

NATIONAL CHILDREN'S ALLIANCE

Putting Standards into Practice

A Guide to Implementing the 2017 Standards
for Accredited Members

Revised 2016



NATIONAL
CHILDREN'S
ALLIANCE®

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A Guide to Implementing the 2017 Standards for Accredited Members

National Children's Alliance

in cooperation with the
Regional Children's Advocacy Centers

This project was supported by Grants No. 2014-CI-FX-K001 and No. 2015-CI-FX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Points of view or opinions in this document are those of the author and editors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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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 diversity 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 of 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 ten accreditation standards is 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 diversity 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.

CHILDREN’S ADVOCACY CENTERS

Definition

A Children’s Advocacy Center (CAC) is a child-focused, 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 community-based programs, CACs are designed to meet the unique needs of the communities they serve and, as such, no two CACs look or operate exactly alike. They are founded on a shared belief that child abuse is a multifaceted community problem and no single agency, individual, or discipline has the necessary knowledge, skills, or resources to serve the needs of all children and their families. 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, developmentally and culturally 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 case-management 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 and cross-cultural 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.

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 800 members in 2016.

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.

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 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 or choose to apply for another level of membership with NCA.

An Associate/Developing CAC must provide documentation of the following requirements:

- 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 remaining current with:

- Payment of annual dues;
- Submission of required statistics report to NCA.

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. An Affiliate member must provide documentation of the following:

- 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 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 child-focused 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.

Supporting Member/Partner

While NCA is a membership organization of Children's Advocacy Centers (CACs), it also recognizes working groups and MDTs that adhere to the general tenets of the CAC model but do not yet meet the more rigorous requirements of NCA's other categories of membership. NCA also recognizes its many community partners—including allied organizations, stakeholders, and individuals—that are empowering communities to respond collaboratively to child abuse and are committed to supporting and sustaining CACs. The Supporting Member/Partner category allows all of these entities and individuals to affiliate with NCA and receive valuable membership benefits.

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 <http://www.mrcac.org/edunet/>
- Annual SRCAC in-person Accreditation Bootcamp www.nationalcac.org/southern-regional-child-advocacy-center/about-srcac.html

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. Most RCAC services and activities are either free-of-charge or offered at low cost.

RCACs provide training and technical assistance on the overall development and operations of CACs within their respective regions. NCA strongly encourages CACs to consult with their respective RCAC prior to beginning the application process. Given their experience with CAC development and their participation as accreditation site reviewers, 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).

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 ten 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. Cultural Competency and Diversity
3. Forensic Interviews
4. Victim Support and Advocacy
5. Medical Evaluation
6. Mental Health
7. Case Review
8. Case Tracking
9. Organizational Capacity
10. Child-Focused Setting

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.



MULTIDISCIPLINARY TEAM

A multidisciplinary team for response to child abuse allegations includes representation from the following:

- Law Enforcement
- Child Protective Services
- Prosecution
- Medical
- Mental Health
- Victim Advocacy
- Children's Advocacy Center



1. MULTIDISCIPLINARY TEAM

Rationale

A functioning and effective multidisciplinary team (MDT) is the foundation of a Children's Advocacy Center (CAC). An MDT is a group of professionals from specific, distinct disciplines that collaborates from the point of report and throughout a child and family's involvement with the CAC. MDTs coordinate intervention so as to reduce potential trauma to children and families and improve services overall, while preserving and respecting the rights, mandates and obligations of each agency.

A CAC is not just a facility, but serves as an interagency coordinated response center. All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate, and professional response. Quality assurance and a review of the effectiveness of the collaborative efforts are also critical to the MDT response.

The core MDT is comprised of representatives from law enforcement, child protective services, prosecution, medical, mental health, and victim advocacy, together with CAC staff. Some CACs, including those in small, 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 all functions are performed by a member of the MDT.

MDTs may also be expanded to include other professionals 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 is needed and appropriate for an individual child, family, or community.

Generally, a coordinated, MDT approach facilitates efficient interagency communication and information sharing, ongoing involvement of key individuals, and support for children and families. Each agency gains the benefit of a broadened knowledge base from which decisions are made, thorough and shared information, and improved and timely evidence gathering. Involvement of the prosecutor from the beginning stages of the case may also contribute to a more successful criminal justice outcome. MDT interventions in a neutral, child-focused CAC setting are associated with less anxiety, fewer interviews, and more appropriate and timely referrals for needed services. An MDT response fosters needed education, support, and treatment for children and families that may enhance their willingness to participate in the criminal justice system as effective witnesses. In addition, parents and other caregivers are empowered to protect and support their child throughout the investigation and prosecution and beyond.

1. MULTIDISCIPLINARY TEAM (continued)

Benefits by MDT Function

Law Enforcement:

- Suspects may be more likely to cooperate when confronted with evidence generated by a coordinated MDT approach.
- Support and advocacy functions are attended to by other MDT functions, leaving law enforcement personnel more time to focus on other aspects of the investigation.
- Collaboration with CPS and other MDT members allows law enforcement to utilize MDT members' training and expertise in working on child protection issues, communicating with children and understanding family dynamics.

CPS Workers:

- Effective information sharing places CPS workers in a better position to monitor child safety and parental support, provide assistance to non-offending parents, and provide recommendations regarding placement and visitation.

Medical Providers:

- History obtained during the coordinated interview provides medical personnel important information in making medical decisions.
- In turn, medical providers are available for consultation on specialized medical evaluations and for interpretation of medical findings and reports.

Mental Health Providers:

- Mental health personnel provide the MDT with valuable information regarding the child's emotional state, treatment needs, and ability to participate in the criminal justice process.
- A mental health professional helps ensure that assessment, treatment, and related services are routinely offered and made available to children and families.

Victim Advocates:

- Victim advocates are available to provide needed crisis intervention, safety planning, referrals for additional services, ongoing support, information and case updates, and court advocacy in a timely fashion.
- Victim advocates allow the MDT to anticipate and respond to the specific needs of children and their families more effectively, lessen the stress of the court process, and increase access to resources needed by the child and family, including access to victims of crime funding.

Prosecutors:

- Prosecutors hold offenders accountable and ensure community safety.

CRITERIA - Essential Components

A. The CAC/MDT has a written interagency agreement signed by authorized representatives of all MDT components that clearly commits the signed parties to the CAC/MDT model for its multidisciplinary child abuse intervention response. The interagency agreement includes:

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 interagency cooperation and commitment to CAC/MDT policy ensuring continuity of practice. Written agreements may be in differing forms including memoranda of understanding (MOUs), and/or interagency agreements (I/As), and are signed by the leadership of participating agencies (e.g. police chiefs, prosecuting attorney, agency department heads, supervisors, etc.) or their designees. These documents should be developed with input from the MDT, reviewed annually, and re-executed upon change in practice, policy or current agency leadership.

Practical Approaches to Meet This Standard

1. The CAC's interagency agreement (IA) or memorandum of understanding (MOU) is a collaboratively created vision of multidisciplinary, interagency practice. This agreement states the mission and goals of a CAC and commits each agency to participate routinely as a member of the multidisciplinary team 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 that 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' 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 the written protocols and/or guidelines required in (B) below

1. MULTIDISCIPLINARY TEAM (continued)

- B. Written protocols and/or guidelines address the functions of the MDT, the roles and responsibilities of each discipline, and their interaction in the CAC. Protocols are developed with input from the MDT, reviewed minimally every 3 years, and updated as needed to reflect current practice.**

STATEMENT OF INTENT:

The involvement of the agency leaders and MDT members is critical to ensuring that the policies and procedures by which investigations are conducted and services provided are consistently followed.

Practical Approaches to Meet This Standard

1. The CAC's protocol defines the mission and goals of the Center, expectations of the MDT process and cross-disciplinary training, roles of each agency/discipline on the multidisciplinary team, and standard operating procedures regarding: intake, investigations, forensic interview guidelines, service planning and case coordination (including medical, mental health and victim advocacy referrals and process), information sharing and confidentiality, case review process, follow-up, 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 by all MDT members to ensure shared understanding and implementation of all identified protocols.

1. MULTIDISCIPLINARY TEAM (continued)

- C. All members of the MDT—including appropriate CAC staff, as defined by the needs of the case—are routinely involved in investigations and/or MDT interventions.**

STATEMENT OF INTENT:

The purpose of multidisciplinary involvement for all interventions is to assure that the unique needs of children are recognized and met. This allows for informed decision-making to occur at all stages of the case so that children and families benefit optimally from a coordinated response.

Multidisciplinary intervention begins at initial outcry or report and includes, but is not limited to, first response, pre- and post-interview debriefings, forensic interviews, consultations, advocacy, evaluation, treatment, case reviews, and prosecution.

Practical Approaches to Meet This Standard



1. The CAC routinely has all team members present for the forensic interview, as well as pre- and post-interview debriefings. Scheduling enables 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 advocacy present, as long as necessary input is sought from the other team members. Documentation of interviews is made available to other 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 advocacy representatives 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 follow-up with the family and referrals for services can be made shortly thereafter. A full MDT discussion generally occurs during case review or 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 a victim advocacy representative only. CAC staff informs all other team members of the outcome of the interview as well as identified next steps, and CAC staff and/or the victim advocate make necessary referrals. Relevant input is sought from particular team members per needs of individual cases. All members of the MDT participate in case review.

D. 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 caretakers to receive the services they need.

Practical Approaches to Meet This Standard

1. The CAC's formal interagency agreement delineates the importance of interagency information sharing and of an understanding of legal, ethical, and professional requirements. MDT partner agencies need to 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 will immediately share and receive pertinent case information in adherence to relevant state laws. Every effort will be made to gain informed consent from the legal guardian of child clients to enable the MDT to respond to the immediate and ongoing needs of the child and family. Said consent will be limited to a prescribed and agreed upon period of time.
2. The interagency agreement incorporates state law that dictates MDT information sharing and confidentiality practices. These issues are fully explained to each family so that the legal guardian can make an informed decision regarding consent on a signed release. Said release describes MDT investigation and interventions, limits to information sharing, confidentiality, and case review practices; and states a prescribed and agreed upon period of time.
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 personnel and clearly explains the importance of information sharing for the child, family, and team members. It states how information is shared, the limitations prescribed by law, and the need for consent to share legally protected information for a prescribed period of time.

1. MULTIDISCIPLINARY TEAM (continued)

E. 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 confidentiality, but they may differ across disciplines. States may also have laws such as the Health Information Portability and Accountability Act (HIPAA) that govern this practice. The CAC/MDT must create written confidentiality and information sharing policies that align to these standards and specifically apply to the MDT, staff, and volunteers.

Practical Approaches 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 consent is secured to enable effective information sharing.

1. MULTIDISCIPLINARY TEAM (continued)

- F. 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 allowing MDT members to regularly provide feedback regarding the operations of the CAC, operational/administrative matters (e.g., transportation for clients, use of the facility, equipment upgrades) and multidisciplinary team issues (e.g., communication, case decision making, documentation and record keeping, conflict resolution, 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 ideas and raise concerns.

Feedback and/or suggestions from MDT members may be obtained via the Outcome Measurement Survey tool (OMS), team satisfaction surveys, suggestion boxes, MDT meetings specifically scheduled for this purpose, and other methods.

Practical Approaches to Meet This Standard

(Note – these examples can be combined to form a comprehensive response)

1. 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.
2. The CAC has an anonymous feedback mechanism (e.g., a Suggestion Box placed in the observation room) for team members and staff and implements a process for addressing suggestions as a team.
3. Feedback on MDT practice and CAC operations is a regular agenda item for case review meetings, and opportunities and mechanisms are in place to provide one-on-one feedback depending upon the issue.
4. Interagency leadership meetings convene at regular intervals to discuss policy and practice issues among and between agencies.

1. MULTIDISCIPLINARY TEAM (continued)

G. The CAC/MDT annually provides or facilitates relevant training or other educational opportunities focused on issues relevant to investigation, prosecution, and service provision for children and their non-offending caregivers. The CAC demonstrates documented MDT member participation in 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. These should include topics that enhance the skills of MDT members, are cross-discipline in nature, and are MDT-focused.

Practical Approaches to Meet This Standard

1. Team members bring available outside trainings and conferences to the attention of CAC staff and the MDT 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 trainings. In-service training is planned based on the assessed needs of the MDT members and CAC staff.
3. For orientation and training of new MDT members, the CAC provides a manual that details information about the CAC/MDT philosophy, MDT protocol(s), and other relevant information about each discipline's role and responsibilities. New team member orientation also includes "shadowing" of MDT members when appropriate.
4. Additional case review meetings and/or MDT meetings may be scheduled and can 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 can provide a list of resources to new team members.
5. 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, cross-cultural and legal issues, and roles and responsibilities of all team members. CAC and partner agencies share costs to implement said training plan.
6. Each year, funding is allocated for the MDT to hold a team retreat and/or attend outside conferences as a group. Efforts are made to increase resiliency of the MDT.
7. Team members receive a monthly/quarterly newsletter that includes a variety of online training opportunities through the RCAC and CAC and in-person trainings offered by regional staff.



CULTURAL COMPETENCY AND DIVERSITY

The Children's Advocacy Center provides culturally competent services for all CAC clients throughout the duration of the case.



2. CULTURAL COMPETENCY AND DIVERSITY

Rationale

Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to appreciate, understand, and interact with members of diverse populations within the local community. Cultural competency is a fundamental component of the CAC philosophy and is as central to operations as developmentally appropriate, child-friendly practice. Like developmental considerations, cultural norms influence nearly every aspect of working with children and families, such as welcoming a child and family to the center, employing effective forensic interviewing techniques, assessing the likelihood of abuse, selecting appropriate mental health providers, and securing services that are relevant and accessible to a child and family. To effectively meet clients' needs, the CAC and MDT must be willing and able to understand the clients' worldviews, adapt practices as needed, and offer assistance in a manner in which it can

be utilized. Striving towards cultural competence is an important and ongoing endeavor and an integral part of a CAC's operations and service delivery.

Proactive, culturally competent planning and outreach should focus on culture and degree of acculturation, ethnicity, religion, socioeconomic status, disability, gender, gender identity and expression, and sexual orientation. These factors contribute to a client's experiences and perspectives, and must be considered and accommodated throughout the investigation, intervention, and case management processes. Addressing these factors in a culturally sensitive environment helps children and families of all backgrounds feel welcomed, valued, and respected by staff, MDT members and volunteers.

2. CULTURAL COMPETENCY AND DIVERSITY (continued)

CRITERIA - Essential Components

A. The CAC conducts a community assessment at a minimum of every 3 years, which includes:

1. Community demographics
2. CAC client demographics
3. Analysis of disparities between these populations
4. Methods the CAC utilizes to identify and address gaps in services
5. Strategies for outreach to un- or underserved communities
6. A method to monitor the effectiveness of outreach and intervention strategies.

STATEMENT OF INTENT:

In order to serve a community in a culturally competent manner, a CAC must complete a comprehensive assessment of the entire community and jurisdiction that they serve. The assessment should focus on a range of issues including, but not limited to, race, ethnicity, gender, gender identity and expression, sexual orientation, disabilities, income, geography, religion and culture. The assessment should inform the development of goals and strategies that ensure that the CAC delivers high quality, relevant, and accessible services to all children and families in need.

Practical Approaches to Meet This Standard



1. The CAC has a method for conducting a community assessment that includes gathering demographic information from sources including the U.S. Census as well as CAC client demographic information from its tracking system. The CAC uses this baseline information to further assess disparities highlighted by this data and assesses gaps in services in coordination with MDT members. CAC staff and MDT partner agency representatives discuss strategies for conducting outreach to underserved populations in their jurisdiction and methods for monitoring progress. This assessment process is included in the CAC's protocol and reassessment is expected every three years.
2. The CAC incorporates a community assessment as a component of its strategic plan. Each year, the assessment is updated and strategies are created to provide outreach and services to under- and unserved populations in the community. This plan includes delineation of tasks, persons responsible, and timeframes. The CAC staff and MDT members monitor progress with the assistance of the Board (where appropriate).
3. The CAC creates an interdisciplinary subcommittee with diverse representation reflective of agency and community composition to develop a proposed plan eligible for review and finalization by CAC staff, MDT members, and the Board (where appropriate). The plan is reviewed at least every three years and implementation of the plan is monitored.

2. CULTURAL COMPETENCY AND DIVERSITY (continued)

- B. The CAC must ensure that provisions are made for non-English speaking and deaf or hard of hearing children and their family members throughout the investigation, intervention, and case management processes.**

STATEMENT OF INTENT:

The ability to effectively communicate is critical in creating an environment in which children and families feel comfortable and safe, and are respected and supported. Language barriers can significantly impact the CAC and/or MDT's abilities to communicate expectations and obtain accurate information from the child and family. Similarly, language barriers hamper the ability for children and families to understand their roles and communicate their concerns and decisions regarding the investigation and intervention services. Language barriers may compound children and families' feelings of fear, anxiety, and confusion. The CAC must explore a variety of resources or solutions to ensure adequate provisions are made to overcome language and communication barriers. In order to protect the integrity of the investigation and services, care should be taken to ensure that appropriate translators are utilized. CACs should not utilize children or client family members to translate for MDT members.

Practical Approaches to Meet This Standard



1. The CAC compiles a list of available interpreter services and contracts with them to provide services as needed for CAC clients and MDT members throughout the investigation, intervention, and case management processes. The CAC's written protocol/guidelines address how needs are assessed, how interpretive services are accessed, the manner in which the CAC engages in the process, mutual expectations, and required cross-training.
2. The CAC has staff and/or MDT members with training and expertise in providing interpreter services for children and their family members throughout the investigation, intervention, and case management processes. The CAC's written protocols/guidelines delineate roles and responsibilities of said staff, including professional boundaries and appropriateness of serving in the role of interpreter for different types of communications (i.e., case updates vs. official court interpretation). Written protocols/guidelines also prohibit children and family members from serving as translators. Where gaps in training and expertise exist among CAC staff and/or MDT members, the CAC contracts with other resources to provide needed interpretation services.

2. CULTURAL COMPETENCY AND DIVERSITY (continued)

C. CAC services are accessible and tailored to meet the individualized and unique needs of children and families regarding culture, development, and special needs throughout the investigation, intervention, and case management processes.

STATEMENT OF INTENT:

It is the responsibility of the CAC and MDT members to understand and tailor services to the diverse backgrounds and unique needs of the children and families being served. From the moment of first contact with the child and family, the MDT should identify any issues that may affect service delivery.

Ascertaining the a client's background allows CAC/MDT members to better understand child and family perceptions of the abuse and attributions of responsibility; understand the family's degree of acculturation and comprehension of laws; address any religious or cultural beliefs which may affect disclosure and follow-up with services, and recognize the impact of prior experience with police and government authorities both in this country and in their countries of origin.

Furthermore, the CAC must be accessible to children with physical disabilities. Investigation and case management services must be responsive to children with cognitive delays and medical and mental health disorders.

With knowledge, preparation, and necessary skills, the MDT can obtain as complete and accurate information as possible and more effectively interpret and respond to the child and family's needs.

Practical Approaches to Meet This Standard

1. The CAC intake process gathers information from referral sources and clients to ascertain cultural, linguistic, and physical accessibility needs throughout the investigation, intervention, and case management processes. Services are implemented in ways that address the identified needs.
2. The CAC facility is accessible to children and family members with physical disabilities. If physical barriers at the CAC cannot be overcome, there is a pre-determined plan that accommodates the physical needs of all clients by providing all CAC services at an alternate and accessible location.



2. CULTURAL COMPETENCY AND DIVERSITY (continued)

D. The CAC demonstrates ongoing efforts to recruit, hire, and retain staff, volunteers, and board members that reflect the demographics of the community.

STATEMENT OF INTENT:

Actively seeking to recruit, hire, and retain staff, volunteers, and board members that reflect the demographics of the community and the clientele served is critical to achieving an overall response to children and families that is inclusive, relevant and effective.

Practical Approaches to Meet This Standard



1. The CAC has current staff, volunteers, and board members that reflect the demographic composition of the community. The CAC has formal relationships with allied community agencies, organizations, and institutions that assist in recruitment efforts for staff, volunteers, and board members. Postings and relevant informational materials for said positions are created in a variety of languages with the assistance of community partners.
2. The CAC staff, volunteers, and board members do not currently reflect the demographics of the community, but the CAC has identified and implemented strategies for building alliances with community agencies, organizations, and institutions to assist in recruitment efforts.



FORENSIC INTERVIEWS

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.



3. FORENSIC INTERVIEWS

Rationale

The purpose of a CAC forensic interview is to obtain information from a child about abuse allegations that will support accurate and fair decision making by the MDT within the criminal justice, child protection, and service delivery systems. Forensic interviews are conducted in a manner that is developmentally and culturally sensitive, unbiased, fact-finding, and legally sound. When a child is unable or unwilling to provide information regarding any concern about abuse, other interventions to assess the child's experience and safety are required.

The CAC/MDT must adhere to research-based forensic interview guidelines that create an interview environment that enhances free recall, minimizes interviewer influence, and gathers information needed by all the MDT members in order to avoid duplication of the interview process.

CAC/MDT protocols and practices need to be congruent. The CAC/MDT must monitor these guidelines over time to ensure that they reflect current practice.

Forensic interviews are the foundation for multiple CAC/MDT functions including child abuse investigation, prosecution, child protection, and implementation of appropriate services, and may also be the beginning of the road toward healing for many children and families. The manner in which a child is treated during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to, the intervention process and/or criminal justice system.

Quality interviewing involves an appropriate, neutral setting, effective communication among MDT members, and employment of legally sound interviewing techniques.

CACs vary with regard to who conducts the forensic interview, but the role must be fulfilled by a selected, supervised, and appropriately trained professional. This includes a CAC-employed forensic interviewer, law enforcement officers, CPS workers, federal law enforcement officers, or other MDT members according to the resources available in the community. At a minimum, any professional in the role of a forensic interviewer must have initial and on-going formal forensic interviewer training that is approved by National Children's Alliance (NCA) for purposes of accreditation. State laws may dictate which professionals can or should conduct forensic interviews.

The CAC/MDT's written documents must include the general interview protocol, selection of an appropriately trained interviewer, specifications for sharing of information among MDT members, and a mechanism for collaborative case planning. Additionally, for CACs that conduct Extended Forensic Evaluations, a separate, well-defined protocol must be also be articulated.

3. FORENSIC INTERVIEWS (continued)

CRITERIA - Essential Components

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

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. Content that includes: child development, question design, implementation of protocol, dynamics of abuse, disclosure process, cultural competency, suggestibility
5. Practice component with a standardized review 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.

STATEMENT OF INTENT:

A system must be in place to provide initial forensic interview training for anyone conducting a forensic interview at the CAC. Many CACs use a combination of MDT members and CAC staff to conduct forensic interviews. While many of the members of the MDT may have received general interview training, forensic interviewing of alleged victims of child abuse in the context of an MDT response is considered specialized and thus requires additional training prior to conducting forensic interviews.

Practical Approaches 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. FORENSIC INTERVIEWS (continued)

- B. Individuals with forensic interviewing responsibilities must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 8 contact hours every 2 years.**

STATEMENT OF INTENT:

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who conduct forensic interviews to receive specialized training. It is vitally important that forensic interviewers remain current on developments in the fields relevant to their delivery of services to children and families and continue to develop their expertise.

Practical Approaches 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 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 MRCAC 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 CALiO and demonstrate attendance and completion through certificates or other documentation of training requirements, totaling eight hours of continuing education every two years.

3. FORENSIC INTERVIEWS (continued)

C. CAC/MDT protocol 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
4. Preparation, information sharing and communication between the MDT and the forensic interviewer
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 model(s))
9. Introduction of evidence in the forensic interviewing process
10. Sharing of information among MDT members
11. A mechanism for collaborative case coordination
12. Determining criteria and process by which a child has a multi-session or subsequent interview

STATEMENT OF INTENT:

The general forensic interview process must be described in the agency's written guidelines or agreements. These guidelines help to ensure consistency and quality in interviews as well as in subsequent MDT discussions and decision-making.

Practical Approaches to Meet This Standard



1. The CAC has all 12 required elements of the forensic interview process detailed within their written protocols/guidelines that reflect consensus and approval of MDT partner agencies.
2. The CAC has created a separate forensic interview protocol/guidelines document that includes all 12 required elements and reflects consensus and approval of MDT partner agencies. This document is included as an addendum to the overall agreed upon and approved CAC protocol.

3. FORENSIC INTERVIEWS (continued)

- D. MDT members with investigative responsibilities on a case must observe the forensic interview(s) 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 for the forensic interview. This practice provides MDT members access to the information necessary to fulfill their respective professional roles. MDT members present include local, state, federal or tribal child protective services, law enforcement, and prosecution; others may vary based on the circumstances of each case.

Practical Approaches 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 team members with investigative roles and CAC personnel observe the forensic interview, with others observing routinely or when available and requested, in accordance with CAC agreed upon protocols. If the victim advocate meets with the parent/guardian while the interview is taking place, they participate in the pre- and post-interview meetings and facilitate 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 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 "live" and allows for communication with team members during the process.
3. Whether utilizing Example 1 or 2, if other individuals are invited to attend (GALs, school personnel, child care licensing, etc.) and/or participate in the pre- and post-interview information sharing meetings, the CAC delineates and implements necessary confidentiality procedures.

3. FORENSIC INTERVIEWS (continued)

- E. For cases meeting the CAC case acceptance criteria as outlined in the MDT protocol, forensic interviews are conducted at the CAC, at 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.

On rare occasions when interviews take place outside the CAC as determined and approved by the MDT, the agreed-upon forensic interview guidelines must be 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.

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 the various types of abuse which children are victims of and/or witness, other forms of violence/trauma, jurisdictional issues, or the ages of children.

Practical Approaches 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. FORENSIC INTERVIEWS (continued)

F. Individuals who conduct forensic interviews at the CAC must participate in a structured peer review process for forensic interviewers a minimum of 2 times per year, as a matter of quality assurance. Peer review serves to reinforce the methodologies utilized as well as provide support and problem-solving for shared challenges. Peer review includes participants and facilitators who are trained to conduct child forensic interviews. Structured peer review includes:

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

STATEMENT OF INTENT:

Participation in peer review is vital in assuring that forensic interviewers further develop and strengthen their skills based on new research and developments in the field that impact the quality of their interviews. Peer review is a complement, not a substitute, for supervision, case review, and case planning.

Practical Approaches to Meet This Standard



1. Forensic interviewers attend statewide or regional peer reviews at least twice a year and retain 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 retain 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 review 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.
4. Forensic interviewers participate in online peer review through Regional CAC and retain copies of attendance sheets and agendas detailing inclusion of all four required elements of the structured peer review process.

3. FORENSIC INTERVIEWS (continued)

G. 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 duplication of information gathering from the child and family members and ensure information sharing among MDT functions.

Practical Approaches 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 and family during the medical exam.



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.



4. 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 a core component of MDT response, as encouraged by coordinated victim advocacy services. Up-to-date information and ongoing access to comprehensive services are critical to a child and family's comfort and ability to participate in an ongoing investigation, possible prosecution, intervention and treatment.

Victim support and advocacy responsibilities are implemented consistent with victims' rights legislation in the CAC's state and the complement of services in the CAC's coverage area. Many members of the MDT may serve as advocates for a child within their discipline systems or agencies. However, victim-centered advocacy is a discipline unto itself with a distinct role on the MDT that coordinates and provides services to ensure a consistent and comprehensive network of support for the 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. Specific victim support services may be provided in a variety of ways, as dictated by the needs of the case or CAC, such as:

- Employing staff members to perform advocacy functions

E.g., family advocates, care coordinators, victim advocates, and child life specialists.
- Linking with local community-based advocates

E.g., domestic violence advocates, rape crisis counselors, and Court Appointed Special Advocates.
- Linking with system-based advocates

E.g., law enforcement victim advocates, prosecutor-based victim witness coordinators.
- Combining victim support services.

All advocates providing services to CAC clients must meet the prescribed training and supervision requirements.

CRITERIA - Essential Components

A. Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training in victim advocacy. The CAC must demonstrate that all Victim Advocates who provide services to CAC clients have successfully completed a minimum of 24 hours of instruction including, but not limited to:

1. Dynamics of 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. Assistance in accessing/obtaining victims' rights as outlined by law
8. Court education, support and accompaniment
9. Assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, interpreters, among others as determined for individual clients.

STATEMENT OF INTENT:

Victim support and advocacy is fundamental to the MDT response. The support/advocacy responsibilities may be filled by a designated victim advocate who is an employee of the CAC or another victim-serving agency. Or, another MDT member with appropriate experience and training may also serve as a victim advocate as long as the role does not conflict with the other MDT functions s/he may have.

If more than one victim advocate is providing services to the same family, case management meetings are required in order to discuss individual and shared case responsibilities, needed services, follow-up, and ongoing assessment and intervention.

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.

Practical Approaches 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 that provide services for CAC clients.
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.
3. All victim advocates providing advocacy services to CAC clients throughout the life of the case can demonstrate completion of the necessary training requirements.

4. VICTIM SUPPORT AND ADVOCACY (continued)

- B. Individuals who provide victim advocacy services for children and families at the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of 8 contact hours every 2 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. It is vitally important that victim advocates remain current on developments in the fields relevant to their delivery of services to children and families and to continue to develop their expertise.

Practical Approaches 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 every two years of continuing education through one or more of the following, including relevant documentation of attendance and completion:
 - 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)

4. VICTIM SUPPORT AND ADVOCACY (continued)

C. Victim Advocates serving CAC clients must provide the following constellation of services:

1. Crisis assessment and intervention, risk assessment, and safety planning and support for children and family members at all stages of involvement with CAC
2. Assessment of individual needs and cultural considerations for the child and family to ensure those needs are addressed
3. Presence at CAC during the forensic interview in order to participate in information sharing; inform and support family about the coordinated, multidisciplinary response; and assess needs of child and non-offending caregiver
4. Provision of education and access to victims' rights and crime victims' compensation
5. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance etc.)
6. Provision of referrals for specialized, trauma focused, evidence-supported mental health and medical treatment, if not provided at the CAC
7. Access to transportation to interviews, court, treatment and other case-related meetings
8. Engagement in child and family response regarding participation in the investigation and/or prosecution
9. Participation in case review in order to discuss the unique needs of the child and family and plan associated support services, ensure the seamless coordination of services, and ensure the child and family's concerns are heard and addressed
10. Provision of updates to the family on case status, continuances, dispositions, sentencing, and inmate status notification (including offender release from custody)
11. Provision of court education and courthouse/courtroom tours, support, and accompaniment
12. Coordinated case management meetings with all individuals providing victim advocacy services.

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 assessment and intervention, advocacy, and support services help to identify the child and family's unique needs, reduce fear and anxiety, and expedite access to appropriate services. Families can be assisted through the various phases of crisis management with 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.

4. VICTIM SUPPORT AND ADVOCACY (continued)

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 may also be entitled to services. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained as necessary and made available to all children and their caregivers.

Practical Approaches to Meet This Standard



1. The CAC details the role and responsibilities of victim advocates—including all 12 required services—in its victim advocate job descriptions and qualifications, as well as 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.
2. The CAC victim advocate(s) compiles and provides a folder of information to the non-offending caregiver during their first visit to the CAC. This folder includes information for children and families that includes the advocate's role and responsibilities; a CAC brochure; explanation of the forensic interview, medical exam, mental health services, victim compensation; names and contact information of MDT members and referrals for follow-up services.
3. In addition to Example 1 above, the victim advocate(s) utilizes the child advocate checklist for quality assurance that all required services have been offered and/or delivered.
4. The CAC has linkage and/or interagency agreements with victim advocacy providers outside the CAC to provide some or all of the required constellation of advocacy services for CAC clients. Examples may include, but are not limited to D.A. based victim witness advocates, community advocacy agencies, L.E. or court advocates.

4. VICTIM SUPPORT AND ADVOCACY (continued)

D. Active outreach and follow-up support services for caregivers are consistently available.

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

Practical Approaches 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.

4. VICTIM SUPPORT AND ADVOCACY (continued)

- E. The CAC/MDT's written protocols and guidelines include availability of victim support and advocacy services for all CAC clients throughout the life of the case and participation of the victim advocate(s) in MDT case review.**

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 to Meet This Standard



1. The CAC protocol/guidelines include detailed information describing the role of the victim advocate and other participating victim service agencies at all stages of the case, as well as the process for coordinating advocacy services. 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.



MEDICAL EVALUATION

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



5. MEDICAL EVALUATION

Rationale

All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a provider with specialized training. The collection and documentation of possible forensically significant findings are vital. However, the referral of children for medical examinations should NOT be limited to those for which forensically significant information is anticipated. Medical evaluations should be prioritized as emergent, urgent and non-urgent based on specific screening criteria. Criteria must be developed by specially trained and skilled medical providers or by local multidisciplinary teams that include qualified medical representation. Some children also benefit from follow-up examinations to re-assess findings and conduct further testing.

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 non-medical member of the MDT is obtaining the in-depth forensic interview, further medical history will still likely be needed from the caregiver and/or child to complete the medical evaluation. Information gathering must be coordinated to avoid duplication (see *Med-Appendix 1 for an example of Components of Medical History for Child Sexual Abuse Evaluation*).

CRITERIA - Essential Components

A. Medical evaluations are conducted by health care providers with specific training in child sexual abuse that meets at least ONE of the following training standards:

Training and Eligibility Standards for a Medical Provider:

1. Child Abuse Pediatrics Sub-board eligibility or certification
2. Physicians without board certification or board 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).

5. MEDICAL EVALUATION (continued)

3. 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. This means a 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).

Physicians, advanced practice nurses, physician assistants and sexual assault nurse examiners (SANEs) without advanced practice training may all engage in medical evaluation of child abuse as a medical provider. 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 medical provider of a CAC (regardless of whether the exams are occurring on or off-site).

Regardless of provider type, 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 “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 access to qualified medical providers as full or part-time staff while others provide this service through affiliation and linkage agreements with local providers or other regional facilities. Whether the exams occur on-site or off-site 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 medical component of the CAC:

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

5. MEDICAL EVALUATION

of Pediatrics Committee on Child Abuse and Neglect, 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 MDT. The medical provider must provide documentation of participation in Continuous Quality Improvement 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 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

5. MEDICAL EVALUATION (continued)

B. Medical professionals providing services to CAC Clients must demonstrate continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 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 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

5. MEDICAL EVALUATION (continued)

- C. Medical professionals providing services to CAC clients must demonstrate, at a minimum, that 50% of all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone expert review by an “advanced medical consultant.”**

STATEMENT OF INTENT:

While it is recommended that ALL examinations with findings that the medical provider deems abnormal or “diagnostic” of trauma from sexual abuse be submitted for expert review, the medical provider must be able to provide documentation of participation in expert review with an “advanced medical consultant” on at least 50 % of abnormal exams for the purpose of CAC case tracking information that could be requested for review in the accreditation process.

The following providers qualify as “advanced medical consultants” that could offer expert review of examination findings:

- **Child abuse pediatrician (preferred)**
 - Review with a child abuse pediatrician can occur via 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.”
- **Physician or advanced practice nurse with the following qualifications:**
 - Meets the minimum training standards outlined for a CAC medical provider
 - Performed at least 100 child sexual abuse examinations
 - Is 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).

Practical Approaches to Meet This Standard



1. All CAC medical providers receive in-house expert review from an advanced medical consultant for at least 50% of abnormal exams. This requirement and review process are 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 at least 50% of abnormal exams have been submitted and reviewed.
3. All CAC medical providers subscribe to “MyCaseReview” through the Midwest Regional CAC and provide documentation that at least 50% of abnormal exams have been submitted and reviewed.
www.mrcac.org/medical-academy/mycasereview/
4. When CAC clients receiving medical exams conducted by a SANE and resulting 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.

5. MEDICAL EVALUATION (continued)

D. Specialized medical evaluations for the child client are available on-site or with other appropriate agencies or providers through written linkage agreements.

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 the linkages to a facility with a qualified medical provider and other needed healthcare services.

Practical Approaches to Meet This Standard

1. Medical evaluations are conducted on site at the CAC by a Board certified child abuse pediatrician.* or other 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.”

5. MEDICAL EVALUATION (continued)

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 exam, or apply for reimbursement through Victim Compensation. In either scenario, ability to pay should never be a factor in determining who is offered a medical evaluation.

Practical Approaches to Meet This Standard



1. CAC submits medical costs to client insurance for reimbursement. If client is underinsured, arrangements are made for 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.
3. CAC obtains unrestricted grant funds to cover cost of medical evaluation.
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 cost of medical evaluations for CAC clients.

5. MEDICAL EVALUATION (continued)

F. The CAC/MDT's 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 would occur. CACs that provide medical evaluations for sexual abuse, but not specifically for physical abuse or neglect, need written procedures for how a medical evaluation will be obtained when there are allegations of physical abuse or neglect. These procedures should include how to obtain treatment for injuries and how to manage emergency or life-threatening conditions that may become evident during a sexual assault exam.

Practical Approaches 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. In addition to Example 1 above, written protocols may also include other information relative to providers' requirements for training, review of findings, and payment.

G. The CAC/MDT's written protocols and guidelines include the circumstances under which a medical evaluation for child sexual abuse is recommended.

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:

- Help ensure the health, safety, and well-being of the child
- Evaluate, document, diagnose, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family
- Refer for therapy to address trauma related to the abuse/assault, if not provided by another member of the MDT/CAC.

CACs differ in their practices of how the medical evaluation is made available. The MDT's written protocol or agreement must include qualified medical input to define the referral process and how, when, and where the exam is made available. Examinations can be differentiated between those needed emergently (without delay), urgently (scheduled as soon as possible with qualified provider), or non-urgently (scheduled at 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 examiners at the appropriate location and time, and that exams 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 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 follow-up with relevant medical colleagues and MDT. This agreement or MOU is included in the general CAC protocols/guidelines.

H. Documentation of medical findings by written record and photo- documentation.

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, 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 examiners. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

Practical Approaches 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.

5. MEDICAL EVALUATION (continued)

- 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 clients and/or caregivers regarding the medical evaluation.**

STATEMENT OF INTENT:

The medical evaluation for suspected sexual abuse often raises significant anxiety in children and their families, usually due to misconceptions about how the exam is conducted and what findings, or lack of findings, mean. When an appropriately trained provider performs the examination, it is usually well-tolerated. In many CAC settings, the client is introduced to the exam by non-medical personnel. Therefore, it is essential for non-medical MDT members and CAC staff to undergo training regarding the nature and purpose of a medical evaluation so that they can competently respond to common questions, concerns, and misconceptions.

Practical Approaches to Meet This Standard



1. Medical Providers provide workshops or in-service 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.

5. MEDICAL EVALUATION (continued)

J. Findings of the medical evaluation 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 so that concerns can be discussed and case decisions can be made effectively. The duty to report findings of suspected child abuse to the mandated agencies is an exception outlined by the HIPAA privacy requirements, which allow for ongoing communication between functions of the MDT.

Practical Approaches to Meet This Standard



1. The CAC has a formal process for MDT members with investigative responsibility to receive verbal and written findings of the medical evaluation within a timely manner as agreed upon in the CAC protocols.



MENTAL HEALTH

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



6. MENTAL HEALTH

Rationale

A CAC's mission is to protect the child, provide justice, and promote healing. The common focus of the MDT is to foster healing by minimizing potential trauma to children, and intervention begins at first contact with the child and family. Without effective therapeutic intervention, many traumatized children will suffer ongoing or long-term adverse social, emotional, developmental and health outcomes that may impact them throughout their lifetimes. Evidenced-based treatments and other practices with strong empirical support reduce the impact of trauma and the risk of future abuse. For these reasons, an MDT response must include a trauma history, screening and assessment of trauma and abuse-related symptoms, and evidence-based, trauma-focused mental health services for child victims and caregivers.

Evidence shows that family members are often the key to the child's recovery and ongoing protection, and that mental health is often an important factor in a caregiver's capacity to support the child. Therefore, family members

may benefit from counseling and support that aids in addressing the emotional impact of abuse allegations and issues which the allegations may trigger, as well as in reducing or eliminating the risk of future abuse. Mental health treatment for caregivers—many of whom have victimization histories themselves or are current victims of intimate partner violence—may provide information, support, and coping strategies for themselves and their child about sexual abuse, dealing with issues of self-blame and grief, family dynamics, parenting education and the impact of abuse and trauma histories. Siblings and other children may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic setting.

Evidence also demonstrates the importance of collaboration of community professionals to improve outcomes for children and families. The CAC case review process provides a vehicle for these collaborative discussions.

CRITERIA - Essential Components

A. Mental health services are provided by professionals with training in, and who deliver, trauma-focused, evidence-supported, mental health treatment. All mental health providers for CAC clients, whether providing services on-site or by referral and linkage agreement with outside individuals and agencies, must meet the following training requirements:

1. The CAC must demonstrate that its mental health provider(s) has completed 40 contact hour CEUs in accordance with the provider's mental health related license requirements, CEUs from specific evidence-based treatment for trauma training, and clinical supervision hours by a licensed clinical supervisor.

6. MENTAL HEALTH (continued)

2. In addition, the CAC must further demonstrate that its mental health provider(s) meets at least ONE of the following academic training standards:
 - Master's degree, licensed, certified, or supervised by a licensed mental health professional
 - Master's degree or license-eligible in a related mental health field
 - 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 previously indicated 40 hour training requirements.)

Practical Approaches 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, 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 that employs 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, an additional eight hours of continuing education every two years, and submit documentation of completion to the CAC.
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, an additional eight hours of continuing education every two years, and submit documentation of completion to the CAC.
4. CAC utilizes a masters 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.

6. MENTAL HEALTH (continued)

- B. Clinicians providing mental health treatments to CAC clients must demonstrate completion of continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 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 impact their delivery of services to clients.

Practical Approaches 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.
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.

6. MENTAL HEALTH (continued)

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

1. Trauma-specific assessment including traumatic events and abuse-related trauma symptoms
2. Use of standardized assessment measures initially to inform treatment, and periodically to assess progress and outcome
3. Individualized treatment plan based on assessments that are periodically re-assessed
4. Individualized, evidence-supported treatment appropriate for the child client and other family members
5. Child and caregiver engagement in treatment
6. Referral to other community services as needed.

STATEMENT OF INTENT:

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

Practical Approaches 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(ies) whose staff has 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.

6. MENTAL HEALTH (continued)

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

STATEMENT OF INTENT:

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

Practical Approaches 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(ies) 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.

6. MENTAL HEALTH (continued)

- E. The CAC/MDT's Interagency Agreement/MOU or written protocols and guidelines include access to appropriate trauma-informed 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 accessed by CAC child clients.

Practical Approaches to Meet This Standard



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

6. MENTAL HEALTH (continued)

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

1. Attendance and participation in MDT case review
2. Sharing relevant information with the MDT while protecting the clients' rights to confidentiality
3. Serving as a clinical consultant to the MDT on issues relevant to child trauma and evidence-based treatment
4. Supporting the MDT in the monitoring of treatment progress and outcomes.

STATEMENT OF INTENT:

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

Practical Approaches 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, as well 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 on-loan to the MDT) to offer consultation to the team regarding the effects of trauma generally on children and non-offending caregivers, as well as their needs and interactions with other agencies and systems.

6. MENTAL HEALTH (continued)

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 or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Each CAC should 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 local laws and professional practice standards.

Practical Approaches 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.

6. MENTAL HEALTH (continued)

H. The CAC must provide supportive services for caregivers to address:

1. Safety of the child
2. Emotional impact of abuse allegations
3. Risk of future abuse
4. Issues or distress that allegations may trigger.

Services are made available on-site or through linkage agreements with other appropriate agencies or providers.

STATEMENT OF INTENT:

Evidence clearly demonstrates that caregiver support is essential to sibling support, the recovery of child victims, and overall family functioning and well-being. CACs have long provided such supportive services for caregivers and siblings through support groups and mental health services, including 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 children 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.

Practical Approaches 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(ies) that provides assessment and treatment for adult 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.

6. MENTAL HEALTH (continued)

I. Clinicians providing mental health treatments to CAC clients must participate in ongoing clinical supervision/consultation.

STATEMENT OF INTENT:

Clinical supervision/consultation for mental health clinicians provides ongoing support and training necessary to ensure appropriate and quality services to the clients they serve. Moreover, this clinical supervision is required for licensure in many states and may include individual and/or group supervision. Options for meeting this standard include:

- Supervision by a senior clinician on-staff at the CAC
- Negotiation with a senior clinician in the community who serves children and families and accepts referrals from the CAC (in cases when a CAC does not have more than one clinician)
- Participation in a supervision call with mental health providers from other CACs within the state, either individually or as a group
- 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 (TFCBT) master trainers for on-going clinical consultation. While there are many options for implementing appropriate clinical supervision/consultation, it is important to remember that having supervision for one evidence-based treatment does not necessarily encompass all the clinical interventions needed within a CAC. Therefore, comprehensive interventions will need to be addressed throughout ongoing clinical supervision.

Practical Approaches to Meet This Standard



1. CAC mental health staff participates 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, 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.



CASE REVIEW

A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status, and services needed by the child and family must occur on a routine basis.

7. CASE REVIEW (continued)

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. 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 and
- Informed, collective decisions are made.

The process encourages mutual accountability and helps to assure that children's needs are met sensitively, effectively, and in a timely manner. Case review should occur at least once a month. Case review is intended to plan and

monitor current cases, and is not intended as a retrospective case study.

It is not meant to preempt ongoing discussions, and ongoing discussions are not meant to take the place of formal case review.

Every CAC must implement a process and set the criteria for reviewing cases. Depending on the size of the CAC's jurisdiction or caseload, the method and timing of case review may vary to fit the unique needs of a CAC community. Some CACs review every case, while other programs review only complex or problematic cases or cases involved in prosecution. Representatives from each core discipline must attend and/or provide input at case review. Confidentiality should be addressed in the written protocol or guidelines. State and/or federal law may govern information sharing among MDT members, including during case review.

CRITERIA - Essential Components

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

The CAC/MDT's written documents must include:

1. Frequency of meetings
2. Designated attendees
3. Case selection criteria
4. Process for adding cases to the agenda
5. Designated facilitator and/or coordinator
6. Mechanism for distribution of agenda and/or notification of cases to be discussed

7. CASE REVIEW (continued)

7. Procedures for follow-up recommendations to be addressed
8. Location of the meeting.

STATEMENT OF INTENT:

To maximize efficiency and to enhance the quality of case review, the CAC's written documents clearly define the process.

Practical Approaches to Meet This Standard



1. The CAC's protocols/guidelines delineate the agreed upon purpose of multidisciplinary case review and the specific procedures for conducting case review as required in this standard.
2. The CAC has a separate written case review protocol that outlines 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.

7. CASE REVIEW (continued)

B. A forum for the purpose of reviewing 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 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 conducted in addition to informal discussions and pre- and post-interview debriefings.

Practical Approaches 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 does not allow case review for all those referred to the CAC has a formal process for selecting cases that will be included in their regular case review meetings.

7. CASE REVIEW (continued)

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 representation at case review promotes an informed process through the contributions of diverse professional perspectives and expertise. Case review must be attended by the identified agency representatives capable of making, informing and/or advocating for 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. The forensic interviewer, irrespective of which agency employs him/her, should 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 rather than their supervisors, in order to ensure direct communication between all parties. In those rare circumstances that a discipline cannot be present in person, alternative means (including conference call or video conferencing) should be used to ensure the participation of all required disciplines.

Practical Approaches 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.

7. CASE REVIEW (continued)

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

STATEMENT OF INTENT:

In order to make informed case decisions and improve client outcomes, essential information and professional expertise are required from all disciplines. This means that decisions are made with as much information as available; interventions are made with the input, discussion, and support of all involved professionals; efforts are coordinated and non-duplicative; and all aspects of the case are covered. The process should ensure that no one discipline dominates the discussion, but rather all team members have a chance to adequately address their specific goals, mandates, case interventions, questions, concerns and outcomes.

Generally, the case review process should:

- Review interview outcomes
- Discuss, plan, and monitor the progress of the investigation
- Review medical evaluations
- Discuss child protection and other safety issues
- Provide input for prosecution and sentencing decisions
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs
- Assess the family's reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems
- Review criminal and civil (dependency) case updates, ongoing involvement of the child and family, and disposition
- Make provisions for court education and court support
- Discuss ongoing cultural and special needs issues relevant to the case
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

Practical Approaches to Meet This Standard

1. Case review serves as an informed decision-making process with all members of the MDT, utilizing a standard agenda for each case, including all of the 11 listed components above. The standard agenda requires all case review participants to come prepared to address relevant issues on the agenda and provide case updates. The facilitator ensures that the discussion is well-organized, that all team members contribute to discussion and decision-making, and that next steps are clear and defined.
2. In addition to Example 1, case review may also include MDT discussions evaluating the general successes and challenges in their collaborative team response and training/educational opportunities.

7. CASE REVIEW (continued)

E. A designated individual coordinates and facilitates case review and communicates the recommendations for follow-up.

STATEMENT OF INTENT:

The person designated to lead and facilitate the meetings should have training and/or experience in facilitation. Proper planning and preparation for case review includes setting the agenda, notifying all case review participants, ensuring that all relevant information is shared and discussed, and ensuring that the child and family's input is considered. A comprehensive review of cases in a well-facilitated manner helps secure mutual accountability and quality assurance. A process for communicating recommendations and decisions from case review to the appropriate individuals for implementation must be outlined as well.

Practical Approaches to Meet This Standard



1. The CAC designates a staff member with effective facilitation skills and an excellent understanding of all of the roles and responsibilities of MDT members, to lead all case review meetings. This individual is responsible for leading inclusive, comprehensive discussions for all cases and for communicating recommendations and necessary follow-up to MDT members in a timely manner. Team members report on follow-up for monitoring purposes and for further follow-up as needed.
2. The CAC case review meetings are facilitated by a MDT member selected by the MDT representatives. 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.



CASE TRACKING

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



8. CASE TRACKING (continued)

Rationale

Case tracking systems provide essential demographic information, case information, and investigation/intervention outcomes. Case tracking can be used for program evaluation (e.g., identifying areas for continuous quality improvement and assessing ongoing case progress and outcomes) and generating statistical reports. Effective case tracking systems can also enable MDT members to accurately inform children and families of the current status and disposition of their cases.

Case tracking systems also allow for ease of access to data that is frequently requested for grants and other reporting purposes. Data—collected across programs—can be assembled locally, regionally, statewide, and nationally for advocacy, research, and legislative purposes in the field of child maltreatment. This data also may be required for federal funding reporting requirements. Each CAC must determine the case tracking system that will suit its needs and can be supported by its available resources. Case tracking should be compliant with all applicable privacy and confidentiality requirements.

CRITERIA - Essential Components

A. The CAC/MDT's written protocol and guidelines include tracking case information through final 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 to better inform decision-making. The CAC/MDT's written documents must detail a process for case tracking.

Practical Approaches 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.

8. CASE TRACKING (continued)

B. The CAC tracks and is able to retrieve NCA Statistical Information.

NCA statistical information minimally includes the following data:

1. Demographic information about the child and family
2. Demographic information about the alleged offender
3. Type(s) of abuse
4. Relationship of alleged offender to child
5. MDT involvement and outcomes
6. Charges filed and case disposition in criminal court
7. Child protection outcomes
8. Status/follow-through of medical and mental health referrals.

STATEMENT OF INTENT:

CACs are required to collect and demonstrate the ability to retrieve case specific information for all CAC clients. This includes basic demographic information, services provided, and outcome information from MDT partner agencies. An accurate, comprehensive case tracking system is only possible when all MDT members support the need to submit data in a thorough and timely fashion. Codifying case tracking procedures in CAC/MDT's written documents underscores its importance and helps to assure accountability in this area.

Practical Approaches 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 as required by NCA at a minimum.
3. The CAC has a sophisticated database that was created uniquely for its use and that allows for the required NCA reporting.

8. CASE TRACKING (continued)

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

STATEMENT OF INTENT:

Case tracking is an important function of the CAC and can be a time-consuming task depending on case volume. Accuracy is critical and, for this reason, an individual must be identified to implement and/or oversee the case tracking process. 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 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. Alternatively, designated MDT members may be 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.
2. 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.

8. CASE TRACKING (continued)

D. CAC/MDT's written protocols and guidelines must outline how MDT partner agencies access case specific information and/or aggregate data for program evaluation 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. Centers should also develop policies regarding how this data may be released to participating agencies or parties other than the MDT that adheres to confidentiality requirements.

Practical Approaches 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.

8. CASE TRACKING (continued)

E. CAC has a mechanism for collecting client feedback so as 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 the services they received so that improvements may be made in service delivery on an ongoing basis. Client feedback may include client satisfaction surveys and/or outcome data. Care should be taken that survey instruments are valid and reliable. CACs may use a variety of valid instruments and assessment tools to meet this requirement. However, CACs that actively participate in NCA's Outcome Measurement System (OMS) may be assured that they meet and exceed this requirement.

Practical Approaches to Meet This Standard



1. The CAC uses the NCA Outcome Measurement System (OMS) to evaluate their 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.
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.



ORGANIZATIONAL CAPACITY

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



Rationale

Every CAC must have a designated legal entity responsible for the governance of its operations. The role of this entity is to oversee ongoing business practices of the CAC, including setting and implementing administrative policies, hiring and managing personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.

CAC organizational structure depends upon the unique needs of its community. A CAC may be an independent non-profit agency, affiliated with an umbrella organization such as a hospital

or another non-profit 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 its strengths, limitations, and implications for collaboration, planning, governance, community partnerships, and resource development. Ultimate success requires that, regardless of where the program is housed or under what legal auspices, all agencies in this collaborative effort feel equal investment in, and ownership of, the program.

CRITERIA - Essential Components

A. The CAC is an incorporated, private non-profit organization or government-based agency or is a component of such entities.

STATEMENT OF INTENT:

The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This can be an independent not-for-profit, a government-based agency, or a component of such entities.

Practical Approaches 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.

9. ORGANIZATIONAL CAPACITY (continued)

3. 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.
4. 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.

B. The CAC maintains, at a minimum, current general commercial liability, professional liability, and Directors and Officers liability 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, and Directors and Officers liability insurance. Government-based CACs must carry, at a minimum, general commercial liability and professional 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.

Practical Approaches 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.

9. ORGANIZATIONAL CAPACITY (continued)

C. The CAC has written 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 include, at a minimum:

1. Job descriptions
2. Personnel policies
3. Financial management policies
4. Document retention and destruction policies
5. Safety and security policies.

Practical Approaches to Meet This Standard



1. A free-standing, nonprofit CAC has comprehensive written policies and procedures including, but not limited to, those required by this standard that guide CAC operations and 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.

9. ORGANIZATIONAL CAPACITY (continued)

D. The CAC has an annual independent financial review (budget is equal to or less than \$200,000) or financial audit (budget exceeds \$200,000).

STATEMENT OF INTENT:

Confidence in the integrity of the fiscal operations of the CAC is critical to the long-term 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 to or less than \$200,000. CACs with annual budgets exceeding \$200,000 must complete a financial audit.

Reporting Requirements for Audited Financial Statements:

All centers with annual actual expenses (as determined by United States generally accepted accounting principles) in excess of \$200,000 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) equal to or less than \$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 to Meet This Standard



1. If the CAC has an operating budget of \$200,000 or less, it conducts an annual independent financial review. Documentation of the current review (within the preceding 12 month period) can be produced.
2. If the CAC has an operating budget of over \$200,000, it conducts an annual independent audit of its financial statements. Documentation of the current audit (within the preceding 12 month period) can be produced.
3. If the CAC is a program of an umbrella 501c3 agency, the umbrella agency is able to provide documentation of its annual independent audit. Said audit identifies the CAC financial information within the completed audit.
4. If the CAC is a program of a government agency, said agency is able to provide documentation of the annual audit conducted for the city, county, or applicable entity.

- E. The CAC has, and demonstrates compliance with, written screening policies for staff and volunteers that include criminal background, sex offender registration, and child abuse registry checks and provides training and supervision to staff and volunteers.**

STATEMENT OF INTENT:

Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts 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.

Volunteers perform a wide variety of functions within CACs. CACs can at times attract volunteers who are emotionally unprepared for the nature and expectations of the work and/or may attract potential or actual offenders. Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts a formal screening process for on-site volunteers, as well. Upon placement, volunteers must receive training and supervision relevant to their roles.

Practical Approaches to Meet This Standard



1. The CAC has a written policy mandating criminal background and child abuse registry checks for all staff and volunteers. The procedure for executing the policy is incorporated in CAC overall administrative policies and includes examples of the forms process 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. Records are maintained by the CAC and compliance can be demonstrated.
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.

9. ORGANIZATIONAL CAPACITY (continued)

F. The CAC has a written succession plan to insure the orderly transition and continuance of operation of the CAC.

STATEMENT OF INTENT:

A succession plan assists in safeguarding the CAC against unplanned or unexpected change. This kind of risk management is equally helpful in facilitating a smooth transition when leadership change is predictable and planned. A succession plan outlines a leadership development and emergency succession plan for the CAC, and reflects its commitment to sustaining a 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.

Practical Approaches 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. Senior staff, MDT agency leadership, and board members (where appropriate) provide input and approval to said plan.
2. The CAC's Board establishes guidelines for a succession plan and works with the Director to develop the details and assign duties and responsibilities.

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 should have a plan that addresses programmatic and operational needs. The governing entity may be an oversight committee or a board of directors, as appropriate for the CAC's organizational structure.

Practical Approaches to Meet This Standard



1. The CAC Director facilitates a discussion of the MDT leaders and CAC staff to determine key areas of growth and 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 the Board or other governing body. The plan includes a process for monitoring progress and addressing obstacles.
2. The CAC contracts with an organizational consultant to meet with all staff, partners, and board members individually to assess needs, and 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.
3. 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 monitoring progress and addressing obstacles.

H. The CAC promotes employee well-being by providing training and information 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 reduce employee burnout and improve employee retention, the CAC should develop practices that identify and mitigate against factors that negatively influence staff well-being, quality of services, and staff turnover. This includes not only identifying the risk of vicarious trauma for front-line staff but also providing techniques for building resiliency in workers and maintaining organizational and supervisory strategies to address and respond to vicarious trauma among staff members.

Practical Approaches to Meet This Standard

1. The CAC provides vicarious trauma and resiliency training as part of employee orientation as well as in-service training for the entire staff on an annual basis.
2. The CAC affords opportunities for CAC staff to attend outside in-person and online trainings 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 as well as to identify next steps.

I. The CAC promotes MDT well-being by providing access to training and information on vicarious trauma and building resiliency to MDT members.

STATEMENT OF INTENT:

CACs have an important role in strengthening the functioning of the MDT. A highly functioning multidisciplinary team is one in which vicarious trauma can be acknowledged and addressed. While MDT partner agencies have primary responsibility for the health of their workers, the CAC is responsible for providing access to training and information regarding vicarious trauma and resiliency to team members. Moreover, the health of the MDT directly impacts service delivery to children and families. Therefore, attention given to this issue can improve outcomes for abused children and their caregivers.

Practical Approaches to Meet This Standard



1. The CAC provides annual resiliency and vicarious trauma training for CAC staff and invites all members of their MDT to participate.
2. 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.
3. The CAC provides information to MDT members about outside in-person and online training opportunities addressing vicarious trauma and resiliency.
4. The CAC includes discussion of vicarious trauma as a regular agenda item for case review/MDT meetings.



CHILD-FOCUSED SETTING

The child-focused setting is comfortable, private, and both physically and psychologically safe for diverse populations of children and their family members.

10

10. CHILD-FOCUSED SETTING (continued)

Rationale

A CAC requires a separate, child-focused setting designed to provide 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 to define some specific ways that the environment can help children and families feel physically and psychologically safe and comfortable. These include attending to the physical setting and assuring it meets basic child safety standards, ensuring that alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating an 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 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 that 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 and sharing necessary information.

Special attention should be given to designing and decorating the client service areas. The appearance of the CAC can help facilitate the participation of children and families in the process, largely by helping to 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 and child-oriented place for all children and their non-offending family members.

CRITERIA - Essential Components

A. The CAC is a designated, task-appropriate facility which aligns to the following criteria:

1. The CAC is maintained in a manner that is physically and psychologically safe for children and families
2. The CAC provides observation or supervision of clients within sight or hearing distance by CAC staff, MDT members or volunteers at all times
3. The CAC is convenient and accessible to clients and MDT members
4. Areas where children may be present as well as toys and other resources are “childproofed,” cleaned, and sanitized to be as safe as possible.

STATEMENT OF INTENT:

The CAC has an identified, separate, child-focused space designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other services can be provided for

10. CHILD-FOCUSED SETTING (continued)

children and families. CACs range from small, refurbished houses, to a renovated wing of a county office building or community hospital, to newly built facilities.

A physically safe space is central to the creation of a child-focused setting. This can be a challenge as centers are host to children of a variety of ages and developmental stages. Materials and center furnishings should be selected with this in mind.

To assure a physically and psychologically safe environment, children and families must be observed or supervised by CAC staff, MDT members, or volunteers ensuring that they are within sight or hearing distance at all times. 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.

When planning the location of a center, it is important to evaluate the site's accessibility for clients and MDT partner agencies. Considerations should include transportation assistance, travel distances, availability of parking, public transportation, and how welcoming a particular neighborhood is for clients of diverse cultural and socioeconomic backgrounds. Additionally, planning should include consideration for clients who will return to the center for ongoing services such as follow-up meetings, medical appointments, or therapy services.

Practical Approaches to Meet This Standard



1. There is no one “right” way to build, design or decorate a CAC. CACs range from small, refurbished houses, to renovated wings of county office buildings or 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). Child-proofing, soundproofing, and other measures 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 constantly observed and supervised.
2. Special attention should be paid to designing and decorating the waiting room and interviewing room(s) to create a warm, welcoming, comfortable, and safe environment for all clients. Some centers have consulted state day-care center guidelines to assure that waiting rooms and other areas for children have adequate square footage and are “child-proofed,” 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.

10. CHILD-FOCUSED SETTING (continued)

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 should enable the opportunity for children to be supervised 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.
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 center. This is particularly true in large metropolitan areas or in instances in which one center serves a geographically large county. Location of the center is also important to clients who may return to the center on several occasions for follow-up meetings, medical appointments, or therapy services. It is important to evaluate the center'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 "childproof":

When children are present, are all areas effectively supervised by a responsible 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. Have staples or paperclips 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?

10. CHILD-FOCUSED SETTING (continued)

- Are cleaning supplies and other hazardous materials locked or out of reach and stored away from food?
- Are all plants non-poisonous?
- Do all toys meet federal safety standards and are they in good condition?
- Are the bathrooms “child friendly” so that children do not have to climb on countertops to use sinks? Are bathrooms 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? Does staff 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 center 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 non-toxic?
- 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?

10. CHILD-FOCUSED SETTING (continued)

B. The CAC has, and abides by, written policies and procedures that ensure separation of victims and alleged offenders.

STATEMENT OF INTENT:

The CAC has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and as appropriate 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. 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 to 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 child victims and their families. This includes protected service times during which child victims are not at the center, separate entrances and waiting areas, or off-site services through linkage agreements.

Practical Approaches 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 center, they will be asked to leave the premises immediately in an appropriate manner by staff and/or 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 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 can be created to ensure that children and families are not present in the same public areas as alleged offenders.

10. CHILD-FOCUSED SETTING (continued)

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

STATEMENT OF INTENT:

Not all centers are located in custom-designed or new buildings; however, CACs should make reasonable accommodations to make the facility physically accessible to clients and family members as needed. If the CAC cannot be structurally modified, arrangements for equivalent services should be made at alternate locations. CACs must be in compliance with guidelines stipulated in the Americans with Disabilities Act (ADA) and/or state legislation.

Practical Approaches to Meet This Standard



1. The center is located in a refurbished Victorian house that is not physically accessible to clients in wheelchairs. The center has access to a room in a nearby child and family services agency that is wheelchair-accessible. When necessary, the team schedules interviews there. 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.

D. The facility allows for live observation of interviews by MDT members.

STATEMENT OF INTENT:

Multiple interviews and/or interviewers are often stressful for children, particularly those children already experiencing trauma. In order to create a psychologically safe space and lessen or eliminate the need for duplicative interviews, interviews should be observed by MDT members in a space other than the interview room, whether or not interviews are recorded. The MDT should also have the ability to communicate with the interviewer in some manner to provide input and feedback during the live interview with the child.

Practical Approaches to Meet This Standard



1. A one-way mirror and unobtrusive, high-quality 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 soundproofed for this reason.

10. CHILD-FOCUSED SETTING (continued)

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

STATEMENT OF INTENT:

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

Practical Approaches 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.
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.

Medical Evaluation Standard Appendices

The sample resources in the appendix are intended for resource and example only and are not intended to “prescribe” how an individual CAC would address specific issues in the medical standard.



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 (HxPI):

- 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 (PMHx):

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

Family History (FamHx):

- Significant health problems in parents, siblings and close relatives

Social History (SocHx):

- 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)

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

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 3-5 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
	Pediatrician (MD or DO)	Undergraduate Degree 4 years of Medical School 3 years of Residency 1-3 years of Fellowship (optional)		American Board of Pediatrics (ABP)
	Child Abuse Pediatrician	Undergraduate Degree 4 years of Medical School Peds or Med Peds Residency Child Abuse Fellowship Board examination in Child Abuse Pediatrics		American Board of Pediatrics (ABP)
Advance Practice Nurse (APRN)		Undergraduate Degree 2 years of Graduate School Clinical Certification Exam	16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse	State Nursing Board
	Nurse Practitioner (NP)	Undergraduate Degree 2 years of Graduate School Clinical Certification Exam		State Nursing Board
	Pediatric Nurse Practitioner (PNP)	Undergraduate Degree 2 years of Graduate School Clinical Certification Exam		State Nursing Board
Physician's Assistant (PA)		Undergraduate Degree 2 years of Graduate School Certification Exam		State Licensing Board
Nurse (RN)		Nursing Degree Certification Exam	40 hours of formal didactic training in the medical evaluation of Child Sexual Abuse Competency Based Clinical Preceptorship	State Nursing Board
	Adolescent/ Adult Sexual Assault Nurse Examiner (SANE-A)	Nursing Degree (RN or BSN) 40-hour SANE-A training Competency Based Clinical Preceptorship		Some states have state-specific forensic nursing requirements. Providers who have completed SANE training and preceptorship may choose to apply for certification by IAFN.
	Pediatric Sexual Assault Nurse Examiner (SANE- P)	Nursing Degree (RN or BSN) 40-hour SANE-P training Competency Based Clinical Preceptorship		

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 have included in their policies and procedures how the continuous quality improvement activity of expert review is documented.
2. The CAC should track if an exam is felt to be abnormal either through 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 between the CAC/medical provider and the person serving as the expert reviewer outlining the roles and responsibilities should be considered to delineate roles and expectations.

EXPERT REVIEW

NCA Medical Standard for Accreditation states that “all medical professionals providing services to CAC clients must demonstrate, at a minimum, that 50% 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 ano-genital area indicating that abuse/assault has occurred. Laboratory testing for STI’s or pregnancy and DNA evidence collection are NOT included in the definition of an abnormal exam.

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 Examinations¹

	Timing of Exam	Medical Indications
Indications for emergency evaluation	Exam scheduled without delay	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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
Indications for follow-up evaluation	As determined by qualified provider	<ul style="list-style-type: none"> • Findings on the initial examination are unclear or questionable necessitating reevaluation Further testing for STIs not identified or treated during the initial examination • 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

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.

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
 - › Many STI's do not cause symptoms
3. Perpetrator exposed
 - › Sibling/household contacts of the alleged offender
4. Pornography (child) use by caregiver/household contact
5. Patient/parent concern
 - › Patients often have distorted thoughts of body due to perpetrator manipulation
 - › Initial partial disclosures are common

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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This project was supported by Grants No. 2014-CI-FX-K001 and No. 2015-CI-FX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Department of Justice.