NCA also recognizes that CACs will not likely meet all the required criteria perfectly and consistently over time. Factors such as longevity of the center, community resources and funding, geography, demographics, and size and location of a center's facility, all affect a CAC's ability to meet the required standards and its method of implementation. However, the beauty of the CAC model is its ability to deliver high quality services to children and families in creatively adapted and operationalized ways. While NCA accredits CACs based on the minimum standards it has established, centers are encouraged to continuously aspire to exceed these standards however possible. This manual, therefore, also serves as a tool for dynamic and creative evidence- based program development.

Each of NCA's nine accreditation standards are addressed individually in this manual, and includes a stated rationale, as well as a statement of intent: for all specific criteria that must be met. This manual also contains examples of implementation that are reflective of the many different types of CACs. The examples provided are neither the ideal nor the only options for implementation. They simply represent a range of methods that are currently in use, some of which are quite basic and others that are more elaborate. The examples are intended to stimulate team discussion and help you to determine the best ways for your CAC to meet and/or strengthen particular program components. In addition, this manual contains numerous resources from NCA and the Regional Children's Advocacy Centers (RCACs) that you and your teams are encouraged to utilize as you further develop your programs and services. CACs are also encouraged to utilize their state chapters for additional technical assistance.

CHILDREN'S ADVOCACY CENTERS

Definition

A Children's Advocacy Center (CAC) is a childfocused, facility-based 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 communitybased 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. The CAC's coordinated and comprehensive response is also guided by a shared philosophy that the combined expertise of professionals across disciplines results in a more complete understanding of case issues and better provides help, support, and protection to children and families as they pursue healing and justice.

Goals

The primary goal of all CACs is to ensure that children are not further victimized by the intervention systems designed to protect them. Program objectives include the development and provision of:

- A comprehensive multidisciplinary and developmentally appropriate, evidence-based response to the needs of children and their families in a specific community;
- A neutral, child-friendly facility where forensic interviews and coordinated case planning can be conducted;
- Trauma-focused, evidence-supported medical and mental health treatment and a wide array of victim services;
- Effective and coordinated casemanagement efforts based on open communication, information sharing, and collaborative decision making;
- Comprehensive case tracking that monitors investigative, prosecutorial, child protection, medical, mental health, and victim advocacy services so that cases do not "fall through the cracks";
- More effective prosecutions of child abuse cases; and
- Cross-disciplinary training as well as discipline-specific continuing education that enhances professional practice.

Benefits

Communities that have developed a CAC experience many benefits including, but not limited to:

- More immediate investigative response to child abuse reports;
- More efficient and specialized medical and mental health services and referrals;
- Accessible, relevant, and comprehensive victim services;
- Reduction in the number of child interviews;
- Increased successful prosecutions; and
- Consistent, evidence-based support for child victims and their families with outcomes identified through Outcome Measurement System (OMS) data.

Multidisciplinary team (MDT) members also experience a number of benefits including, but not limited to:

- Greater appreciation and understanding of the roles, responsibilities, strengths, and limitations of other agencies, systems, and disciplines;
- Increased access to professional and cross-disciplinary training;
- More informed decision making with improved outcomes for clients and providers;
- Opportunities to enhance policies and practice that improve system response; and
- Collegial support that helps address vicarious trauma.

CITATIONS

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NATIONAL CHILDREN'S ALLIANCE (NCA)

History

The nation's first Children's Advocacy Center opened its doors on May 1, 1985 in Huntsville, Alabama. In 1987, the National Children's Alliance (formerly known as the National Network of Children's Advocacy Centers) was founded to assist communities seeking to improve their responses to child abuse by establishing, strengthening, and sustaining CACs. NCA has grown from 22 members in 1992 to more than 900 members in 2021.

Services

The National Children's Alliance provides:

- Training, technical assistance, and networking opportunities for professionals and communities;
- Media materials for professional and public education about child abuse, CACs, and the multidisciplinary team (MDT) approach;
- National accreditation standards for CACs;
- Leadership in coordinated investigations and state-of-the-field child abuse interventions;
- Legislative and other policy advocacy for CACs on a national level and guidance for similar activities on the state level*; and
- Funding support through grants and special projects.

Membership Information

NCA is committed to providing exceptional membership services and support.

Visit www.nationalchildrensalliance.org.

* Federal funds cannot be used for any legislative or policy advocacy related activities.

NCA members receive:

- Opportunities for funding;
- Professional training on a wide variety of topics related to child maltreatment;
- Access to national, state, and local conferences, as well as extensive online training, technical assistance, and networking opportunities;
- Management and MDT training and resources;
- Information and assistance regarding policy and legislative initiatives*;
- Access to CALiO (Child Abuse Library Online) operated by the National Children's Advocacy Center;
- Use of the Outcome Measurement System (OMS); and
- Customizable public relations campaigns.

NCA offers several levels of membership to CACs, MDTs, Chapters, and Supporting Individuals seeking to address child abuse through a coordinated community response.

Accredited Membership

To receive accreditation as a Children's Advocacy Center, applicants must meet the Standards for Accredited Members as demonstrated in their written documents, in practice, and during an in-person or virtual site visit. The standards and their accompanying criteria ensure that children and families throughout the country receive effective, efficient, relevant, and compassionate services.

Accredited Members must participate in the reevaluation site review process every five years to demonstrate ongoing compliance with the Standards.

Associate/Developing CAC Membership

Children's Advocacy Centers that are in the process of implementing the Standards for Accredited Members may be granted Associate/Developing CAC status. A CAC with this level of membership can maintain its status for a period of five years, at which time the CAC must achieve accredited status, apply for a one year extension on their Associate/Developing Membership, or choose to apply for another level of membership with NCA.

An Associate/Developing CAC must provide documentation demonstrating all of the following requirements are being met:

- A functioning MDT with representation from law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and CAC staff;
- An interagency agreement and MDT protocols signed by all required partner agencies;
- A facility designated for conducting forensic interviews of children, team practice, and the delivery of other necessary services;
- Plans for implementing all standards for accreditation;
- Case review process conducted on a regularly scheduled basis and attended by all designated MDT members;
- A letter of recommendation from the Chapter in its jurisdiction (if applicable).
- Associate/Developing membership is maintained by meeting the above requirements and remaining current with:
  - Payment of annual dues;
  - Submission of required statistics report to NCA.

* Federal funds cannot be used for any legislative or policy advocacy related activities.

Affiliate Membership

Affiliate membership is offered to MDTs that are implementing a collaborative investigation and intervention response to children and families following reports of abuse. You may remain an Affliate member indefinitely, but are encouraged to apply for the membership level that best reflects your provision of service. An Affiliate member must provide documentation demonstrating each of the following requirements are being met:

- A functioning MDT with representation from law enforcement, child protective services, and prosecution. NCA strongly encourages representation and participation of the additional disciplines (i.e., medical, mental health, and victim advocacy);
- A signed interagency agreement and MDT protocols;
- A letter of recommendation from the Chapter in its jurisdiction (if applicable);
- Case review conducted on a regularly scheduled basis and attended by all MDT representatives; and
- Forensic interviews conducted in a neutral and child-focused setting.
- Affiliate membership is maintained by meeting the above requirements and remaining current with:
    - Payment of annual dues;
    - Annual documentation of forensic interviewing processes and ongoing MDT case review.

Satellite Membership

Satellite membership is available to childfocused settings offering on-site forensic interviews and victim advocacy services under the sponsorship and oversight of a Host CAC accredited by NCA.

Eligibility Requirements for NCA Satellite CAC Membership

- The Host CAC must be accredited prior to initiating a Satellite application and is responsible for completing the application process. [Note: Applications for Satellite membership status will be accepted by NCA on a rolling basis. Once the Satellite application is received, the Satellite will be linked to the Host CAC in all NCA records, including the Host CAC's accreditation renewal schedule.]
- The Host CAC must demonstrate coordination with its Chapter during the planning process. [Note: This may be demonstrated through letters of support for the Satellite application and/ or involvement in the required community needs assessment and/or feasibility studies.]
- The Chapter must provide requested technical assistance to the Host CAC during the Satellite planning process.
- The Host CAC must demonstrate that the Satellite links to its NCA-approved Chapter growth plan and does not duplicate service coverage of any existing Accredited or Developing/Associate Centers.
- The Host CAC must conduct a needs assessment and feasibility study that demonstrates local support for establishment of a Satellite and outcomes.
- The Host CAC must demonstrate governance of the Satellite site. [Note: This may be demonstrated through signed interagency agreements and/or strategic plans.]
- The Satellite must have a child-focused setting/ facility and provide on-site forensic interviews and victim advocacy services.
- The Satellite CAC must have the capacity for the provision of medical and mental health services on-site or through linkages in the local community.

- The Host CAC must have signed interagency agreements or memorandums of understanding (MOUs) with partner agency representatives from the Satellite service area.
- The Host CAC must demonstrate case review and case tracking systems specific to the Satellite's jurisdiction.
- The Satellite must maintain designated staff that coordinates the response and provision of services to clients within the Satellite's jurisdiction.
- The Host CAC, inclusive of its Satellite, must remain in good standing with NCA.

Furthermore, NCA strongly encourages Host CACs to assist their Satellites in meeting the Standards for Accredited Members and incorporating quality assurance efforts into their strategic plans. The requirements for a child-focused setting/facility, as well as the provision of on-site forensic interviews and victim advocacy services will be synchronized with any future updates of the Standards.

Chapter Membership

A Chapter of the National Children's Alliance is an organization that:

- Represents a collaboration among member CACs, Chapter staff, and its governing entity;
- Provides support, training, and technical assistance to emerging and existing CACs and MDTs;
- Promotes sustainability of the CAC model throughout the state;
- Facilitates a statewide network dedicated to a coordinated and comprehensive response to child abuse; and
- Serves as a leading state resource regarding child abuse and the CAC model.

To become an accredited Chapter, applicants must meet each of the five standards outlined in the Standards for Accredited Chapters. Chapters must participate in the reevaluation process every five years to demonstrate ongoing compliance with the Standards.

NATIONAL CHILDREN'S ALLIANCE STANDARDS FOR ACCREDITATION

From its earliest days, NCA has recognized the need for standards that define Children's Advocacy Center's distinct model of response.

Standards for CACs are important guides for planning, organizing, and delivering services in order to most effectively meet the needs of children and families in the aftermath of a report of abuse. They are also useful measures for increasing public awareness, interest, and support of CACs, as well as explaining and justifying funding requests to public and private funders.

CACs that have met the Standards for Accredited Members are recognized as having achieved a desired level of multidisciplinary team practice and coordinated service delivery that positively impacts the experience and well-being of children and families served. CACs applying for accreditation are evaluated on their level of compliance with the NCA standards and criteria. Once accredited, CACs undergo reevaluation every five years.

SITE REVIEW

PURPOSE

The purpose of the site review is to:

- Verify program compliance with the Standards for Accredited Members;
- Ensure CACs are providing evidence-based services to children and families and to the communities they serve.

PROCESS OF VERIFICATION

Through the work of trained site reviewers, NCA has a direct opportunity to observe the CAC's operations described in its accreditation application. The overall verification process includes review of the CAC's program components, protocols, guidelines, and interagency agreements; direct observation of certain practices; and interviews of staff and team members. Each of the standards contains essential components, scored on a pass/ fail basis. The use of an online scoring tool increases objectivity and fairness in the site review process and enables the results to be reviewed by NCA staff and the Accreditation Committee before they are submitted for final approval by the NCA Board of Directors. Each component must be successfully demonstrated by the CAC in order to be awarded accreditation.

A site review requires the participation of:

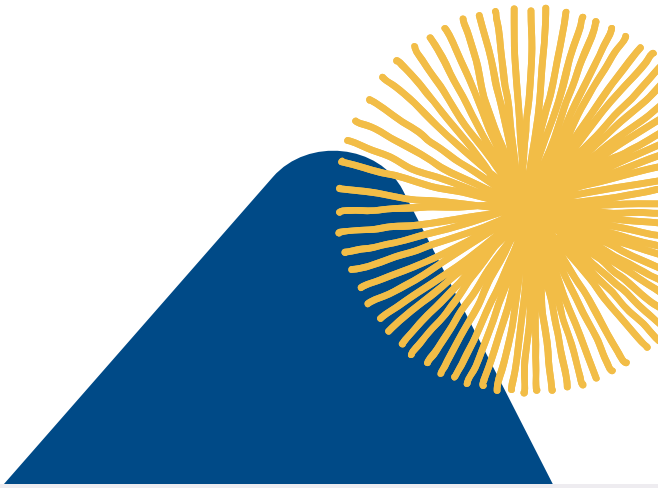
- All signatories to the CAC's interagency agreements/operating protocols, or their designees;
- Members of all required disciplines on the MDT, including investigators, service providers, and CAC staff; and
- Representatives of the Board of Directors or Advisory Board.

STRENGTHENING PRACTICE

The site review provides an opportunity for a CAC to demonstrate its structure and operations, as well as receive objective, positive, and constructive feedback on its compliance with each standard and essential component. In situations where significant modifications or improvements are needed, site reviewers and NCA staff work with a CAC to develop and implement a formal Action Plan to correct the identified deficiencies. CACs undergoing reevaluation maintain their accredited status while implementing such corrections. RCACs and Chapters provide technical assistance wherever needed throughout this process to assist CACs in achieving compliance.

LEADERSHIP AND INNOVATION

The Standards for Accredited Members represent current evidence-based practice. As the relevant fields of practice integral to the CAC response are constantly evolving, NCA ensures that standards and criteria are reviewed and revised at appropriate intervals. Revisions are often informed by innovations in practice implemented at the local level and are critical to advancing NCA's mission. Any proposed updates to the Standards are extensively reviewed by task forces comprised of subject matter experts and reviewed and approved by the NCA Board of Directors.



THE ROLE OF NCA DURING THE APPLICATION & SITE REVIEW PROCESS

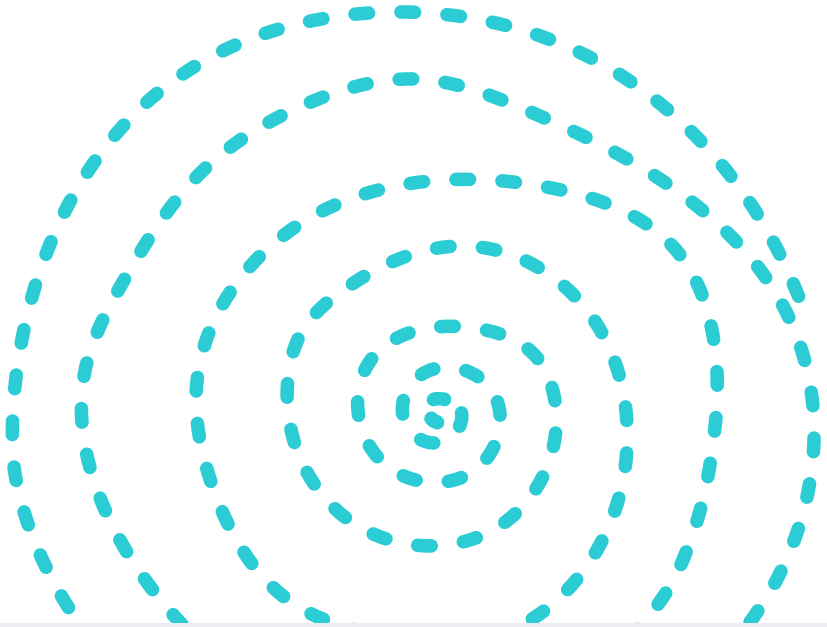
The accreditation application is processed, reviewed, and responded to in a professional and timely manner. Site reviewers are carefully selected based upon their knowledge and experience of CACs and of the different ways in which the standards may be implemented. Typically, site reviewers are assigned to conduct a particular CAC's site review based on their direct knowledge and experience with CACs of similar organizational structure, geography, size, and demographics.

The CAC applicant receives ongoing support and assistance throughout the application and site visit processes, including any required follow-up based on the site review recommendations.

The following resources include a variety of instructional materials to assist in the accreditation process:

- NCA website www.nationalchildrensalliance.org
- Online Accreditation Bootcamp video series

Many CACs request customized technical assistance or consultations from their RCACs and/ or Chapters when preparing for the accreditation process. CACs may also receive technical assistance from NCA specific to the online application process. For this latter purpose, requests for assistance should be sent to accreditation@nca-online.org



THE ROLE OF RCACs IN THE APPLICATION & SITE REVIEW PROCESS

In an effort to help communities improve their responses to child abuse by developing and enhancing CACs, the U.S. Department of Justice established four Regional Children's Advocacy Centers (RCACs) responsible for providing information, consultation, training, and technical assistance to new and established centers. RCACs provide training and technical assistance on the overall development and operations of CACs within their respective regions.

Given their experience with CAC development RCAC staff members provide valuable assistance and resources to CACs in providing guidance for the application and site review process as well as assessing application readiness.

The country is divided into four regions as follows:

- Northeast, www.nrcac.org (serving Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont);
- Southern, www.srcac.org (serving Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia);
- Western, www.westernregionalcac.org (serving Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming);
- Midwest, www.mrcac.org (serving Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin).

THE ROLE OF CHAPTERS IN THE APPLICATION & SITE REVIEW PROCESS

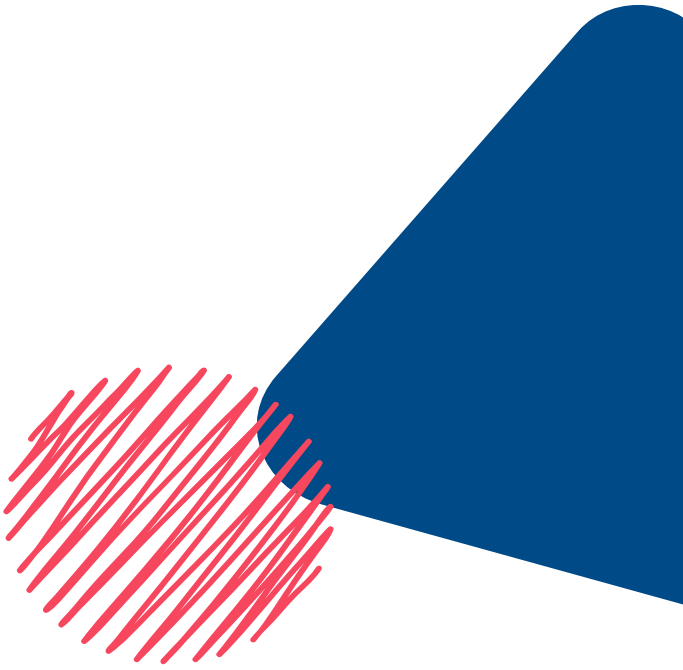
As the CAC movement has progressed and the number of CACs in each state has increased, Chapters have been established in every state. While Chapters vary in size, structure, and capacity, their mission includes ensuring that the CACs within their state networks have the resources and support they need to develop, grow, and sustain their teams and services, and achieve and maintain accreditation. Chapters provide guidance to CACs and RCACs and aid in the development of mentoring relationships between CACs in their state or geographical region that are of similar size, structure, and demographics. Communication and collaboration with Chapter staff before, during, and after the accreditation process not only benefits the individual CAC, but also helps build a stronger and more durable network of services for children and families throughout the state.

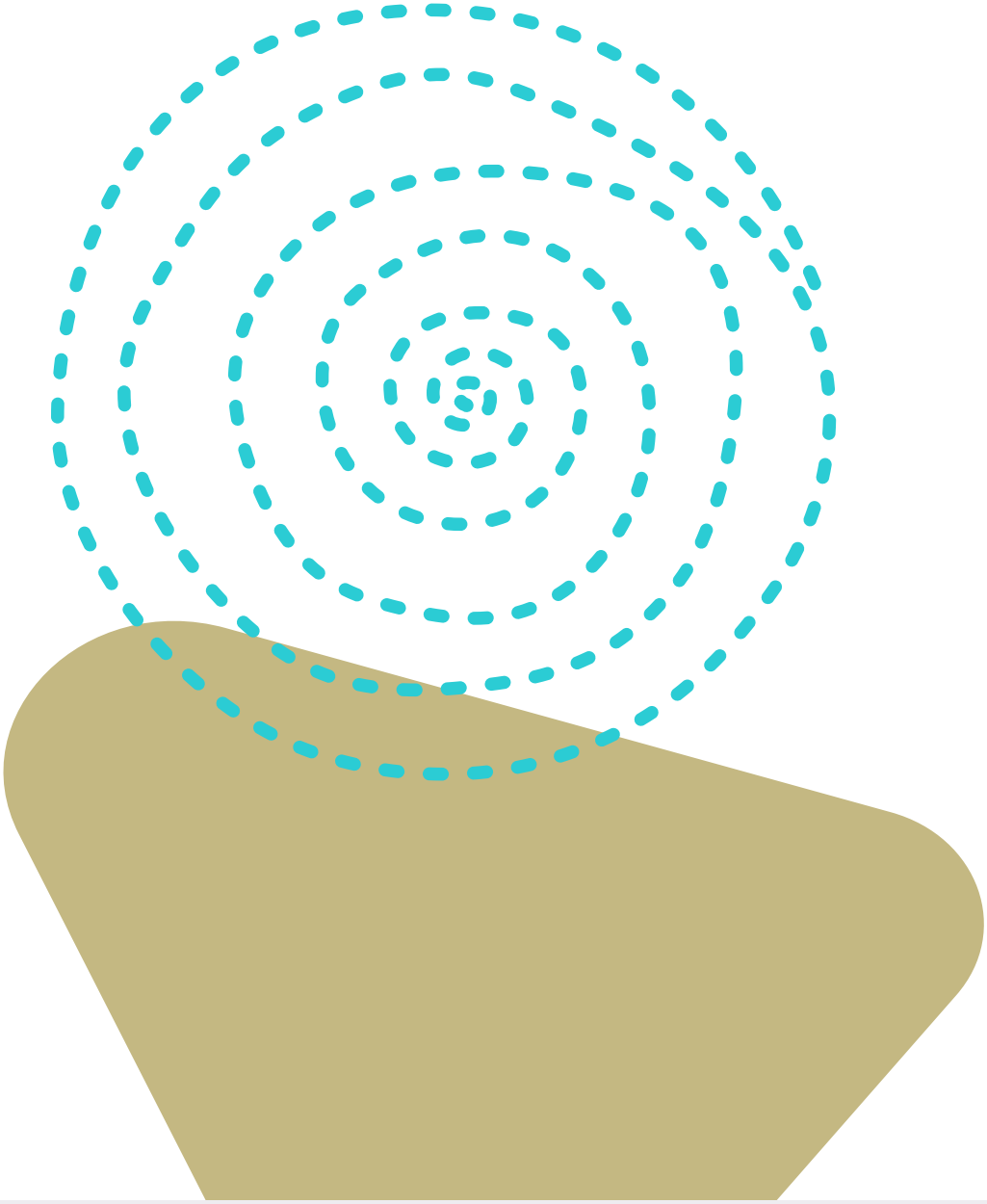
NCA STANDARDS FOR ACCREDITATION

The following nine standards define a CAC's comprehensive model of response. A CAC must meet all essential components for each of these standards in order to be accredited by the National Children's Alliance.

1. Multidisciplinary Team (MDT)
2. Forensic Interviews
3. Victim Support and Advocacy
4. Medical Evaluation
5. Mental Health
6. Case Review and Coordination
7. Case Tracking
8. Organizational Capacity
9. Child Safety and Protection

At the end of each standard below are examples describing some of the possible ways a CAC may meet the requirements of the essential component within that standard. These examples are not meant as mandates or directives for how a CAC chooses to design their practice and/or protocol for providing services in their community. Their purpose is to provide guidance for CACs developing practice that will meet minimum accreditation standards. NCA recognizes that the CAC model allows for the creation of service delivery that will meet the unique needs of the community served, while ensuring that child abuse victims throughout the country receive effective, efficient, and compassionate services.





Standard 01

Multidisciplinary Team

A multidisciplinary team 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



01. Multidisciplinary Team

Rationale

A committed and effective multidisciplinary team (MDT) with a shared common goal is the foundation of a Children's Advocacy Center (CAC). An MDT is a group of professionals from specific and distinct disciplines that collaborates from the point of report and throughout a child and family's involvement with the CAC. MDTs coordinate investigations and service delivery to mitigate potential trauma to children and families, to keep open the lines of communication and maintain transparency and foster trust, and to help optimize a quality response overall, while preserving and respecting the rights of the clients, and the mandates and obligations of each agency.

A CAC is an agency or organization that facilitates the interagency coordinated response. All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate response that is relevant and accessible to its clients. Quality assurance and a review of the effectiveness of the MDT's collaborative efforts are also critical aspects of the MDT response.

The core MDT must be composed of representatives from law enforcement, child protective services, prosecution, medical providers, mental health providers, victim advocates, MDT leadership, and CAC staff. CAC staff may provide any of the above functions, or additional functions, such as forensic interviewers. Some CACs, including those in small or otherwise under-resourced rural communities, may employ one person to fill multiple roles. For example, the CAC director may also serve as the victim advocate, or a CPS worker may function as a forensic interviewer and a caseworker. What is important is that clear boundaries are maintained between each function, and that the MDT response is inclusive of and utilizes all of the required functions outlined in these Standards.

MDTs may be expanded to include professionals with other relevant roles and responsibilities, including guardians ad litem, adult and juvenile probation officers, dependency (civil) attorneys, out-of-home care licensing personnel, federal investigators, school personnel, domestic violence providers and others as deemed necessary and appropriate for an individual child, family or community on a case-by-case or routine basis.

Generally, a coordinated MDT approach results in efficient interagency communication and information sharing, ongoing collaboration of key individuals, and a network of support for children and families. Each agency benefits from the knowledge and expertise of MDT colleagues, thorough and shared information, and improved and timely gathering of evidence that guide individual and collective interventions and help ensure the most efficacious outcomes for the clients and all of the MDT partners. CACs function within a trauma-informed framework designed to reduce harm and support healing. MDT interventions in a neutral, child-focused CAC setting are associated with clients experiencing less anxiety, having to undergo fewer interviews, and seeing more appropriate and timely referrals for needed services and meaningful participation by clients in the protective services, criminal justice, and other systems where applicable. In addition, a coordinated MDT response can empower parents and other caregivers to protect and support their children throughout the life of the case and beyond.

BENEFITS OF THE MDT APPROACH BY MDT FUNCTION

Law Enforcement

- May generate additional evidence to create a stronger case that is less reliant on only the victim's disclosure.
- Support and advocacy functions are attended to by other MDT partners, leaving law enforcement personnel more time to focus on their investigatory role.
- Enhanced collaboration between investigative partners results in a better understanding of family dynamics and improved response to child protection issues.

CPS

- Contributes historical family information, which enhances MDT's abilities to foster child safety and provide parental support and assistance with service plans, minimizing need for escalated CPS interventions.
- Provides additional support and intervention in cases where safety cannot be assured.

Medical Providers

- History and other information obtained during the coordinated forensic interview prevents unnecessary duplication of effort and guides medical decisions.
- Provide consultation on specialized medical evaluations and interpretation of medical findings and reports.

Mental Health Providers

- Contribute valuable information to the MDT regarding the child's emotional state, treatment, and other service needs, and are able to participate in the criminal justice process and other systems where necessary.
- Help ensure that trauma-informed and relevant assessment, treatment, and related services are routinely made available and accessible to children and families.

Victim Advocates

- Provide crisis assessment and intervention, safety planning, referrals for additional services, ongoing support, information and case updates, and court advocacy where necessary in a timely manner.
- Help ensure the MDT's ability to anticipate and respond effectively to the specific needs of children and their families; lessen the stress of, and afford legal rights and meaningful participation in, various systems and the court process; and increase access to services and resources for the child and family, including crime victims' compensation.

Prosecutors

- Provide information about the criminal justice process, victim rights, and seek input from children and families to inform decisions.
- Integrate input from MDT members to optimize ability to hold offenders accountable and ensure community safety.

Children's Advocacy Center

- Coordinates the MDT response to ensure the child and family are receiving nonduplicative services.
- Offers a child-focused setting where trained professionals conduct forensic interviews and other needed services are provided.

Essential Component A:

The MDT Coordinator/Facilitator coordinates and facilitates the day-to-day information sharing and activities of the MDT. The MDT facilitator/coordinator must complete training that includes a minimum of eight hours of instruction. **(This may be the same or different from the person who facilitates case review sessions, as some case reviews are facilitated by MDT members.)**

Training topics which cover the function of the MDT Coordinator/Facilitator may include:

- Developing and maintaining relationships with and among MDT members
- Defining roles and responsibilities of team members
- Defining mission, vision, and values of the MDT
- Managing change and turnover on the MDT
- Navigating and resolving conflict
- Knowledge of evidence-informed team development models
- Facilitating shared decision-making
- Ensuring adherence to MDT agreements and protocols
- Understanding of the various meeting structures that support effective teams
- Facilitating effective communication processes
- Creating psychological safety
- Building resilience for the MDT

STATEMENT OF INTENT:

The person designated to coordinate and facilitate the MDT should have training experience in team facilitation to ensure a participatory process that will ultimately benefit the child client MDT coordinators/facilitators may come from a variety of professional backgrounds. Often they have subject matter expertise in child abuse, child abuse investigations, or other human services occupations. However, facilitating a team of multidisciplinary professionals is a unique skill set. It requires an understanding of group dynamics, conflict resolution techniques, and team. This requires specialized training in order to set the MDT Facilitator/Coordinator up for success. The MDT Facilitator/Coordinator may be a person employed by the CAC who has another role in addition (such as an Executive Director, forensic interviewer, or victim advocate) or may exclusively act as the MDT Coordinator/Facilitator. In some CACs this person also facilitates case review. In others, an MDT member may facilitate case review while the MDT Coordinator/Facilitator is responsible for coordinating day to day information-sharing. However, it is constructed the CAC must be able to identify this role, who fills, it and the role must be viewed by the team as the go-to by MDT members for case coordination, information-sharing among team members, and addressing team functioning. The CAC employee who fills this role must have the required baseline training. In the rare instance in which someone outside the CAC plays this vital role, the training requirement does not apply (though is highly encouraged).

Practical Approaches for Rural CACs to Meet This Standard

1. The CAC designates a staff member with required training, effective facilitation skills and an excellent understanding of the roles and responsibilities of MDT members, who will lead all case review meetings. This individual is responsible for leading comprehensive discussions for all cases and for communicating recommendations and necessary follow-up to MDT members in a timely manner. This individual also ensures that team members report back to the team on follow-up for monitoring purposes and additional steps as needed.

2. The CAC case review meetings are facilitated by an MDT member selected by the MDT representatives who has the required training and skill. Follow-up recommendations and notifications are the responsibility of a CAC staff member who collaborates with the case review facilitator to ensure that all information is communicated appropriately for follow-up to the MDT.
3. MDT facilitator training may be offered through state chapters or other partnering training organizations.
4. MDT facilitator training may be one eight-hour training session or a combination of various applicable trainings to meet the eight hour training requirement.

Essential Component B

The designated MDT facilitator must demonstrate participation in continued education in the field of child maltreatment and/or facilitation for a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC must provide ongoing opportunities for the MDT facilitator/coordinator employed by the CAC to receive ongoing training. It is important that team facilitators remain current on developments in facilitation and other relevant fields of practice to further enhance their expertise.

Practical Approaches for Rural CACs to Meet This Standard:

1. The designated MDT facilitator attends statewide, regional, or national conferences and relevant workshops. Designated MDT facilitators demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.
2. Designated MDT facilitators complete online courses on a variety of relevant child maltreatment and/or facilitation topics. Demonstration of attendance and completion can be done through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.

Essential Component C

The CAC/MDT has, and facilitates, a written interagency agreement signed by authorized representatives of all MDT members that clearly commits the signed parties to its collaborative multidisciplinary response to reports of child abuse and the needs of children and families it serves. The interagency agreement must include:

1. Law enforcement
2. Child protective services
3. Prosecution
4. Mental health
5. Medical
6. Victim advocacy
7. Children's Advocacy Center

STATEMENT OF INTENT:

Written agreements formalize commitment to the overall CAC mission and goals, interagency cooperation and collaboration, and adherence to CAC/MDT policies ensuring consistent, high quality, trauma-informed and culturally relevant practice. Whether written agreements are referred to as memoranda of understanding (MOUs) or interagency agreements (IAs), or something else, they must be signed by the leadership of participating agencies (e.g., police chiefs, prosecuting attorney, agency directors or department heads, supervisors, etc.) or their authorized designees. These documents should be developed with input from the

MDT, reviewed annually, and revised and re-executed when necessary to reflect changes in leadership/signatories, practice, or policy.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's interagency agreement (IA) or memorandum of understanding (MOU) states the mission and goals of a CAC and commits each agency to participate routinely as a member of the MDT to achieve the CAC's overarching goals. The IA or MOU further commits each signatory to shared referral, intake, and interviewing procedures; collaborative decision-making; and coordinated case planning and service delivery. While agency designees may do the drafting of agreement, it is the agency leaders who approve and ultimately sign the agreement to ensure commitments at the highest level. Annual review and updates of the agreement are conducted, and new signatures are obtained as needed, reaffirming all agencies' ongoing commitments to CAC operations.
2. The CAC may implement an IA or MOU that includes the mission, goals, commitments, and signatories outlined above with agreed-upon policies, procedures, and practices as a component or addendum. The annual review includes updates on these components as well. If crafted in this manner, an IA or MOU would be consistent with or subsume the written protocols and/or guidelines required in (D) below.

Essential Component D

Written protocols and/or guidelines address the functions of the MDT, the roles and responsibilities of each discipline/role and their interaction with the CAC throughout the life of the case, including the role of the MDT facilitator/coordinator. Protocols are developed with input from the MDT, updated and signed by all MDT partner agencies minimally every three years. The protocols should be reviewed annually and updated as needed to reflect current practice between three-year signing cycles.

STATEMENT OF INTENT:

The active involvement and commitment of all of the MDT agency leaders and their representatives are critical to ensuring that the policies and protocols by which investigations are conducted and services provided are consistently followed.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's protocol defines the mission and goals of the center, expectations of the MDT process and crossdisciplinary training, roles of each agency/ discipline on the MDT, and standard operating procedures regarding: intake, investigations, forensic interviews, service planning, and case coordination (including medical, mental health, and victim advocacy referrals and process), information sharing and confidentiality, case review process, follow-up with clients and MDT members, case tracking, and methods for client and team feedback and quality improvement. The protocol is reviewed and revised by the MDT and CAC staff with approval by agency leadership every three years at a minimum.
2. A CAC requests each agency's individual policy, procedure, and practice guidelines to be coordinated into one comprehensive and shared protocol that is reviewed and agreed upon by all MDT members, ensuring shared understanding and implementation of the combined protocols.

Essential Component E

All core members of the MDT, including appropriate CAC staff, are routinely and actively involved in investigations, case management and/or MDT interventions throughout the life of the case, in accordance with the defined needs of children and families and the case.

STATEMENT OF INTENT:

The purpose of multidisciplinary involvement for all interventions is to assure the unique needs of children and families are assessed and addressed. Coordination and collaboration among MDT members allow for informed decision-making to occur at all stages of the case to ensure optimal benefit to children and families. Multidisciplinary intervention begins at initial report and includes, but is not limited to, child protection and/or law enforcement response, forensic interviews, pre- and post-forensic interview meetings, consultations, advocacy, medical and mental health screening, assessment and treatment, referrals for other services, case review and possible prosecution.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC routinely has all team members present for the forensic interview and pre- and post-interview debriefings. Scheduling should enable full participation; however, if scheduling conflicts arise, pre- and post-interview debriefings and forensic interviews may be conducted as planned if there is a minimum of law enforcement, CPS (if involved in the case), CAC staff, and victim advocates present, as long as necessary input is sought from the other team members. Documentation of interviews is made available to absent team members for review and input, enabling follow-up and comprehensive discussion during case review.
2. Pre- and post-interview debriefings and forensic interviews occur with law enforcement, CPS (if involved in the case), prosecution, victim advocates and CAC staff present. This group makes immediate decisions regarding child protection issues, investigation, and charging decisions. Mental health and medical personnel are available for consultation during interviews but do not regularly attend. CAC staff provides timely verbal reports to those not in attendance at the interview regarding disclosures and next steps, so that followup with the family and referrals for services can be made shortly thereafter. A full MDT discussion generally occurs during case review and on an ad hoc basis in advance of case review.
3. Pre- and post-interview debriefings and forensic interviews occur with investigators (law enforcement and CPS), CAC staff and/or victim advocates only. CAC staff informs all other team members of the outcome of the interview and identifies next steps, and the victim advocate makes necessary referrals. Relevant input is sought from particular team members per needs of individual cases. All members of the MDT participate in case review.
4. MDTs may secure a consultative relationship with a mental health expert on children with problematic sexual behavior when serving those cases. This professional may be their existing mental health MDT member or an additional uniquely experienced professional for consultation on these types of cases. This person would be available in person or via a virtual platform to provide the MDT with guidance on up-to-date knowledge on normative versus problematic sexual behavior in children, current research outcomes, locating qualified mental health providers and resources, etc. Further, this person can guide and support the team's implementation of their investigative protocol specific to cases of children with problematic sexual behavior (e.g., forensic interview, medical exam, mental health assessment and provision of evidence-based treatment).

Essential Component F

CAC/MDT members participate in effective information sharing that is consistent with legal, ethical, and professional standards of practice and ensures the timely exchange of case information within the MDT.

STATEMENT OF INTENT:

Regular and effective communication and information sharing minimizes duplicative efforts, enhances decision-making, and maximizes the opportunity for children and families to receive the services they need. Understanding of issues of confidentiality and privacy and relevant legal and ethical obligations must be considered and respected.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's formal interagency agreement delineates the importance of information sharing and an understanding of legal, ethical, and professional requirements. MDT partner agencies review, discuss, and revise proposed language for said agreement to ensure consensus and compliance. Sample language is as follows:

   "Agencies/organizations participating in the CAC as members of the MDT will share and receive pertinent case information in a timely manner and in adherence to relevant state laws. To enable the MDT to respond to the immediate and ongoing needs of the child, caregiver, and family, every effort will be made to gain informed consent from the legal guardian of child clients with appropriate parameters on the scope and timeframe of said consent."

2. The interagency agreement incorporates state law that dictates MDT information sharing and adherence to confidentiality. These issues are fully explained to each family so that the legal guardian can make an informed decision regarding consent on a signed written release. Said release describes MDT investigation and interventions, specific scope and timeframe of information sharing, confidentiality, and case review practices.

3. The interagency agreement outlines the importance of information sharing among the MDT members at all points during the case. The related protocol delineates the roles of CAC and/or MDT members and clearly explains the importance of information sharing for the child, caregiver, family, and team members. It states how information is shared, statutory limitations, and the need for consent to share relevant and legally protected information for a prescribed period of time.

Essential Component G

The CAC has written documentation describing how information sharing is communicated among MDT members and how confidential information is protected.

STATEMENT OF INTENT:

Most professions represented on the MDT have legal, ethical, and professional standards of practice with regard to client privacy, confidentiality and privileged communications. The standards and requirements may differ across disciplines. States may have relevant laws in addition to the federal Health Information Portability and Accountability Act (HIPAA) that govern such practices. The CAC/MDT must create written confidentiality and information-sharing guidance that align to these standards and specifically apply to the MDT members, staff, and volunteers.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's protocol details what and how information is shared among team members, including forensic interview and medical exam results, mental health and victim advocacy services, law enforcement investigation, CPS involvement, and case

review. A team confidentiality agreement is signed at each case review meeting by all participants and references the ability to share information with relevant colleagues within each agency. Said protocol is explained to the family at the outset, and informed consent is secured to enable effective and relevant information sharing.

Essential Component H

The CAC provides routine opportunities for MDT members to give feedback and suggestions regarding procedures and operations of the CAC/MDT. The CAC has a formal process for reviewing and assessing the information provided.

STATEMENT OF INTENT:

CACs should have both formal and informal mechanisms for eliciting regular feedback from MDT members regarding the operations and administration of the CAC (e.g., transportation for clients, use of the facility, equipment upgrades, etc.) and MDT issues (e.g., communication, case decision-making, documentation and record-keeping, conflict resolution, training, etc.).

CACs should foster opportunities for open communication in order to create an atmosphere of trust and respect and to enable MDT members to share responsibility for enhancing the quality of the MDT response with their ideas and concerns. Various methods for eliciting feedback and/or suggestions from MDT members may be utilized, including the Outcome Measurement Survey (OMS) tool team satisfaction survey, suggestion boxes and MDT meetings specifically scheduled for this purpose, among others.

Practical Approaches for Rural CACs to Meet This Standard:

(Note: The following examples can be combined to form a comprehensive response.)

1. The CAC Director can send out the OMS survey one-two times per year and share the results with the MDT through email.
2. The CAC participates in NCA's Outcome Measurement System (OMS) by utilizing the MDT survey and shares results with all members of the MDT and CAC staff.
3. The CAC has an anonymous feedback mechanism (e.g., a suggestion box placed in the observation room or other appropriate location) for team members and staff and implements a process for discussing and addressing suggestions as a team.
4. Feedback regarding MDT practice and CAC operations is a regular agenda item for case review meetings, and mechanisms are in place to provide one-on-one feedback depending upon the issue.
5. Interagency leadership meetings convene at regular intervals to discuss policy and practice issues among and between agencies.

Essential Component I

The CAC/MDT annually provides and/or facilitates relevant training or other educational opportunities focused on issues relevant to investigation, prosecution, and service provision to children and their nonoffending caregivers. The CAC demonstrates documented MDT member participation in this annual professional development.

STATEMENT OF INTENT:

Ongoing learning is critical to the successful operation of CAC/MDTs. The CAC identifies and/or provides relevant educational opportunities for MDT members, including topics that enhance the knowledge and skills of MDT members, collaborative work across disciplines and a deeper understanding of each discipline's role in service provision.

This may include directly providing training to MDT members, sharing opportunities to attend conferences, and/or online training opportunities offered by the State Chapter, Regional CACs, or state or national training providers.

Practical Approaches for Rural CACs to Meet This Standard:

1. MDT members bring available outside training and conferences to the attention of CAC staff and MDT colleagues and encourage attendance. The CAC works with partner agencies to determine ways to support participation whenever possible, particularly on topics with cross-disciplinary relevance.
2. The CAC takes responsibility for developing a training calendar of events, including in-service and outside training. In-service training is planned based on the assessed needs of MDT members and CAC staff.
3. Additional case review meetings and/ or MDT meetings may be scheduled and may include outside speakers or additional training. A minimum number of continuing education hours for MDT members is determined and supported by interagency leadership. The CAC will provide a list of training resources to new team members.
4. The interagency agreement acknowledges the importance of cross-discipline training and requires interagency leadership to create a training plan provided to all new team members. Training includes forensic interviewing, team dynamics and effectiveness, legal issues, and roles and responsibilities of all team members. CAC and partner agencies share costs to implement said training plan.
5. Each year, funding is allocated for the MDT to hold a team retreat and/or attend outside conferences as a group. These include a focus on increasing the resiliency of the MDT.
6. MDT members receive a monthly/ quarterly newsletter that includes a variety of online training opportunities as well as in person opportunities through the Regional CAC, State Chapter and CAC.
7. MDT encourages members to complete training specific to children with problematic sexual behaviors and encourages partner agencies to regularly provide or create access to these trainings for all MDT members.
8. CAC Director can send an email to the MDT with upcoming training opportunities or add those training opportunities to the case review agendas.

Essential Component J

The CAC/MDT provides formal orientation for new MDT members regarding CAC/MDT process, policies and procedures, and code of conduct.

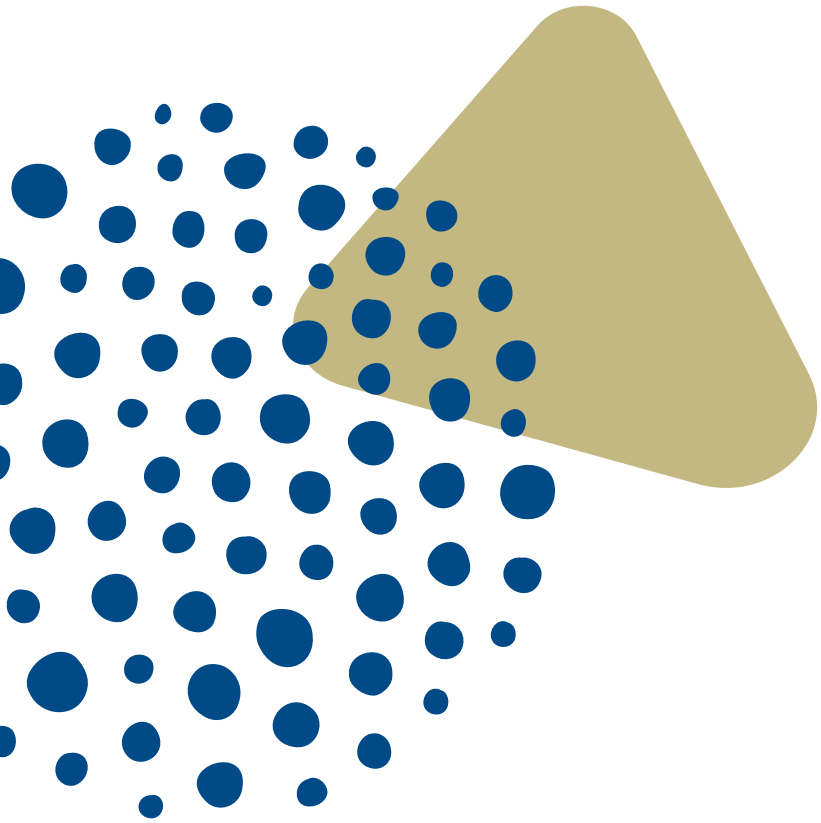
STATEMENT OF INTENT:

New MDT members arrive experienced in their profession but often inexperienced with multidisciplinary team principles and practice. Providing an orientation for new MDT members ensures that they understand how the team functions, what is expected of their role, and how each member of the team contributes to the case and to better child outcomes. Orienting team members well at the beginning can reduce confusion and conflict and contribute to better overall team function.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC/MDT 101 Manual: The CAC in partnership with team members develops a manual containing process, policies and procedures, and code of conduct that is provided to all new team members.

2. A formal MDT mentoring program is developed by the CAC to ensure that new team members have the one-to-one support needed to become productive contributors to the team. This mentoring program is memorialized with the mentor and mentee signing commitment and confidentiality forms.
3. The CAC records a video of the "back of the house" so all MDT members understand the inner workings of the CAC. This includes instructions for running recording equipment, using copy machines, how to access the CAC during off hours, etc. Additionally, this video has a tutorial outlining CAC/MDT process, policies and procedures, and code of conduct.
4. An in-person tour and training for new MDT members is provided by the CAC. This opportunity includes CAC/MDT process, policies and procedures, and code of conduct.
5. CAC Directors can host quarterly MDT orientation for new MDT members, this can occur virtually or in person.
6. CAC Directors can host MDT orientation for new MDT members whenever a new MDT member joins the team, this can occur virtually or in person.
7. For orientation and training of new MDT members, the CAC provides a manual that details information about the CAC/MDT philosophy, MDT protocols, and information about each discipline's role and responsibilities. New team member orientation also includes "shadowing" of MDT members when appropriate.



Standard 02

Forensic Interview

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



02. Forensic Interview

Rationale:

The purpose of CAC forensic interviews is to facilitate information gathering from children to determine whether abuse occurred and, if so, the nature of the allegations. This information is intended to contribute to accurate and fair decision-making by the MDT members relative to the criminal justice, child protection and relevant service delivery systems. Forensic interviews are conducted in a manner that is developmentally responsive, unbiased, fact-finding and legally sound. When a child is unable to provide information regarding any concern of abuse through the forensic interview process, other interventions to assess the child's safety and well-being are required.

The CAC/MDT must adhere to research-based forensic interview guidelines that create an interview environment that enables free recall, minimizes interviewer influence, and gathers information needed by all the MDT members in order to avoid duplication of the interview process. The CAC/MDT must monitor these guidelines over time to ensure they reflect current research-based practice, and CAC/ MDT protocols and practices need to be congruent.

Forensic interviews are the foundation for multiple CAC/MDT functions, including child protection and criminal investigations, prosecution, and implementation of services critical to helping ensure children and families' paths toward safety, healing, and justice. The child's experience during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to, the ensuing steps in the various aspects of the intervention process.

Skilled forensic interviewing by appropriately trained individuals requires an appropriate neutral setting and effective communication among MDT members. While CACs vary with regard to who conducts forensic interviews, the role must be fulfilled by an appropriately trained, qualified, supervised professional who engages in peer review and ongoing professional development. This may include a CAC-employed forensic interviewer, law enforcement officers (local, state, and/or federal), CPS workers, or others determined by the CAC/MDT in accordance with the resources available in their respective communities. At a minimum, any professional in the role of a forensic interviewer must have initial and ongoing formal forensic interviewer training that is approved by National Children's Alliance (NCA) for purposes of accreditation. State laws may also dictate which professionals can or should conduct forensic interviews.

The CAC/MDT's written documents must include the general interview protocol, guidelines for selecting an appropriately trained interviewer, specifications for sharing of interview information among MDT members, and a mechanism for collaborative case planning, peer review and continuing education. Additionally, for CACs that conduct Extended Forensic Evaluations, an additional protocol for this purpose must also be articulated.

Essential Component A

Forensic interviews are provided by MDT/CAC staff with specialized training in conducting forensic interviews.

The CAC must demonstrate that all forensic interviewer(s) have successfully completed training that includes the following elements:

1. Minimum of 32 hours of instruction and practice
2. Evidence-supported interview protocol
3. Pre- and post-testing that reflects understanding of the principles of legally sound interviewing
4. Child development; question design; implementation of protocol; dynamics of abuse; disclosure process; and suggestibility
5. Practice opportunities with a standardized evaluation process
6. Required reading of current articles specific to the practice of forensic interviewing

Curriculum must be included on NCA's approved list of nationally or state-recognized forensic interview trainings or submitted with the accreditation application for review and approval.

STATEMENT OF INTENT:

The CAC/MDT must have a process to ensure initial forensic interview training for anyone conducting a forensic interview at the CAC. While MDT members may have received general interview training, conducting forensic interviews of children in the context of an MDT response requires specialized training and qualifications.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC is able to demonstrate that all of its forensic interviewers have completed training from NCA's approved list of forensic interview trainings.
2. Forensic interviewers have successfully completed a state-based or national forensic interview training protocol which has been approved by NCA.
3. Coordinate a regional forensic interviewer pool that meet the criteria set by NCA to assist in meeting the need for rural centers to share in this expenses and resources.
4. Rural CACs can have another staff or MDT member trained in forensic interviewing to conduct the interview if the primary interviewer is unavailable.

Essential Component B

Individuals who conduct forensic interviews must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing for a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC/MDT must provide ongoing opportunities for professionals who conduct forensic interviews to receive specialized training. It is vitally important that forensic interviewers remain current on developments in forensic interviewing and other relevant fields of practice to further enhance their expertise.

Practical Approaches for Rural CACs to Meet This Standard:

1. Forensic interviewers attend statewide, regional, or national child abuse conferences and relevant workshops. Forensic interviewers demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.
2. Forensic interviewers attend Advanced Forensic Interviewing Training or Extended Forensic Interviewing Training from national training providers or at other locations, and they demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.

3. Forensic interviewers complete online courses through the Regional Children's Advocacy Centers on a variety of relevant child abuse topics and demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.
4. Forensic interviewers complete online courses at NCAC's virtual training center and demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.

Essential Component C

CAC/MDT forensic interview protocols must reflect the following items:

1. Case acceptance criteria
2. Criteria for choosing an appropriately trained interviewer (for a specific case)
3. Personnel expected to attend/observe the interview on-site, specifically including those with investigative responsibilities for the case
4. Information sharing and communication between the MDT and the forensic interviewer before and after the interview
5. Use of interview aids
6. Use of interpreters
7. Recording and/or documentation of the interview
8. Interview methodology (i.e., state- or nationally recognized forensic interview training models)
9. Introduction of evidence in the forensic interviewing process
10. Sharing of information among MDT members
11. A mechanism for collaborative case coordination
12. Criteria and process for conducting a multisession or subsequent interview
13. The use of technology for remote live observation of the forensic interview using a secure method (if applicable)
14. The criteria and process for the use of teleforensic interviews (if applicable)

STATEMENT OF INTENT:

The forensic interview process must be described in comprehensive detail in the agency's written guidelines or agreements. These guidelines help ensure consistency and quality of interviews, inform MDT discussions pre-and post-interview, and support subsequent decision-making. Technology now makes it possible to both conduct and observe (in real time) forensic interviews online and remotely. Centers that wish to do either or both should clearly identify in the written guidelines or agreements the circumstances in which this is allowed and the process for doing so. Children who receive a tele-forensic interview must be afforded the full range of CAC services and MDT interventions as with any other clients. Care must be taken that the use of remote live observation does not result in the need for repeated interviews or miscommunication between team members. And any use of remote live observation requires the team's written guidelines and agreements to outline who may do so, and under what circumstances.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC has all 14 required elements of the forensic interview process detailed within their written protocols/guidelines that reflect consensus and approval of all MDT partner agencies.
2. The CAC has created a separate forensic interview protocol/guidelines document that includes all 14 required elements and

reflects consensus and approval of all MDT partner agencies. This document is included as an addendum or integrated into the overall agreed-upon and approved CAC protocol.

Essential Component D

The CAC allows for real-time observation of forensic interviews by MDT members.

STATEMENT OF INTENT:

In order to create a psychologically safe space and lessen or eliminate the need for duplicative interviews, interviewers should be observed by MDT members in a space other than the interview room. The MDT should also have the ability to communicate with the interviewer in some manner to provide input and feedback during the real-time interview with the child to reduce the need for additional interviews.

Practical Approaches for Rural CACs to Meet This Standard:

1. A one-way mirror and unobtrusive, highquality microphones enable team members to observe and listen to live interviews. The mirror is positioned at a slight angle to prevent reflection into the observation room. Transparent tables allow the team to observe a child's body language during the interview. The interviews are recorded on two DVD recorders. The rooms are appropriately soundproofed.
2. The CAC is equipped with a professional closed-circuit TV system that projects the interview into a nearby room where the team gathers to watch. The cameras are positioned such that observers can see the child's facial expressions and body language. The interview room is appropriately soundproofed.
3. In a small facility, the director's office doubles as the observation room. The team uses the director's computer monitor to observe the interview. The office is appropriately soundproofed.

Essential Component E

MDT members with investigative responsibilities on a case must participate in live/real-time observation of forensic interviews to ensure necessary preparation, information sharing and MDT/interviewer coordination throughout the interview and post-interview process.

STATEMENT OF INTENT:

MDT members, as defined by the needs of the case, are present to observe the forensic interview and participate in pre- and postinterview discussions. This practice provides MDT members with access to the information necessary to fulfill their respective investigatory and related professional roles. MDT members who are present for forensic interviews typically include local, state, federal or tribal child protective services, and law enforcement; others may vary based on the circumstances of each case.

Practical Approaches for Rural CACs to Meet This Standard:

1. Representatives from the full MDT (CPS, law enforcement, prosecution, CAC personnel, victim advocacy, mental health and medical) are routinely present to share information in advance of the forensic interview and after its completion. All MDT members with investigative roles and CAC personnel observe the forensic interview, with others observing routinely or when available and requested, in accordance with agreed-upon CAC protocols. The victim advocate meets with the parent/guardian while the interview is taking place and participates in the pre- and post-interview meetings and facilitates and supports the caregiver's participation.
2. At a minimum, CPS and law enforcement personnel are present and observe all interviews with CAC personnel and facilitate information sharing from others in advance of and after the interview. A victim advocate meets with the parent/guardian while the interview is taking place

and coordinates with the team members before and after the interview. The CAC has a protocol for following up with MDT members who are not present, in order to share relevant information and discuss next steps. In some cases, a CAC may facilitate remote observation by MDT members who cannot be present on-site. This observation occurs in real time and allows for communication with team members throughout the process.

3. Whether utilizing Example 1 or 2, if other individuals are invited to attend (GALs, school personnel, childcare licensing, etc.) and/or participate in the pre- and post-interview information sharing meetings, the CAC delineates and implements necessary confidentiality procedures. Caregivers are fully informed of the purpose of the entire process in all examples and are engaged and supported relative to their own needs and how to best support and protect their children after the interview and throughout the ensuing process.

Essential Component F

Cases meeting the CAC case acceptance criteria, as outlined in the MDT protocol, have forensic interviews conducted at the CAC, or through a secure tele-forensic method, a minimum of 75% of the time.

STATEMENT OF INTENT:

Forensic interviews of children, as defined in the CAC/MDT's written protocols, will be conducted at the CAC, where the MDT is best equipped to meet the child's needs during the interview.

Written protocols must also address the rare occasions when interviews may need to take place outside the CAC with the agreed-upon forensic interview guidelines utilized. Some CACs have established interview rooms outside of the primary CAC, such as at a satellite office. In an alternate setting, MDT members must assure the child's comfort, privacy and protection from alleged offenders and others who may unduly influence the child. Remote or tele-forensic interviews may also occur when appropriate and/or necessary to increase access and utilization of CAC forensic interviews. All such alternatives must be agreed upon by the MDT and codified in the written protocols. And any alternative must continue to afford child clients the full range of CAC services.

CACs are encouraged to develop policies that will provide the most comprehensive services and benefits to all children in their communities. Case acceptance criteria may include various types of abuse, other forms of direct or indirect exposure to violence/trauma, jurisdictional issues, and the ages of children, among others.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC protocol/guidelines clearly state criteria for case acceptance that is agreed upon and approved by all MDT partner agencies. The protocol/guidelines further state that at least 75% of said cases have forensic interviews conducted at the CAC. The CAC is able to demonstrate compliance with this minimum requirement by tracking and reporting such information. Said protocol/guidelines also delineate agreed-upon limited circumstances in which interviews may be conducted off-site.

2. The CAC has developed a process for ensuring each partner agency is able to compile ongoing data of all cases meeting the adopted CAC case acceptance policy. The process is detailed in the CAC protocols/guidelines and has been agreed upon by each partner agency. This data is provided to the CAC on an agreed-upon reporting interval. The tracking of this data allows the CAC to demonstrate compliance with the 75% requirement.

3. Investigative MDT members should be able to clearly articulate CAC protocol/guidelines for criteria for case acceptance and be able to verify that 75% of those cases have forensic interviews conducted at the CAC, or through a secure tele-forensic method. Additionally, MDT members should be able to explain why a case-meeting criterion for case acceptance would not be brought to the CAC for a forensic interview.

Essential Component G

Individuals who conduct forensic interviews must participate in a structured forensic interviewer peer review process a minimum of two times per year. Peer review serves as a quality assurance mechanism that reinforces the methodologies utilized and provides support and problem solving for participants. Structured peer review includes:

1. Ongoing opportunities to network with, and share learning and challenges with, peers
2. Review and performance feedback on actual interviews in a professional and confidential setting
3. Discussion of current relevant research articles and materials and implications for forensic interview practice
4. Training opportunities specific to forensic interviewing of children and CAC-specific methodologies.

STATEMENT OF INTENT:

Participation in peer review is vital for quality assurance of forensic interviewers and allows for the further development and enhancement of their skills based on new research and developments in the field. Peer review is a complement, not a substitute, for supervision, as well as multidisciplinary case review and case planning.

Practical Approaches for Rural CACs to Meet This Standard:

1. Forensic interviewers attend statewide or regional peer reviews at least twice a year and maintain copies of attendance sheets and agendas detailing inclusion of all four required elements of the structured peer review process.
2. Forensic interviewers attend peer review with surrounding CACs at least twice a year and maintain copies of attendance sheets and agendas detailing inclusion of all four required elements of the structured peer review process.
3. Forensic interviewers in large CACs with multiple interviewers conduct peer reviews internally on a regular basis and demonstrate inclusion of all four required elements of the structured peer review process. This individual CAC process, including its frequency, is delineated in the CAC's agreed-upon and approved protocol/guidelines and is documented in some manner for purposes of demonstrating compliance with accreditation standards.
4. Forensic interviewers participate in online peer review through Regional CACs and maintain copies of attendance sheets and agendas detailing all four required elements of the structured peer review process.

Essential Component H

The CAC/MDT coordinates information gathering, including history taking, assessments and forensic interview(s) to avoid duplication.

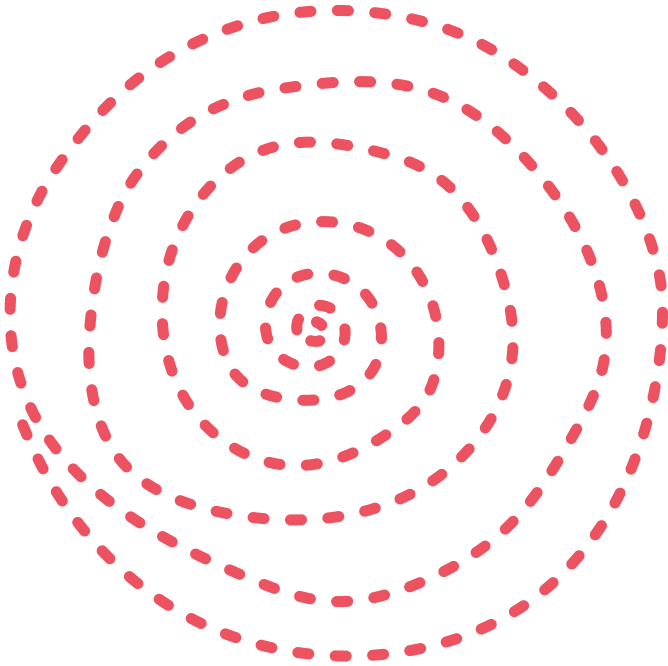
STATEMENT OF INTENT:

All members of the MDT need information to complete their respective assessments and evaluations. Whether it is initial information gathered prior to the forensic interview, history taken by the medical provider, or intake by the

mental health or victim services provider, every effort should be made to avoid unnecessary duplication of information gathering from the child and family members and ensure effective information sharing among MDT members.

Practical Approaches for Rural CACs to Meet This Standard:

1. All members of the MDT are present at the interview and for pre- and post interview meetings to collaboratively gather information and avoid unnecessary duplication of effort.
2. If MDT members are not all present at the interview and/or pre- and post-interview meetings, the CAC has an identified individual to provide information relative to the interview and next steps, avoiding unnecessary duplication of history taking.
3. When a CAC client is referred for a medical exam subsequent to the forensic interview, there is a formal process in place to provide the medical provider with information gathered prior to and during the forensic interview, which will avoid duplication of information gathering from the child, caregiver and family during the medical exam.



Standard 03

Victim Support and Advocacy

Victim support and advocacy services are provided to all CAC clients and their caregivers as part of the multidisciplinary team response.



03. Victim Support and Advocacy

Rationale:

Research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members. Client access to, and participation in, investigation, prosecution, treatment, and support services are core components of MDT response, and are informed and supported by coordinated victim advocacy services. Up-to-date information and ongoing access to comprehensive services are critical to a child and family's well-being and ability to participate in an ongoing investigation, possible prosecution, intervention, and treatment.

Victim support and advocacy responsibilities are implemented consistent with legal and, where relevant, state constitutional victims' rights and the complement of services in the CAC's coverage area. Many members of the MDT may advocate for children and families within their discipline systems or agencies. However, victim advocacy is a discipline unto itself with a distinct and central role on the MDT. Victim advocates provide services and resources to ensure a consistent and coordinated comprehensive network of support for each child and family.

Children and families in crisis need assistance in navigating the multiple systems involved in the CAC response. More than one victim advocate may perform these functions at different points throughout a case, requiring continuity and consistency in service delivery. Coordination of victim support is the responsibility of the CAC and must be defined in the CAC/MDT's written documents, including understanding of relevant statutes and ethics regarding confidentiality and privilege. Specific victim support services may be provided in a variety of ways, as dictated by the needs of the CAC clients and case, such as:

- Employing staff members with varying job titles to perform advocacy functions (e.g., family advocates, care coordinators, victim advocates and child life specialists, among others)
- Linking with local community-based advocates, including, but not limited to domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates
- Linking with system-based advocates (e.g., law enforcement victim advocates, prosecutor-based victim witness coordinators)
- Combining victim support services depending upon the individual needs of children and families

All advocates who serve on the MDT and are providing services to CAC clients must meet the prescribed training and supervision requirements. This includes advocates on staff at the CAC and/or advocates from outside organizations providing advocacy services and serving as members of the MDT.

Essential Component A

Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training that includes a minimum of 24 hours of instruction, including, but not limited to:

1. Dynamics of child abuse
2. Trauma-informed services
3. Crisis assessment and intervention
4. Risk assessment and safety planning

5. Professional ethics and boundaries
6. Understanding the coordinated multidisciplinary response
7. Understanding, explaining, and affording of victim's legal rights
8. Court education, support, and accompaniment
9. Knowledge of available community and legal resources, referral methods and assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, and interpreters, among others as determined for individual clients
10. Caregiver resilience
11. Domestic violence/family violence/ children's exposure to domestic violence and poly-victimization

STATEMENT OF INTENT:

Victim support and advocacy is fundamental to the MDT response. These professional support/advocacy responsibilities may be filled by a designated victim advocate who is an employee of the CAC or another victimserving agency. Another MDT member with appropriate experience and training in victim advocacy may also serve in this role; however, in doing so, it must not conflict with the other MDT functions they may have.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC protocol/guidelines include the stated necessary training requirements, including all listed topics and number of hours, for all victim advocates who provide services for CAC clients and serve as a routine member of the MDT.
2. The CAC maintains a list of the victim advocates providing said services, whether on CAC staff and/or through linkage agreements and demonstrates completion of the required training for each who provides services to CAC clients and serves as a routine member of the MDT.
3. All victim advocates providing advocacy services to CAC clients throughout the life of the case and serving as routine members of the MDT can demonstrate completion of the necessary training requirements.
4. The CAC utilizes an intern trained in victim advocacy to support the family during the forensic interview and during the life of the case.
5. Rural CACs can have another staff member trained in victim advocacy to support the family during the forensic interview if a victim advocate is unavailable.

Essential Component B

Individuals who provide victim advocacy services for the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who provide advocacy services to receive specialized training and peer support. As with all other disciplines represented on the MDT and serving CAC clients, it is vitally important that victim advocates remain current on developments in fields relevant to their delivery of services to children and families.

Practical Approaches for Rural CACs to Meet This Standard:

1. All victim advocates providing services to CAC clients, whether on CAC staff and/or through linkage agreements, demonstrate a minimum of eight hours of continuing

education every two years, through one or more of the following, including relevant documentation of attendance and completion of:

A. Statewide, regional, or national child abuse conferences

B. Online courses through MRCAC on a variety of child abuse topics

C. Online courses through CALiO at NCAC

D. OVC Victim Advocacy Online (VAT online)

E. National victim advocacy training and conferences relevant to the delivery of trauma-informed victim services

Essential Component C

Victim advocates serving CAC clients must provide the following services:

1. Crisis assessment and intervention, risk assessment and safety planning and support for children and family members at all stages of involvement with the CAC
2. Assessment of individual needs for child/family and help to ensure those needs are being addressed in concert with the MDT and other service providers
3. Presence at the CAC during the forensic interview in order to participate in information sharing with other MDT members, inform and support the family regarding the coordinated, multidisciplinary response, and assess needs of children and nonoffending caregivers
4. Provision of education and assistance in ensuring access to victim's rights and crime victim's compensation
5. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance, civil legal services, etc.)
6. Provision of referrals for trauma-focused, evidence-supported mental health and specialized medical treatment, if not provided at the CAC
7. Facilitating access to transportation to interviews, court, treatment, and other case-related meetings
8. Engagement with the child and family to help them understand the investigation/prosecution process and help ensure understanding of crime victims' rights
9. Participation in case review to communicate and discuss the unique needs of the child and family and associated services planning; and help ensure the coordination of identified services and that the child and family's concerns are heard and addressed
10. Provision of case status updates to the family, including investigations, court date, continuances, dispositions, sentencing and inmate status notification (including offender release from custody)
11. Provision of court education and support, including court orientation and accompaniment

STATEMENT OF INTENT:

While the particular combination of services required will vary based upon the child and family's unique needs and the legal requirements of any civil and/or criminal cases, all children and families need support in navigating the various systems they encounter that are often unfamiliar to them. Crisis and risk assessments and intervention, advocacy, and support services will help to identify the child and family's unique needs, reduce fear and anxiety, and expedite access to appropriate services and resources. Families can be assisted with crisis management, including problem solving, access to critical treatment and other services, and ongoing education, information, and support. Crises may recur with various precipitating or triggering events, including, but not limited to, financial hardships, child placement, arrest, change/

delay in court proceedings and preparation for court testimony. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including victims of child abuse, are informed of their rights as crime victims, including information about, and eligibility for, crime victim compensation. Caregivers who are affected by the crime are also entitled to services and may be eligible for victim compensation. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained at the outset of their involvement with the CAC/MDT and made available to all children and their caregivers.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC details the role and responsibilities of victim advocates — including all 11 required services — in its victim advocate job descriptions and qualifications, and at orientation and training of MDT members. In addition, information about the CAC, victim advocacy services and the role of the victim advocate are provided in written form to the client during their initial meeting and reviewed as needed over time.
2. The CAC victim advocate(s) compiles and provides a folder of information to the nonoffending caregiver during their first visit to the CAC. This folder includes information that is accessible for children, caregivers and families that includes the advocate's role and responsibilities; a CAC brochure; explanation of the forensic interview, medical exam, mental health services and victim compensation; names and contact information of MDT members and referrals for follow-up services.
3. In addition to providing key information to clients, the victim advocate(s) utilizes the child advocate checklist as a tool for quality assurance that all required services have been offered and/or delivered.
4. The CAC has linkage and/or interagency agreements with victim service agencies/programs outside the CAC to provide some or all of the required constellation of advocacy services for CAC clients. Such agencies/programs may include, but are not limited to, prosecutor-based victim witness advocates, domestic and sexual violence agencies, CASA volunteers and/or law enforcement victim advocates.

Essential Component D

Active outreach and follow-up support services for caregivers consistently occurs.

STATEMENT OF INTENT:

Often, families have never been involved in this multi-system response, which can prove intimidating and confusing. Active outreach requires follow-up with families beyond initial investigation, assessment, and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case.

In the aftermath of victimization, the child and family typically feel a significant loss of control. Education provides information that is empowering. Victim education must be ongoing and even repetitive as needed, as families may be unable to process so much information at one time, particularly in the midst of a crisis. The family may be dealing with immediate safety issues and may be coping with the emotional impact of the initial report and ensuing forensic interview and investigation process. They may need a variety of concrete medical, mental health, and social services. As the case dynamics change, and as the case proceeds through the various systems, the needs of the child and family will also change. It is important that their needs

continue to be assessed, so that additional relevant information, support, and services can be offered and so that said services are accessed and relevant.

Practical Approaches for Rural CACs to Meet This Standard:

1. Victim advocates utilize a case management system that ensures that follow-up calls are made on a regular basis in order to assess continued family needs, provide access to services and support caregivers. The CAC protocols/guidelines delineate this requirement as part of the comprehensive delivery of services by all victim advocates serving CAC clients. Ongoing contact with caregivers is documented for follow-up purposes.
2. As part of their continued follow-up services, victim advocates complete a victim advocate follow-up form to document ongoing outreach to caregivers.
3. All victim advocates serving CAC clients determine a follow-up plan and the delineation of roles to ensure seamless and consistent coordination of contact and services, and to avoid unnecessary duplication of effort. Documentation of follow-up is maintained and shared among all victim service providers.

Essential Component E

The CAC/MDT's written protocols/guidelines include availability of victim support and advocacy services for all CAC clients throughout the life of the case and participation of victim advocate(s) in the MDT case review. This participation must be in accordance with legal requirements regarding confidentiality.

STATEMENT OF INTENT:

Because victim support/advocacy is a central function of the CAC response, the availability and provision of ongoing victim support and advocacy by designated, trained individuals must be included in the CAC/MDT's written documents. Service coordination, both within and outside the CAC, must be clearly defined, including the role of the victim advocate during the interview process, follow-up, and case review.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC protocol/guidelines include detailed information describing the role of the victim advocate and the relevant participating victim service agencies that employ them at all stages of the case. It also delineates a process for coordinating victim advocacy services where clients are engaged with various providers, agencies, and systems. The CAC protocols/guidelines also clearly define the role of the victim advocate on the MDT as a distinct professional discipline, including their required and active participation in case review meetings.

Essential Component F

Coordinated case management must occur with all individuals providing victim advocacy services to CAC clients.

STATEMENT OF INTENT:

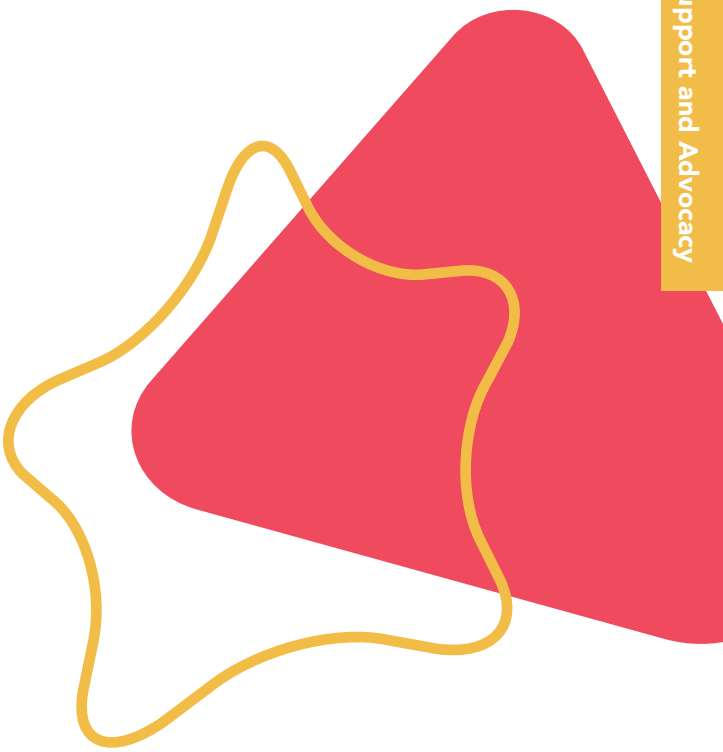
If multiple advocacy agencies share the delivery of services, the CAC is responsible for establishing protocols and linkage agreements agreed upon by the MDT that clearly define the victim advocacy roles and ensure seamless coordination of victim advocacy services.

In any community or jurisdiction a CAC serves, there may be various agencies and programs providing advocacy and support services to child and adult victims and survivors who have experienced abuse and trauma. In addition to victim advocates who may be employed by the CAC, there may be advocates on staff in law enforcement agencies, prosecutors' offices,

domestic and sexual violence communitybased agencies, hospitals, and CASA programs, among others. While specific job titles may vary, children and families engaged with the CAC/ MDT may also be receiving services from some or all of these agencies/programs. To better understand each other's roles, optimize crossreferrals for CAC clients, avoid unnecessary duplication and ensure meaningful coordination of services, the CAC must develop a process for achieving these goals in collaboration with one another. This process will need to include understanding and respect for issues of confidentiality and methods for sharing casespecific information accordingly.

Practical Approaches for Rural CACs to Meet This Standard:

1. Regular meetings are scheduled to convene victim service providers from all agencies/programs that provide services to CAC clients. A formal process is jointly developed by all participants to optimize relationship-building, share information and resources, discuss ways to deal with interagency challenges and avoid duplication of services and address policy and practice needs.
2. Advocates who serve on the MDT will meet before or after regular case review to discuss coordination of their involvement and relevant information to share with other team members, and to debrief afterward about service delivery issues that were raised in general and/or to discuss next steps on particular cases.
3. Informal, regular contact is established whether in person, by phone or virtually to ensure and strengthen collaborative efforts, understanding of strengths and limitations of their respective roles and approaches to service delivery.
4. Regular forums also provide opportunities for peer support and peer-led learning.





Standard 04

Medical Evaluation

Specialized medical evaluation and treatment services are available to all CAC clients and are coordinated as part of the multidisciplinary team response.



04. Medical Evaluation

Rationale

All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a health care provider with specialized training and expertise. The collection and documentation of forensic findings are vital. However, the referral of children for medical examinations should NOT be limited to those where forensically significant findings are anticipated. Medical evaluations should be prioritized as emergent, urgent, and non-urgent based on specific screening criteria. Said criteria must be developed by specially trained and skilled medical providers, who may be those serving on local multidisciplinary teams. Additional considerations include the ability to conduct follow-up examinations to reassess findings and conduct further testing where deemed necessary.

A medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate and complete history is essential in making medical diagnoses and determining appropriate treatment of child abuse. Recognizing that there are several acceptable models that can be used to obtain a history of the abuse allegations, and that forensic interview techniques are specialized skills that require training, information gathering must be coordinated with the MDT to avoid duplication. Because many children are familiar with the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators. In fact, some children are able to describe residual physical symptoms to medical providers even when no injury is seen. If a nonmedical member of the MDT is conducting the in-depth forensic interview, further medical history will still likely be needed from the caregiver and/or child to complete the medical evaluation. As such, information gathering and sharing must be coordinated to avoid duplication and help ensure a comprehensive response (see Med-Appendix 1 for an example of Components of Medical History for Child Sexual Abuse Evaluation).

Essential Component A

Medical evaluations are conducted by health care providers with specific training in child sexual abuse who meet at least ONE of the following training standards:

1. Child Abuse Pediatrics Subboard eligibility or certification
2. Physicians without board certification or eligibility in the field of child abuse pediatrics, advanced practice nurses, and physician assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse (see Med-Appendix 2)
3. Sexual assault nurse examiners (SANEs) without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency- based clinical preceptorship with an experienced provider in a clinical setting, where the SANE can demonstrate competency in performing exams (see Med-Appendix 2 or IAFN guidelines)

STATEMENT OF INTENT:

Physicians, advanced practice nurses, physician assistants and SANEs without advanced practice training may all engage in medical evaluations of child abuse. Due to differences

in foundational training in pediatric assessment by provider type (see Med-Appendix 2), the above training and eligibility standards must be met by the health care provider of a CAC (regardless of whether the exams are occurring on- or off-site).

All providers should be licensed to practice and be in current good standing by their corresponding state board of practice regulation. Nurses must practice within the scope of their applicable state nurse practice acts. A medical director (physician or advanced practice nurse) is needed for non-advanced practice nurses to assist with the development of practice protocols and the treatment needs of the patient, including referrals for other medical or mental health issues that are discovered during the evaluation. The medical director may or may not also meet qualifications as an "advanced medical consultant" (as defined in the "Continuous Quality Improvement" section) who can perform review of examination findings. If the medical director does not also serve as a medical provider for the CAC, this person should, at a minimum, be familiar with the essential components of the medical standard and the mission of the CAC.

Some CACs have qualified medical providers as full- or part-time staff, while others provide this service through affiliation and linkage agreements with local providers or regional facilities. Whether the exams occur on-site or off-site, or by CAC staff or via a linkage agreement, the medical provider must meet the Training and Eligibility Standards for Training (above) and Continuous Quality Improvement.

Continuous quality improvement (CQI) for the CAC's medical component:

The medical provider must be familiar and up to date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect, the American Professional Society on the Abuse of Children, and the Centers for Disease Control and Prevention. Accuracy in interpretation of examination findings is vitally important to the child, family, and the MDT as a whole. The medical provider must provide documentation of participation in CQI activities, including continuing education and expert review of positive findings with an "advanced medical consultant" in order to stay current in the field of child sexual abuse.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC hires, contracts and/or has a signed linkage agreement with a physician with Child Abuse Pediatrics Sub-board certification/eligibility and appropriate documentation.
2. CAC hires, contracts and/or has a signed linkage agreement with a physician, advanced practice nurse or physician assistant with a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse and appropriate documentation.
3. CAC hires, contracts and/or has a signed linkage agreement with a certified sexual assault nurse examiner (SANE) (without advanced practitioner training) with a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse, followed by a competency based clinical preceptorship and appropriate documentation.

Essential Component B

Medical professionals providing services to CAC clients must demonstrate continuing education in the field of child abuse consisting of a minimum of eight contact hours every two years.

Teaching experience in the area of child abuse that is approved to provide CEU or CME activity also qualifies for ongoing education credit.

Practical Approaches for Rural CACs to Meet This Standard:

1. All medical providers serving CAC clients attend and participate in one or more of the following and provide documentation of completion:
   - A. Midwest Regional CAC EduNet Webinar Series or other online medical training approved for CMEs
   - B. Local, statewide, or national conferences approved for Continuing Education Credits
   - C. Medical provider facilitation and/or instruction of an educational course approved for Continuing Education Credits
   - D. May also include topics such as sexual development, normative, concerning, and problematic sexual behavior, engagement strategies and caregiver responses

Essential Component C

Medical professionals providing child sexual abuse evaluations to CAC clients must demonstrate that all findings deemed abnormal or "diagnostic" of trauma from sexual abuse have undergone expert review by an "advanced medical consultant."

- Expert review with a child abuse pediatrician is preferred and can occur in multiple ways, including via a direct linkage agreement with a specific provider, through myCasereview sponsored by the Midwest Regional CAC, or through other identified state-based medical expert review systems that have access to an "advanced medical consultant."
- Physicians or advanced practice nurses can also provide said review if they have the following qualifications:
  - Meet the minimum training standards outlined for a CAC medical provider
  - Have performed at least 100 child sexual abuse exams
  - Are current in CQI requirements

The CAC and medical provider must work collaboratively to establish a method to track de-identified case information as part of the CQI process (see Med-Appendix 3).

STATEMENT OF INTENT:

The accuracy and integrity of forensic medical evaluation findings is critically important in child sexual abuse cases. While a small percentage of medical evaluations result in a positive or diagnostic finding for sexual abuse (about 3–5% in the literature), it is critical to both the future safety of the child and the integrity of any criminal justice case that the findings are accurate. Research indicates that the most important in diagnostic accuracy over time is consistent review. Because a false positive ("overcalling") can lead to a miscarriage of justice, given the reliance of MDT members on medical findings in making charging decisions and the reliance on such findings at trial, it is essential to have 100% of all medical findings diagnostic for child sexual abuse reviewed by an advanced medical consultant.

The medical provider must be able to provide documentation of participation in expert review with an "advanced medical consultant" on all abnormal sexual abuse exams for the purpose of CAC case-tracking information that could be requested for review in the accreditation process.

The providers who qualify as "advanced medical consultants" to offer expert review of examination findings are listed above in the essential component, as is the critical importance of collaboratively establishing the required CQI process.

Practical Approaches for Rural CACs to Meet This Standard:

1. All CAC medical providers receive in-house expert review from an advanced medical consultant for 100% of abnormal exams. This requirement and review process are agreed upon and included in the CAC protocols and all medical providers have documentation of the expert review sessions.

2. All CAC medical providers receive expert review through a linkage agreement with an advanced medical consultant and provide documentation that 100% of abnormal exams have been submitted and reviewed.
3. All CAC medical providers subscribe to "MyCaseReview" (www.mrcac.org/medical-academy/mycasereview/) through the Midwest Regional CAC and provide documentation that 100% of abnormal exams have been submitted and reviewed.
4. When CAC clients receive medical exams that are conducted by a SANE and result in diagnostic or abnormal findings, a board-certified SANE-P can review and assist in confirming the findings and help determine if the case should be moved forward for advanced medical consultation.

Essential Component D

Specialized medical evaluations for child clients are available on-site or through linkage agreements with other appropriate institutions, agencies, or providers.

STATEMENT OF INTENT:

Specialized medical evaluations can be provided in a number of ways. Some CACs have a qualified medical provider who comes to the center on a scheduled basis, while in other communities, the child is referred to a medical clinic or health care agency for this service. CACs need not be the primary care provider, but they must have protocols in place outlining and facilitating the linkages to a facility with a qualified medical provider and other needed health care services.

Practical Approaches for Rural CACs to Meet This Standard:

1. Medical evaluations are conducted onsite at the CAC by a Board-certified child abuse pediatrician or another qualified medical professional (i.e., physician, nurse practitioner, or physician assistant).*
2. Medical evaluations are conducted at the local children's hospital by a qualified medical professional (i.e., physician, nurse practitioner or physician assistant).*
3. Medical evaluations are conducted at the local emergency room by a qualified SANE.*

***See Standard A for information on requirements of "qualified medical professional."**

Essential Component E

Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.

STATEMENT OF INTENT:

In many communities, the cost of a medical evaluation is covered by public funds. In other settings, limited public funding requires that individuals who can pay or are insured cover the cost of their own examinations, or for those clients who require support, MDT members can help facilitate reimbursement through victim compensation. Regardless of the source of funding for the examinations, ability to pay should never be a factor in determining who is offered and able to access a medical evaluation.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC submits medical costs to client insurance for reimbursement. If a client is underinsured, arrangements are made for the client to receive charity care and/or reduced or no-cost medical care.
2. CAC assists clients in submitting victim compensation applications to reimburse the cost of the evaluation or to delay payment until victim compensation claim is approved and paid.
3. CAC obtains unrestricted grant funds to cover the cost of medical evaluations.

4. Medical evaluations are reimbursed by funds from local MDT partner agency or other state agency (i.e., law enforcement, child protection, or prosecutor's office).
5. CAC utilizes available VOCA funds to cover the cost of medical evaluations for CAC clients.

Essential Component F

CAC/MDT written protocols and guidelines include access to appropriate medical evaluation and treatment for all CAC clients.

STATEMENT OF INTENT:

Because medical evaluations are a critical component of the CAC's multidisciplinary response, the CAC's written protocols must detail how its clients access these services. Many CACs provide services to victims of physical abuse and neglect as well as to victims of sexual abuse. All CACs must have written protocols and agreements outlining how medical evaluations for all types of abuse and neglect should occur. CACs that provide medical evaluations for sexual abuse, but not specifically for physical abuse or neglect, must include written procedures for how to access medical evaluations for alleged physical abuse or neglect, including treatment for injuries and management of emergency or life-threatening conditions that may become evident during a sexual assault exam.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC's written protocols outline how medical evaluations are provided, conducted, and made accessible to all CAC clients, and include referral criteria and processes for treatment follow-up when needed. Protocols delineate specific criteria for sexual abuse, physical abuse, and neglect in accordance with overall CAC case criteria.
2. Written protocols may also include other information relative to providers' requirements for training, review of findings and payment.
3. Additional medical professionals may be included as MDT members or as casespecific participants in case review.

Essential Component G

CAC/MDT written protocols and guidelines include the circumstances under which a medical evaluation for child sexual abuse is recommended, provided, and accessed.

STATEMENT OF INTENT:

The purpose of a medical evaluation in suspected child abuse extends far beyond providing an evidentiary examination for the purpose of the investigation. The primary goals of the medical evaluation are to:

1. Help ensure the health, safety, and wellbeing of the child
2. Evaluate, document, diagnose and address medical conditions resulting from abuse
3. Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
4. Document, diagnose and address medical conditions unrelated to abuse
5. Assess the child for any developmental, emotional, or behavioral issues needing further evaluation and treatment and make referrals as necessary
6. Educate the child and family regarding all aspects of the medical examination and outcomes
7. Provide support relative to any recommended next steps and reassurance regarding child's overall health and wellbeing
8. Make recommendations regarding mental health and other services to address trauma related to the abuse/assault in coordination with other members of the MDT/CAC

CACs differ in their practices for how medical evaluations are made available. The MDT's written protocols or agreement must include qualified medical input to define the referral process and how, when and where examinations are made available. Examinations can be differentiated between those needed emergently (without delay), urgently (scheduled as soon as possible with a qualified provider), or nonurgently (scheduled at the convenience of family and provider but ideally within 1–2 weeks). Some patients may also benefit from a follow-up examination (see Med-Appendix 4). CACs are responsible for ensuring that exams are performed by experienced, qualified medical providers at the appropriate location and time, and that examinations are photo-documented to minimize unnecessary repeat examinations. This often requires initial conversations with emergency departments and primary care providers to develop a process for referral to the specialized medical provider as defined by the needs of the child.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC protocol outlines the criteria for medical evaluation referrals and the information sharing process for follow-up with relevant medical colleagues and MDT.
2. CAC has a linkage agreement and/or a memorandum of understanding with a qualified medical provider that outlines the criteria for medical evaluation referrals and the information sharing process for followup with relevant medical colleagues and MDT. This agreement or MOU is included in the general CAC protocols/guidelines.
3. All approaches are reflective and respectful of legal and ethical confidentiality requirements.

Essential Component H

Documentation of medical findings is maintained by written record and photodocumentation. Medical records storage must be HIPAA compliant. The medical records storage must be secured, sufficiently backed up and accessible to authorized personnel in accordance with all applicable federal and state laws.

STATEMENT OF INTENT:

The medical history and physical examination findings must be carefully, thoroughly, and legibly documented in the medical record. The medical record should also include a statement as to the significance of the findings and treatment plan. Medical records should be maintained in compliance with federal rules governing protection of patient privacy. Medical records may be made available to other medical providers for the purpose of needed treatment of the patient and to those agencies mandated to respond to a report of suspected child abuse. Even in situations where the medical record can legally be provided without separate written consent or court order, a log of disclosures should be maintained with the medical record in accordance with federal privacy rules (see Med-Appendix 5).

Diagnostic-quality photographic documentation of the ano-genital exam findings should be obtained in all cases of suspected sexual abuse using still and/or video documentation. This is particularly important if the examination findings are thought to be abnormal. Photographic documentation allows for review for CQI and for obtaining consultation or second opinion and may also obviate the need for a repeat examination of the child. CACs should have policies in place for storage and release of examination images that protect the sensitive nature of the material. In the uncommon exception that photo-documentation is not possible due to the child's discomfort with the equipment or equipment malfunction, diagram drawings with detailed written description of findings should occur.

Detailed procedures for the documentation and preservation of evidence (labeling, processing, and storing) in written protocols and agreements can help to assure the quality and consistency of medical evaluations. Such protocols can also serve as a checklist and

training document for new medical providers. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC medical providers collect photographic documentation of ano-genital exam findings using any of the following:
   - A. A colposcope with mounted DSLR camera or video camera
   - B. A 35-mm DLSR camera
   - C. A digital video camera system and tripod with focusing rails

Essential Component I

MDT Members and CAC staff are trained regarding the purpose and nature of the medical evaluation for suspected sexual abuse. Designated MDT members and/or CAC staff educate children and caregivers regarding the medical evaluation.

STATEMENT OF INTENT:

The medical evaluation for suspected child sexual abuse often raises significant anxiety in children and their caregivers, usually due to misconceptions about how the examination is conducted and what findings, or lack of findings, mean. An appropriately trained medical provider performing the examination typically addresses this anxiety. In many CAC settings, the client is introduced to the examination by nonmedical personnel. Therefore, it is essential for nonmedical MDT members and CAC staff to have the training needed to explain the nature and purpose of a medical evaluation, and to respond to common questions, concerns, and misconceptions, to similarly ease anxiety.

Practical Approaches for Rural CACs to Meet This Standard:

1. Medical providers provide workshops or inservice trainings for MDT members on the purpose and nature of a medical evaluation to assist them in educating clients and/or caregivers.
2. Medical providers are designated and assume responsibility for directly educating clients and/or caregivers regarding the purpose and nature of a medical evaluation.
3. CAC designates one or more members of the MDT or staff to educate clients and/or caregivers on the purpose and nature of a medical evaluation.

Essential Component J

Findings of medical evaluations are shared with the MDT in a routine, timely and meaningful manner.

STATEMENT OF INTENT:

Because the medical evaluation is an important part of the response to suspected child abuse and neglect, findings of the medical evaluation should be shared with, and explained to, the MDT in a routine and timely manner to facilitate discussion of concerns, and ensure case decisions can be made effectively. The legal duty to report findings of suspected child abuse to child protective services is an exception outlined by the HIPAA privacy requirements, allowing for ongoing relevant communications between and among the members of the MDT.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC collaboratively develops and implements an agreed-upon formal process for MDT members with investigative responsibilities and others providing information and support to clients to receive verbal and written findings of the medical evaluation within a timely manner as agreed upon in the CAC protocols.

Standard 05

Mental Health

Evidence-based, trauma-focused mental health services, designed to meet the unique needs of the child and caregivers, are consistently available as part of the multidisciplinary team response.



05. Mental Health

Rationale

A CAC's mission is to promote and foster safety, healing and justice for children and families. The common focus of the MDT is to foster healing and avoid potential retraumatization of children and families by the systems designed to respond to their needs. The CAC's response begins at first contact with the child and family. Without effective therapeutic intervention, many children who have experienced trauma may suffer ongoing or long-term adverse social, emotional, developmental and health outcomes. Evidence-based treatments and other practices with strong empirical support help reduce the impact of trauma and the risk of future abuse and other negative consequences. For these reasons, an MDT response must include screening for trauma exposure and/ or symptoms by identified members of the MDT as part of the MDT response, who then use that information to link to mental health services for assessment and trauma-focused mental health treatment for child victims and caregivers.

Evidence shows parental/family support is often the key to the child's recovery and ongoing protection, and mental health services are often an important factor in a caregiver's capacity to support their children. Therefore, family members may benefit from counseling and support that aids in addressing the emotional impact of abuse allegations and related emotional triggers, and in reducing or eliminating the risk of future abuse. Mental health treatment for caregivers is a critical component of CAC services, given that many may have trauma histories themselves or are current victims of intimate partner violence. Such services include information, support and coping strategies for themselves and their children about sexual abuse, dealing with issues of self-blame and grief, family dynamics, parenting education and the impact of abuse and trauma histories. Siblings, other children in the family such as cousins, and, in some cases, extended family members may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic setting. The nature of the impact on children and families underscores the importance of collaboration with community providers to improve outcomes for their health and wellbeing. The CAC case review process provides a vehicle for these collaborative discussions.

Essential Component A

Mental health services are provided by professionals trained in delivering trauma-focused, evidence-supported mental health treatment. All mental health providers for CAC clients, whether providing services onsite or by referral and linkage agreement with outside individuals and agencies, must meet the following training and education/license requirements:

EDUCATION/LICENSE REQUIREMENT

1. The CAC must demonstrate that its mental health provider(s) meets at least ONE of the following academic training standards:

   A. Master's degree/licensed/certified in a related mental health field.

   B. Master's degree in a related mental health field and working toward licensure; supervised by a licensed mental health professional.

   C. Student intern in an accredited mental health related graduate program, when supervised by a licensed/certified mental health professional. Both the student intern and supervising

licensed mental health professional must meet the indicated 40-hour training requirements. Students who are currently enrolled in a training to deliver an EBT may provide services to children as a part of their EBT training.

TRAINING REQUIREMENT

2. The CAC must demonstrate its mental health provider(s) has completed 40 contact hours in training and consultation calls to deliver an evidence-supported mental health treatment to children who have experienced trauma from abuse. (Examples include TF-CBT, PCIT, AF-CBT, CFTSI, EMDR — see "Putting Standards into Practice"). Training programs that include fewer than 40 hours (including consultation calls) may be supplemented with contact hours in evidence-based assessment.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC hires a licensed mental health provider with a relevant master's degree who must complete the foundational 40-hour training requirement and an additional eight hours of continuing education every two years and submit documentation of completion to the CAC.
2. CAC has a linkage agreement with a local mental health agency or agencies that employ a licensed mental health provider with a relevant master's degree who participates on the MDT. Designated provider(s) must complete the foundational 40-hour training requirement and an additional eight hours of continuing education every two years and submit documentation of completion to the CAC. The CAC compiles and maintains said documentation.
3. CAC has a linkage agreement with a local mental health agency that employs a license-eligible master's-level mental health provider(s). Said provider(s), including the supervisor, must complete the foundational 40-hour training requirement and an additional eight hours of continuing education every two years and submit documentation of completion to the CAC.
4. CAC utilizes a master's-level intern(s) through a partnership with a university and/or college. The CAC must demonstrate that said intern(s) is being supervised by a licensed/certified mental health provider and that both the student and supervising mental health provider meet the 40-hour training requirements. Both intern(s) and supervisor must submit documentation of completion of the required training to the CAC.
5. Rural CACs may utilize a pool of mental health clinicians that have the required training and licensure to meet essential component A. These services can be provided in person or through tele-mental health.

Essential Component B

Clinicians providing mental health treatments to CAC clients must demonstrate completion of continuing education in the field of child abuse, trauma, and/or clinical practice consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

Because new research constantly emerges regarding the efficacy of mental health treatment modalities, it is vital for clinicians to remain updated about new research, evidence-supported treatment methods, and developments in the field that would help ensure the delivery of high-quality, relevant, and accessible services to clients.

Practical Approaches for Rural CACs to Meet This Standard:

1. Mental health providers attend statewide, regional, or national child abuse conferences and relevant workshops. Providers demonstrate attendance and completion through certificates or other documentation of training requirements,

totaling eight hours of continuing education every two years. The CAC compiles and maintains said documentation.

2. Mental health providers complete online courses specific to child maltreatment and/or the delivery of mental health treatment services and demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.

Essential Component C

Evidence-supported, trauma-focused mental health services for the child client are consistently available and include:

1. Trauma-specific assessment of traumatic events and abuse-related trauma symptoms to determine the need for treatment;
2. Evidence-based assessments to inform treatment;
3. Individualized treatment plan based on assessments that are periodically reassessed;
4. Individualized evidence-supported treatment appropriate for the child clients and other family members;
5. Child and caregiver engagement in treatment;
6. Monitoring of trauma symptom reduction;
7. Referral to other community services as needed.

STATEMENT OF INTENT:

The above description of services should guide discussions about expectations with all professionals who may provide mental health services, whether on-site or by referral and linkage agreement. This will ensure that appropriate, relevant, and accessible services are available for child clients and that the services are outlined in linkage agreements.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC employs on-site mental health provider(s) that deliver evidence-supported, trauma-focused mental health services including standardized assessment, treatment plans and/or treatment for both the child and non-offending caregiver.
2. CAC has a linkage agreement with a local mental health agency or agencies whose staff have the requisite training and experience utilizing evidence-supported, trauma-focused mental health services. Said staff members participate as part of the MDT and provide services to both child and adult CAC clients.
3. Both mental health professionals and victim advocates can assist with the assessment piece of this requirement.

Essential Component D

Mental health services are available and accessible to all CAC clients regardless of their ability to pay.

STATEMENT OF INTENT:

CACs have a responsibility to identify and secure alternative funding sources to ensure all children and caregivers have access to appropriate, specialized mental health services.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC obtains unrestricted grant funds to pay the salaries of mental health provider(s) who are, as a result, able to offer treatment at no cost to the client.
2. CAC bills clients' insurance and/or offers a sliding scale for families who are under- or uninsured based on clients' needs and ability to pay.

3. The local mental health agency or agencies with which the CAC has a linkage agreement offers free/low-cost mental health services for CAC clients.
4. The CAC has a linkage agreement with a VOCA-funded agency that is required to provide said services free of charge.

Essential Component E

The CAC/MDT's Interagency Agreement/ MOU or written protocols and guidelines include access to appropriate traumain-formed mental health assessment and treatment for all CAC clients.

STATEMENT OF INTENT:

Because mental health is a core component of a CAC's multidisciplinary team response, the CAC/MDT's Interagency Agreement/MOU or written protocols and guidelines must detail how such care may be provided and accessed by all CAC clients.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC interagency agreement or MOU delineates the commitment of mental health agencies to ensuring access to evidence-supported, trauma-informed, mental health services for children, caregivers, and families. CAC protocols/guidelines detail case referral criteria, intake, assessment, and treatment processes.

Essential Component F

The CAC/MDT's written protocols and guidelines define the role and responsibility of the mental health professional(s) on the MDT, to include:

1. Attending and actively participating in MDT case review and case management
2. Sharing relevant information with the MDT while protecting the clients' right to confidentiality and the mental health professional's legal and ethical requirements
3. Serving as a clinical consultant to the MDT regarding child trauma and evidencebased treatment
4. Monitoring and sharing with the MDT the child's and caregiver's engagement in, and completion of, treatment.

STATEMENT OF INTENT:

Evidence shows the importance of collaboration among community professionals serving children and families to improve outcomes. A trained mental health professional participating in the MDT case review process assures that the child's and caregiver's treatment needs and mental health can be monitored, assessed and reassessed, and taken into account as the MDT makes case decisions. In some CACs, the child's and caregiver's treatment provider(s) serves in this role; in others, it may be a mental health consultant.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's mental health provider (on staff or through a linkage agreement with local mental health agency) regularly attends and participates in MDT case review, sharing information to the extent possible within legal and ethical rules of confidentiality. Mental health providers educate MDT members regarding the effects of trauma generally on children and non-offending caregivers, and their needs and interactions with other agencies and systems.
2. The CAC contracts with a qualified mental health provider (or has a linkage agreement with an agency that provides a consultant to serve on the MDT) to offer consultation to the team regarding the effects of trauma generally on children and non-offending caregivers, and their needs and interactions with other agencies and systems.

Essential Component G

The CAC/MDT's written protocols and guidelines include provisions about the sharing of mental health information and how client confidentiality and mental health records are protected in accordance with state and federal laws.

STATEMENT OF INTENT:

The forensic process of gathering evidentiary information and determining what the child may have experienced is separate from mental health treatment processes. Mental health treatment is a clinical process designed to assess and mitigate the long-term adverse impacts of trauma and/or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Each CAC must be aware that medical and mental health treatment records containing identifiable protected health information (PHI) are protected by HIPAA. Records pertaining directly to an investigation of child abuse can be exempt from HIPAA and do not require caregiver consent for release. The CAC should maintain a log of disclosures of medical and mental health treatment information per HIPAA regulations.

MDT protocol must include specific guidelines for the MDT and mental health providers regarding what and how information can be shared with the MDT during case review, in accordance with state laws and professional ethical practice standards.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC protocols/guidelines delineate the procedures that must be followed for mental health providers to be able to share confidential information of clients with the MDT. Consent forms are developed and approved by the MDT and included in the protocols/guidelines, with confidentiality laws, both federal and state, also cited.

Essential Component H

The CAC must provide services for caregivers to address:

1. Safety and well-being of the child
2. Caregiver involvement in their child's treatment when appropriate
3. Emotional impact of abuse allegations
4. Risk of future abuse
5. Issues or distress that the allegations may trigger, including own history of trauma and/or current experience of abuse, violence and/or other trauma

These services may be provided directly by the CAC and/or with linkage agreements with other appropriate providers.

STATEMENT OF INTENT:

Evidence clearly demonstrates that caregiver support is essential to sibling support, the recovery of children directly experiencing or exposed to abuse and violence, and overall family functioning and well-being. CACs have long provided such supportive services for caregivers and siblings through support groups, mental health services and ongoing follow-up, either on-site or by linkage agreement.

It is important to consider the range of mental health issues that could impact the child's recovery or safety with particular attention to the caregiver's mental health, substance abuse, domestic violence, and other trauma history. Caregivers, siblings, and other family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues that the allegations may trigger. Assessments and supports may be provided by clinicians, victim advocates or others, either on staff at the CAC or via linkage agreement.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC mental health staff provides assessment and treatment services for caregivers on-site.

2. The CAC has a linkage agreement(s) with a local mental health agency or agencies that provide assessment and treatment for caregivers either on-site at the CAC or at their own agency if necessary.
3. The mental health provider(s) coordinates with victim advocates, in accordance with confidentiality requirements, to make appropriate referrals for other services identified through clinical assessment and treatment including, but not limited to, domestic violence and substance abuse agencies, community food share programs, and other community mental health agencies for siblings and/or other family members.
4. Specialized attention should be considered for caregivers where a sibling has had Problematic Sexual Behavior with another sibling, given the stress this situation places on the caregiver as they work to meet the safety and well-being of all their children. This may involve having a child placed in another home for safety reasons while treatment is being provided.

Essential Component I

Clinicians providing mental health treatment services to CAC clients must participate in ongoing clinical supervision and/or consultation.

STATEMENT OF INTENT:

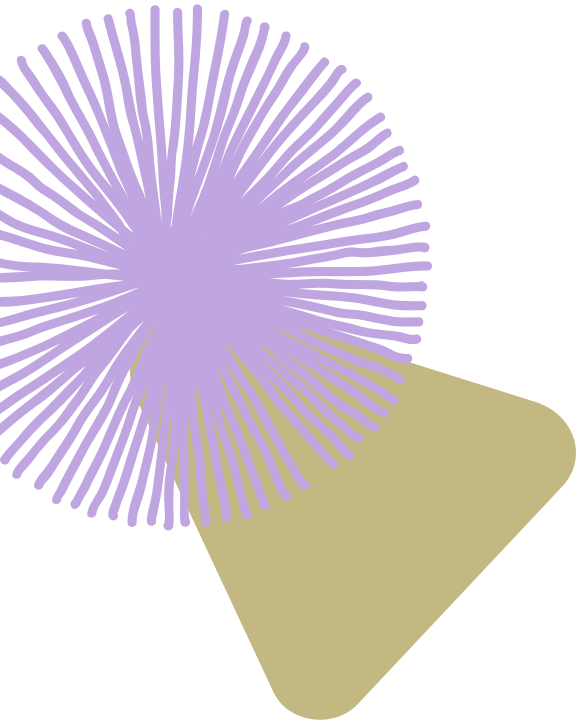
Clinical supervision and/or consultation with others trained in evidence-based treatment is necessary to ensure appropriate and quality services to the clients. Moreover, this clinical supervision is required for licensure in many states. Individual and/or group supervision options for meeting this standard include:

1. Supervision by a senior clinician on staff at the CAC
2. Supervision with a senior clinician in the community who serves children and families and accepts referrals from the CAC (when a CAC does not have more than one clinician)
3. Participation in a supervision call with mental health providers from other CACs within the state, either individually or as a group
4. Participation in a State Chapter or one or more CAC contracts with a senior clinician to provide supervision and consultation calls

Most clinical professions (i.e., clinical social workers, licensed professional counselors, marriage, and family therapists, etc.) have a structure for clinicians to become clinical supervisors. CACs may wish to investigate this option in their state. CACs can also negotiate Trauma-Focused Cognitive Behavior Therapy (TF-CBT) master trainers for ongoing clinical consultation. As supervision for one evidence-based treatment does not necessarily encompass all the clinical interventions needed within a CAC, comprehensive interventions will need to be addressed throughout ongoing clinical supervision.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC mental health staff members participate in regularly scheduled clinical supervision with a CAC senior clinician.
2. Linkage agreements with local mental health agencies delineate requirements for mental health providers to participate in regularly scheduled clinical supervision with a senior clinician at the agency.
3. CAC mental health staff members, and others providing services through linkage agreements, participate in regularly scheduled group supervision led by a senior clinician.
4. Mental health providers serving CAC clients participate in regularly scheduled statewide group supervision or a consultation group led by a contracted senior clinician.



Standard 06

Case Review and Coordination

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.



06. Case Review and Coordination

Rationale

Case review is the formal process that enables the MDT to monitor and assess its independent and collective effectiveness so as to ensure the safety and well-being of children and families. The process encourages mutual accountability and helps to assure that children's and families' needs are met sensitively, effectively and in a timely manner. Case review serves multiple purposes:

- Experience and expertise of MDT members is shared and discussed
- Collaborative efforts are fostered
- Formal and informal communications are promoted
- Mutual support is provided
- Protocols and procedures are reviewed
- Informed, collective decisions are made
- Services are coordinated

Case review must occur at least once a month. Its focus is on planning and monitoring current cases. It is a formal process that serves as a complement to ongoing case discussions among the MDT partners. Every CAC must implement a defined process and set the case criteria for review. The method and timing of case review may vary to fit the unique needs of a CAC community. For example, some CACs review every open case, while others review only complex or problematic cases or cases involved in prosecution. Representatives from each core discipline on the MDT must participate and provide input at case review. Confidentiality should be addressed in the CAC's written protocols or guideline, in keeping with state and/or federal laws and professional ethics that govern information sharing among MDT members, including during case review.

Essential Component A

The CAC/MDT's written protocols/guidelines include criteria for case review and case review procedures.

The CAC/MDT's written documents must include:

1. Purpose of meetings
2. Frequency of meetings
3. Designated attendees
4. Case selection criteria and process for developing case review agenda
5. Designated facilitator and/or coordinator
6. Mechanism for distribution of agenda and cases to be discussed
7. Procedures for addressing follow-up recommendations
8. Location of the meeting — may be in person or virtual

STATEMENT OF INTENT:

To maximize efficiency and to enhance the quality of a comprehensive case review, the CAC's written documents clearly define the process and expectations for all MDT partners.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's protocols/guidelines delineate the agreed-upon purpose and specific

procedures for conducting multidisciplinary case review.

2. The CAC's protocols/guidelines speak to the importance and conduct of case review, and the commitment to participate by all MDT members. It has a companion written case review protocol that details the specific procedures for conducting case review and the criteria for case selection. This document has been approved and adopted by all CAC partner agencies.

Essential Component B

An intentional forum for the purpose of reviewing, collaborating, and coordinating cases is conducted at least once a month.

STATEMENT OF INTENT:

Case review affords the MDT the opportunity to review active cases, provide updated case information, address obstacles to effective investigations and service delivery, and coordinate interventions. It is a planned, regularly scheduled meeting of all MDT partners and occurs at least once a month for cases coming from the CAC's primary service area. Case review is a formal process that is conducted in addition to informal discussions and pre- and post-interview meetings.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC conducts formal monthly case review meetings attended by representatives of all MDT member agencies.
2. The CAC conducts full MDT case review meetings once per month. In addition, CAC staff holds weekly, and in some cases daily, morning briefing meetings to review immediate scheduling and case issues for the week/day.
3. CACs with a significant case volume, that do not readily allow for case review for all those referred to the CAC of all cases, have a formal process for selecting cases, based on agreed-upon criteria, that will be included in their regular case review meetings.
4. CACs may conduct their case review virtually or via a hybrid of virtual and in person meetings.

Essential Component C

MDT partner agency representatives actively participating in case review must include, at a minimum:

1. Law enforcement
2. Child protective services
3. Prosecution
4. Medical
5. Mental health
6. Victim advocacy
7. Children's Advocacy Center

STATEMENT OF INTENT:

Full MDT participation at case review allows for the contributions of diverse professional perspectives and expertise to optimize informed decision-making, case planning and coordinated service delivery. Case review must be attended by the identified agency representatives capable of making, informing and/or advocating for independent and collective decisions and providing the team with knowledge and expertise of their specific professions. All those participating should be familiar with the CAC/MDT process and the purpose and expectations of case review. Forensic interviewers, irrespective of which agency employs them, must be present at case review. Moreover, it is strongly encouraged that case review participants be those who are actively working on the cases under review in order to ensure direct communication between all parties. This does not preclude additional

agency representatives or supervisors from participating as well. Participation in person is optimum; however, participation can be accomplished virtually as necessary to ensure the participation of all required disciplines and to respond to public health emergencies.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC case review is regularly attended by representatives from all seven required disciplines. MDT representatives attending case review are those directly assigned and responsible for the investigation and delivery of services for each case being reviewed.
2. CAC case review is regularly attended by representatives from all seven required disciplines. MDT representatives attending case review are in supervisory roles and, as such, are capable of making, informing and/or advocating for case decisions. These representatives are prepared with case-specific information from the individuals assigned to the case and relay MDT feedback and recommendations back to them.
3. The CAC utilizes a combination of Examples 1 and 2 above in their case review practice, informed by discussions among the MDT members and agreed upon collaboratively.
4. For cases involving youth with problematic sexual behaviors, MDT may consider expanding the traditional case review attendance to include additional disciplines that are routinely involved in these cases, such as the juvenile justice system and school personnel. Addition of these members may invite the opportunity to allocate dedicated time during case review meetings to review only cases of children with problematic sexual behaviors or consider hosting a regularly scheduled separate case review meeting for these cases only.
5. CAC hosts hybrid case review meetings which allow partners geographically distant from the CAC to participate.
6. CAC contracts with experienced & trained individual who is capable of advising, informing, and advocating for case decisions when service provider is unavailable/unable to attend.

Essential Component D

Case review is an informed and collaborative decision-making process with input from all MDT partner agency representatives.

Generally, the case review process should include:

- Review of forensic interview outcomes
- Discussion, planning and monitoring of the progress of the investigation
- Review of medical evaluation findings
- Discussion of child protection and other safety issues
- Input for prosecution and sentencing decisions
- Discussion of emotional support and treatment needs of children and family members and strategies for meeting those needs
- Assessment of the family's reaction and response to the child's disclosure and involvement in the criminal justice and/or child protection systems
- Review of criminal and civil (dependency) case updates and ongoing involvement with the child and family as well as disposition
- Provisions for court education and court support and accompaniment
- Ensuring that all children and families are afforded the legal rights and comprehensive services to which they are entitled

- Discussion of how the CAC and MDT intervention is impacting the child and their family, including positive changes and challenges
- Child well-being and outcomes, as available

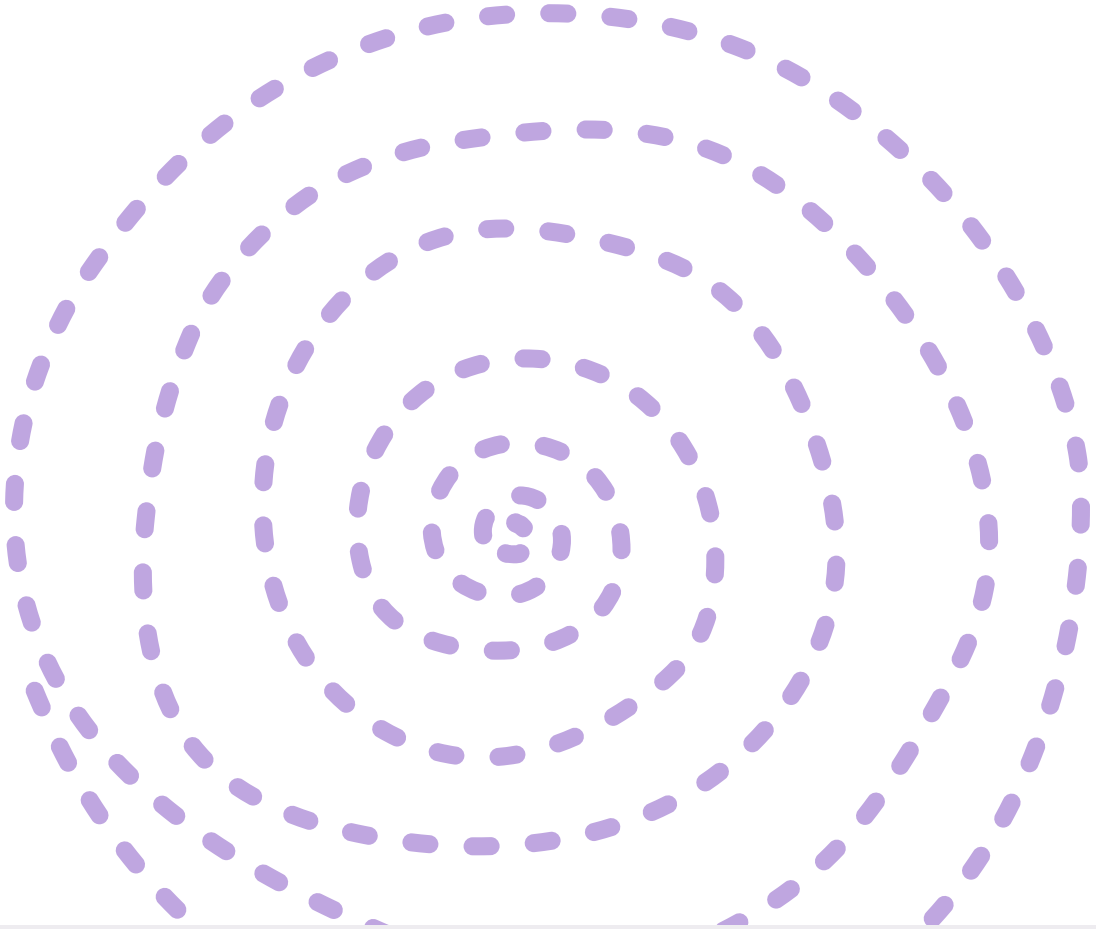
STATEMENT OF INTENT:

In order to make informed case decisions, optimize service delivery and improve client outcomes, essential information and professional expertise are required from all disciplines. Decisions and interventions must be made with the input, discussion and support of all involved professionals, and efforts must be coordinated, comprehensive and nonduplicative. The process and facilitation must ensure there is equal participation and discussion among all MDT members to adequately address their respective and shared goals, mandates, interventions and services, questions, concerns, and outcomes.

Practical Approaches for Rural CACs to Meet This Standard:

1. Case review serves as an informed decision-making process with all members of the MDT, based on agreed-upon case criteria and process, and including, at a minimum, all of the 12 listed components above. Standard expectations require that all case review participants come prepared to discuss cases on the agenda, provide case updates, and address relevant issues. The facilitator must be skilled at ensuring a well-organized, comprehensive discussion, inclusive of all team members' contributions that inform individual and collective decision-making, and that clearly define next steps.
2. Case review may also include an MDT focus on the general successes and challenges in their collaborative team response and training/educational opportunities, and on the need for systemic improvements and revisions to policies and procedures.





Standard 07

Case-Tracking

Children's Advocacy Centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.



07. Case-Tracking

Rationale

Case-tracking systems are able to collect and document essential demographic and case information and investigation/ intervention outcomes as well as generate statistical reports. The data collected is useful for monitoring ongoing case progress and program evaluation to inform continuous quality improvement, enabling MDT members to provide accurate information on the current status and disposition of cases to clients, and providing critical support for seeking funding and responding to grant requirements.

Data collected nationally from all local programs, relevant statewide and regionally, are useful for advocacy, research, and legislative purposes to advance the field of child maltreatment. It may also be required for federal funding reporting requirements. Each CAC utilizes the case-tracking system that suits its determined needs and is able to be supported by its available resources. Any case-tracking system implemented must be compliant with all applicable privacy and confidentiality requirements.

Essential Component A

The CAC/MDT's written protocols/guidelines includes the case-tracking process and information gathered through case closure at the CAC, including final civil and/or criminal disposition.

STATEMENT OF INTENT:

Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response. Often, MDT members will have a system to collect their own agency data; however, the MDT response requires the sharing of this information among its members to better inform individual and collective decisionmaking, ensure accurate updates to children and families, and inform quality improvements in coordinated service delivery. The CAC/ MDT's written documents must detail the CAC's purpose, information to include, and a process for case tracking.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's protocols/guidelines include the necessity for comprehensive case tracking/ data collection, and a commitment on the part of MDT agencies to track required and agreed-upon case information from intake to final disposition.

Essential Component B

The CAC tracks and, at a minimum, is able to retrieve and report NCA Statistical Information.

NCA statistical information includes the following data:

1. Demographic information about the child and family
2. Demographic information about the alleged offender
3. Type(s) of alleged abuse
4. Relationship of alleged offender to child
5. MDT members' involvement with children and families and relevant outcomes
6. Criminal charges filed and case dispositions

7. Child protection outcomes
8. Status/follow-through of medical and mental health referrals

STATEMENT OF INTENT:

CACs are required to demonstrate the ability to collect and retrieve case-specific information for all CAC clients. This includes basic demographic information, services provided, and outcome information contributed by MDT partner agencies in a thorough and timely fashion. Codifying case-tracking procedures in CAC/MDT's written documents underscores its importance and helps to assure the MDT members are accountable to each other and, ultimately, to the children and families they individually and collectively serve.

Practical Approaches for Rural CACs to Meet This Standard:

1. At a minimum, the CAC utilizes NCAtrak to capture the data required for NCA reporting.
2. The CAC uses a statewide password-protected data-tracking system to track and retrieve case information that is, at a minimum, required by NCA.
3. The CAC has a sophisticated database that was created uniquely for its use and that allows, at a minimum, for the required NCA reporting and contributes to evaluation and improvement of investigations and interventions.
4. The CAC may also track additional items for youth-initiated cases of problematic sexual behavior cases, to include placement disruption, reunification, or development of a strategy to flag cases to ensure safety and scheduling.

Essential Component C

An individual is identified to implement the case-tracking process.

STATEMENT OF INTENT:

Case tracking is an important function of the CAC that requires dedicated time and accuracy in its implementation. A designated individual(s) must be identified to implement and/or oversee the case-tracking process, and the number and type of individual(s) charged with this responsibility is determined by the CAC's staffing and case volume. Some CACs define case tracking as part of the MDT coordinator's or case manager's role. Some dedicate a staff position, part- or full-time, for data collection and database maintenance, or assign the responsibility to an administrative assistant. Other programs utilize trained volunteers (who have signed confidentiality agreements) to input data.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC designates a staff person (e.g., team coordinator, forensic interviewer, victim advocate, administrative assistant) who is responsible for gathering and inputting the necessary data from MDT members at case review and/or via email.
2. Designated MDT members are responsible for entering their case-specific data directly into the database. The CAC staff person maintains and monitors the case tracking system and generates reports as required or requested.
3. The CAC designates a staff person to maintain and monitor the case tracking system. Trained MDT members enter their own case-specific information into the database and keep it updated. The CAC staff person is responsible for generating necessary reports.

Essential Component D

The CAC/MDT's written protocols/guidelines must outline how MDT partner agencies can access case-specific information and aggregate data for quality assurance, quality improvement, funding, and research purposes.

STATEMENT OF INTENT:

Because case data may be useful to MDT members for a variety of purposes, it is important that all members have access to aggregate and/or specific case information as determined through discussions with all participating agencies. Policies must also include how the release of this data to participating agencies and other parties complies with confidentiality requirements.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC protocols/guidelines delineate how MDT members can access both case-specific and aggregate data directly from the tracking system. Potential options include:
   - A. MDT members are provided training on the use of the database to access data directly.
   - B. CAC director or their designee generates and disseminates aggregate data reports to all MDT members. A protocol, agreed upon by all MDT partner agencies, is in place to allow parties outside of the MDT to access aggregate data (e.g., via written requests to CAC director).
   - C. MDT partner agencies may obtain case-specific and/or aggregate data by contacting the CAC's designated individual responsible for the tracking system.

Essential Component E

The CAC collects client feedback to inform client service delivery.

STATEMENT OF INTENT:

Continuous quality assurance is the hallmark of a well-functioning CAC. This requires seeking feedback directly from clients regarding their experiences with all aspects of CAC services so that improvements may be made as needed on an ongoing basis. Soliciting client feedback can be accomplished through the use of various tools including, but not limited to, client satisfaction surveys. To optimize the quality of the feedback received, survey instruments need to be valid and reliable. CACs that actively participate in NCA's Outcome Measurement System (OMS) can be assured they meet and exceed this requirement.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC uses the NCA Outcome Measurement System (OMS) to evaluate its client service delivery. Families complete surveys electronically or by hand while at the CAC and/or are contacted by a victim advocate as part of their follow-up. CACs that actively participate in the OMS can be assured they meet and exceed this requirement.
2. The CAC uses master's-level interns to administer a telephone survey within a prescribed period of time shortly after a client's visit to the CAC. The interns collate data from the surveys to create a program evaluation report.
3. The CAC has developed an individualized survey instrument that is provided to clients to collect feedback and inform client service delivery.

Standard 08

Organizational Capacity

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



08. Organizational Capacity

Rationale

Every CAC must have a designated legal entity responsible for the governance and implementation of its operations. This entity oversees ongoing business practices of the CAC, including setting and implementing administrative policies, hiring, and managing personnel, obtaining funding, supervising program and fiscal operations, and longterm planning. CAC organizational structure depends upon the unique needs and resources of its community; it may be an independent nonprofit agency, a component of an umbrella organization such as a hospital or nonprofit human service or victim service agency, or part of a governmental entity, such as prosecution, social services, or law enforcement. Each of these options has strengths, limitations and implications for collaboration, planning, governance, community partnerships and resource development. Regardless of where the program is housed or under what legal auspices, all CACs must create a structure such that participating agencies feel equal investment in, and collaborative responsibility for, its operations and services.

Practical Approaches for Rural CACs to Meet This Standard:

1. If the CAC is an independent nonprofit, it is able to demonstrate its status by providing a copy of the agency's IRS letter designating it as an independent 501c3 organization. If the CAC is part of a larger nonprofit agency, that agency can provide a copy of its IRS letter and an organizational chart demonstrating that the CAC is a program within it.
2. If the CAC is administered by a government agency, said agency can provide a document (e.g., letter from agency leader or interagency agreement) delineating its role in providing administrative oversight and management of the CAC.
3. If the CAC is administered by a hospital, they can provide a copy of the hospital IRS letter and organizational chart demonstrating the CAC as a program of the hospital.
4. The CAC is created as a public/private partnership.

Essential Component A

The CAC is an incorporated, private nonprofit organization, government-based agency, tribal entity, or a component of such an organization, agency, or tribal entity.

STATEMENT OF INTENT:

The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This is critical to the ability to maintain, grow and ensure sustainability of the CAC and all of its components and services.

Essential Component B

The CAC maintains, at a minimum, current general commercial liability, professional liability, directors' and officers' liability, and cyber liability insurance as appropriate for its organization.

STATEMENT OF INTENT:

Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Nonprofit CACs, including those that are a component of an umbrella nonprofit or nonprofit hospital, must carry, at a minimum,

general commercial liability, professional liability, cyber liability, and directors' and officers' liability insurance. Governmentbased CACs must carry, at a minimum, general commercial liability, professional liability, and cyber liability insurance or provide documentation of comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed, including renters, property owners and automobile insurance, depending upon their individual needs.

Practical Approaches for Rural CACs to Meet This Standard:

1. A nonprofit CAC, or one that is part of a larger nonprofit, can maintain and produce updated documentation of its current insurance policies as required by this standard.
2. A CAC administered by a government agency that is self-insured can produce updated documentation or request that the government agency produce documentation of said coverage in general and/or as it relates to the CAC.

Essential Component C

The CAC has administrative policies and procedures that apply to staff, board members, volunteers, and clients.

Every CAC must have written policies and procedures that govern its administrative operations. Administrative policies and procedures must include, at a minimum:

1. Personnel policies, procedures, and documents
   - A. Job descriptions for all positions
   - B. Anti-discrimination policy
   - C. Conflict of interest policy
   - D. Whistleblower policy
   - E. Social media use policy
2. Financial management policies and procedures
   - A. Accounting policies and procedures that demonstrate adequate internal controls and segregation of duties
   - B. Credit card usage policy
3. Safety and security policies and procedures
   - A. Code of conduct (this should guide behavior between staff, between staff and team members, and between staff/team members and clients)
   - B. Child protection policies, including the obligation to report abuse
   - C. Emergency response policies
   - D. Building security and safety policy and procedures
   - E. Anti-Violence in the Workplace policy
   - F. Weapons on premises policies and procedures
   - G. Drug usage policy
   - H. Smoke-free environment
4. Information technology policies
   - A. Document retention and destruction policies
   - B. Data security policies
   - C. Confidentiality policies — HIPAA requirements

STATEMENT OF INTENT:

The CAC has clearly developed organizational policies and procedures that ensure appropriate administrative governance. This is critical to the ability to maintain, grow and ensure sustainability of the CAC and all of its components and services.

Practical Approaches for Rural CACs to Meet This Standard:

1. A freestanding nonprofit CAC has comprehensive written policies and procedures including, but not limited to, this standard's minimum requirements, which are maintained and updated as needed.
2. A CAC that is a program of a larger nonprofit or government agency operates under the overall policies and procedures that govern the umbrella agency, including, but not limited to, those required by this standard. In addition, the CAC has implemented policies and procedures that are specific to CAC operations and personnel in accordance with those required by this standard.
3. A CAC that operates as a public/private partnership has clearly defined policies and procedures that govern the structures and roles required by both components.

Essential Component D

The CAC is required to conduct an annual independent financial audit when its annual actual expenses meet or exceed $750,000. Organizations whose annual gross expenses fall below $750,000 and meet or exceed $200,000 must conduct a CPA-completed financial review. Those organizations with gross annual expenses below $200,000 must provide their Board-approved financial statements.

STATEMENT OF INTENT:

Confidence in the integrity of the fiscal operations of the CAC is critical to the longterm sustainability of the organization. An annual independent audit is one tool to assess for fiscal soundness and internal controls for financial management. A financial review is sufficient for those CACs with annual actual expenses equal are less than $750,000 and that meet or exceed $200,000. CACs with annual budgets below $200,000 must provide their Board-approved financial statements.

Reporting Requirements for Audited Financial Statements: All centers with annual actual expenses (as determined by United States generally accepted accounting principles) that meet or exceed $750,000 are required to have an audit of their financial statements. If a management letter is prepared by the independent accountant (CPA), it should be included with the audit report.

Reporting Requirements for Reviewed Financial Statements: All centers with annual actual expenses (as determined by United States generally accepted accounting principles) less than $750,000 that meet or exceed $200,000 are required to have a review of their financial statements. The review must be in compliance with SSARS 19. If a management letter is prepared by the independent accountant (CPA), it should be included with the review report.

Practical Approaches for Rural CACs to Meet This Standard:

1. If the CAC has an operating budget of less than $200,000, it provides their Board-approved financial statement. Documentation of the current financial statements (within the preceding 12-month period) can be produced.
2. If the CAC has an operating budget equal to or over $200,000 but one less than $750,000, it provides a CPA-completed financial review of its financial statements. Documentation of the current CPA-completed financial review (within the preceding 12-month period) can be produced.
3. If the CAC operating budget meets or exceeds $750,00, it provides its audit of its financial statements. Documentation of the current audit (within the preceding 12-month period) can be produced.
4. If the CAC is a program of an umbrella 501c3 agency, the umbrella agency can provide documentation of its annual independent audit. Said audit identifies the CAC financial information within the completed audit.

5. If the CAC is a program of a government agency, said agency can provide documentation of the annual audit conducted for the city, county, or applicable entity.

Essential Component E

The CAC has, and demonstrates compliance with, written screening policies for staff, board members and volunteers that include national criminal background, sex offender registration, and child abuse registry checks, and it provides training and supervision to staff and on-site and/or ongoing volunteers. In discussion with its Board and MDT, a CAC must determine what is a disqualifying finding in a background check.

STATEMENT OF INTENT:

Due to the sensitive and high-risk nature of CAC work, it is imperative that the CAC conduct a formal screening process for staff. This process should be documented in a written policy. Staff must receive initial and ongoing training and supervision relevant to their role.

In addition, volunteers perform a wide variety of functions within CACs, and CACs can attract volunteers who are emotionally unprepared for the nature and expectations of the work and/or individuals who have potential to be, or have current or past histories as, offenders. Due to the sensitive and high-risk nature of CAC work, it is imperative that the CAC also conducts a formal screening process for on-site volunteers. Upon placement, volunteers must receive training and supervision relevant to their roles.

For similar reasons, screening must be conducted for board members as they serve and publicly represent the CAC in a variety of ways, both on- and off-site.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC has a written policy mandating national criminal background and child abuse registry checks for all staff, volunteers, and Board members. The procedure for executing the policy is incorporated in CAC overall administrative policies and the forms used for submitting the screening checks and obtaining results. All staff and volunteers are informed of the screening policy and the required background check procedures. No hiring is official until the results of the screening are received and reflect no concerns. The CAC maintains background check documentation in its records, and compliance is able to be demonstrated appropriately.
2. In those states where a child abuse registry is not provided, or state statute disallows access, the CAC can provide documentation of their inability to comply with this requirement. NCA maintains a list of waivers that have been approved on a statewide basis upon review of appropriate documentation.

Essential Component F

The CAC has a written succession plan to ensure the orderly transition and continued operation of the CAC.

STATEMENT OF INTENT:

A succession plan assists in guiding the CAC through, and safeguarding the CAC against, unplanned or unexpected changes. This kind of risk management, mission and business continuity is equally important in facilitating a smooth transition when leadership change is predictable and planned. A succession plan outlines leadership development and emergency responsibilities for the CAC, and it reflects its commitment and helps ensure a sustained, healthy functioning organization. The plan should be developed specific to the uniqueness of the CAC and include, at a minimum:

- Temporary staffing strategies
- Long-term and/or permanent leadership replacement procedures
- Cross-training plan
- Financial considerations
- Communication plan
- Key positions/functions essential to the operation of the CAC

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC's director drafts a plan outlining fiscal, facility, and personnel management, including qualified individuals to assume responsibility for leadership functions in the event of an unanticipated absence or in preparation for a transition of leadership. Relevant individuals named in the plan are included in discussions and are clear about their proposed roles and responsibilities. Senior staff, MDT agency leadership and Board members (where appropriate) provide input and approval to said plan and it is shared with all relevant parties.
2. The CAC's Board establishes guidelines for a succession plan and works with the director to develop the details and to discuss with and assign duties and responsibilities to all relevant parties.

Essential Component G

The CAC has addressed its sustainability through the implementation of a current strategic plan approved by the governing entity of the CAC.

STATEMENT OF INTENT:

In order to assure long-term viability of the organization, the CAC must have a plan that addresses programmatic and operational needs. The governing entity for such a plan may be an oversight committee or a board of directors, as appropriate for the individual CAC's organizational structure and needs.

In general, in order to be considered current, a strategic plan should be no more than three to five years old. It should be actively implemented, and there should be a mechanism in place to monitor the progress on the plan.

Plan should include at, a minimum:

- Stakeholder input in plan creation
- Goals, objectives, and timeline
- Review and approval by CAC board or relevant governing body

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC contracts with an organizational consultant to meet with all staff members, partners, and Board members individually to assess needs, and it facilitates a group discussion to set priorities and determine tasks, individuals and timeframes required. The consultant drafts a plan for discussion and approval by all CAC participants, including a method for monitoring progress and addressing obstacles.
2. The CAC sponsors a planning retreat with all staff and MDT agency representatives to develop a plan reviewed and approved by the Board or other governing body. The plan includes a process for assessing organizational and team needs, prioritizing action steps, implementing organizational strategies, monitoring progress, and addressing obstacles.

Essential Component H

The CAC promotes employee well-being by providing training and resources regarding the effects of vicarious trauma, providing techniques for building resiliency, and maintaining organizational and supervisory strategies to address vicarious trauma and its impact on staff.

STATEMENT OF INTENT:

To help ensure the health and well-being of all employees and improve employee retention, the CAC must raise awareness about the impact of work-related trauma exposure through training and develop organizational practices that identify and mitigate against negative consequences for staff, the delivery of quality of services, and staff turnover. This includes identifying the risk of vicarious trauma for frontline staff and those exposed to the associated trauma of the work more indirectly. It also includes providing techniques for individual self-care and resiliency building as well as integrating and maintaining organizational and supervisory strategies to address and respond to vicarious trauma among all staff.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC provides vicarious trauma and resiliency training as part of employee orientation and in-service training for the entire staff on an annual basis. Said orientation can be conducted for all new hires across MDT partner agencies.
2. The CAC affords opportunities for CAC staff to attend outside in-person and online trainings for professional development and for addressing vicarious trauma and resiliency.
3. The CAC provides written materials, articles and tools that address the issue of vicarious trauma for their staff and maintains said materials in an accessible place for all staff and MDT members.
4. The CAC incorporates a regular focus on vicarious trauma in individual and group/peer supervision.
5. The CAC provides forums for staff discussion of vicarious trauma at staff meetings.
6. The CAC supports a process for debriefing after critical incidents and in response to other staff needs related to chronic exposure to abuse and violence.
7. The CAC conducts an agency-wide assessment of its organizational response to vicarious trauma in order to determine strengths and gaps and to identify priorities and action steps.

Essential Component I

The CAC provides training opportunities and resources on vicarious trauma and building resiliency to all MDT members.

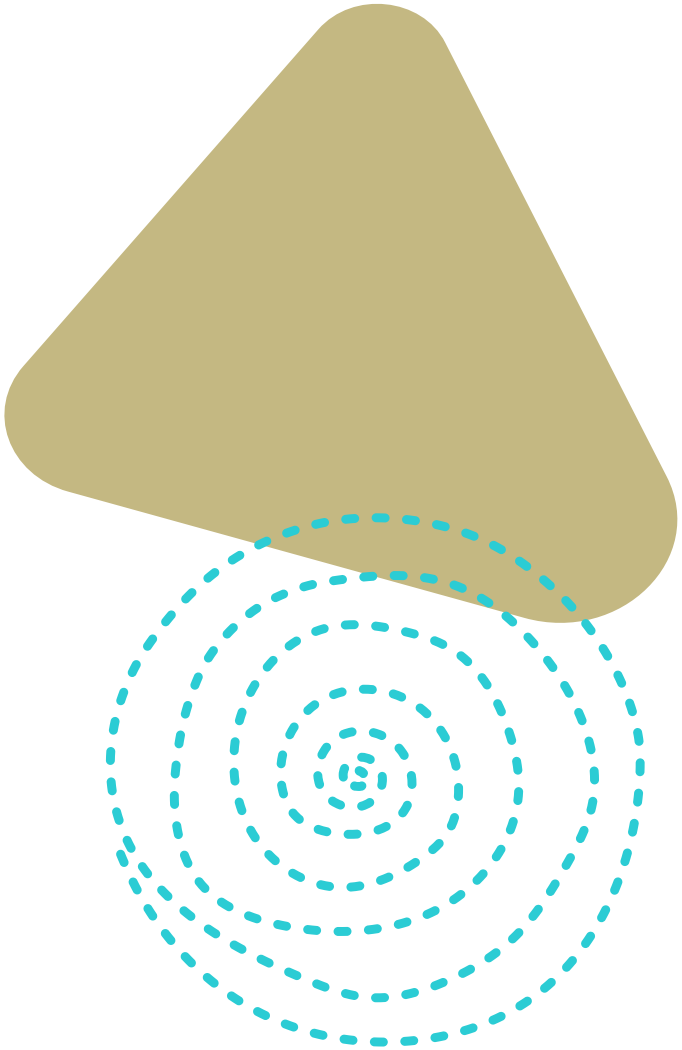
STATEMENT OF INTENT:

CACs have a primary role in building and enhancing the functioning of the MDT. A highly functioning MDT assures vicarious trauma is acknowledged and addressed and has an awareness and understanding of the importance of work-related trauma exposure and its potential consequences. While MDT partner agencies have primary responsibility for the health and well-being of their respective staff, the CAC is responsible for providing access to training, ongoing recognition, and discussion and strategies to collaboratively address vicarious trauma and help build team members' resiliency. Moreover, the health of the MDT as a whole directly impacts service delivery to children and families. Therefore, attention to this issue is important for helping to ensure high-quality services and improve outcomes for abused children and families.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC provides annual resiliency and vicarious trauma training for CAC staff and invites and encourages all members of their MDT to participate.
2. The CAC provides vicarious trauma and resiliency training as part of employee orientation and in-service training on an annual basis that can be done collaboratively with MDT partner agencies.
3. The CAC affords opportunities for MDT members to attend outside in-person and online trainings for professional development and for addressing vicarious trauma and resiliency.

4. The CAC provides MDT members written articles, materials and tools that address the issue of vicarious trauma and maintains their access and availability for MDT members on an ongoing basis.
5. The CAC provides information to MDT members about outside in-person and online training opportunities that address vicarious trauma and resiliency.
6. The CAC includes discussion of vicarious trauma as a regular agenda item for case review/MDT meetings.
7. MDT retreats can be implemented to further grow and strengthen collaborations, a protective factor for addressing vicarious trauma. Said retreats include an express focus on normalizing discussion of vicarious trauma and collaboratively developing strategies for individual and team health and wellness.
8. The CAC director openly discusses the issue of work-related trauma exposure with MDT partner leaders and CAC staff, including the responsibility of leadership to ensure a comprehensive response to its impact. Training is developed and provided for all CAC staff members, volunteers, and Board members to raise awareness about vicarious trauma and its potential negative consequences and strategies to individually and organizationally address it. An organizational assessment is conducted to determine key areas of strength and needs for improvement for team practice, training, and service delivery. A plan outlining goals, objectives, activities, persons responsible and timelines is developed for review and approval by a CAC's vicarious trauma workgroup, Board, or other governing body. The plan includes a process for monitoring progress and addressing obstacles.



Standard 09

Child Safety and Protection

The CAC is comfortable, private and both physically and psychologically safe for populations of children and their family members.



9. Child Safety and Protection

Rationale

A CAC requires a separate, child/youthfocused setting that provides a safe, comfortable, and neutral place where forensic interviews and other CAC services can be appropriately provided for children and families. While every center may look different, the criteria below help define specific ways the environment can help children and families feel physically and psychologically safe and comfortable. These include making sure the physical setting meets basic child safety standards, ensuring alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating a welcoming environment that reflects the diversity of clients served.

There is no one right way to build, design or decorate a CAC. The CAC should have adequate square footage for its determined on-site operations and conform to generally accepted safety and accessibility guidelines, fire codes, etc. Consideration should be given to future growth and the need for additional space as caseloads increase and additional program components are needed. Care should be taken to ensure MDT members have access to workspace and equipment on-site to carry out the necessary functions associated with their roles on the MDT, including, but not limited to, meeting with families, participating in forensic interviews and sharing necessary information.

Special attention should be given to designing and decorating the client service areas to reflect the community's population. The appearance of the CAC can help facilitate the participation of children and families in the process, largely by helping alleviate anxiety and instill confidence and comfort in the intervention system. It should communicate, through its design, decor, and materials, that the CAC is a welcoming place for all children and their nonoffending family members.

Essential Component A

The CAC is a designated, task-appropriate facility or space that:

1. Is maintained in a manner that is physically and psychologically safe for children and families
2. Provides observation or supervision of clients within sight or hearing distance by CAC staff, MDT members or volunteers at all times
3. Is convenient and accessible to clients and MDT members
4. Is appropriate for the delivery of CAC services
5. Provides age-appropriate toys and other resources that are childproofed, cleaned, and sanitized to be as safe as possible.

STATEMENT OF INTENT:

The CAC is a child focused setting that ensure both physical and psychological safety for all children and families. Special attention should be paid to the location, design and accessibility of the CAC for the children, families and MDT members that utilize the center.

Practical Approaches for Rural CACs to Meet This Standard:

1. CACs can range from small, refurbished houses to renovated wings of county office buildings, from community hospitals to

newly built facilities. Every CAC should be in a location that is central and/or otherwise accessible by clients and team members, including access to public transportation where possible and accommodations for parking. The CAC requires designated areas that accommodate the necessary operational and client needs (in smaller centers, some rooms may serve dual or multiple purposes). Childproofing and soundproofing are incorporated into the facility to ensure physical and psychological safety. Areas occupied by children are situated such that physically and/or operationally, they can be consistently observed and supervised and allow for immediate responses to clients' needs.

2. Some centers have consulted state daycare center guidelines to assure that waiting rooms and other areas for children have adequate square footage and are childproofed, conforming to generally accepted safety guidelines such as height and securing of shelves, disinfecting of toys and materials, compliance with fire codes, etc. Other centers follow JCAHO (Joint Commission on the Accreditation of Healthcare Organizations) guidelines for this purpose.

3. The interview room(s) should help a child feel as comfortable, safe, and free of distractions as possible, with furniture that addresses the needs of children and teens of varying ages and sizes. Research shows that a comfortable, supportive, neutral setting is conducive to obtaining accurate information from children.

4. Physical design and use of staff are important in order to be responsive to clients' needs while in the waiting area. To assure a physically and psychologically safe environment, children and families must be observed or supervised by CAC staff, volunteers, or team members at all times by remaining present or within sight and hearing distance. For example, some CACs are built so that the waiting room can be seen from the receptionist's desk. Other CACs have volunteers scheduled to supervise play in the waiting room whenever the center is open for clients and to help create a warm and supportive experience for children, caregivers, and families.

5. Access is key to a CAC's success. A frequent and ongoing concern of team members who are not located on-site is the distance from the community in which they work to the CAC. This is particularly true in large metropolitan areas or in instances in which one center serves a geographically large county. Location of the CAC is also important to clients who may return on several occasions for followup meetings, medical appointments, or therapy services. It is important to evaluate the CAC's accessibility to a majority of clients and participating agencies, and to make provisions, such as transportation assistance, if necessary.

The following questions may be helpful in assessing whether your center is safe and childproofed:

- When children are present, are all areas effectively supervised by a responsible and responsive adult at all times?
- Is the room(s) clean?
- Is the floor free of small or sharp objects that could be touched or ingested by a small child? (In an office environment, this requires constant monitoring. E.g., have staples or paper clips been dropped?)
- Are counters and tabletops free of breakable or heavy objects that could be toppled by a toddler or preschooler?
- Is furniture sturdy and secured to the wall so that it cannot be toppled by a climbing child or fall during an earthquake or other disaster?
- Are the electrical outlets covered?
- Are area rugs non-skid?
- Do garbage cans have secure covers?
- Are windows (especially those on upper floors) locked with safety latches?

- Are cleaning supplies and other hazardous materials locked or out of reach and stored away from food?
- Are all plants nonpoisonous?
- Do all toys meet federal safety standards, and are they in good condition?
- Are the bathrooms ADA-compliant? Are they "child-friendly" so that children do not have to climb on countertops to use sinks? Are bathrooms made off-limits to crawling infants or toddlers who could fall into toilets and drown?
- Are there safety and evacuation plans in place in the event of an emergency?
- Do glass doors and full-length windows have decals on them at both child and adult heights?
- Are electrical cords out of children's reach and away from doorways and traffic paths?
- Are smoking and drinking hot liquids prohibited in the children's areas?
- In any multipurpose area, are all hot surfaces (e.g., stoves, coffee pots, hot plates, etc.) out of children's reach and covered to prevent burns?
- Is the tap water temperature set at 120 degrees or lower to prevent scalding?
- Are the sharp edges of furniture (e.g., tables) covered with corner guards?
- Is there a first aid kit present and fully stocked?
- Is the number for poison control posted?
- Are there functioning smoke detectors? Have the batteries been replaced within the last year? Is there an A-B-C–type fire extinguisher present? Do staff members know how to use it?
- Is there a segregated play area for infants and toddlers? Is there a daily check to assure that no small game pieces, coins, staples, safety pins or other small items are accessible to small children?
- Is the CAC free of chipped paint and splinters?
- Are there gates on stairs in unsupervised areas? (NOTE: Accordion-style gates are not safe. Special gates are required at the top of stairs.)
- Are all art supplies nontoxic?
- Are activity areas for older children supervised? Have any materials that could be dangerous for smaller children been put away when the activity is complete?

Essential Component B

The CAC has, and abides by, written policies and procedures that ensure separation of victims and alleged adult offenders during the investigative process and throughout delivery of services at the CAC. CACs may provide services to youth with problematic sexual behaviors, but they must have developed and implemented appropriate safety protocols to protect other children receiving services at the CAC.

STATEMENT OF INTENT:

The CAC has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and throughout delivery of the full array of CAC services. During the investigative process, logic dictates that children will not feel free to disclose abuse if an alleged offender accompanies them to the interview and/or remains on location throughout the duration of intervention. This separation of children from alleged offenders should also extend to children and perpetrators in unrelated cases. In addition, caregivers may also be at risk of abuse and violence by alleged offenders and are in need of physical and psychological safety for themselves and their children. If a CAC shares space with an existing agency that provides services to offenders, facility features and scheduling must assure separation between children and family members and alleged offenders.

Many CACs serve a vital role in their communities by providing services for children with problematic sexual behaviors. CACs that offer services to this population should have policies and procedures in place to maintain physical and psychological safety for other child victims and their families visiting the CAC.

Practical Approaches for Rural CACs to Meet This Standard:

1. CAC policies do not allow alleged perpetrators to be on the premises at any time and prohibit the delivery of services to alleged adult perpetrators. If any known or alleged perpetrators are found to be on the property, including those who may have accompanied the child to the CAC, they will be asked to leave the premises immediately in an appropriate manner by predetermined law enforcement personnel. Law enforcement and/or CPS arrange to interview or meet with suspected perpetrators off-site. A security "panic" button is installed at the receptionist's desk that immediately summons law enforcement in case of emergency.
2. Additional policies address situations when juveniles with problematic sexual behaviors are in need of a victim interview at the CAC, and when sexually reactive children are receiving other services at the CAC. Separation is achieved by scheduling their appointments when there are no other children in the building; when they do not come in contact with the potential child victim in the case; when they are supervised at all times; and/or when they are escorted directly to interview or therapy rooms where they do not have contact with other children in the waiting room.
3. If a CAC is located in a large government building where services are also provided on-site to alleged offenders, a separate section with a separate entrance needs to be created to ensure that children, caregivers and families are not present in the same public areas as alleged offenders.

Essential Component C

The CAC makes reasonable accommodations to make the facility physically accessible.

STATEMENT OF INTENT:

This requirement is for new buildings and custom-designed facilities. CACs operating in older buildings or facilities must make reasonable accommodations to make the facility physically accessible to clients and family members, CAC staff and MDT members. If the CAC cannot be structurally modified, arrangements for equivalent services should be made at alternate locations within or outside the facility. CACs must be in compliance with guidelines stipulated in the Americans with Disabilities Act (ADA) and/or state legislation.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC is located in a refurbished house that is not physically accessible to clients in wheelchairs. As a result, the CAC utilizes a room in a nearby child and family services agency that is wheelchair-accessible. When necessary, the MDT schedules interviews at that location. CAC therapists can also make arrangements to utilize the room for ongoing counseling sessions.
2. A two-story CAC is wheelchair-accessible on its first floor. Handicapped parking is available, and ramps lead up to the CAC entrance. The waiting room and an interview room are on the first floor and have doors wide enough for wheelchairs. The bathroom on the first floor is wheelchair accessible. Signs on doors are also written in Braille.
3. A CAC is located on the fourth floor of a hospital. The entrance to the building and all rooms are wheelchair-accessible, and the building has elevator service.
4. In addition to being wheelchair-accessible, a CAC is designed specifically for child accessibility. The reception counter is low so that small children can see over it. There are two sets of handrails on the stairs – one

at adult height and one at a level that can be easily grasped by small children. Toilets, sinks and towel dispensers in the bathrooms are at a height most conducive to children.

3. A large CAC has more than one waiting room to provide privacy for families that are at the center for interviews and other services at the same time. The rooms are appropriately soundproofed.

Essential Component D

Separate and private area(s) are available for confidential case consultation and discussion, for meetings or interviews, and for clients awaiting services.

STATEMENT OF INTENT:

To ensure a physically and psychologically safe environment for children and families, confidentiality and respect for client privacy is of paramount concern in a CAC. CAC staff and MDT members require privacy to discuss cases with children or families in a location where visitors or others not directly involved with the case may overhear them. Separate areas should also be available for private family member interviews and so that individual family members may privately discuss aspects of their case with staff and MDT members. Care should be taken to ensure that private meeting areas are not only physically separate but also soundproofed, so conversations cannot be overheard. Some centers place soundproofing materials in or on walls when building or refurbishing their centers. Others place stereos or sound machines in rooms to block sound.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC has a designated private family room for staff and MDT members to meet with families. There is a white noise machine placed outside the door to ensure confidentiality and privacy.
2. The CAC uses conference rooms on different ends of the building for meeting with the families. The rooms are stocked with brochures and other resources for children and families. White noise machines are used to help ensure privacy.

Essential Component E

CACs are required to implement a code of conduct for staff and MDT members ensuring the safety of children and families. The code of conduct must include child abuse prevention practices. Staff members must have received and agreed to the code of conduct. MDT members must be informed of the CAC's code of conduct and the expectation that it guides work within the CAC.

Code of conduct content must include:

- Child safety and well-being as a primary priority and value in the CAC and one that guides policy and practice decisions.
- Contact not related to CAC service provision between staff and a child/client is prohibited.
- Physical contact between child/client and staff/MDT members must be consistent with the safety and well-being of the child/client.
- Staff interaction with child clients should be interruptible and/or observable.
- It is the duty of staff to report suspected child abuse.

STATEMENT OF INTENT:

A code of conduct is a set of rules around the behavior for CAC staff and MDT members, and it acts as an explicit expression of personal and professional expectations in their work with one another and with clients. It also serves as an external statement of the CAC/MDT's commitment to its core values and principles for interdisciplinary, cross-agency work. In

addition, a code of conduct helps provide for a healthy work environment for staff and MDT members, and thereby helps ensure the delivery of high-quality, relevant, and accessible child- and family-centered services. In the event of any violations of stated codes of conduct, it also provides an understanding of how to report and/or address them.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC will develop a code of conduct including the five items listed above, along with any other safety areas it would like to include that all staff and MDT members agree to. This code of conduct will be introduced to new staff and MDT members during orientation and routinely referenced as appropriate during staff and case review meetings.
2. The code of conduct is a part of a larger employee handbook document that CAC staff agree to upon hiring at the CAC.
3. The code of conduct is included in the MDT policies and procedures document that all CAC staff and MDT partner agencies agree to when committing to the MDT response to child abuse within their community.

Essential Component F

A child safety assessment must be conducted annually to ensure that the building and CAC space is a safe and child-focused setting for children and their families.

STATEMENT OF INTENT:

Core to CACs is their ability to provide a setting that underscores the critical importance of providing and/or restoring a sense of safety, both physically and psychologically, for children and families in crisis. Safety must be assured if children and families are able to participate in forensic interviews, investigations, evaluations and identified services. As such needs and safety measures change or are updated, assessments must be conducted at least annually.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC will develop a safety assessment suitable to evaluate the safety, both physically and psychologically, for the child and families served at the center as well as the staff and MDT. The CAC will conduct the assessment at least annually.
2. The CAC will conduct the safety assessment more frequently if it rearranges, modifies, or moves to a new physical space.

Essential Component G

CAC staff are mandatory reporters. CACs are required to ensure that mandated reporter training is provided to all staff and volunteers. Updates to state statutes and mandated reporter laws must be provided to staff and volunteers annually, if applicable.

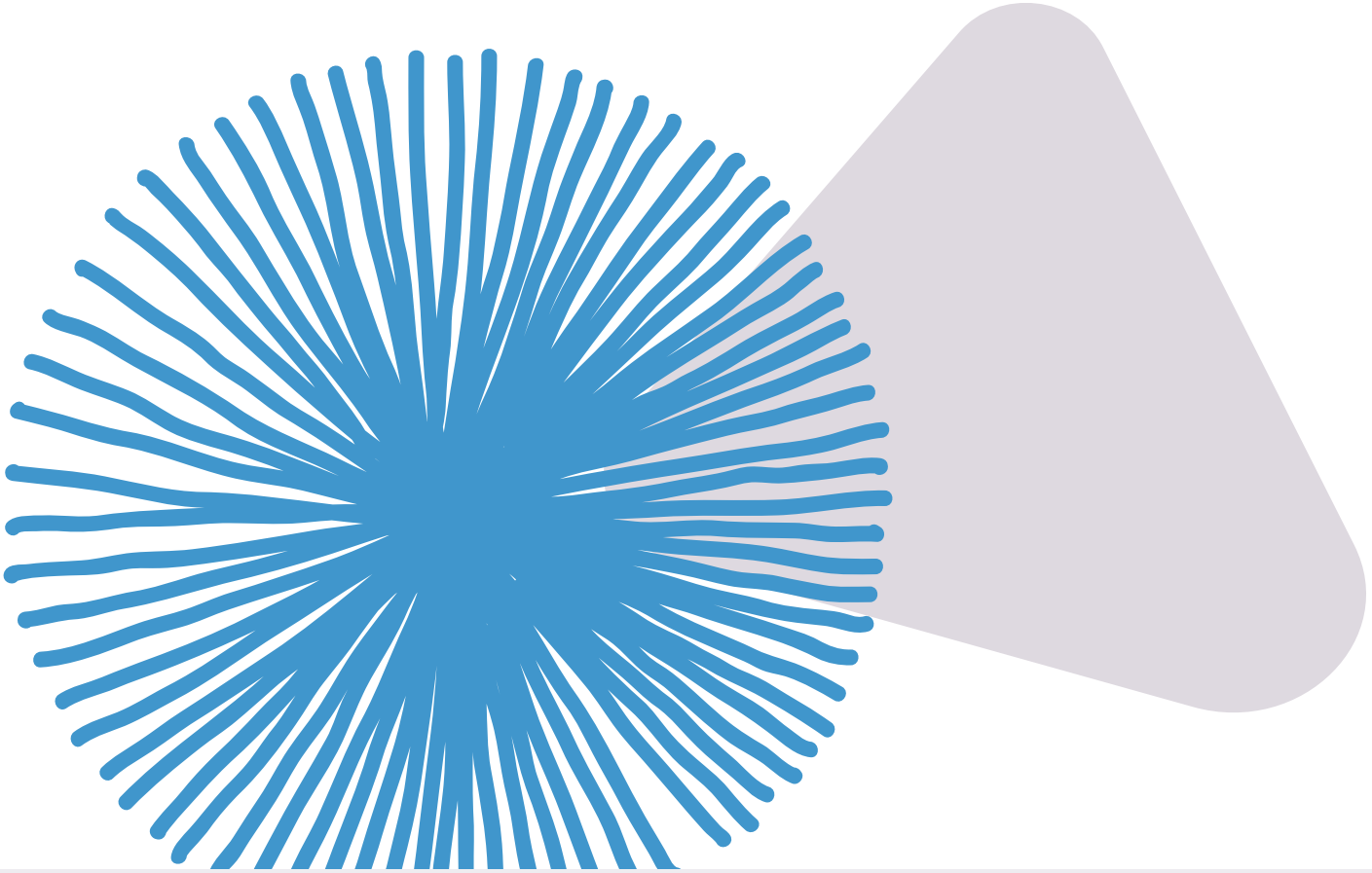
STATEMENT OF INTENT:

Given the nature of the work of CACs/MDTs, all those involved in the delivery of services to children and families must be trained and understand the requirements of mandated reporter laws and the procedures for reporting known or suspected instances of child abuse and neglect. Annual training is important to ensure that changes in the law and/or agency reporting procedures can be understood and observed.

Practical Approaches for Rural CACs to Meet This Standard:

1. The CAC will include mandated reporter training as part of its annual training schedule for CAC staff and volunteers. Included in the training will be any updates to state statutes and mandated reporter laws.
2. As part of CAC policy, mandated reporter training will be provided annually to CAC staff and center volunteers following any state statute updates addressing mandated reporter protocol.

3. The CAC develops an agreed-upon process for CAC staff, and MDT members have training on mandated reporting as part of their orientation and that there is an annual review and update. CACs may create a video training that is developed and required for all new staff and MDT members and can be used as a refresher for other staff and team members.



Medical Evaluation Standard Appendices

Appendix 1

Medical History for Child Sexual Abuse

COMMON COMPONENTS OF MEDICAL HISTORY FOR POSSIBLE SEXUAL ABUSE

(Needed to guide testing, treatment and make diagnosis)

Sources: Child, Parent/caregiver, Investigator/FI, social work/advocate, medical records. Coordination and collaboration should occur to avoid duplication in the child being asked to recount details of the abuse event.

History of Present Illness (HPI):

- History of the event:
  - What happened, when, where, who was involved
- History of the contact:
  - Body sites involved, actions involved, associated symptoms
- What has happened since the event?
  - Physical/emotional symptoms/ behavioral response
  - Safety threats, bullying, school performance
  - Family relationships
- What response has already occurred?
  - Prior medical exam and treatment
  - Interview by investigators or CAC staff
  - Counseling/mental health screening

Past Medical History (PMH):

- Significant Illnesses/Surgeries/Hospitalizations
- Development (including sexual development and menstrual history in girls)
- Behavioral, educational or mental health issues
- Prior abuse and sexual history including consensual partners
- Medications, allergies and vaccination history (esp. HPV and Hep B)

Family History (FH):

- Significant health problems in parents, siblings and close relatives.

Social History (SH):

- Home composition, violence in the home, substance abuse by patient or those in the home.
- Does the patient feel safe and supported by current caretakers?
- Prior child welfare involvement in the family.

Review of Body Systems (ROS): Ongoing or current problems/concerns (usually 10 systems)

- HEENT - Head, Eyes, Ears, Nose, Throat
- Respiratory-breathing
- Cardiac- heart
- Hematology- bruising or bleeding
- Endocrine - glands,weight gain/loss
- Neurology-headaches, seizures, balance
- Gastrointestinal-nausea, vomiting, constipation, diarrhea, rectal pain/ bleeding/DC
- Genitourinary-discharge, burning, dysuria, bleeding, pain, lesions
- Musculoskeletal-(muscles, bones and joints
- Skin- rashes, lesions, tattoos, bruises

Appendix 2

IMPORTANT DEFINITIONS

Didactic Training

Didactic training for CAC medical providers should cover examination positions (supine, lateral, knee chest), examination techniques (gathering of forensic evidence, samples for STI testing, labial traction, use of cotton swab with pubertal females to demonstrate edges of hymen, foley catheter, etc), and the review of multiple examples of:

A. anatomical variants

B. acquired or developmental conditions that mimic abuse

C. accidental trauma and sexual abuse trauma

D. STIs and forensic evidence

Competency Based Clinical Preceptorship

A preceptorship has a clinical training component that provides observation and training with an experienced examiner. The length of the preceptorship is determined by the time it takes the trainee to demonstrate competency in obtaining medical history, using appropriate exam techniques, obtaining diagnostic quality photodocumentation, and applying strategies for testing and prophylaxis for STIs and pregnancy.

TABLE 1: MEDICAL DISCIPLINES, NCA TRAINING REQUIREMENTS AND CREDENTIALING ENTITY

	Foundational Training Requirements	NCA Training Requirements	Licensing Entity
Physician (MD or DO)	Undergraduate Degree 4 years of Medical School 3 years of Residency 1-3 years of Fellowship (optional)	✓ 16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse	State Medical Board
Pediatrics, Family Medicine, or other physician,	Undergraduate Degree 4 years of Medical School 3 years of Residency		State Medical Board
Child Abuse Pediatrician	Undergraduate Degree 4 years of Medical School 3 years of Residency 3 years of Child Abuse Fellowship Board certification in Child Abuse Pediatrics	*No additional training requirements*	State Medical Board

	Foundational Training Requirements	NCA Training Requirements	Licensing Entity
Advance Practice Nurse (APRN), Nurse Practitioner (NP), Pediatric Nurse Practitioner (PNP)	Undergraduate Degree 2 years of Graduate School Certification Exam	✓ 16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse	State Nursing Board
Physician's Assistant (PA)	Undergraduate Degree 2 years of Graduate School Certification Exam		State Licensing Board
Sexual Assault Nurse Examiner (SANE)- Adult and Pediatric	Nursing Degree (RN or BSN) Licensure Exam Adult and/or pediatric and adolescent SANE training consistent with IAFN guidelines Competency Based Clinical Preceptorship Providers who have completed SANE training and preceptorship may also choose to apply for SANE-A and/or SANE-P certification by IAFN.	✓ 40 hours of formal didactic training in the medical evaluation of Child Sexual Abuse ✓ Competency Based Clinical Preceptorship	State Nursing Board Some states have state-specific forensic nursing requirements.

Appendix 3

Continuous Quality Improvement

IMPORTANT DEFINITIONS

Continuous Quality Improvement

is the process-based, data-driven approach to improving the quality of a product or service. It operates under the belief that there is always room for improving operations, processes, and activities to increase quality.

Advanced Medical Consultant

A Child Abuse Pediatrician, Physician or Advanced Practice Nurse who:

1. Has met the minimum training outlined for a CAC provider (see above)
2. Has performed at least 100 child sexual abuse examinations
3. Current in CQI requirements (continuing education and participation in expert review on their own cases)

Expert Review

Expert review of examination findings is a de-identified continuous quality improvement (CQI) activity and is NOT a consultation/ second opinion.

1. The CAC should nclude in their policies and procedures the documentation procedure for continuous quality improvement .
2. The CAC should track examinations determined to be abnormal, using either a patient log kept in a secured location or through the MDT case review process. The number of abnormal exams and percent of exams reviewed by an expert provider should be available if requested for site review purposes/practice audits.
3. The medical provider or organization who provides the expert review should maintain a de-identified log noting how many times they have provided examination review for a specific provider. Notation of whether consensus was reached is also recommended.
4. A MOU to delineate roles and expectations between the CAC/medical provider and the person serving as the expert reviewer outlining the roles and responsibilities should be considered.

EXPERT REVIEW

NCA Medical Standard for Accreditation states that "all medical professionals providing services to CAC clients must demonstrate that 100% of all findings deemed abnormal or "diagnostic" of trauma from sexual abuse have undergone expert review by an advanced medical consultant".

A. Advanced Medical Consultants as defined above should also have abnormal exams reviewed by another expert.

B. An abnormal exam is one that has acute or healed physical findings in the anogenital area indicating that abuse/assault has occurred. Laboratory testing for STIs or pregnancy and DNA evidence collection are NOT included in the definition of an abnormal exam.

SAMPLE EXPERT REVIEW LOG

Below is a sample table that can be created in an Excel document or preferred database to track the review of abnormal exams by an advanced medical consultant. It is recommended that every CAC Medical provider keep such a log on file for review by NCA Site Reviewers.

Date	Site/examiner	Pre/post puberty	Examiner findings/ concerns	Reviewer findings

SAMPLE LANGUAGE FOR MEMORANDUM OF UNDERSTANDING WITH ADVANCED MEDICAL CONSULTANT

MOU for Expert Review of Examinations with Abnormal Findings

It is understood that the examination review services represent a continuous quality improvement (CQI) activity and are not intended to serve as medical consultation or provision of direct patient care so results of CQI activity should not be documented in the patient's medical record. It is the responsibility of the medical provider of the CAC to document the findings of the examination in the patient's medical record, establish referral protocols with the CAC's medical director, communicate the findings with the appropriate MDT members and be available for case review and court testimony if needed. This MOU for examination review services does not act as or substitute for the role of the local medical director of the CAC.

A process for tracking information from the examination review process is needed for both CQI as well as for application for accreditation/re-accreditation with the National Children's Alliance.

The CAC and/or the medical provider will maintain a de-identified log of the number of cases in which the medical examination was deemed to represent an abnormal examination. An abnormal exam is defined as an exam in which acute or healed genital or anal injuries are identified as consistent with sexual abuse . Abnormal laboratory tests (sexually transmitted infections and pregnancy) and results of biologic evidence collections are not included in the definition of abnormal exams for the purpose of this examination review activity.

The medical provider of the CAC will maintain a log documenting the number of cases with abnormal findings submitted for expert review. Patient information on the log will either be de-identified or maintained in a secure, locked location to protect sensitive health information.

The medical provider serving as the expert reviewer will maintain a de-identified case log listing the date, examiner and whether the reviewer agreed with the examiner's conclusion of abnormal findings on the examination.

Logs should be maintained for a minimum of 5-years to coincide with the cycle for re-accreditation.

CAC Director	Date
CAC Medical Provider	Date
Expert Reviewer	Date

Appendix 4

Examination Referral and Timing

IMPORTANT DEFINITIONS

Suspected victim of sexual abuse

A suspected victim of sexual abuse may be identified by the following criteria:

1. Disclosure of abuse
2. Witness of abuse by an adult or child
3. Exposure to high-risk offender (i.e. adult in possession of child pornography, sibling/household contact of a child victim)

TABLE 2: TIMING OF MEDICAL EXAMINATIONS[1]

	Timing of Exam	Medical Indications
Indications for emergency evaluation	Exam scheduled without delay	• Medical, psychological or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking • Alleged assault that may have occurred within the previous 72 hours (or other state-mandated time interval) necessitating collection of trace evidence for later forensic analysis • Need for emergency contraception • Need for post-exposure prophylaxis (PEP) for STIs including Human Immunodeficiency Virus (HIV)
Indications for urgent evaluation	Exam scheduled as soon as possible with qualified provider	• Suspected or reported sexual contact occurring within the previous 2 weeks, without emergency medical, psychological or safety needs identified
Indications for non-urgent evaluation	Exam scheduled at convenience of family and provider but ideally within 1-2 weeks	• Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by MDT, or family concern for sexual abuse, but contact occurred more than 2 weeks prior without emergency medical, psychological or safety needs identified

1 Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt CJ, Shapiro RA, Moles RL, Starling SP, Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused, *Journal of Pediatric and Adolescent Gynecology* (2015), doi: 10.1016/j.jpag.2015.01.007.

	Timing of Exam	Medical Indications
Indications for follow-up evaluation	As determined by qualified provider	• Findings on the initial examination are unclear or questionable necessitating reevaluation • Documentation of healing/resolution of acute findings • Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations • Further testing or treatment for STIs

THE 5 P'S

Other indications for medical evaluation even if outside of the DNA collection window

1. Pain/bleeding with/after contact
2. Potential for STI's due to nature of contact
   A. Many STI's do not cause symptoms
3. Perpetrator exposed
   A. Sibling/household contacts of the alleged offender
4. Pornography (child) use by caregiver/household contact
5. Patient/parent concern
   A. Patients often have distorted thoughts of body due to perpetrator manipulation
   B. Initial partial disclosures are common

Appendix 5

Disclosure Log for Protected Health Information (PHI)

Maintain in patient's chart

Date	Type of PHI disclosed	Entity receiving PHI	Purpose of Disclosure (Investigation, billing, continuity of care…)	Person making disclosure



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