NATIONAL CHILDREN'S ALLIANCE

Standards for Accredited Members

2017 Edition

NATIONAL CHILDREN'S ALLIANCE®

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Guiding Principles of Revising the *Standards*

The *Standards* value diversity in CACs, including organizational structure, staffing patterns, and socio-economic factors in communities.

The *Standards* balance the goal to serve more children through a growing NCA membership with the goal to sustain the professional credibility of CACs and the value of the NCA accreditation process through a fair and equitable review process.

The *Standards* are minimum standards of operation and are not to be viewed as best practice standards.

The *Standards* are evidence-supported and evolve over time and require revision as research progresses.

NCA strives to make all *Standards* measurable, and the basis of measurement readily apparent.

As the success of the *Standards* rests upon the field's willingness to support and adhere to them, NCA recognizes that support hinges upon a credible and inclusive process.

Purpose of the *Standards for Accredited Members*

To ensure that all children across the U.S. who are served by Children's Advocacy Centers receive consistent, evidence-based interventions that help them heal.

In addition to serving as the set of standards by which Children's Advocacy Centers (CACs) may be accredited as capable of providing consistent and evidence-based healing interventions, the *Standards for Accredited Members* also perform several secondary functions. The *Standards* 1) act as a compass for CACs during leadership transition so that Multidisciplinary Teams (MDTs), Boards, and other stakeholders know how to maintain the course; 2) to serve as a valuable roadmap for new CACs as they develop; and 3) to demonstrate the high-quality work of Accredited CACs to policymakers, funders, and supporters.

How the *Standards* Were Revised

The National Children's Alliance *Standards for Accredited Members* are reviewed by an Accreditation Committee every five years to coincide with the five-year period for which an accreditation status is valid before re-accreditation is required. NCA and its Accreditation Committee conduct these regular reviews of the current accreditation standards to ensure that the *Standards* take into consideration the newest evidence-based practices in the field, and also convey clear and concise uniform thresholds across each standard.

The first step of the process of reviewing and revising the *Standards* was the commission and publication of an Annotated Bibliography of the Empirical and Scholarly Literature Supporting the Ten *Standards* for Accreditation by the National

Children's Alliance, first published in 2011, then reviewed and republished in a 2013 second edition. (Relevant research published in the interim period was added to the draft Bibliography and also reviewed.) Research support for all existing standards was identified at that time, providing good evidence that the existing standards at that time and extant research were in alignment. Therefore, the intent of the revision process was not to increase the practice thresholds to be met by CACs but rather to clarify the minimum requirements and to alleviate any existing ambiguity and/or redundancy in the language.

Beginning in September 2012, NCA conducted a stakeholder survey of site reviewers (those responsible for evaluating CACs against the *Standards*, regional CAC leaders, State Chapter directors, and NCA board members and staff. During this time, NCA's Accreditation Committee also reviewed accreditation outcome and evaluation data from the period 2010-2012 to identify trouble spots or areas requiring further inquiry or clarification.

After the collection, review, and approval of the final Bibliography plus the outcome and evaluation data, the Accreditation Committee formed five *Standards* Task Forces covering groupings of related standards: 1) Organizational Capacity, Case Tracking, and Child-Focused Setting; 2) Multidisciplinary Team, Case Review, and Forensic Interview; 3) Cultural Competency & Diversity and Victim Services & Advocacy; 4) Medical; and 5) Mental Health. Each Task Force was composed of subject matter experts and representatives from Regional CACs, the NCA Accreditation Committee, and NCA senior staff. Special care was taken to ensure that each Task Force included representatives experienced with CACs of diverse organizational structure, caseload, geography, and service population size. These Task Forces met monthly to complete revisions to their grouping of *Standards*, completing their work in the first half of 2014.

After the five Task Forces submitted their combined revisions to the *Standards*, a final review period began in mid-2014 with a readers' pool selected from across all five Task Forces. Another draft revision based upon feedback from the readers' pool was submitted to the Regional CACs, select State Chapters, and select Accredited CACs for further review. The Accreditation Committee reviewed the revised draft last before submitting, and made further revisions before forwarding the revised *Standards* to NCA's Executive Committee and full Board of Directors.

NCA's Executive Committee reviewed the draft revisions at the end of 2014, and made any final revisions before submitting the standards for a vote by the full Board held January 2015, where the 2017 Edition of the *Standards for Accredited Members* was approved. The *Standards* were unveiled at NCA's 2015 Leadership Conference along with training materials for the field, allowing more than 18 months for CACs to come into compliance before the revised *Standards* become effective for all CACs beginning January 1, 2017.

Process of Accreditation by Evaluation Against the *Standards*

Newly accredited CACs, whether applying as a brand-new center or as a center in another membership category, are accredited by site review and evaluation against the *Standards* in the year in which they apply. Accredited Centers must undergo re-accreditation every five years on a rolling basis from their previous accreditation.

CACs applying for new or re-accreditation begin by filling out a comprehensive application detailing how the center meets each standard. This application must include attached documentation establishing the center's claim to meet the standards. NCA staff then screen the application for completeness. Then, a two-person site review team will review the application and send any questions to the site before a required site visit.

Within six months of the application submission, a two-person site review team will conduct an on-site review meeting with board members, staff, and multidisciplinary team members to review practices and documentation for compliance with the *Standards*. Based upon their findings in a site review, the site review team scores the site for adherence to the *Standards* and make a recommendation as to the center's accreditation status.

NCA's Accreditation Committee reviews only those site review recommendations that do not pass and recommend a "pending" status for those sites they deem fail to meet the *Standards* in agreement with the site review team. NCA's Board of Directors reviews and, if in agreement with the findings, approves the Accreditation Committee's recommendations and awards accreditation.

Centers seeking new or re-accreditation are notified of the outcome of the review process at this time. Sites determined as "Pending" for failing to meet the *Standards* are given a one-year period to implement a corrective action plan, documenting corrective actions and current compliance. At the end of the one-year "pending" period, progress against the corrective action plan and documentation are reviewed by the original site reviewers, the Accreditation Committee, and the Board. The Board determines whether after the pending period the center is in compliance or not, and either awards or denies accreditation accordingly. Centers denied accreditation may at this point appeal the denial or begin a new accreditation process.

What's New in the 2017 Edition

In order to ensure CACs provide services that are responsive to the latest evidence and trends within both the child maltreatment intervention field and communities, NCA's Accreditation Committee convenes to revise the *Standards for Accredited Members* every five years. In the 2017 Edition of the *Standards,* the following points represent notable changes since the release of previous edition:

- All standards have been updated based upon the latest research published over the last five years.
- Clear benchmarks are now set across all essential components.
- The site review process of measuring CAC practice against the *Standards* for accreditation has moved to a pass/fail basis.
- Training standards are now part of the Victim Advocacy standard.
- Continuing education requirements are now consistent across all standards related to practice.
- *Standards* now recognize the importance of responding to vicarious trauma in staff and MDT members.

Acknowledgements

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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

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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.

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.

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.

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.

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.

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.

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.

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.

CULTURAL COMPETENCY AND DIVERSITY

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

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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.

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.

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.

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.

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.

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.

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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.

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.

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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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.

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.

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

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).
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 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.

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.)

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).

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.

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.

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.

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.

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.

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.

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.

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

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.

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.)

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.

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.

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.

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.

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.

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.

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.

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.

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

7. CASE REVIEW

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. 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.

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.

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.

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.

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.

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

8. CASE TRACKING

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.

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.

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.

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.

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.

ORGANIZATIONAL CAPACITY

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

9

9. ORGANIZATIONAL CAPACITY

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,

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.

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.

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.

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.

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.

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.

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.

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.

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

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 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.

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.

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.

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.

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.

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.

A1

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 PedsResidency Child Abuse Fellowship Board examination in Child Abuse Pediatrics	*No additional training requirements*	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 tvo 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.

Sample Expert Review Log

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

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

Sample Language for Memorandum of Understanding with Advanced Medical Consultant

MOU FOR EXPERT REVIEW OF EXAMINATIONS WITH ABNORMAL FINDINGS

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

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

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

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

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

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

CAC Director Date

CAC Medical Provider Date

Expert Reviewer Date

Examination Referral and Timing

IMPORTANT DEFINITIONS

Suspected victim of sexual abuse: A suspected victim of sexual abuse maybe identified by the following criteria:

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

TABLE 2: Timing of Medical Examinations[1]

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