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Children's Advocacy Centers *of* Georgia

CHILDREN'S ADVOCACY CENTERS OF GEORGIA STANDARDS FOR ACCREDITED MEMBERS

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1. MULTIDISCIPLINARY TEAM

STANDARD: 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**

Rationale

A functioning and effective multidisciplinary team approach (MDT) is the foundation of a CAC. An MDT is a group of professionals who represent various disciplines and work collaboratively from the point of report to assure the most effective coordinated response possible for every child. The purpose of interagency collaboration is to coordinate intervention so as to reduce potential trauma to children and families and improve services, while preserving and respecting the rights and obligations of each agency to pursue their respective mandates. This interagency collaboration is based on a system response and not just on the facility. Collaborative response begins with case initiation and is promoted through understanding and exploring case issues. Insight from each MDT representative provides the environment for a coordinated, comprehensive, compassionate professional response. Quality assurance is a necessary component of this joint response to review the effectiveness of the collaborative efforts.

Six disciplines; law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, together with CAC staff, comprise the core MDT.

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 an interviewer and a case worker. Community resources may limit personnel and require some to wear multiple hats. What is important is that each of the above-mentioned functions be performed by a member of the MDT while maintaining clear boundaries for each function. MDT's may also expand to include other professionals, such as guardians ad litem, adult and juvenile probation, dependency (civil) attorneys, out-of-home care licensing personnel, federal investigators, school personnel, domestic violence providers and others, as needed and appropriate for that community.

Generally, a coordinated, MDT approach facilitates efficient gathering and sharing of information, broadens the knowledge base with which decisions are made by including information from many sources, and improves communication among agencies. From each agency's perspective, there are also benefits to working on an MDT. More thorough and shared information, improved and timely evidence gathering, and the involvement of the prosecutor from the beginning stages of the case may contribute to a more successful outcome. An MDT response also fosters needed education, support and treatment for children and families that may enhance their willingness to participate and their ability to be effective witnesses. MDT interventions, particularly when provided in a neutral, child-focused CAC setting, are associated with less anxiety, fewer interviews, increased support, and more appropriate and timely referrals for needed services.

In addition, non-offending parents are empowered to protect and support their children throughout the investigation and prosecution and beyond. Law enforcement personnel find that a suspect may be more likely to cooperate when confronted with the strength of the evidence generated by a coordinated MDT approach. Law enforcement personnel also appreciate that support and advocacy functions are attended to, leaving them more time to focus on other aspects of the investigation. They work more effectively with CPS on child protection issues and benefit from other MDT members' training and expertise in communicating with children and understanding family dynamics. As a result of effective information sharing, CPS workers are often in a better position to make recommendations regarding placement, visitation and can assist the MDT by monitoring the child's safety and parental support, and evaluating non-offending parents. Medical providers benefit from the MDT's complete history taking and, in turn, are available to consult about the advisability of a specialized medical evaluation and the interpretation of medical findings and reports. Mental health professionals can provide the MDT with valuable information regarding the child's emotional state and treatment needs and ability to participate in the criminal justice process. A mental health professional on the MDT helps ensure that assessment and treatment and related services are more routinely offered and made available to children and families. Victim advocacy personnel are available to provide needed crisis intervention, support, information and case updates, and advocacy in a timely fashion. This helps the MDT anticipate and respond to the needs of children and their families more effectively, lessens the stress of the court process, and increases access to resources needed by the family, which may include access to victims of crime funding.

CRITERIA
Essential Components

1. **The CAC/MDT has a written interagency agreement (e.g. Interagency Agreement, MOU or Protocol) signed by authorized representatives of all MDT components that commits the signed parties to the CAC model for its multidisciplinary child abuse intervention response.**

Written agreements formalize interagency cooperation and commitment to MDT/CAC practice and policy ensuring continuity of practice even when personnel, heads of departments, and elected officials change. Written agreements may be in different forms such as memoranda of understanding (MOUs), protocols and/or guidelines, 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 must be developed with input from the MDT, reviewed annually and updated as needed to reflect current practice and current agency leadership. The documents must be signed and dated within 12 months of the site review.

2. **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.**

The purpose of multidisciplinary involvement for all interventions is to assure that the unique needs of children are recognized and met. This means that informed decision- making occurs 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. The CAC/MDT follows an agreed upon process for collaborative intervention across the continuum of the case.

3. **The CAC written documents address information sharing that ensures the timely exchange of relevant information among MDT members, staff, and volunteers and is consistent with legal, ethical and professional standards of practice.**

Effective communication and information sharing happen at many points in a case. Both are key dynamics for MDTs in order to minimize duplicative efforts, enhance decision making, and maximize the opportunity for children and caretakers to receive the services they need. The CAC/MDT's written documents must delineate how pertinent information is communicated and how confidential information is protected. Most professions represented on the MDT have legal, ethical and professional standards of practice with regard to confidentiality, but they may differ among disciplines. States may 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 specifically apply to the MDT, staff and volunteers. Written documents should reference and should not conflict with Georgia mandated laws.

4. **The CAC/MDT participates in ongoing and relevant training and educational opportunities, including cross-discipline, MDT, peer review and skills-based learning.**

Ongoing learning is critical to the successful operation of CACs/MDTs. The CAC identifies and/or provides relevant educational opportunities. These should include topics that are cross-discipline in nature, are MDT focused, and/or enhance the skills of the MDT members. Training must be provided within 12 months of the site review.

5. **The CAC provides routine opportunities for MDT members to provide feedback and suggestions regarding procedures/operations of the CAC/MDT.**

CACs should have both formal and informal mechanisms allowing MDT members to regularly provide feedback regarding the operations of the CAC, addressing both practical, operational/administrative matters (e.g., transportation for clients, use of the facility, equipment upgrades) and multidisciplinary teaming issues (e.g., communication, case decision making, documentation and record keeping, “turf” issues, etc.). CACs should strive to create an atmosphere of trust and respect that fosters opportunities for open communication and enables MDT members to share ideas and raise concerns.

2. CULTURAL COMPETENCY AND DIVERSITY

Standard: Culturally competent services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

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 as basic to the CAC philosophy as developmentally appropriate, child-friendly practice. Like developmental considerations, diversity issues influence nearly every aspect of work with children and families, such as welcoming a child and family to the center, employing effective forensic interviewing techniques, gathering information to make a determination about the likelihood of abuse, selecting appropriate mental health providers and securing help for a family in a manner in which it is likely to be utilized. To effectively meet clients' needs, the CAC and MDT must be willing and able to understand the clients' world view, adapt practices as needed, and offer help in a manner in which it can be utilized. Striving towards cultural competence is an important and ongoing endeavor.

Proactive planning and outreach should focus on culture and degree of acculturation, ethnicity, religion, socioeconomic status, disability, gender and sexual orientation. These factors contribute to a client's world view, unique perceptions and experiences throughout the investigation, intervention, and case management process. By addressing these factors in a culturally competent environment, children and families of all backgrounds feel welcomed, valued, respected and acknowledged by staff, MDT members and volunteers.

CRITERIA
Essential Components

1. **The CAC has developed a cultural competency plan that includes community assessment, goals, and strategies.**

In order to serve a community in a culturally competent manner, a CAC must have a written cultural competency plan. Such a plan should include several components. First, a CAC must conduct a thorough community assessment that focuses on a range of issues including, but not limited to: race, ethnicity, gender, disabilities, sexual orientation, economics, rural v. urban, religion and culture. The key is to ensure that the assessment evaluates the unique make-up of the entire community. From that assessment, goals and strategies are developed to ensure that CAC services are delivered to those children and families in need.

2. **The CAC must ensure that provisions are made for non-English speaking and deaf or hard of hearing children and their non-offending family members throughout the investigation process.**

The ability to effectively communicate is critical in creating an environment in which children and families feel comfortable and safe. Language barriers can significantly impact the ability to obtain accurate information from the child and family, and hamper the ability of the CAC/MDT to convey their roles, expectations, concerns and decisions regarding the investigation and intervention services. Language barriers may compound already-existing possibilities for miscommunication between children and adults. The CAC can explore a variety of resources or solutions to ensure adequate provisions are made to overcome language/communication challenges. In order to protect the integrity of the process, care should be taken to ensure that appropriate translators are utilized. CACs should not utilize children or client family members to translate.

3. **The CAC and MDT members ensure that all services are provided in a manner that addresses culture and development throughout the investigation, intervention, and case management process.**

All children and families who come to the CAC should feel welcome. While there are many ways of accomplishing this, materials such as dolls, toys, books, magazines, artwork and other decorations should reflect the different interests, ages, developmental stages, ethnicities, religions and genders of children and families served. It is the responsibility of the CAC and MDT members to know the ethnic and cultural background of the child being served and what languages they speak and/or comfortable speaking. From the moment of first contact with the child and family, the CAC and MDT should identify any cultural or linguistic issues that may affect service delivery. Understanding the child and family's background will help to: effectively elicit relevant history; understand decisions made by the child and family; understand the perception of the abuse and attribution of responsibility made by the child, family and community; understand the family's degree of acculturation and comprehension of laws; address any religious or cultural beliefs which may affect the disclosure; and recognize the impact of prior experience with police and government authorities both in this country and in other countries of origin. With knowledge and preparation, the CAC and MDT can structure services to obtain the most complete and accurate information and more effectively interpret and respond to the child and family's needs.

4. **The CAC engages in community outreach with underserved populations.**

CACs should strive to reach all members of the community in order to ensure that all children have access to the services of the center. This requires CACs to actively engage with underserved populations in the area and may involve developing partnerships with organizations or individuals that serve and/or represent these populations.

5. The CAC actively recruits staff, volunteers, and board members that reflect the demographics of the community.

CACs serve clients who are a part of the community in which the CAC is located. It is important that the CAC strive to recruit, hire and retain staff, volunteers and board members that reflect the demographics of the community and the clientele served.

6. The CAC's cultural competency plan has been implemented and evaluated.

In order to serve a community in a culturally competent manner, a CAC must have a cultural competency plan. Such a plan should include several components: community assessment, goals, strategies, implementation and evaluation. Included in the plan's goals and strategies may be things such as formal and informal training for staff, MDT members, volunteers, and board members; production and distribution of informational materials; outreach to underserved

3. FORENSIC INTERVIEWS

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

Rationale

Forensic interviews create an environment that provides the child an opportunity to talk to a trained professional regarding what the child has experienced or knows that resulted in a concern about abuse. Forensic interviews are typically the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution, and may 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; employment of legally sound interviewing techniques; and the selection, training and supervision of interviewers.

The purpose of a forensic interview in a Children's Advocacy Center is to obtain a statement from a child, in a developmentally and culturally sensitive, unbiased and fact- finding manner that will support accurate and fair decision making by the involved multidisciplinary team in the criminal justice and child protection systems. Forensic interviews should be child-centered and coordinated to avoid duplication. 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.

CACs vary with regard to who conducts the child forensic interview. At a minimum, anyone in the role of a forensic interviewer should have initial and ongoing formal forensic interviewer training. This role may be filled by a CAC employed forensic interviewer, law enforcement officers, CPS workers, medical providers, federal law enforcement officers or other MDT members according to the resources available in the community. State laws may dictate which professionals can or should conduct forensic interviews.

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

CRITERIA

Essential Components

1. **At least 3 of the involved agencies (CAC staff, LE, DFCS investigator, and Prosecution) attend child interviews consistently with at least 2 disciplines present at each interview.**

Interviews must be conducted in a timely manner.

2. **The majority of forensic interviews are routinely conducted at the CAC.**

Forensic interviews of children, as defined in the CAC's written documents, will be conducted at the CAC rather than at other settings. The CAC is the setting 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, steps must be taken to utilize appropriate forensic interview guidelines. Some CACs have established other interview spaces such as a satellite office. MDT members must assure the child's comfort and privacy and protection from alleged offenders or others who may unduly influence the child.

3. **All professionals conducting forensic interviews at a CAC Member Center will have training in a nationally recognized forensic interview technique (i.e. Corner House, Finding Words, NCAC, APSAC) prior to conducting forensic interviews with children.**

4. **The CAC's written documents describe the general forensic interview process including pre- and post-interview information sharing and decision making, and interview procedures.**

The general forensic interview process should be described in the agency's written guidelines or agreements. These guidelines help to ensure consistency and quality of interviews and related discussions and decision-making. These guidelines or agreements must include criteria for choosing an appropriately trained interviewer (for a specific case), which personnel are to attend/observe the interview, preparation/ information sharing with the forensic interviewer, use of interview aids, use of interpreters, communication between the MDT and the interviewer, recording and/or documentation of the interview, and interview process/methodology (such as the state or nationally recognized forensic interview training model[s]).

5. **Forensic interviews are conducted in a manner that is legally sound, non-duplicative, non-leading and neutral.**

Following research-based guidelines will help ensure a sound process. These guidelines as recognized by the members of the MDT should be monitored over time to ensure that they reflect current day practice. Guidelines should be developed and

followed to create an interview environment that enhances free recall, minimizes interviewer influence and gathers information needed by all the MDT members involved to avoid duplication of the interview process.

6. **The CAC's written documents include:**

- Selection of an appropriate, trained interviewer;
- Sharing of information among MDT members; and
- A mechanism for collaborative case planning.

7. **The CAC provides opportunities for those who conduct forensic interviews to participate in on-going training and peer review.**

The CAC provides opportunities for those who conduct forensic interviews to participate in ongoing training and peer review.

In addition, there must be demonstration of the following Continuous Quality Improvement

Activities:

(a) On-going education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 3 hours per every 2 years of CEU/CME credits

(b) Participation in a formalized peer review process for forensic interviewers.

Training forums may include:

(a) Attendance at workshops or conferences;

(b) Reading current research and literature on forensic interviewing;

(c) Role playing,

(d) Interviewing children on non-abuse related topics

(e) Review of recorded interviews,

(f) Observations of interviews

(g) Peer review

(h) On-going supervision

8. **The CAC coordinates information gathering whether through history taking, assessment or forensic interview(s) to avoid duplication.**

All members of the MDT need information to complete their assessment/evaluation. Whether it is the initial information gathered prior to the forensic interview, the history taken by the medical provider prior to the specialized medical evaluation, or the intake by the mental health provider every effort should be made to avoid duplication of information gathering from the child and non- offending family members and should be a process of information sharing among MDT members.

NOTES:

4. VICTIM SUPPORT AND ADVOCACY

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

Rationale

The focus of victim support and advocacy is to help reduce trauma for the child and non- offending family members and to improve outcomes. Coordinated victim advocacy services encourage access to and participation in investigation, prosecution, treatment and support services and thus are a necessary component in the MDT's response. Up-to-date information and ongoing support is critical to a child and family's comfort and ability to participate in intervention and treatment.

The victim support and advocacy functions may be filled in a number of ways consistent with victims' rights legislation and the complement of services in the CACs coverage area. Many members of the MDT may serve as an advocate for a child within their discipline system; however, victim-centered advocacy coordinates services to ensure a consistent and comprehensive network of support for the child and family.

Children and families in crisis need assistance in navigating through the systems' response. While more than one person may perform victim advocacy functions at different points in time, coordination that ensures continuity and consistency is the responsibility of the CAC and must be defined in the CAC/MDT's written documents. CACs may have staff (e.g. family advocates, care coordinators, victim advocates, child life specialists) that performs advocacy functions. CACs may link with local community advocates (e.g. domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates), and/or system-based advocates (e.g. victim witness coordinators, law enforcement victim's advocates). Some CACs both employ and link with such advocates.

Victim support and advocacy may include but is not limited to:

- Crisis intervention and support at all stages of investigation and prosecution
- Attendance and/or coordination of interviews and/or case review
- Greeting and orientation of children to the CAC
- Provision of education about the coordinated, multidisciplinary response
- Providing updates to the family on case status, continuances, dispositions, sentencing, offender release from custody
- Assessment of the child's/family's attitudes and feelings about participation in the investigation/prosecution
- Provision of court education/support/accompaniment

- Providing tours of the courthouse/courtroom
- Securing transportation to interviews, court, treatment and other case-related meetings
- Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, crime victims compensation, transportation, public assistance etc.)
- Providing referrals for mental health and medical treatment, if not provided at the CAC.

CIRITERIA

Essential Components

1. **Crisis intervention and ongoing support services are routinely made available for children and their non-offending family members on-site or through written linkage agreements with other appropriate agencies or providers.**

Children and families need support in navigating the various systems they encounter which may be unfamiliar to them. Crisis intervention, assessment and support services help to assess the child and family's needs; reduce fear and anxiety; and expedite access to appropriate services. Families can be assisted through the cycles of crisis management, problem solving, treatment stabilization, and maintenance. This cycle may be repeated as precipitating events occur such as financial hardships, child placement, arrest, and change/delay in court proceedings. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide some of these services through support groups for children and their non-offending family members and/or provide access to mental health services through linkage agreements with other community agencies or providers.

2. **Education regarding the dynamics of abuse, the coordinated multidisciplinary response, treatment, and access to services is routinely available for children and their non-offending family members.**

Often families have not been involved in this multi-systems response. In the aftermath of victimization, the child and family may feel a loss of control; education provides information that is empowering. Education must be an ongoing process because families may be unable to process all information at one time and their needs change over time. They are in crisis, may be dealing with immediate safety issues, and are coping with the emotional impact of the initial report and the ensuing process. As family needs and case dynamics change, these changes must be assessed so that additional relevant information and services can be offered.

3. **Information regarding the rights of a crime victim is routinely available to children and their non-offending family members and is consistent with legal, ethical and professional standards of practice.**

State and federal laws require that victims of crime, including child abuse, be informed regarding their rights as a crime victim, including information about crime victim's compensation. Non-offending family members who are affected by the crime may also be entitled to services. Some states afford specific rights to crime victims. Generally, children and their families will be unfamiliar with their rights. Therefore, information regarding the rights and services to which they are entitled should be routinely and repeatedly explained as necessary and made available to all children and their non- offending caregivers.

4. **The CAC's written documents include availability of victim support and advocacy services for all CAC clients.**

Because victim support/advocacy is a crucial function of the CAC response, the availability and provision of victim support and advocacy must be included in the CAC's written documents. The manner in which services are coordinated must be clearly defined.

5. **A designated, trained individual(s) provides comprehensive, coordinated victim support and advocacy services including, but not limited to:**
    - **Information regarding dynamics of abuse and the coordinated multidisciplinary response;**
    - **Updates on case status;**
    - **Assistance in accessing/obtaining victims' rights as outlined by law;**
    - **Court education, support and accompaniment; and**
    - **Assistance with access to treatment and other services such as protective orders, housing, public assistance, domestic violence intervention and transportation.**

Victim support and advocacy is integral and fundamental to the MDT response. The support/advocacy function may be filled by a designated victim advocate or by another member of the MDT. Regardless of the CAC's model, appropriately trained individual(s) must be identified to fulfill these responsibilities.

6. **Procedures are in place to provide initial and on-going support and advocacy with the child and/or non-offending family members.**

We have learned from children and families that one of the most stressful aspects of participation in the child abuse intervention system is dealing with the complexities of the multidisciplinary response. The critical role of the victim advocate is to educate clients, help them anticipate possible stressors, provide accurate, up-to-date information, and ensure continued access to rights and services. This process should be articulated in the CAC's written documents so that all MDT members have an understanding as to how these services are provided and by whom, throughout the course of the case.

OPTIONAL NCA COMPONENT:

7. **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.**

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.

1. **Victim Advocates serving CAC clients must provide the following constellation of services:**
   a) Crisis assessment and intervention, risk assessment and safety planning and support for children and family members at all stages of involvement with CAC,
   b) Assessment of individual needs, cultural considerations for child/family and ensure those needs are addressed,
   c) 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,
   d) Provision of education and access to victim's rights and crime victim's compensation,
   e) Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance etc.),
   f) Provision of referrals for trauma focused, evidence -supported mental health and specialized medical treatment, if not provided at the CAC.
   g) Access to transportation to interviews, court, treatment and other case-related

meetings,

h) Engagement in the child's/family's response regarding participation in the investigation/prosecution,

i) Participation in case review to: communicate and discuss the unique needs of the child and family and associated support services planning; ensure the seamless coordination of services; and, ensure the child and family's concerns are heard and addressed,

j) Provision of updates to the family on case status, continuances, dispositions, sentencing, inmate status notification (including offender release from custody),

k) Provision of court education & courthouse/courtroom tours, support, and court accompaniment.

l) Coordinated case management meetings with any and all individuals providing victim advocacy services.

While the particular constellation of services required by children and families will vary based upon their 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 which 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 such as financial hardships, child placement, arrest, change/delay in court proceedings, preparation for court testimony, etc. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including child abuse, are informed regarding 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.

Victim support and advocacy is integral and fundamental to the MDT response. The support/advocacy function may be filled by a paid CAC staff person or a trained MDT member serving in that designated role. Regardless of the CAC's model, appropriately trained individual(s) must be identified to fulfill these responsibilities. If more than one victim advocate is providing services to the same family, case management meetings that provide opportunities for discussion of individual and shared case responsibilities, needed services, follow-up, and ongoing assessment and intervention are required.

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 feels a significant loss of control. Education provides information that is empowering. Education must be ongoing and even repetitive as needed because families may be unable to process so much information at one time, particularly in the midst of a crisis, and their needs change over time. 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 must continue to be assessed so that additional relevant information, support and services can be offered.

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

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 feels a significant loss of control. Education provides information that is empowering. Education must be ongoing and even repetitive as needed because families may be unable to process so much information at one time, particularly in the midst of a crisis, and their needs change over time. 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 must continue to be assessed so that additional relevant information, support and services can be offered.

5. SPECIALIZED MEDICAL EVALUATION

Standard: Specialized medical evaluation and treatment services are made available to all CAC clients and coordinated with the multidisciplinary team response.

Rationale

All children who are suspected victims of child abuse should be assessed to determine the need for a specialized medical evaluation. Specialized medical evaluations should be required based on specific screening criteria developed by skilled medical providers or by local multidisciplinary teams which include qualified medical representation.

A specialized medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate history is essential in making the medical diagnosis 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. Because children learn early the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators.

Physicians, nurse practitioners, physician assistants and nurses may all engage in specialized medical evaluation of child abuse. Some CACs have expert evaluators as full- or part-time staff while others provide this service through affiliation with local hospitals or other facilities. Programs in smaller or more rural communities may not have easy access to qualified healthcare providers and may develop mentoring or consultative relationships with experts in other communities.

Photographic documentation of examination findings is the standard of care. Photo-documentation enables peer review, continuous quality improvement, and consultation. It may also obviate the need for a repeat examination of the child.

CRITERIA

Essential Components

1. **Specialized/forensic medical evaluations for the child client are routinely made available on-site or through written linkage agreements with other appropriate agencies or providers.**

Specialized medical evaluations can be provided in a number of ways. Some CACs have a medical provider that 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 provider of primary care but CACs must have protocols in place outlining the linkages to primary care and other needed healthcare services.

2. **Specialized medical evaluations are provided by health care providers with pediatric experience and child abuse expertise.**

The CAC must demonstrate that its medical provider meets at least ONE of the following *Training Standards*:

- Child Abuse Pediatrics Sub-board eligibility
- Child Abuse Fellowship training or child abuse Certificate of Added Qualification
- Documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations
- Documentation of 16 hours of formal medical training in child sexual abuse evaluation The criteria outlined above apply equally to all healthcare providers. Nurses must practice within the scope of their applicable state Nurse Practice Acts.

And

Documentation of 4 hours of formal medical training in general child abuse evaluation (i.e. physical abuse and neglect evaluation).

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

In many communities, the cost of the specialized medical evaluation is covered by public funds. In other settings, limited public funding requires that those 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 referred for a specialized medical evaluation.

4. **The CAC/MDT's written documents include access to specialized medical evaluation and treatment for all CAC child clients.**

Because specialized medical evaluations are a critical component of a multidisciplinary CAC response, the CAC/MDT documents must detail how these services are accessed by its clients.

NOTES:

5. **The CAC/MDT's written documents include:**

(a) The circumstances under which a specialized medical evaluation is recommended;

All children who are suspected victims of child sexual abuse should be referred for a specialized medical evaluation. The timing and detail of the evaluation should be based on specific screening criteria developed by

qualified medical providers or by local multidisciplinary teams which include qualified medical representation. The CAC should have protocols in place to identify those children in need of medical care for suspected or possible injury or illness resulting from the abuse or unmet medical needs.

(b) The purpose of the specialized medical evaluation;

The purposes of a specialized medical evaluation in suspected child abuse include:

- Help ensure the health, safety, and well-being of the child;
- Diagnose, document, 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;
- Diagnose, document, 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; and
- Reassure and educate the child and family.

(c) How the specialized medical evaluation is made available;

CACs differ in their practices of how the specialized 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.

(d) How medical emergency situations are addressed;

A medically-based screening process will determine the need for an emergency evaluation. The timing, location, and provider of the specialized medical evaluation should be chosen so that a skilled evaluation is conducted, acute injuries and/or other physical findings are documented photographically and in writing and, when indicated, trace evidence is collected and preserved.

Reasons for emergency evaluation include, but are not limited to:

•Medical intervention is needed emergently to assure the health and safety of the child;

•The alleged assault may have occurred within the previous 72 hours (or other state-mandated time interval) and the transfer of trace evidence may have occurred which will be collected for later forensic analysis;

•The need for emergency contraception;

• The need for post-exposure prophylaxis for STI (sexually transmitted infections) including HIV;

•The child complains of pain in the genital or anal area;

• There is evidence or complaint of anogenital bleeding or injury; and

•The child is experiencing significant behavioral or emotional problems and needs evaluation for possible suicidal ideation/plan.

(e) How multiple specialized medical evaluations are limited;

Multiple evaluations should be avoided by identifying the best location and timing for the evaluation. 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. In addition, exams should be performed by experienced healthcare providers and photo-documented to minimize repeat examinations.

(f) How medical care is documented;

All medical records are also legal documents. The medical history and physical examination findings must be carefully and thoroughly documented in the medical record. Diagnostic-quality photographic documentation using still and/or video documentation of examination findings is the standard of care, and is particularly important if the examination findings are thought to be abnormal. Photographic documentation allows for peer review, for obtaining an expert or second opinion, and may also obviate the need for a repeat examination of the child. Detailing 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 specialized medical evaluations. Such protocols can also serve as a "checklist" and training document for new healthcare providers. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

(g) How the specialized medical evaluation is coordinated with the MDT in order to avoid duplication of interviewing and history taking;

Coordination with the MDT is important both in reducing duplicative interviewing and utilizing information from the specialized medical evaluation to assure appropriate follow- up treatment and referrals, often coordinated by other MDT members. Medical diagnosis and treatment of child abuse includes obtaining a medical history. Information needs to be gathered from the parent or other caretakers as well as from the child regarding past medical history and signs or symptoms that may be relevant to the medical assessment.

(h) Procedures are in place for medical intervention in cases of suspected physical abuse and maltreatment, if applicable.

Many CACs provide specialized medical evaluation of child physical abuse and neglect in addition to sexual abuse. These CACs must have written

protocols and agreements for specialized medical evaluations performed including, but not limited to sexual abuse, physical abuse, neglect, and commercially sexually exploited children (CSEC). CACs that provide specialized medical evaluations for sexual abuse but not specifically for physical abuse need written procedures for medical intervention when there are also physical injuries, including how to obtain treatment for injuries and the management of emergency or life-threatening conditions that may become evident during a sexual assault exam.

6. **The CAC shares* or provides** opportunities for those who conduct specialized medical evaluations to participate in ongoing training and peer review.**

The medical provider should be familiar and keep up-to-date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect and the Centers for Disease Control and Prevention.

The provider should have a system in place so that consultation with an established expert or experts in child abuse specialized medical evaluation is available when a second opinion is needed regarding a case in which physical or laboratory findings are felt to be abnormal. An advanced medical consultant is generally accepted to be a physician or advanced practice nurse who has considerable experience in the specialized medical evaluation and photo-documentation of children suspected of being abused, and is involved in scholarly pursuits which may include conducting research studies, publishing books or book chapters on the topic, and speaking at regional or national conferences on topics of specialized medical evaluation of children with suspected abuse.

The above must be demonstrated through the following *Continuous Quality Improvement*

Activities:

- Ongoing education in the field of child sexual abuse consisting of a minimum of 3 hours per every 2 years of CEU/CME credits and 8 contact hours every 2 years.
- Photo-documented examinations are reviewed with advanced medical consultants.
- Review of all exams with abnormal findings is strongly encouraged.

*Sharing will not meet /fulfill NCA requirements.

** Providing opportunities will meet/fulfill NCA requirements

7. **MDT members and CAC staff are trained regarding the purpose and nature of the evaluation and can educate clients and/or non-offending caregivers regarding the specialized medical evaluation.**

The specialized medical evaluation often raises significant anxiety for children and their families, usually due to misconceptions about how the exam is conducted and what findings, or lack of findings, mean. In many CAC settings, the client is introduced to the exam by non-medical personnel. Therefore, it is essential for MDT members and CAC staff to be trained about the nature and purpose of a specialized medical evaluation so that they can competently respond to common questions, concerns and misconceptions.

8. **Findings of the specialized medical evaluation are shared with the MDT in a routine and timely manner (at least a monthly basis).**

Because the specialized medical evaluation is an important part of the response to suspected child abuse and neglect, findings of the specialized medical evaluation should be shared with and explained to the MDT in a routine and timely manner (at least monthly)so that case decisions can be made effectively. The duty to report findings of suspected child abuse to the mandated agencies is an exception to HIPAA privacy requirements, which also allows for ongoing communication

OPTIONAL NCA COMPONENT:

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

10. **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".**

While it is recommended that ALL examinations with findings that the medical provider deems are 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 an "advanced medical consultant" that could offer expert review of examination findings:

*Child Abuse Pediatrician (preferred)

Review with a Child Abuse Pediatrician could occur via direct linkage agreement with a specific provider or through *MyCaseReview* sponsored by the Midwest Regional CAC, or other identified State-based medical expert review systems that has access to an "advanced medical consultant."

*Physician or Advanced Practice Nurse with the following qualifications:

1. Has met the minimum training standards outlined for a CAC medical provider (outlined above).

2. Has performed at least 100 child sexual abuse examinations.

3. Current in CQI requirements (continuing education and participation in expert peer review on their own cases).

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

6. MENTAL HEALTH

Standard: A CAC shall make referral to and/or provisions for appropriate specialized therapeutic treatment services for child victims and non-offending family members provided by mental health professionals with experience in the treatment of child abuse and specific training in the field of child abuse.

Rationale

Children's Advocacy Centers have as their missions: protection of the child, justice and healing. Healing may begin with the first contact with the MDT, whose common focus is on minimizing potential trauma to children. Without effective therapeutic intervention, many traumatized children will suffer ongoing or long term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetimes. Today we have evidenced-based treatments and other practices with strong empirical support that will both reduce the impacts of trauma and the risk of future abuse. For these reasons, an MDT response must include trauma assessment and specialized trauma-focused mental health services for child victims and non-offending family members.

Family members are often the key to the child's recovery and ongoing protection. Their mental health is often an important factor in their capacity to support the child. Therefore, family members may benefit from counseling and support to address the emotional impact of the abuse allegations, reduce or eliminate the risk of future abuse, and address issues which the allegation may trigger. Mental health treatment for non-offending parents or guardians, many of whom have victimization histories themselves, may focus on support and coping strategies for themselves and their child, information about sexual abuse, dealing with issues of self-blame and grief, family dynamics, parenting education and 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 relationship.

CRITERIA

Essential Components

1. **Specialized trauma-focused mental health services for the child client are routinely made available on-site or through written linkage agreements with other appropriate agencies or providers.**

Specialized trauma-focused mental health services for the child client include:

- Crisis intervention services
- Trauma-specific assessment including full trauma history
- Use of standardized measures (assessment tools) initially and periodically

- Family/caregiver engagement
- Individualized treatment plan that is periodically re-assessed
- Individualized evidence-informed treatment appropriate for the children and family seen
- Referral to other community services as needed
- Clinical supervision

The above description of services should guide discussions with all professionals who may provide mental health services. This will assure that appropriate services are available for child clients and that the services are outlined in linkage agreements.

2. **Mental health services are provided by professionals with pediatric experience and child abuse expertise.**

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.

The CAC must demonstrate that its mental health provider meets at least **ONE** of the following *Training Standards*:

- Masters prepared in a related mental health field.
- Student intern in an accredited graduate program.
- Licensed/certified or supervised by a licensed mental health professional.
- A training plan for 40 contact hours of specialized, trauma-focused mental health training, clinical consultation, clinical supervision, peer supervision, and/or mentoring within the first 6 months of association (or demonstrated relevant experience prior to association).

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

CAC's have a responsibility to identify and secure alternative funding sources to assure that all children have access to appropriate mental health services. Ability to pay should never be a factor in the accessibility to mental health services.

4. **The CAC/MDT's written documents include access to appropriate mental health evaluation and treatment for all CAC clients.**

Because mental health is a crucial and core component of a multidisciplinary CAC response, the CAC/MDT's written documents must detail how such care may be accessed by its clients.

5. **The CAC/MDT's written documents include:**

   a) the role of the mental health professional on the MDT including provisions for attendance at case review.

   The CAC/MDT's written documents clearly delineate the role and responsibilities of the mental health professional. A trained mental health professional participates in case review so that children's treatment needs can be assessed and the child's mental health can be monitored and taken into account as the MDT makes decisions. In some CACs, this may be the child's treatment provider; in others, it may be a mental health consultant.

   b) Provisions regarding sharing relevant information with the MDT while protecting the clients' right to confidentiality

   The CAC/MDT's written documents include provisions about how mental health information is shared and how client confidentiality and mental health records are protected.

   c) How the forensic process is separate from mental health treatment

   The forensic process of gathering evidentiary information and determining what the child may have experienced to account for the allegation is separate from mental health treatment. 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.

6. **The CAC and/or MDT provide opportunities for those who provide mental health services to participate in ongoing training and peer review.**

In addition, there must be demonstration of the following *Continuous Quality Improvement*

Activities:

Ongoing education in the field of child abuse consisting of a minimum of 8 contact hours per year

7. **Mental health services for non-offending family members and/or caregivers are routinely made available on-site or through written linkage agreements with other appropriate agencies or providers.**

Mental health services for non-offending family members and/or caregivers include screening, assessment, and treatment on-site or by referral. 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. Family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues which the

allegations may trigger. 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 relationship.

OPTIONAL NCA COMPONENT:

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

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:

a. Supervision by a senior clinician on-staff at the CAC; or

b. When a CAC does not have more than one clinician, negotiating with a senior clinician in the community who serves children and families and accepts referrals from the CAC; or

c. Participating in a supervision call with mental health providers from other CACs within the state, either individually or as a group; or

d. 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 with those who are 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 on one evidence-based treatment does not necessarily include all the clinical interventions needed within a CAC. Therefore, comprehensive.

7. CASE REVIEW

STANDARD: Participate in a formal Multi-disciplinary Team (CAC, Law Enforcement, DFCS, Medical, Mental Health, Victims Advocacy and Prosecution) case staffing at least monthly for the purposes of information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis.

Rationale

Case review is the formal process which enables the MDT to monitor and assess its effectiveness - independently and collectively - ensuring the safety and well-being of children and families. It is intended to monitor current cases and is not meant as a retrospective case study. This is a formal process by which knowledge, experience and expertise of MDT members is shared so that informed decisions can be made, collaborative efforts are nurtured, formal and informal communication is promoted, mutual support is provided, and protocols/procedures are reviewed. Case review should occur no less than once a month. Case review encourages mutual accountability and helps to assure that children's needs are met sensitively, effectively and in a timely manner. Case review is not meant to pre-empt ongoing discussions, and ongoing discussions are not meant to take the place of formal case review.

Every CAC must have a process for reviewing cases. Depending on the size of the CAC's jurisdiction or caseload, the method/timing of case review may vary to fit the unique 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 interagency protocol. State and/or federal law may govern information sharing among MDT members, including during case review.

CRITERIA

Essential Component

1. **Case Staffing/Multidisciplinary Team meets at least monthly.**

2. **CAC's written documents include criteria for case review and case review procedures.**

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

The CAC/MDT's written documents must include:

- Frequency of meetings;

- Designated attendees;
- Case selection criteria;
- Designated facilitator and/or coordinator;
- Mechanism for distribution of agenda and/or notification of cases to be discussed;
- Procedures for follow-up recommendations to be addressed; and
- Location of the meeting.

3. **Case review is an informed decision making process with input from all necessary MDT members based on the needs of the case.**

In order to make informed case decisions, essential information and professional expertise are required from all disciplines. This means that decisions are made with as much information as available, interventions receive the support of all involved professionals (or provides an opportunity for discussion if dissention exists), 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 relevant team members have a chance to adequately address their specific case interventions, questions, concerns and outcomes.

Generally, the case review process should:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation (including status and outcomes);
- Review specialized 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 non-offending family members and strategies for meeting those needs;
- Assess the family's reactions and response to the child's disclosure and involvement in the criminal justice/child protection systems;
- Review criminal and civil (dependency) case disposition;
- Make provisions for court education and court support; and
- Discuss cross-cultural issues relevant to the case.

4. **A designated individual coordinates and facilitates the case review process, including notification of cases that will be reviewed**.

Proper planning and preparation for case review including notification of cases to be reviewed, maximizes the quality of the discussions and decision making. A process for identifying and adding cases to the agenda must be articulated and understood by all MDT members. The skill with which case review meetings are facilitated directly impacts on the success of the case review process and team functioning. The person designated to lead and facilitate the meetings should have training and/or experience in facilitation.

5. **Representatives routinely participating in case review include, at a minimum:**
    - Law enforcement
    - Child protective services (DFCS)
    - Prosecution
    - Medical
    - Mental health
    - Victim advocacy and
    - Children's Advocacy Center

Full MDT representation at case review promotes an informed process through the contributions of diverse professional perspectives. Case review should be attended by the identified agency representatives capable of participating on behalf of their specific profession. CACs should establish policies regarding those required to attend case review and identify a means of communicating with MDT members who cannot regularly attend. All those participating should be familiar with the CAC/MDT process as well as purpose and expectations of case review.

9. **Recommendations from case review are communicated to appropriate parties for implementation.**

Appropriate follow-up on and communication of recommendations ensure that pertinent information derived from case review is promptly given to responsible parties. A process is defined to communicate recommendations or MDT decisions from case review to the appropriate individuals for implementation.

10. **Case review meetings are utilized as an opportunity for MDT members to increase understanding of the complexity of child abuse cases.**

CACs should strive to create an environment where complex issues can be raised and discussed.

Case review should provide an opportunity for MDT members to increase their knowledge of the dynamics of child abuse cases. Discussions may include, but not be

limited to, relevant theories; research; agency interventions, limitations, or service gaps; issues of family dynamics; developmental and/or emotional disabilities; parenting styles and child-rearing practices; gender roles; religious beliefs; socioeconomics; and cultural dynamics and behaviors.

8. CASE TRACKING

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

Rationale

Case tracking is an important component of a CAC. "Case tracking" refers to a systematic method in which specific data is routinely collected on each case served by the CAC. Today, case tracking systems are generally computerized, although in some communities with limited resources or small caseloads, case tracking may be done manually.

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

There are additional reasons for establishing a case tracking system. One is the usefulness and ease of access to data that is frequently requested for grants and other reporting purposes. When collected across programs, data can be used to assemble local, regional, statewide and national statistics that are useful for advocacy, research and legislative purposes in the field of child maltreatment. Each CAC needs to determine the type of case tracking system that will suit its needs. Case tracking should be compliant with all applicable privacy and confidentiality requirements.

CRITERIA

Essential Components

1. **The CAC/MDT's written documents include tracking case information until final disposition.**

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 sharing of this information to better inform decision making. The CAC/MDT's written documents must include a process for case tracking.

2. **The CAC tracks and minimally is able to retrieve CACGA Statistical Information.**

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.

CACGA statistical information minimally includes the following data:

- Demographic information about the child and family;
- Demographic information about the alleged offender;
- Type(s) of abuse;
- Relationship of alleged offender to child;
- MDT involvement and outcomes;
- Charges filed and case disposition in criminal court;
- Child protection outcomes; and
- Status/outcome of medical and mental health referrals.

3. **An individual is identified to implement the case tracking process.**

Case tracking is an important function of the CAC and can be a time-consuming task depending on case volume. Accuracy is important and for this reason, an individual is 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 job. Some dedicate a position, part- or fulltime, 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.

4. **MDT partner agencies have access to case information as defined by the CAC's written documents.**

Because case data may be useful to MDT members for a variety of purposes, it is important that they 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.

5. **All MDT partner agencies provide their specific case information and disposition.**

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.

6. **MDT partner agencies have access to case information as defined by the CAC's written documents.**

Because case data may be useful to MDT members for a variety of purposes, it is important that they 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.

OPTIONAL NCA COMPONENT:

12. **The CAC tracks and minimally is able to retrieve NCA Statistical Information. NCA statistical information minimally includes the following data:**

    a. Demographic information about the child and family;

    b. Demographic information about the alleged offender;

    c. Type(s) of abuse;

    d. Relationship of alleged offender to child;

    e. MDT involvement and outcomes;

    f. Charges filed and case disposition in criminal court;

    g. Child protection outcomes; and

    h. Status/follow-through of medical and mental health referrals.

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.

13. **CAC has a mechanism for collecting client feedback to inform client service delivery.**

Continuous quality assurance is the hallmark of a well-functioning CAC. This requires seeking feedback directly from caregivers 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, those Children's Advocacy Centers who actively participate in NCA's OMS (Outcome Measurement System) may be assured that they meet and exceed this requirement.

9. ORGANIZATIONAL CAPACITY

Standard: Be a private non-profit 501 (c) 3 organizations or government-based agency responsible for program and fiscal operations and have the specific, stated purpose of providing services for children in cases of suspected child abuse.

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.

There are many options for CAC organizational structure depending upon the unique needs of its community. CACs may be an independent non-profit agency, affiliated with an umbrella organization such as a hospital or other non-profit agency, human service or victim service agency, or part of a governmental entity, such as prosecution, social services, law enforcement. Each of these options has its 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

1. **CAC has appropriate paperwork identifying it as a private non-profit 501(c)3 organization AND CAC has appropriate paperwork identifying it as a Georgia Charitable Organization (or exemption documentation) AND CAC has appropriate paperwork identifying it as a Georgia Corporation.**

   (if this standard does not apply to your CAC move to component #2)

2. **CAC has appropriate paperwork identifying it as a distinct component of an agency-based organization OR CAC has appropriate paperwork identifying it as a government-based agency**

3. **CAC has its own separate mission statement consistent with "providing services for children in cases of suspected child abuse."**

4. **The CAC maintains, at a minimum, current general commercial liability, professional liability, and Directors and Officers liability as appropriate to its organization structure.**

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 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 such as renters, property owners, and automobile insurance.

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

Every CAC must have written policies and procedures which govern its administrative operations. Examples of administrative policies and procedures include: job descriptions, personnel policies and related staffing procedures; non- discrimination; grievance policies; fiscal management; documentation and record-keeping; health and safety policies and emergency procedures; security policies; use of the facility; etc. These policies and procedures may be found in various organizational documents such as board policies, hiring policies, employee handbook and MDT protocols.

6. **The CAC has designated, accessible staff assigned solely to the operation of the program for a minimum of 20 hours per week.**

The CAC must provide evidence that CAC has personnel responsible for its operations and program services. Minimum staffing requirements shall include the hiring of a paid executive director by the nonprofit entity who is answerable to the board of directors.

The executive director shall not be the exclusive salaried employee of any public agency partner.

7. **New CAC executive directors shall receive training approved by CACGA and participate in the mentoring program within time limits established by CACGA.**

8. **The CAC has an annual independent financial audit.**

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. The conduct of the audit should be board-approved.

9. **The CAC has, and demonstrates compliance with, written screening policies for staff that include criminal background and child abuse registry checks and provides training and supervision.**

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.

10. **The CAC has, and demonstrates compliance with, written screening policies for on-site volunteers that include criminal background and child abuse registry checks and provides training and supervision.**

Volunteers perform a wide variety of functions within CACs. Sometimes, CACs can attract people who may not be emotionally prepared for the activities of the CAC 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 onsite volunteers. This process should be documented in a written policy. Volunteers must receive training and supervision relevant to their role.

11. **Centers shall establish a method of confidentiality of records and other information relating to clients that is included in the written protocols or best practices guidelines.**

12. **The CAC provides education and community awareness on child abuse issues.**

One component of CAC work is education and outreach to the community regarding child abuse, its effects, how to seek help when abuse is suspected, and services provided by the CAC. Community education and outreach may be provided by staff, MDT members or volunteers.

13. **The CAC has addressed its sustainability through the development of a strategic plan that includes a funding component.**

In order to assure long-term viability of the organization, the CAC should undertake a comprehensive planning process. This plan should explore program needs, staffing levels, and funding for future growth and sustainability.

OPTIONAL NCA COMPONENT:

14. **The CAC promotes employee well-being by: providing training and information regarding the effects of vicarious trauma; providing techniques for building resiliency to its employees; and maintaining organizational and supervisory strategies to address vicarious trauma and its impact upon staff.**

To reduce employee burnout and improve employee retention the CAC should develop practices that identify and mitigate against those factors impacting 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 techniques for building resiliency in workers. Furthermore, the CAC must develop and maintain organizational and supervisory strategies to address vicarious trauma when it arises in staff.

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

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.

10. CHILD FOCUSED SETTING

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

Rationale

A Children's Advocacy Center (CAC) requires a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other CAC services can be 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 case loads increase and additional program components are needed. Care should be taken to ensure that MDT members have access to work space and equipment onsite to carry out the necessary functions associated with their role on the Multidisciplinary Team (MDT) including, but not limited to, meeting with families and appropriate exchange of necessary information.

Special attention should be given to designing and decorating the client service areas. The appearance of the CAC can help facilitate children's and families' participation 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

1. **The CAC is a designated, well-defined, task appropriate facility or contiguous space within an existing structure**

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

2. **The CAC has written policies and procedures that ensure separation of victims and alleged offenders.**

The CAC has a setting that is physically and psychologically safe for child clients and separation for children and alleged offenders is ensured. During the investigative process, logic dictates that children may not feel free to disclose abuse if an alleged offender accompanied them to the interview and was sitting just down the hall in the waiting room. 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 must assure separation between children and non-offending family members and alleged offenders. 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. In addition, CACs that serve sexually reactive children should also make provisions to assure physical and psychological safety of all children who visit the center.

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

Recognizing that not all centers are located in custom-designed or new buildings, CACs should make reasonable accommodations to make the facility physically accessible. If the CAC cannot be structurally modified, arrangements for equivalent services are made at alternate locations. The Americans with Disabilities Act (ADA) and/or state legislation can provide guidelines on accessibility.

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

Understanding that multiple interviews and/or multiple interviewers is often stressful for children, interviews should be observed by MDT members in a space other than the interview room to reduce or eliminate a need for separate interviews, whether or not interviews are recorded. The MDT should also be able to communicate with the interviewer to provide input and feedback during the live interview with the child.

5. **CAC has age-appropriate waiting room, interview room, and ancillary service space.**

6. **The CAC is maintained in a manner that is physically safe and "child proof".**

A center that is physically safe for children 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. Any areas where children may be present should be “childproofed” and cleaned to be as safe as possible for infants and toddlers. Toys and materials should be sanitized on a regular basis.

7. **Children and families are observed or supervised by staff, volunteers, and/or MDT members.**

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

OPTIONAL NCA COMPONENT:

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

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 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 segregated meeting areas are not only physically separate, but also soundproofed so that conversations cannot be overheard. Some centers have placed soundproofing materials in walls when building or refurbishing their centers. Others have placed stereos or “white noise” machines in rooms to block sound.