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Evidence Supporting National Guidelines for Canada's Child Advocacy Centres

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1.0 INTRODUCTION

1.1 Background

Children and youth who have experienced or witnessed violence face unique challenges in the criminal justice system. Involvement in the criminal justice process, and particularly testifying in court, can be extremely traumatic for a child. Child advocacy centres (CACs)[1] address these challenges by providing a coordinated and collaborative approach to assisting children and youth, and their families, when they are involved in the criminal justice system. According to the National Children's Alliance website[2] in the United States:

> *A children's advocacy center is a child-friendly facility in which law enforcement, child protection, prosecution, mental health, medical and victim advocacy professionals work together to investigate abuse, help children heal from abuse, and hold offenders accountable.*

In 2010, Canada provided funding for the creation and enhancement of CACs across the country to assist child victims of crime through the Department of Justice Victims Fund under the Federal Victims Strategy. At the same time, the Department began building a knowledge base on CACs by conducting consultations with experts in the area. Additional resources were provided in the 2012 budget for CACs. As of 2016, 22 CACs were operating in Canada and at least 7 others were in development (Department of Justice Canada, 2017).

The Department of Justice Canada chairs and coordinates a national network of CACs. In response to interest expressed by a number of Canadian CACs, a working group including members of the national network, an official from the Department and representatives of KPMG Consulting was established in 2014 to explore the development of Canadian guidelines for CACs. The goals of the working group in the development of Canadian guidelines are to: promote consistency across the country; ensure that Canadian guidelines reflect how child abuse cases are addressed in Canada as compared to the United States; assist new organizations as they work toward establishing a CAC; and ensure that the integrity of the CAC model is retained.

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[1] The terms "*Child Advocacy Centre*" (CAC) and "*Child and Youth Advocacy Centre*" (CYAC) are used interchangeably throughout this report, and references to "*child*" or "*children*" include both children and youth. Also note that we use the Canadian spelling of "*centre*" instead of the American spelling of "*center*" unless we are referring to the name of a specific organization in the United States.

[2] See http://www.nationalchildrensalliance.org/our-story.

The working group, which has been led by a steering committee composed of representatives from the Sheldon Kennedy Child Advocacy Centre in Calgary, the Boost Child and Youth Advocacy Centre in Toronto, the Department of Justice Canada and KPMG Consulting, proposed national guidelines for CACs in 2015. These guidelines were adapted from guidelines developed by the Boost Child and Youth Advocacy Centre, a Toronto-based organization that collaborates with community partners to provide services to child and youth victims of crime and their families, partly based on the National Children's Alliance standards for accreditation for CACs in the United States. In 2015, the Canadian Research Institute for Law and the Family was contracted by the Department, which has provided coordination support to the working group, to undertake research on the evidence base supporting the proposed new national guidelines for child advocacy centres. These guidelines are currently in the discussion stage and have not yet been adopted as the Canadian standards.

1.2 Purpose and Objectives

The purpose of this project is to update the 2015 report prepared by the Institute by reviewing any new national and international research related to the evidence, background and context to support the rationale for each of the ten guidelines for Canadian CACs. The revision also examines whether the new research identified suggests any changes to the guidelines. It is important to note that these guidelines are intended to be aspirational for child advocacy centres and represent the "gold standard" supported by the research literature. It is recognized that achievement of all ten guidelines may not be possible for all CACs, but the guidelines will provide direction to CACs as they are established and develop. There is currently no mechanism in place in Canada to accredit CACs.[3]

1.3 Methodology

1.3.1 The Initial Report

The Department of Justice Canada had already collected a considerable amount of information relevant to the project and this work was shared with the Institute. In particular, we relied heavily on the excellent work conducted by the Boost Child and Youth Advocacy Centre in developing draft guidelines for CYACs in Ontario based on the U.S. National Children's Alliance Standards for Accredited Members Revised 2011. The Ontario draft guidelines also provided the basis that the CAC national guidelines

[3] Note, however, that some Canadian CACs, such as Sophie's Place Child Advocacy Centre in Surrey, British Columbia, have sought accreditation with the National Children's Alliance in the United States.

working group used in its March 2015 visioning session for the development of Canadian guidelines.

The Department provided the following research questions to guide the project:

(1) What social science and legal evidence is there that supports each of the ten proposed guidelines?

(2) Where evidence does not support a proposed guideline, what would the contractor recommend (wording, content, etc.) so that a guideline reflects current evidence?

(3) What are the key differences between the National Children's Alliance U.S. standards and what is being proposed for Canada? What are the differences between the criminal justice and child protection systems in Canada and in the United States that necessitate different wording or content in the guidelines?

(4) Have other countries established standards/guidelines documents for their CAC-like services? Would these be relevant?

(5) Is there evidence for any new guidelines that are not currently included? If so, what is it and how would that guideline be framed? For example, there has been some discussion amongst the working group members about a guideline to address vicarious trauma among CAC staff and partners. There was also some discussion about a guideline regarding privacy and information sharing.

To address the research questions, the Institute conducted an international literature search to identify social science and legal research relevant to each of the ten proposed guidelines, as well as any other guidelines that may be appropriate for Canada. Literature both in support of and contrary to the draft guidelines was identified and critically analyzed.

Further, each of the proposed guidelines was reviewed by the legally-trained members of the research team to verify their applicability to the Canadian legal context. Any wording or content changes that were necessary because of the differences between the criminal justice and child protection systems in Canada and the United States have been made.

1.3.2 The Present Update

To conduct the present update of the Institute's 2015 report, we searched for any literature that became available in 2016 or 2017 that was related to the guidelines and determined if this new research supports any changes to the guidelines. We have also relied on four recent reports: (1) the final report of the evaluation of the Boost CYAC in Toronto (Child Welfare Institute, 2017); (2) the final report of an evaluation of Snowflake Place for Children and Youth in Winnipeg (Gjuric, 2016); (3) the final report of an examination of six CACs in Canada (Department of Justice Canada, 2017); and (4) the final report of a social impact study of Boost CYAC (Deloitte, 2017). In addition, the feedback provided at a February 2017 national CAC training event was reviewed and incorporated as necessary, and the 2017 revised National Children's Alliance guidelines (National Children's Alliance, 2017b) were reviewed to determine if they suggest the need for any changes to Canada's guidelines.

1.4 Organization of the Report

Chapter 2.0 of this report presents a history of the development of child advocacy centres in the United States and elsewhere, as well as research on the effectiveness of CACs. Chapter 3.0 contains the proposed guidelines, along with the rationale and evidence base for each guideline. The recommended guidelines, rationale and key components are presented in the final chapter. New information identified for this revision has been added if and where appropriate.

2.0 DEVELOPMENT OF CHILD ADVOCACY CENTRES

Traditional approaches to the investigation and prosecution of child abuse and maltreatment had the potential to further victimize children who had experienced the traumatic effects of physical or sexual abuse (Cross et al., 2008). Children were frequently subjected to multiple interviews during which they were required to recount the details of their abusive experiences to different professionals who, typically, were strangers to them. The interviewers frequently had little or no training in conducting forensic interviews with children and had little knowledge of children's developmental stages and the effects that differences in development could have on their ability to understand and respond to multiple, repetitive questions about their experiences (Pence & Wilson, 1994). Further, the interviews frequently occurred in intimidating surroundings like police stations, which could add to the stress children were already experiencing. Because there was little coordination among the agencies involved in child abuse investigations, usually police, child protection services and prosecution, responses were adversely affected and children frequently did not receive the services they needed to help them cope with the abuse they had suffered (Cross et al., 2008).

In an attempt to address the negative consequences for children of traditional child abuse investigations, child advocacy centres (CACs) were established in the United States beginning in the mid-1980s. CACs were designed to deal primarily with cases of child sexual abuse and involved "the delivery of key services (medical examinations, psychological support, and advocacy services) at a stand-alone child-friendly facility, also serving as the focal point for a multidisciplinary and multiagency team who collaborate on the investigation of abuse" (Herbert & Bromfield, 2016, p. 341). The multidisciplinary team is the cornerstone of all CACs; by coordinating the activities of all professionals involved in a child abuse investigation, CACs strive to reduce the stress experienced by child victims and their families, as well as the potential for revictimization of children by justice and child protection systems.

As of 2016, there were more than 800 CACs across the United States (National Children's Alliance, 2017a), and the model has been widely adopted internationally in countries such as Canada, the United Kingdom, Australia, New Zealand, South Africa, Israel, Sweden, Norway, Finland, Croatia, Moldova, and Cuba. While the actual form and components of the international centres may vary somewhat from those in the United States, the guiding philosophy is essentially the same.

2.1 The National Children's Alliance

The National Children's Alliance (NCA) was established in 1987 by former Congressman Bud Cramer of Alabama in response to the growing need for a national body to oversee the development, support and guidance of CACs in the United States. The NCA is:

> *a professional membership organization that equips local children's advocacy centers, multidisciplinary teams and child abuse professionals with the support and technical assistance to respond appropriately and effectively to allegations of child abuse or neglect. By facilitating coordinated investigations and intervention services through the multidisciplinary team approach and through local children's advocacy centers, NCA helps communities ensure that children are not re-victimized by the very system designed to protect them…. National Children's Alliance provides guidance on all levels—from funding, accreditation and facilitation at the local level to policy leadership and advocacy on the national level*. (National Children's Alliance, 2013, p. 3)

The NCA has established ten standards that must be met by CACs in the U.S. before they can receive an accredited membership in the organization. In addition to accredited membership, the NCA also offers three additional levels of membership: satellite members, which are child-friendly centres that offer interviewing facilities and victim advocacy services on-site under the sponsorship of an accredited CAC; associate/developing centre membership, which is available to CACs that are working towards accredited membership, but have not yet implemented all ten standards; and affiliate membership, which is available to multidisciplinary teams that strive to improve services to abused children using a collaborative approach (National Children's Alliance, 2013).

The NCA began developing its accreditation standards in 1996, and produced an extensive annotated bibliography providing the research evidence for the standards (Newlin, Steele & Wells, 2013). The NCA reviews and revises these standards as necessary every five to six years; the current standards came into effect in January 2017, and specify that a CAC must include the following components:

- multidisciplinary team;
- cultural competency and diversity;
- forensic interviews;
- victim support and advocacy;
- medical evaluation;
- mental health services;
- case review;
- case tracking;
- organizational capacity; and
- a child-focused setting.

The NCA has established a series of essential components within each standard. The essential components are mandatory and must be met before accreditation is granted. The previous version of the guidelines also included rated criteria that were

important but not necessarily essential, and could be applied depending on each community's unique characteristics and needs; CACs were required to meet at least 50% of the rated criteria before being considered for accreditation.

The NCA tracks the essential components of its standards that are most frequently cited for non-compliance, as well as which ones result in "pending" status most frequently. They typically revolve around the following items:

- conducting case reviews in a way that fully meets the standards both in terms of attendance at case review and in terms of the quality of discussion and case planning;

- ensuring that at least 75% of children meeting the CAC's case acceptance criteria are interviewed at the CAC;

- ensuring that all elements of the medical evaluation standard are met, particularly those around continuing education and peer review of findings; and

- ensuring that all elements of the mental health standard are met, particularly as it relates to continuing education requirements and clinical supervision (Teresa Huizar, Executive Director, NCA, personal communication, 5 October 2015).

The NCA recently completed a review of its standards and the revised standards came into effect in January 2017 (National Children's Alliance, 2017b). While the standards themselves did not substantially change, one major modification is that the rated criteria were removed. Some of the previous rated criteria were made essential components, some were incorporated into related essential components, and some were dropped altogether (Jan Dunn, Director of Accreditation, NCA, personal communication, 1 October 2015).

2.2 The Child Advocacy Centre Model in Other Countries

As noted above, several countries outside of the United States have also developed models for dealing with child abuse cases that are similar to CACs. In general, the international programs are comparable to the American model since most countries have based their guidelines on the National Children's Alliance standards. This section briefly reviews these models.[4]

[4] With the exception of Canada and the Nordic countries, information on child advocacy centres and similar organizations in other countries has been adapted from Fashola, 2012.

Canada has been proactive in applying the CAC philosophy in several centres across the country, and has followed the U.S. model quite closely. As of 2016, there were 22 CACs operating in Canada, with at least another 7 in development or exploring the model (Department of Justice Canada, 2017). While there is currently no mechanism for accrediting CACs in Canada, a working group composed of representatives from Canadian CACs, the Department of Justice Canada and KPMG Consulting have drafted guidelines that are intended to be aspirational for Canadian centres. These guidelines were adapted from Ontario guidelines developed by the Child and Youth Advocacy Centre at Boost Child Abuse Prevention and Intervention, which in turn were modeled on the NCA standards, as adapted to the Canadian context.

The United Kingdom's Crown Prosecution Service offers a court-based CAC-like service. In cases where there is a child victim or witness, the police, social services and other agencies as necessary meet to assess the child's needs and coordinate the provision of appropriate supports. A videotaped forensic interview is typically conducted by a trained police officer in a child-friendly room. Each child victim or witness is assigned a witness care officer from the Witness Care Unit who is responsible for keeping the child and family informed about the progress of the case and identifying any particular needs of the child.

The George Jones Child Advocacy Centre was opened in Perth, Australia in 2011. This CAC has adopted the NCA standards and offers the same types of specialized services included in the U.S. model. In Aukland, New Zealand, Puawaitahi, a multi-agency centre for investigating alleged cases of child abuse was established in 2002. Puawaitahi offers the following services through a multidisciplinary team housed at the centre: needs assessments by the local Department of Child, Youth, and Family Services; health and mental health assessments; police investigation; and video interviews conducted by police and child protection workers on site.

Cape Town, South Africa has a program within its Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) charity that is aimed at the support of child witnesses. This program focuses on court preparation and support for children who will be testifying in child sexual abuse cases. Support is also provided to families of child witnesses. South Africa also has Thuthuzela Care Centres (TCCs) operating across the country, which are hospital-based and available to both child and adult sexual assault victims. As part of a coordinated strategy, TCCs are linked to specialized sexual offences courts, which are staffed by a dedicated team of prosecutors, social workers, police investigators, judges, and health professionals. The services offered by TCCs include: medical examination and treatment following sexual assault; victim-friendly settings; interviewing conducted by a specialized investigation officer; counselling; court preparation for witnesses; and case management.

In Jerusalem and Tel Aviv, Israel, the Beit Lynn Child Protection Centre offers services to children under the age of 18 who have been victims of sexual, physical or psychological abuse. The centre is staffed by a multidisciplinary team including police and professionals from the ministries of health, justice and education, as well as physicians and social workers. The centre aims to intervene as early in a child's treatment process as possible, and it offers clients a safe and friendly environment, assistance from a multidisciplinary team which coordinates all decisions regarding treatment, provides medical evaluations and urgent care, if required, and refers victims and their families to appropriate community services.

The Child Protection Centre in Zagreb, Croatia provides services to abused and neglected children and their families. The centre is staffed by a multidisciplinary team including psychiatrists, psychologists, social workers, pediatricians, special educators, nurses, and legal advisors. All mental health personnel at the centre have received training to conduct forensic interviews and investigations, as well as clinical assessments. One unique procedure that has been adopted by the centre is that judges are encouraged to hold trials in which a child is a witness at the centre. If a trial takes place at the centre, the child is interviewed in a separate room by one of the centre's forensic investigators while the prosecutor, defence lawyer, judge, and accused view the proceedings in another room via video link.

The AMICUL Centre for Psychosocial Assistance for Children and Families is a state-funded service founded in 2003 in Chisinau, Moldova. The centre offers counselling, medical treatment, social assistance, legal consultation, and resocialization services. The centre uses a multidisciplinary team composed of professionals from government, guardianship authorities, law enforcement, local community agencies, and placement centres to plan and monitor all centre activities. Forensic interviews are conducted in a child-friendly room by the centre's child protection specialist.

The Child Protection Centres located in Havana, Santiago de Cuba and Santa Clara, Cuba are based on the U.S. CAC model and are funded by a U.K. charity, the Child Protection Development Trust. The centre is staffed by a team of psychologists and social workers who work closely with other child protection specialists including trained police officers, physicians and prosecutors. The two core services offered at the centres are support and counselling for children and their families and evidential interviews conducted in a child-friendly room.

The Nordic countries of Sweden, Norway, Denmark, Finland, and Iceland have widely adopted the children's advocacy centre model, called Barnahus in those locations. According to Johansson (2012), at the time her article was written, there were approximately 30 centres in Sweden, 7 in Norway, a few in Denmark, one each in Iceland and Greenland, and a pilot project in Finland. The first centre was established in Iceland in 1998 and was based on the U.S. CAC model, and subsequent centres in the

Nordic countries were based on the model adopted in Iceland. However, as noted by Johansson (2012), "detailed differences in judicial systems and regulations [among the Nordic countries] have several consequences for the inter-agency collaboration within Barnahus" (p. 77). Thus, the governance model and funding structure for Barnahus differs somewhat across the Nordic countries, even though the overarching philosophy is the same. "For example, in Iceland the Government's Agency for Child Protection is the responsible agency, in Norway the Department of Justice, administratively tied to the police, while in Finland the Ministry of Social Affairs and Health" is responsible for the operation of Barnahus (Johansson, 2012, p. 80).

2.3 The Effectiveness of Child Advocacy Centres

Several research studies have examined the effectiveness of various components of CACs. In one of the first evaluations of the CAC model in the U.S., Cross et al. (2008) examined the effectiveness of CACs in four sites by comparing them with communities that did not have a CAC. The CACs studied were among the most established centres in the country. Highlights of the findings of this evaluation were:

- *Communities with CACs had greater law enforcement involvement in child sexual abuse investigations, more evidence of coordinated investigations, better access to medical exams, more referrals for child mental health treatment, and greater caregiver satisfaction with the investigation process.*

- *CACs did not reduce the number of interviews children undergo: the vast majority of children in both CAC and comparison communities experienced only one or two forensic interviews.*

- *CACs and comparison communities had similar rates of prosecution and conviction of offenders. However, one CAC filed more criminal charges than the community it was compared with (although it also had more dismissals), and another sentenced offenders to longer jail terms.*

- *In both CAC and comparison communities, 35 percent of children with a clinical need received mental health services. This data was limited to a subset of cases where caregivers consented to an interview.*

- *Children in communities with CACs were removed from their homes more frequently than children in comparison communities.*

- *All the CACs in the study met the NCA standards: however, the structure and methods of the CACs differed. These differences could be used to initiate discussions about performance standards and best practices*. (Cross et al., 2008, p. 2)

Using data collected as part of the Cross et al. (2008) evaluation discussed above, Jones et al. (2007) compared the satisfaction of CAC child clients and their caregivers with children and caregivers from non-CAC communities. The sample was restricted to sexual abuse cases, and included telephone interviews with 229 caregivers associated with CAC cases and 55 caregivers in comparison communities. In cases where the alleged victim was over 8 years of age, they were also interviewed (90 CAC cases and 30 cases from comparison communities). Findings indicated that caregivers in CAC cases reported higher overall levels of satisfaction with the investigation than caregivers from comparison communities; however, no significant difference between CACs and comparison communities was found for children's satisfaction, although there was some evidence to suggest that CACs might reduce children's fears during interviews. The higher caregiver satisfaction ratings in the CAC group were most strongly related to the investigators' response to the abuse allegation and the forensic interview experience.

In an analysis of the data collected by Cross et al. (2008) related to forensic interviews, Cross et al. (2007) reported that CACs had a positive effect on investigations and forensic interviews of alleged victims of child sexual abuse. "Team interviews, videotaping of interviews, joint CPS-police investigations, and police involvement in CPS sexual abuse cases were all more common in CAC cases" (Cross et al., 2007, p. 1048). Cross et al. (2007) noted that there were no differences in the number of forensic interviews of children in CAC compared to non-CAC communities. These authors suggested that this finding may be primarily due to historical change in that "experts have been warning about redundant interviews for over 20 years" (p. 1048). It is likely that these warnings have had an impact on investigations both within CAC and non-CAC investigations.

Focusing on the data related to medical examinations from the Cross et al. (2008) evaluation, Walsh et al. (2007) reported that 48% of child clients of CACs received a forensic medical exam, compared to 21% of alleged victims in non-CAC communities. Similar proportions of children who received medical exams had the exam conducted on the same day as the first report of the abuse in CAC (56%) and non-CAC (50%) communities. Further, when examining cases at both CAC and non-CAC sites, Walsh et al. (2007) found that medical exams were more likely to be conducted in the following circumstances: (1) with younger children; (2) when penetration was suspected; (3) when the child was injured during the abuse; and (4) when the child had non-offending caregivers who were rated as supportive.

In a comprehensive review of evaluation studies of CACs, Herbert and Bromfield (2016) noted that, despite the popularity of CACs in several locations world-wide, their effectiveness has not been well researched and "there has been no systematic review of the evidence that exists for the model…" (p. 341). In examining the effects of CACs, most studies have focused on criminal justice outcomes such as rates of disclosure of abuse,

arrests, prosecutions, convictions, and reduced victimization. Few have examined the efficacy of CACs in terms of assessing child and family outcomes, and those that have attempted to measure these outcomes have largely relied on measures of satisfaction with services received (Herbert & Bromfield, 2016). Few studies have examined whether the CAC model leads to recovery from trauma. "Considering the stated mission of CACs to reduce systemic trauma, it is concerning that no studies have measured these benefits against standard service delivery" (Herbert & Bromfield, 2015, p. 348).

In summarizing the findings from their review of CAC evaluation research, Herbert and Bromfield (2016) made the following observations and suggestions for future work:

> - *Overall the review suggests that this widely adopted service appears to increase the types of practices (e.g., forensic interviews and medical examinations) that are assumed to lead to positive outcomes but that research into these subsequent outcomes is limited;*
>
> - *While individual components of the model may be well evidenced, there is little research evidence for the efficacy of the model as a whole. There does seem to be some evidence for CACs to have better outcomes than standard practice early in the criminal justice/investigative process (Joa & Goldberg-Edelson, 2004; Miller & Rubin, 2009; Ruggieri, 2005);*
>
> - *Limited research has been undertaken on the child and family outcomes of the model;*
>
> - *There is a clear need for more rigorous empirical research of the CAC model, particularly on the impact of the services on child trauma symptoms, both in terms of therapeutic interventions, and to demonstrate reduced child trauma resulting from coordinated/co-located services;*
>
> - *There is a need to develop a clearly articulated theory of change, both for the proper evaluation of CACs and for their ongoing practice improvement. This theory of change needs to recognise the outcomes that CACs can presumably effect some change on (e.g., knowledge of trauma, improved capacity to support traumatised children) and those that the CAC has a limited direct outcome on (e.g., sentencing outcomes).* (p. 352)

The Department of Justice Canada recently funded a five-year evaluation study of six Canadian CACs. The data sources used for this evaluation included case file information from the CACs, interviews with child clients and their non-offending caregivers, and interviews with multidisciplinary team (MDT) members and CAC community stakeholders. A report presenting the mid-project findings of this evaluation

was prepared by Proactive Information Services for the Department of Justice Canada, (2015). This report focused on a process analysis describing how CACs in Canada are operating and measuring client satisfaction with the services received from CACs and with the criminal justice process in general.[5] Findings indicated that the six CACs involved in this research study adopted quite different governance structures. Two CACs operate within a registered charity, but have separate steering committees, while another represents a partnership between police and social services. One CAC is primarily a governmental collaboration, and another has its own Board of Directors and Executive Committee. The final CAC is a demonstration project within a health centre. All CACs have adopted a multidisciplinary team model.

A recent survey of CACs in the U.S. (Herbert, Walsh, & Bromfield, in press) also found that, although some core characteristics were common across all centres, such as the presence of a MDT, a child-friendly facility and child and family advocacy, there are variations across the centres studied in areas not specifically prescribed by the NCA's standards such as whether all services are provided on-site and the number of agencies co-located at the CAC. The authors suggested that these differences reflect the fact that CACs adapt to the needs and resources of the communities in which they are located.

The Canadian CACs involved in the Department of Justice Canada research study also have varied physical locations: two operate in stand-alone facilities; two are housed with other agencies; one is within a hospital; and one is a "virtual" centre with no dedicated physical location. The five centres with physical locations all have a dedicated space for conducting forensic interviews. Forensic medical examinations can be conducted on-site for the centre housed within a hospital setting. All of the CACs have representation from the following sectors as part of their MDT: law enforcement; victim services; and child protection. In addition, all centres have a CAC coordinator/victim advocate. Five of the six centres have representation from the crown prosecutor's office, medical services and mental health services on the MDT, and one centre has representation from a First Nations community. The five CACs with physical locations are all child- and family-friendly spaces.

With the exception of the "virtual" CAC, almost all forensic interviews with children were conducted on-site. At most sites, inter-agency protocols had been developed which provide for joint forensic interviews with police and child protection services. In practice, however, the majority of interviews were conducted by law enforcement personnel. According to Proactive Information Services, 80% of alleged

[5] Only one non-offending caregiver had responded to the questions regarding the criminal justice process at the time the report was prepared; for this reason, data regarding this component of the evaluation are not discussed in this report.

victims had received a forensic interview, and 93% of these were conducted on-site at the CAC (2015).

The frequency of case review meetings varied widely across CACs, with one centre not holding any meetings, and at the other centres the frequency of meetings varied from twice per week to quarterly.

For the mid-project evaluation report, measures of client satisfaction were obtained from 20 in-person interviews with child clients and 28 in-person interviews with non-offending caregivers. Overall, the majority of caregivers reported that they were satisfied with most aspects of their experience with the CAC: 54% were satisfied with the wait time for services; 68% were satisfied with the supports their child received; 71% were satisfied with the information they were provided; and 75% were satisfied with the supports received for themselves. However, only 36% reported satisfaction with the referrals their child received.

Almost two-thirds of the victims who responded (62%) rated their overall experience with the CAC as "great" or "good." When asked about the forensic interview, overall alleged victims thought that it was a stressful and uncomfortable experience, although most rated the interviewer positively.

The Department of Justice Canada (2017) recently published the final evaluation report for this project. Highlights of the findings included that: there is a need for a physical, child-friendly location to ensure that a CAC operates effectively; the co-location of members of the MDT is important; and the presence of a victim advocate is the model's greatest strength. Other important findings of the evaluation were that: "access to mental health services for clients and MDT members is essential; providing case updates and sharing information with clients, especially youth, is important; clients benefit from having both female and male staff in the CACs; and access to private spaces within CACs enhance the experience for clients" (Department of Justice Canada, 2017, p. 6).

Further, the evaluation reported that the CACs reduced both financial and non-financial hardship for children and their families and also reduced stress and revictimization. "The CACs have also addressed many gaps in the system, including access to medical examinations, availability of prosecutors with expertise to work with child victims, use of testimonial aids (e.g., screens and closed-circuit TV), and access to child-friendly environments for forensic interviews and court appearances" (Department of Justice Canada, 2017, p. 7).

The Child Welfare Institute (2017) of the Children's Aid Society of Toronto recently published the results of a 20-month evaluation of the Boost Child and Youth Advocacy Centre (CYAC) in Toronto. Members of the MDT at Boost CYAC are co-

located and include: police officers from the Toronto Police Service; representatives from child protection agencies; advocates, whose role is to provide support, advocacy and referral services to child clients of Boost and their families; members of the Suspected Child Abuse and Neglect (SCAN) Program at the Hospital for Sick Children who provide medical services to child clients and consultations to MDT members, child victims and their families; and mental health professionals who provide assessment and treatment services to child victims and their families.

A total of 1200 cases were included in the evaluation, and multiple data collection sources were used including: police Child Abuse Investigation Case Activity Sheets; child protection worker surveys; advocate surveys; surveys of medical professionals from the SCAN program; surveys of mental health professionals; and caregiver surveys. Selected highlights of the findings are:

Police Investigators

- 76% of police investigations were conducted jointly with child protection services;
- 87% of victims had one investigative interview and only 2% had more than two interviews;
- charges were laid in 21% of cases;

Child Protection Workers

- 65% of child protection investigations were jointly conducted with police;
- 77% of victims had a single interview and 6% were interviewed more than twice;
- 44% of families received referrals to community services, most commonly counselling;

Advocates

- 98% of advocate cases involved a police investigator and 79% involved a child protection worker;
- 81% of victims received an average of 3.3 referrals by the advocate, most frequently to individual counselling and victim witness assistance programs;
- 60% of non-offending caregivers received an average of 2.4 referrals by the advocate, most frequently to individual counselling, crisis intervention and family counselling;

Medical Personnel

- in 97% of cases referred to the SCAN Program, services were provided to the victim and in 7% of cases, services were provided to the caregiver;

- the most common services provided by the SCAN Program were medical consultations and physical examinations;

Mental Health Professionals

- of the families who were referred for mental health services, 72% of families received crisis intervention with two weeks of referral, while the remainder were offered referral, but refused services;
- 46% of victims who were referred to mental health services received individual counselling, 50% of caregivers received individual counselling and 43% of families who were referred received family counselling;

Caregivers

- nearly all caregivers said that they felt heard, respected and safe at the CYAC;
- all caregivers rated the overall service quality they received as either good or excellent; and
- caregivers were particularly satisfied with the services they received from the advocates.

The evaluators of the Boost CYAC concluded that the findings:

> *are quite positive and point to the important role that Boost CYAC played in providing high quality services to child/youth victims and families. Specifically, it appears that the Boost CYAC model led to better coordinated child abuse investigations with evidence of increased collaboration between child protection, police, medical, advocacy, and mental health sectors; this increased collaboration appears to have contributed to investigative efficiencies and additional support to child/youth victims and families* (Child Welfare Institute, 2017, p. 73).

Deloitte (2017) has also recently published a report detailing the findings of an evaluation of Boost CYAC using both qualitative and quantitative methodologies. The qualitative component involved a most significant change (MSC) analysis that used interviews with stakeholders to examine personal accounts of the effectiveness of services provided by Boost. The quantitative component of the evaluation involved a social return on investment (SROI) analysis, which provided an indication of the social value created by Boost's interventions with its child clients and their families by examining social, environmental and economic impacts of the program.

Findings from the MSC component of the evaluation led Deloitte (2017) to conclude that Boost leads to three major outcomes:

1) *Reduced emotional, financial, and physical hardship on children and youth who have been abused and their families through: trauma-informed approach to investigations; efficient and effective communication within the MDT; timely access to therapeutic services; increased information, support and guidance following disclosure; and increased interventions aimed at the family unit level.*

2) *Increased access to services through: increased number of and timely referrals; expedited delivery of care to those with the most urgent needs; and longer engagement with clients to identify additional service needs as they develop.*

3) *Increased capacity of partner agencies through: improved access to consultations with medical and mental health professionals; time savings in collecting and disseminating information during the investigation; time savings in travelling between agencies/other interview locations or to accompany the child and family; and increased access to professional development and practice leadership.*

Findings from the SROI component of the Deloitte (2017) evaluation estimated that for every $1 spent at the Boost CYAC, a social value of between $1.50 and $2.70 is created. This translates to a social value created of between $330 and $2,012 per client at Boost.

Gjuric (2016) conducted an evaluation of Snowflake Place for Children and Youth, a CAC in Winnipeg that began operations in 2013. The evaluation design included interviews with staff and stakeholders of the CAC and an analysis of data maintained by the agency. Highlights of the evaluation findings include:

- during a three-year period from 2013-2016, a total of 673 forensic interviews were conducted with child clients;
- the average age of child clients at Snowflake Place was 9.4 years, and the majority of children were female (64.3%);
- almost all (98.4%) child clients at Snowflake Place during the three-year period received only one forensic interview and 1.5% were interviewed twice;
- in over 80% of cases, the forensic interview was conducted within one month of the report of abuse;
- in 19.7% of cases the evaluators could determine that child clients received a medical exam; in 36.3% of cases the child did not receive a medical exam, and whether a medical exam was received could not be determined in the remaining 44% of cases.
- charges were laid in 48.1% of cases and were pending in a further 7.1%; the majority of charges laid were for sexual abuse (56%);
- the most important factor affecting whether a family reported having a positive experience at the CAC was the amount of information they were provided about the process prior to attending the agency; and

- all of the caregivers interviewed said that the experience of attending the CAC had been a positive one for their children.

3.0 EVIDENCE FOR THE PROPOSED GUIDELINES

This chapter presents the evidence base for the guidelines proposed by the CAC working group on the development of national guidelines. The guidelines were based on the National Children's Alliance standards for accreditation for child advocacy centres (CACs) in the United States, and were adapted for the Ontario Network of Child and Youth Advocacy Centres by Boost Child and Youth Advocacy Centre (CYAC). The rationale and key components presented for each guideline in this chapter were also developed by the Boost CYAC, and its work is gratefully acknowledged. Based on the literature, we conclude the section on each guideline with a recommended guideline for Canada.

One of the key research questions for the original project was to determine if there is evidence for any new guidelines that are not currently included. At the working group's March 2015 visioning session, participants discussed whether there should be an additional guideline addressing vicarious trauma among CAC staff and partners, as well as a guideline regarding privacy and information sharing. It became apparent while reviewing the research literature that underlying each guideline is the need for privacy and confidentiality. In personal communication with the Director of Accreditation for the National Children's Alliance in the United States (29 September 2015), we were informed that the issue of privacy and confidentiality is woven throughout the American standards, rather than addressed as a separate standard or component. It is important that interagency agreements explicitly address issues of privacy and confidentiality.

The research literature does indicate, however, that the issue of vicarious trauma for human service workers needs to be addressed. In the revised Standards for Accreditation in the U.S., effective January 2017, the NCA has added two essential components within the organizational capacity standard to specifically address vicarious trauma and resiliency. Accordingly, we have included the evidence-base for this issue in Section 3.10 on Organizational Capacity, which includes key components addressing hiring, training and supporting staff and partners.

3.1 Child-focused Setting

Ontario's draft guideline regarding child-focused settings states that:

> *The Child & Youth Advocacy Centre provides children, youth and their non-offending family members with a safe, neutral and comfortable child-focused setting.*

At the CAC working group's visioning session on the development of national guidelines, participants replaced "non-offending family members" with "supporting family members," and included a reference to the services provided. The working group

also discussed whether the word "neutral" was needed, and deleted the words "comfortable" and "child-focused." The suggested guideline from the working group is:

> *The Child and Youth Advocacy Centre provides children, youth and their supporting family members with compassionate services in a safe setting in response to suspected maltreatment.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

> *Rationale*
>
> *Children/youth and their non-offending families require a safe, friendly and comfortable setting to meet with professionals when child abuse is reported. A child-focused setting can help alleviate the child/youth's fear and anxiety and help to facilitate his/her involvement and comfort in the process.*
>
> *Guidelines* [Key Components]
>
> - *The waiting room and interview space(s) should be safe, comfortable and neutral, and investigative interviews should be conducted using up-to-date recording equipment. All other child/youth and family spaces within the centre should also promote safety and comfort and reduce anxiety.*
>
> - *The CYAC must be physically and psychologically safe for children/youth. If a CYAC shares space with an existing agency that provides services to offenders, there must be separation (e.g. alleged offenders are seen on different floors, at different times of day) between children and non-offending family members, and alleged offenders.*
>
> - *The CYAC must have policies and procedures that address the separation of victims and alleged offenders during the investigative process, and as appropriate throughout delivery of the full array of CYAC services. In addition, CYACs that serve children with sexual behaviour problems should also make provisions to ensure physical and psychological safety of all children who visit the centre.*
>
> - *Children/youth and families must be supervised by CYAC staff, MDT [Multidisciplinary Team] members, or volunteers ensuring that clients are within sight and hearing distance at all times.*
>
> - *Where all possible, clients involved in different investigations are kept separate to respect the confidentiality of families and investigations.*

- *Confidentiality and respect for privacy is of primary concern in a CYAC. It is not acceptable for team members or CYAC staff to discuss cases with children or families, or with each other, where they may be overheard by anyone not directly involved with the case, and/or where consent to share information has not been given.*

Evidence

Providing services to children and their families in a child-friendly facility is one of the hallmarks of a CAC, and the research literature supports this guideline. Over two decades ago, child advocates began expressing concerns about child interviews being conducted in police stations, child protective service offices, schools or homes (Whitcomb, 1992). Police stations were viewed as potentially frightening for children and may lead children to believe they had done something wrong (Simone et al., 2005). Further, children and their families may fear child protection services because of its power to remove children from the home, schools may lack privacy, and the child's home may be compromised (Cross et al., 2007). These concerns led the American Professional Society on the Abuse of Children to recommend that, whenever possible, children be interviewed in a neutral environment that is private, informal and free from distractions (APSAC, 2002).

To minimize stress, discomfort or intimidation for children, CACs should be specially designed to replicate features of home environments and include playrooms and toys (Herbert & Bromfield, 2016). According to Cross et al. (2007, pp. 1034-1035), child-friendly spaces in CACs are designed to be better environments for interviewing children and their families:

> *Waiting rooms will have decorations and play things designed for children. Alleged offenders are not allowed, interview rooms are private, and CAC staff or volunteers are available to support and monitor children. Often CACs are independent centers separate from other institutions or agencies, making it easier to build a child-friendly setting. When CACs are components of larger agencies like a prosecutor's office, they often have separate wings or entrances.*

An American researcher interviewed 117 CAC directors to assess how eight core components of the National Children's Alliance standards for membership were implemented in practice (Jackson, 2004b). She found that 100% of the member CACs and 89% of the non-member CACs had a child-friendly facility. When examining whether the play areas were developmentally appropriate, however, only 52% of the CACs said their waiting rooms and/or play areas were geared to younger children. According to Jackson (2004b, p. 414), "ideally, the play area should be developmentally appropriate, with different furnishings, accommodations for children with special needs, décor that recognizes diverse cultures, and activities for children of all ages and adolescents."

Similarly, a study examining children's advocacy centres in six municipalities in Sweden, known as Barnahus, evaluated various aspects of the CAC model, including the child-friendly and safe environment (Rasmusson, 2011). While the children and their parents who were interviewed noticed and appreciated the colours, toys and furnishings in the child-friendly facilities, two of the older children commented that the environment was too childish. Two teenaged girls who had previously been interviewed at a police station commented that the environment at the Barnahus was much better and safer.

American researchers conducted a survey of child protective service and law enforcement investigators who use CACs in their investigations (Newman, Dannenfelser & Pendleton, 2005). When asked why they use CACs, the investigators identified five major reasons, one of which is the child-friendly environment. They reported that the CAC provides an essential location for interviewing in contrast to the institutional and intimidating atmosphere of the police station or the child's home where the offender might live. The investigators described the CAC facilities as nurturing, comfortable, homey, warm, and safe. They also commented that the presence of technology and equipment in a child-friendly environment was helpful in their investigation without being threatening to the child. Aids such as a one-way mirror allow other investigators to be present at the interview without overwhelming the child, and videotaping the interview has many benefits, such as recording the child's early accounts of the abuse when their memory is fresh, eliminating the need for multiple interviews, allowing other workers to understand the child's experiences and provide appropriate services, and possibly encouraging offenders to accept a guilty plea (Hill, 2008). The researchers concluded:

> *The deceptively simple idea of a child friendly environment as a prerequisite for a CAC turns out to be critically important. Respondents reported that this environment was not only beneficial in increasing the child victim's comfort and reducing trauma, but also in promoting self-disclosure and improving the accuracy of the information provided. This may strengthen the ability of criminal justice professionals to pursue prosecution and, in some cases, help law enforcement arrange for plea-bargaining.* (Newman et al., 2005, p. 177)

A multi-site evaluation of four CACs in the United States found that all four sites had separate, private and comfortable facilities that were designed for interviewing children (Cross et al., 2008), and 81% of the child interviews took place in these facilities. In contrast, child interviews in the non-CAC comparison communities were more likely to take place at police stations, child protection service agencies, or victims' homes or schools (Cross et al., 2007). However, contrary to the researchers' hypothesis that the number of interviews to which children were subjected would be less in CACs compared to comparison communities, they found that most children in both settings underwent about the same number of interviews.

An ongoing study examining the impact of CACs in Canada reported in its mid-project report that all five sites in the study with dedicated space were child- and family-friendly, bright and welcoming (Proactive Information Services, 2015). As one staff member reported:

> *Children love the Centre. They get a toy and they can't wait to come back! It's not a scary place. It is child friendly and they have a ball, even if they know what they are there for. I have never heard a child say they wanted to get out of there … parents walk in with images of cops and Child & Family Services and here there are toys and quilts hanging on the wall. Everything is friendly. It alleviates fear and tension.* (p. 19)

To gauge client satisfaction, non-offending caregivers were interviewed about various aspects of the CAC (Proactive Information Services, 2015). When asked if their child was comfortable in the interview room, 81.8% responded yes. Children aged 5 to 11 were asked if they would like to draw something they liked about coming to the CAC or something that made them feel good while at the CAC. Five children created a drawing, and of these, three drawings depicted toys or games in the child-friendly surroundings.

Recommended Guideline

The research literature supports the inclusion of a guideline requiring CACs to have a safe, neutral and comfortable child-friendly setting. The suggested changes arising from the visioning session, however, may have resulted in a guideline that is too broad because it is trying to include the mission of a CAC within it, and in the process lessened the importance of the physical characteristics of the CAC's space. The revised guideline from the National Children's Alliance (2017b) emphasizes that the child-friendly setting needs to be appropriate for diverse populations and also needs to be both physically and psychologically safe. Since the literature uses the term "child-friendly" instead of "child-focused," and the concept of neutrality is important from the perception of the child's comfort and safety, the suggested revised guideline is as follows:

> *The CAC/CYAC provides services to diverse populations of children, youth and their supporting family members in a physically and psychologically safe, neutral and comfortable child-friendly setting.*

3.2 Multidisciplinary Team

Ontario's draft guideline regarding the multidisciplinary team states that:

> *The CYAC has a Multidisciplinary Team (MDT) that includes representatives from the core disciplines involved in the investigation, medical evaluation, advocacy and support, and assessment and treatment of child abuse.*

The CAC working group on the development of national guidelines suggested replacing "has a" with "will include" at its visioning session, to make the guideline more directive. The working group also suggested replacing "multidisciplinary" with "integrated." It further suggested adding representatives from mental health, prevention, justice, and protection to the potential team members. The suggested guideline from the working group is:

> *The CYAC will include an integrated team from the core disciplines involved in the investigation (e.g., mental health and medical treatment assessment, prevention, justice, protection, advocacy and support).*

According to Ontario's draft guidelines, the rationale and key components for the guideline are as follows:

> *Rationale*
>
> *The purpose of interagency collaboration is to coordinate intervention so as to reduce potential trauma to children and families. A functioning and effective Multidisciplinary Team approach, where members have child, youth and family specific skills and expertise, is the foundation of a CYAC. A MDT works collaboratively to provide the most effective coordinated response possible for every child/youth and their family. MDT interventions, particularly when provided in a child-focused CYAC setting, are associated with less anxiety, fewer interviews, increased support, and more appropriate and timely referrals for needed services. In addition, non-offending parents are empowered to protect and support their children throughout the investigation, prosecution and beyond. Police may find that when the support and advocacy needs of the child/youth and family are looked after, they have more time to focus on other aspects of the investigation. They work more effectively with child protection workers on child protection issues and benefit from other MDT members' training and expertise in communicating with children and understanding family dynamics.*
>
> *A coordinated MDT approach facilitates efficient gathering and sharing of information, broadens the knowledge base with which decisions are made by including information from many sources, and improves communication among agencies. More thorough and shared information, improved and timely evidence*

gathering from the beginning stages of the case may contribute to a more successful outcome. An MDT response also fosters needed education, support and treatment for children/youth and families that may enhance their willingness to participate and their ability to be effective witnesses.

Guidelines [Key Components]

- *Ideally, the core MDT should include the following disciplines:*

    - *Police*
    - *Child protection services*
    - *Medical*
    - *Mental health*
    - *Advocacy for child/youth and family*
    - *Crown Attorney*
    - *In addition to the core partners, MDTs can expand to include other professionals.*

- *Some CYACs, including those in small rural communities, may employ one person to fill multiple roles. For example, the CYAC Director may also serve as the Advocate. Community resources may limit personnel and require some to wear "multiple hats." What is important is that each of the above-mentioned functions be performed by a member of the MDT while maintaining clear boundaries for each function. MDTs may also expand to include other professionals as needed, and appropriate for that community (e.g., teachers, probation officers).*

- *The MDT Partner Agencies have a written interagency agreement signed by authorized representatives of all MDT Partner Agencies that clearly commits the signed parties to the CYAC model for its multidisciplinary child abuse intervention response.*

- *There are written agreements that formalize interagency cooperation and commitment to the CYAC practice and policy so there is continuity of practice even when agency personnel change. Written agreements may be in different forms, such as memoranda of understanding (MOUs), protocols and/or guidelines, and are signed by the leadership of participating agencies (e.g., police chiefs, agency directors, supervisors or their designees). These documents should be developed with input from the MDT, reviewed annually and updated as needed to reflect current practice and current agency leadership.*

- *Advocacy personnel are able to provide crisis intervention, support, information and case updates, and advocacy in a timely fashion. These services*

help the MDT anticipate and respond to the needs of children and their families more effectively.

- *As a result of effective information sharing, child protection workers are often in a better position to make recommendations with respect to placement, visitation and can monitor the child's safety and parental support, and evaluate non-offending parents. Protocols often exist to allow for information sharing between child protection and police. All other organizations require signed consent for the youth/family to share information with each other.*

- *Medical providers are available to consult about the advisability of a specialized medical evaluation, and the interpretation of medical findings and reports.*

- *Mental health professionals can provide the MDT with valuable information with respect to the child's emotional state and treatment needs. A mental health professional on the MDT helps to ensure that assessment and treatment and related services are more routinely offered and made available to children and families.*

- *The purpose of multidisciplinary involvement for all interventions is to assure that the unique needs of children/youth are recognized and met. This means that informed decision-making occurs at all stages of the case so that children and families benefit optimally from a coordinated response. Multidisciplinary intervention begins at the initial report and includes, but is not limited to pre- and post-interview debriefings, forensic interviews, consultations, advocacy, medical evaluation, treatment, case reviews, and prosecution. The MDT follows an agreed upon process for collaborative intervention across the continuum of the case.*

- *CYACs should have both formal and informal mechanisms, such as staff meetings that allow MDT members to regularly provide feedback with respect to the operations of the CYAC, addressing both practical, operational/administrative matters (e.g., transportation for clients, use of the facility, equipment upgrades) and MDT issues (e.g., communication, case decision-making, documentation and record keeping).*

- *The MDT participates in ongoing and relevant training and educational opportunities, including across disciplines, peer review and skills-based learning. Ongoing learning is critical to the successful operation of CYACs. The CYAC identifies and/or provides relevant educational opportunities. These should include topics that are relevant to all disciplines, are MDT focused, and enhance the skills of the MDT members.*

- *CYACs should strive to create an atmosphere of trust and respect that fosters opportunities for open communication and enables MDT members to share ideas and raise concerns.*

Evidence

The research evidence supports the benefits of using a multidisciplinary team approach, such as that found in CACs, to manage cases of alleged child abuse. The traditional child protection service (CPS) approach in which one agency investigates the allegation has been criticized because there may be poor integration of services during an investigation into child abuse which can result in multiple interviews of the child by different interviewers with little interagency coordination (Jones et al., 2005; Smith, Witte & Fricker-Elhai, 2006). "Such case management practice may negatively affect the mental health of the child victim and the victim's family, produce unreliable or inaccurate reports from child victims, and reduce the likelihood of successful prosecution" (Smith et al., 2006, p. 354). According to Smith et al. (2006), "the use of an MDT is intended to increase interagency cooperation, promote accountability, improve tracking of cases, … increase the efficient use of community services and resources, … and reduce the number of interviews that the alleged child victim has to undergo" (p. 355).

In a review of the research evidence supporting the use of MDTs, Jones et al. (2005) found:

- the enhanced interagency collaboration and communication associated with the MDTs can serve to enhance child safety and prevent cases from "falling through the cracks";

- sharing information across agencies could reduce gaps in information collected by different investigators;

- the MDT approach to decision making can lead to more effective and efficient decisions and more timely case resolution;

- in a study of daycare sexual abuse investigations (Finkelhor & Williams, 1988; cited in Jones et al., 2005), professional satisfaction was greater for MDT investigations than for traditional investigations and investigations conducted by MDTs resulted in higher conviction rates; and

- another study (Tjaden & Anhalt, 1994; cited in Jones et al., 2005) found that the greater coordination of investigations was positively related to a number of case outcomes, such as corroboration of the victim's evidence, perpetrator confession, criminal charges, and conviction rates.

Smith et al. (2006) completed a study that compared outcomes of 21 child sexual and serious physical abuse investigations completed at a CAC in one mid-south American community with the outcomes of 55 investigations conducted using traditional CPS services in the same community. Findings of this study largely supported the efficacy of the MDT team approach and included:

- local law enforcement agencies were involved in almost three-quarters of cases investigated by the CAC, but only one-third of CPS cases;
- more than one-half of CAC cases received a medical exam, compared to 12% of CPS cases;
- allegations in CAC cases were more likely to be substantiated than in CPS cases;
- of the substantiated cases, those investigated by the CAC were almost twice as likely to be referred for prosecution than were CPS cases; and
- all substantiated CAC cases were referred for mental health treatment, compared to 70% of substantiated CPS cases.

Walsh et al. (2008) compared the length of time between a report of child sexual abuse and the decision to lay criminal charges in one site that had a CAC and in two communities without CACs. The authors reported that the charging decision for cases at the CAC site was made significantly faster than in the two comparison communities and suggested that this could be due to the greater involvement of prosecutors early in the process at the CAC site. The early involvement of the prosecutors could be attributed to the existence of the MDT, which would ensure their involvement at the outset of the case. Walsh et al. (2008) noted that further research is needed on the effects of case resolution time on child outcomes.

Miller and Rubin (2009) also examined the relationship between the presence of CACs and child sexual abuse prosecutions in two adjoining districts in New York City. One district had experienced a significant increase in CAC involvement in child sexual abuse cases while the other district had not. Findings indicated that prosecutions of child sexual abuse cases in the district with increased CAC involvement doubled over a 10-year period from 1992 to 2002, while prosecutions only increased by 25% in the district where CAC involvement remained constant. However, findings also indicated that the rate of prosecutions resulting in convictions did not change substantially between the two districts over time. While the authors did not explicitly attribute the increase in prosecutions in the district with increased CAC involvement to the existence of the MDT, it may be that, similar to the hypothesis proposed by Walsh et al. (2008), the early involvement of prosecutors due to the MDT may have contributed to higher charging rates.

Bracewell (2015) examined factors related to the likelihood that a child sexual abuse case would be accepted for prosecution. With regard to the effects of the MDT, findings indicated that prosecution of cases was significantly related to the number of members on a MDT: as the number of team members increased, so did the likelihood of prosecution. "These findings do support the widely held belief that the team approach to investigating child abuse leads to different outcomes than the traditional methods of investigation that include little to no coordination" (Bracewell, 2015, p. 93).

Herbert and Bromfield (2017) recently conducted a review of studies that examined the efficacy of MDTs for child abuse cases more broadly, rather than just in the context of CACs. In general, the findings suggest that programs using MDTs achieve more positive outcomes than other approaches to investigating and intervening in child abuse cases. Herbert and Bromfield (2017) note that much of the research examining the effectiveness of MDTs has focused on criminal justice outcomes, with a general finding of greater differences in cases dealt with by MDTs earlier in the criminal justice process, such as more criminal charges, more guilty pleas, and higher rates of substantiation of abuse, than outcomes later in the process, such as convictions.

Research reviewed by Herbert and Bromfield (2017) related to mental health and support services was almost universal in finding that cases involving MDTs were more likely to result in the receipt of more services, such as mental health screening and referrals to counselling. Findings with regard to caregiver and staff satisfaction were more equivocal, with some studies finding higher levels of satisfaction in cases with the involvement of an MDT, and others reporting no differences between cases with MDTs and those without. The authors concluded that more research is needed to examine differences in child and family outcomes for child abuse cases using a MDT model and those using other approaches.

Overall, the available research evidence supports the efficacy of MDTs for child abuse case outcomes. However, in an extensive literature review, Lalayants and Epstein (2005, p. 454) identified a number of potential barriers that can negatively impact the effectiveness of MDTs. In addition to difficulties in defining shared goals and objectives, these barriers included:

- *conflicting theories and ideologies about child abuse and neglect;*
- *lack of consensus;*
- *turf disputes, agency territorialism, and power struggles;*
- *confusion about leadership roles and the ownership of the case;*
- *feelings of excessive case scrutiny; and*
- *interdisciplinary decision-making is more time consuming than traditional approaches*.

As noted by Kolbo and Strong (1997), the most effective strategy for dealing with the challenges faced by MDTs is the provision of initial and ongoing training to team members. In addition, to avoid jeopardizing successful prosecutions, it is important to ensure that roles and responsibilities of MDT members are clearly specified in CAC policies and procedures and interagency agreements. Since research on the role of the prosecutor on the MDT is limited, further work in this area is needed, particularly in the Canadian context.

Recommended Guideline

The research literature supports the inclusion of a guideline regarding the use of a multidisciplinary team for suspected cases of child abuse. In a suggested reworking of Ontario's guideline, the CAC working group proposed replacing the term "multidisciplinary team" with "integrated team." While it is certainly important that a team dedicated to investigating abuse and providing services to abused children is integrated, the term "multidisciplinary" is universally used in the literature and should be retained within Canada's guideline. The suggested revised guideline is as follows:

> *The CAC/CYAC will include an integrated, multidisciplinary team from the core disciplines and agencies involved in the case, usually police, child protection services, medical and mental health assessment and treatment, prosecution, and advocacy and support.*

3.3 Cultural Sensitivity

Ontario's draft guideline regarding cultural sensitivity states that:

> *Inclusive and anti-oppressive services are available to all children/youth and families at the CYAC.*

At the CAC working group's visioning session on the development of national guidelines, participants discussed whether the guideline should specify that the services available should be culturally competent and socially inclusive. In addition, working group members also questioned whether the word "anti-oppressive" was the most appropriate term to use. The suggested guideline from the working group is:

> *Culturally competent, socially inclusive and anti-oppressive services are available to all children/youth and their families and caregivers at the CYAC.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

Rationale

Inclusion and anti-oppression is essential to the CYAC philosophy. Inclusion and anti-oppression issues influence nearly every aspect of work with children/youth and families, such as welcoming a child/youth and family to the centre, employing effective forensic interviewing techniques, gathering information to make a determination about the likelihood of abuse, selecting appropriate mental health providers and securing help for a family in a manner in which it is likely to be utilized.

Proactive planning and outreach should focus on culture, ethnicity, religion, socioeconomic status, disability, gender and sexual orientation. These factors contribute to an individual's worldview, unique perceptions and experiences throughout the investigation, intervention, and case management processes. By addressing these factors in an inclusive and anti-oppressive environment, children/youth and families of all backgrounds feel welcomed, valued, respected and acknowledged by staff, MDT members and volunteers.

Guidelines [Key Components]

- *To effectively meet the needs of children/youth and families, the CYAC must be willing and able to understand each client's worldview, adapt practices as needed, and offer help in a manner in which it can be utilized. Striving toward inclusivity and anti-oppression is an important and ongoing endeavor.*

- *The CYAC must ensure that throughout the investigation process, provisions are made for non-English speaking and Deaf or hearing impaired children/youth and their non-offending family members. Language barriers can significantly impact the ability to obtain accurate information from the child/youth and family, and hinder the ability of the MDT to convey their roles, expectations, concerns and decisions with respect to the investigation and intervention services. Language barriers may compound already existing possibilities for miscommunication between children/youth and adults. In order to protect the integrity of the process, care should be taken to ensure that appropriate interpreters are utilized. CYACs should not have children/youth or family members as interpreters.*

- *All children/youth and families who come to the CYAC should feel welcome. While there are many ways of accomplishing this, materials such as dolls, toys, books, magazines, and artwork should reflect the different interests, ages, developmental stages, ethnicities, religions and genders of children/youth and families served.*

- *It is the responsibility of the MDT members to understand the background of the child being served and what language(s) s/he speaks and/or is comfortable speaking. Understanding the child/youth and family's background will help to: effectively elicit relevant history; understand decisions made by the child/youth and family; understand the perception of the abuse and attribution of responsibility made by the child/youth, family and community; understand the family's comprehension of laws; address any religious or cultural beliefs that may affect the disclosure; and recognize the impact of prior experience with police and government authorities both in this country and in other countries of origin. With knowledge and preparation, the MDT should structure services to obtain the most complete and accurate information and more effectively interpret and respond to the child/youth and family's needs.*

- *CYACs serve clients who are a part of the community in which the CYAC is located. It is important that the CYAC strive to recruit, hire and retain staff, volunteers and Board members that reflect the demographics of the community and the children/youth and families served.*

Evidence

The available research literature generally supports the guideline proposed above. Several studies have found that children who belong to minority groups are more likely to experience sexual and physical abuse, highlighting the need for an understanding of and sensitivity to the diversity of CAC clients. This also underscores the importance of ensuring that diversity is accommodated in all services provided to children, youth and their families.

In Canada, it is essential that CACs are able to accommodate the unique cultural issues that are relevant to Aboriginal clients. While no research has been conducted specifically related to Aboriginal CAC clients, studies have reported that Aboriginal children and youth are disproportionately more likely to be victims of physical and sexual abuse than non-Aboriginal children. For example, Collin-Vézina, Dion, and Trocmé (2009) reported that 25-50% of Aboriginal women were victims of sexual abuse as children, compared to 20-25% of non-Aboriginal women. More recently, Statistics Canada (2015) reported that Aboriginal women were substantially more likely to be victims of sexual assault than non-Aboriginal women, and Aboriginal people were more likely to have experienced violence in their childhood. Using data collected by Statistics Canada's General Social Survey, Brzozowski, Taylor-Butts, and Johnson (2006) reported that Aboriginal young people aged 15 to 34 years were almost two and a half times more likely to experience a violent victimization than were older individuals. Further, for both age groups, victimization rates were much lower among non-Aboriginals.

Dettlaff and Earner (2012) reported that, in the United States, children of immigrants are more than twice as likely to be the subjects of alleged sexual abuse reported to child welfare authorities than children of U.S.-born parents. Similarly, the Child Welfare Information Gateway (2016) and Lawrence et al. (2012) noted that minority children are over-represented in the child welfare system; however, Lawrence et al. (2012) found that the majority of child welfare professionals had not received formal cultural competence training. A 2015 Canadian study on the impact of CACs found that multidisciplinary team members who had received training in cultural competence and diversity had completed their training through their home agencies or their post-secondary education, rather than through the CAC (Proactive Information Services, 2015).

In a literature review conducted by Cohen et al. (2001), the authors concluded that ethnocultural background may be related to the types and severity of symptoms exhibited by abused children. Some of the research reviewed found that minority children display a more complex pattern of symptoms and more lasting negative effects than Caucasian children.

Fontes and Tishelman (2016) stressed the importance of CACs having the capacity to interview children in their preferred language, and Fontes (2010) discussed the issues posed by language barriers when interviewing children of other ethnocultural backgrounds. She noted that an interviewer who understands a bit of a child's language but is not proficient in it may be tempted to conduct the interview without an interpreter, but she advises against this practice. Fontes and Plummer (2010) stress that professionals who work with abused children and their families must endeavor to become proficient in interviewing and assessing those who are from racial, cultural and socioeconomic backgrounds that are different from their own. These authors also recommended employing professionals from diverse backgrounds and ensuring that agencies provide high quality training in cultural issues. Moreover, it is well established in the literature that family members should not act as interpreters for several reasons: they lack professional training; they have limited experience in interpreting; they may withhold or alter sensitive or key information; and there may be ethical concerns including the potential to violate confidentiality (Chand, 2005; Malott & Paone, 2008; Wiener & Rivera, 2004).

Other research has found that the disproportionate prevalence of child abuse among minority children and youth extends beyond ethnocultural minorities, providing evidence that CACs need to be sensitive to the needs of these groups. Smith and Harrell (2013) reported that children with disabilities are three times more likely to be victims of sexual abuse than other children, and those with intellectual or mental health disabilities are at even greater risk. However, these children are less likely to receive victim services and supports. According to 2003 data reported by Lightfoot and LaLiberte (2006), the

rate of maltreatment of children with disabilities was between 1.7 to 3.4 times higher than non-disabled children.

In a school-based study, Sullivan and Knutson (2000) found that the overall rate of maltreatment for children with educationally-relevant disabilities was three times the rate for non-disabled students. Further, disabled children were more likely to have suffered multiple types of abuse. Deaf and hard of hearing children were almost four times as likely to have suffered physical abuse as children without disabilities.

Cassady et al. (2006) discussed the unique issues that arise when working with young victims of abuse who are Deaf or hard of hearing. These issues include:

- up to 90% of children who are Deaf or hard of hearing are raised by parents who do not know sign language;

- English is understood only 30-40% of the time by lip-reading;

- the sign language available for conveying emotions is quite limited and the depth of emotion cannot be understood through sign language;

- education about safety and sexual abuse is limited for the Deaf and hard of hearing; and

- the trauma associated with sexual abuse for a Deaf or hard of hearing child may be compounded by additional trauma related to the inability to communicate effectively about their experience and emotions.

Cassady et al. (2006) concluded that professionals who work with Deaf and hard of hearing children need to understand the relevant cultural considerations and need to be aware of the isolation, oppression, and stigmatization that these children are often confronted with.

In reporting on a meta-analysis of school-based studies conducted in North America, Friedman et al. (2011) found that sexual minority adolescents were 2.9 times more likely to report previous sexual abuse and 1.3 times more likely to report parental physical abuse than were sexual nonminority adolescents. In a re-analysis of seven population-based surveys of high school students in Canada and the United States, Saewyc et al. (2006) found that rates of sexual abuse reported by bisexual and homosexual boys ranged from 20% to 25%, compared to under 10% for heterosexual boys. The rates of reported sexual abuse for bisexual and lesbian girls ranged from 25% to 50%, compared to under 10% to 25% for heterosexual girls. This study also found that heterosexual youth reported lower levels of physical abuse than did bisexual and

homosexual students. The authors also concluded that the discrepancy between the abuse of heterosexual and sexual minority youth has been increasing over time.

Recommended Guideline

The recommended guideline for cultural sensitivity, as suggested by the CAC working group and supported by the research literature, is:

> *Culturally competent and socially inclusive services are available to all children, youth and their families and caregivers at the CAC/CYAC.*

3.4 Forensic Interviews

Ontario's draft guideline regarding forensic interviews is as follows:

> *Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, and are conducted jointly with police and child protection services to avoid duplicative interviewing. Forensic interviews are the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution, and may be the beginning of a process of healing for many children/youth and families. The manner in which a child/youth is treated during any interview may significantly impact his/her understanding of, and ability to respond to the investigation process and/or criminal justice system. Quality interviewing includes: an appropriate, neutral setting; effective communication among MDT members; employment of legally sound interviewing techniques; and the selection, training and supervision of interviewers, focusing on child-specific expertise.*

At the CAC working group's visioning session on the development of national guidelines, participants proposed to adopt the first sentence of Ontario's guideline and to add the wording "follows leading practices" to emphasize that the techniques used in forensic interviews should be evidence-based. The working group also proposed making the guideline more concise by deleting the sentences explaining the purpose of the forensic interview. The suggested guideline from the working group is:

> *Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, follows leading practices and are conducted jointly with police and child protection services to avoid duplicative interviewing.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

> *Rationale*

The purpose of a forensic interview in a CYAC is to obtain a statement from a child/youth, in a developmentally and culturally sensitive, unbiased and fact-finding manner that will support accurate and fair decision-making by the involved MDT for the criminal justice and child protection systems.

Guidelines [Key Components]

- *Some communities may have formal protocols that describe the steps involved in the investigative and interview process, and where these exist they must be followed in the CYAC. CYACs without community protocols should develop and document the process and steps that will be followed in the centre.*

- *Forensic Interviewers must have formal, specialized training in order to conduct interviews in the CYAC. Following research-based guidelines will help ensure a sound process. These guidelines as recognized by the members of the MDT should be monitored over time to ensure that they reflect current practice.*

- *The CYAC should offer an environment that enhances free recall, minimizes interviewer influence and gathers information needed to avoid duplication of the interview process (e.g., safety concerns, criminal acts).*

- *Forensic interviews of children/youth should be conducted at the CYAC whenever possible rather than at other settings (e.g., a police station). The CYAC is the setting where the MDT is best equipped to meet the child's needs during an interview. On occasions when interviews take place outside the CYAC, steps must be taken to utilize appropriate forensic interview guidelines.*

- *The CYAC should provide ongoing opportunities for professionals who conduct forensic interviews to receive specialized training. Training forums may include: attendance at workshops or conferences; reading current research and literature on forensic interviewing; role playing; interviewing children on non-abuse related topics; review of recorded interviews; observations of interviews; peer review; and ongoing supervision.*

Evidence

The available research evidence provides support for the inclusion of a guideline regarding forensic interviewing of alleged child abuse victims within Canada's guidelines. As noted by Cross et al. (2007, p. 1032):

[O]ne of the primary goals of Children's Advocacy Centers (CACs) is to improve child forensic interviewing following allegations of child sexual abuse. They aim

to coordinate law enforcement, child protective, medical, and other agencies, and typically use a single interviewer to provide information to every investigator involved in the case.

The mid-project report on the impact of six Canadian CACs (Proactive Information Services, 2015) reported that, in 80% of the cases examined, the child victim had a forensic interview, and in 81% of cases, only one interview with the victim was conducted. The majority of interviews (83%) were conducted by a police investigator and 38% were conducted by a child protection worker, indicating that both police and child protection were involved in conducting some interviews together.

In a study of 117 CACs in the United States made up of 71 NCA members and 46 non-members, Jackson (2004b) found that 68% of member and 41% of non-member CACs had a trained interviewer on site. All member centres and 91% of non-member centres provided ongoing training for their interviewers. The majority of both member centres (83%) and non-member centres (87%) had adopted the procedure of having one person conduct the forensic interview with other members of the MDT observing, thus avoiding the need for multiple interviews with child victims.

Cross et al. (2007) conducted a comparative study of forensic interviewing practices with a sample of 1,452 cases at four accredited American CACs and four non-CAC communities within the same states. The authors concluded that:

> *[T]hese CACs had a noticeable impact on investigations and forensic interviewing in child sexual abuse cases. Team interviews, videotaping of interviews, joint CPS-police investigations, and police involvement in CPS sexual abuse cases were all more common in CAC cases*. (Cross et al., 2007, p. 1048)

Cross et al. (2007) did not find any differences in the number of forensic interviews between CAC and non-CAC sites: in both cases, the majority of children had only one interview, and very few had more than two interviews. The substantial majority of interviews for the CAC sample took place in the CAC facility; in the non-CAC communities, interviews typically were conducted in police and CPS facilities, and victims' homes and schools.

The manner in which a forensic interview with a child is conducted and the types of questions posed can have a substantial effect on the accuracy of information provided by a child during an interview and, in many cases, "inappropriate interview techniques appear to have compromised the children's testimony, rendering it flawed and inaccurate" (Lamb et al., 2007, p. 1202). A considerable body of research (reviewed by Lamb et al., 2007; Cyr, 2014) has pointed to the efficacy of open-ended questions in eliciting accurate recall in the form of narrative responses as opposed to questions that are posed as more focused prompts, which often require the child to recognize one or

more scenarios that are suggested by the interviewer. The potential of questions relying on recognition to generate inaccurate memories is particularly high for children aged six and under (Lamb et al., 2007; Cyr, 2014).

The relationship between the types of questions asked during a forensic interview with a child and the resulting accuracy of testimony has led to the development of research-based interview protocols, such as the National Institute of Child Health and Human Development (NICHD) Protocol (Orbach et al., 2000), the Step-Wise Interview Technique (Yuille et al., 1993), and the RATAC Protocol (Rapport, Anatomy identification, Touch inquiry, Abuse scenario, and Closure) (Anderson et al., 2010).[6] Proactive Information Services (2015) reported that the majority of Canadian CACs in their study use the Step-Wise Interview Technique; one CAC uses the RATAC Protocol.

The available protocols differ from one another in some aspects of their approach, such as the use of anatomical dolls and diagrams. However, they all share a common philosophy of beginning an interview by building rapport with the child, asking general, open-ended questions first to elicit a narrative account of what happened from the child before moving to more narrow and focused questions, and asking questions that are appropriate for a child's age and developmental level. In addition, all protocols stress the need for extensive and ongoing training for interviewers.

The NICHD Protocol (Orbach et al., 2000; revised by Lamb et al., 2007) was an important and influential development in forensic interviewing (Faller, 2015), and has been the subject of a great deal of empirical research; findings of these studies are likely generalizable to some degree to other available protocols. This structured protocol "guides interviewers through all phases of the investigative interview, illustrating free-recall prompts and techniques to maximize the amount of information elicited from free-recall memory" (Lamb et al., 2007, p. 1204). These researchers report that independent studies from four different countries (Canada, the United States, the United Kingdom, and Israel) have found that interviews conducted using the NICHD Protocol lead to enhanced quality of the information obtained from alleged victims. Similarly, in a study conducted at a CAC in Iceland, Gudjonsson et al. (2010) reported that using the NICHD Protocol may lead to increased disclosure among children suspected of being sexually abused.

Lamb et al. (2002a, 2002b, 2007) stressed the importance of continued training, feedback and supervision for interviewers who are using a structured forensic interviewing protocol. They noted that interviewer training frequently leads to improvement in trainees' knowledge, but that this increased knowledge often does not translate into substantial changes to actual interviewing practices. "Recognizing this,

[6] Faller (2015) presents a detailed discussion and comparison of several forensic interview protocols.

training in the use of the NICHD Protocol has always been accompanied by efforts to provide continued support, guidance, and feedback on interviewer behavior in interviews conducted after starting to use the Protocol" (Lamb et al., 2007, p. 1209).

Pipe et al. (2012) examined the effects of using the NICHD Protocol on various measures of case outcomes in Utah. These investigators compared outcomes of 350 cases that were concluded before the protocol was implemented to 410 cases that were investigated after implementation of the protocol. Both the pre- and post-implementation cases involved the same detectives, prosecutors and judges, so any differences could not be attributed to changes in personnel. Highlights of the findings included:

- 28% of pre-protocol cases were declined by the prosecution, compared to 17.6% of protocol cases;

- 42% of pre-protocol cases led to arrests and subsequent charges, compared to 52.9% of cases investigated after implementation of the protocol;

- of the cases that proceeded to trial, 50% of pre-protocol cases resulted in a conviction, while convictions were obtained in 91% of protocol cases; and

- for both pre-protocol and protocol cases, cases with alleged victims between the ages of 2.8 and 4 years were less likely to have charges laid than cases involving older alleged victims.

Recommended Guideline

The evidence reviewed supports the guideline regarding forensic interviewing suggested by the CAC working group. The working group deleted sentences from Ontario's draft guideline that explained the purpose of forensic interviewing and it is recommended this information be included in the rationale for the guideline. The proposed guideline is:

> *Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, follows leading practices and are conducted jointly by police and child protection services to avoid duplicative interviewing.*

3.5 Advocacy and Support Services

Ontario's draft guideline regarding advocacy and support services states that:

> *Advocacy and support services are neutral and available to all children/youth and families at the CYAC. Advocacy and support are offered to help reduce trauma for*

the child/youth and non-offending family members and to improve outcomes. Advocacy services encourage child/youth and family access to and participation in the investigation, prosecution, assessment, treatment and support services, and are a necessary component of the CYAC. Up-to-date information and ongoing support is critical to a child/youth and family's comfort and ability to participate in intervention and treatment.

At the CAC working group's visioning session on the development of national guidelines, participants proposed adopting the first two sentences of Ontario's guideline without changes. The working group also proposed making the guideline more concise by deleting the sentences explaining the purpose of advocacy and support services, and questioned whether the term "victim" should be included in the guideline. The suggested guideline from the working group is:

Advocacy and support services are neutral and available to all children/youth and families at the CYAC. Advocacy and support are offered to help reduce trauma for the child/youth and non-offending family members and to improve outcomes.

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

Rationale

Advocacy and support for children/youth and their families are important functions of the CYAC response. The manner in which services are provided must be clearly defined to avoid role confusion. Support and advocacy for children/youth and families is integral and fundamental to the MDT response. The support/advocacy function may be filled by a designated Advocate or by another member of the MDT. Notwithstanding the CYAC's model, appropriately trained individual(s) needs to be identified to fulfill these responsibilities.

Children/youth and families need support to navigate the various systems they encounter that may be unfamiliar to them. A crisis may reoccur at times of financial hardship, child placement, arrest, and change/delay in court proceedings. Children/youth may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CYACs provide some of these services through support groups for non-offending family members and/or access to mental health services either at the CYAC or through other community agencies or providers.

Often families have never been involved with the systems that respond to child abuse allegations. In the aftermath of victimization, the child/youth and family may feel a loss of control; education provides information that is empowering. Education is an ongoing process because families may be unable to process all

information at one time and their needs often change over time. Many are in crisis, including dealing with immediate safety issues, and are coping with the emotional impact of the initial report and the ensuing process. As family needs and case dynamics change, these changes must be assessed so that additional relevant information and services can be offered.

Guidelines [Key Components]

- *An Advocate is available to the child/youth and the family to ensure a consistent and comprehensive network of support. Children/youth and families in crisis need assistance in navigating through the system's response. While more than one person may perform Advocacy functions at different points in time, coordination that promotes continuity and consistency is the responsibility of the CYAC. While some CYACs may have dedicated Advocates, others may have other staff (e.g., care coordinators, victim advocates, and child life specialists) that perform Advocacy functions.*

- *Advocacy and support may include but is not limited to:*

    - *crisis intervention and support at all stages of investigation;*
    - *attendance and/or coordination of interviews and/or case reviews;*
    - *greeting and orientation of children/youth to the CYAC;*
    - *providing education about the coordinated multidisciplinary response;*
    - *providing updates to the family on case status, court dates, dispositions, and sentencing;*
    - *assistance with services such as housing, food, transportation, and public assistance; and*
    - *providing referrals for mental health services and court preparation for the criminal justice process.*

- *It is important that individuals be informed with respect to their rights as victims of crime, including information about victims' compensation. Non-offending family members who are affected by the crime may also be entitled to services. Many children/youth and their families are unfamiliar with their rights. Information about the rights and services to which they are entitled should be explained. This information should be provided by a professional who is knowledgeable about the criminal justice system. In some CYACs, this role may be filled by specialized Child Victim Witness professionals or court-based Victim/Witness Assistance Programs.*

Evidence

According to the mid-project report examining the impact of CACs in Canada (Proactive Information Services, 2015), in most CACs the victim advocate is involved as

the central point of contact with the child victim and his or her family. The victim advocate may be responsible for a number of tasks including:

> [Supporting] *the victim and family at the time of the interview, helping to create the supportive and welcoming atmosphere, particularly at the time of the forensic interview. She may also support the victim and family by acting as a liaison with the Crown, attending court interviews, providing information about testimonial aids and victim impact statements, referring victims and family members to outside supports (e.g., counselling), acting as a "system navigator," and providing updates as to how the case is proceeding. A significant role is being the "listening ear" and central point of contact for victims and their families.* (Proactive Information Services, 2015, p. 20)

Little research was identified that was directly related to the specific advocacy and support services offered by CACs and the neutrality of these services or that compared different models of advocacy; much of the available literature dealt with satisfaction of child clients and their non-offending caregivers with the services received. Bonach, Mabry and Potts-Henry (2010) surveyed 120 non-offending caregivers of former CAC clients in a rural community in the eastern United States. Respondents were asked about their overall level of satisfaction with the CAC experience, as well as their satisfaction with three aspects of CAC services: information and logistical coordination; responsiveness and clients' comfort; and staff courteousness and helpfulness. In addition, caregivers were asked about their satisfaction with individual members of the multidisciplinary team including: child welfare services; law enforcement services; district attorney services; medical evaluation services; and victim advocacy services. Results indicated that caregivers' overall rating of satisfaction was significantly related to their satisfaction with the three components of CAC service, as well as level of satisfaction with child welfare services, law enforcement, and victim advocacy. Overall satisfaction was not related to satisfaction with medical services or the services of district attorneys.

In a study that surveyed both sexually abused children and their non-offending caregivers, Kouyoumdijian, Perry and Hansen (2009) identified three specific areas where interventions offered by CACs could be improved, particularly by the individuals involved in victim support and advocacy:

- increased education for children, caregivers and professionals regarding child sexual abuse-related symptoms;

- encouraging abused children to participate in rewarding activities and helping parents to provide support for the child; and

- teaching adults to recognize and acknowledge their biases and behaviours on an ongoing basis.

In discussing the role of child victims in the justice system, Finkelhor, Cross and Cantor (2005) highlighted the points in the progression of a case through the justice system when intervention and support are especially important for child victims. These authors also emphasized the benefits to child victims of having a dedicated individual who stays connected to a case for the duration of a victim's involvement with the justice system. The recommendations made by Finkelhor et al. (2005) are clearly in line with the CAC standard of having an advocate whose role is to assist child victims and their families in navigating through systems that are, in all likelihood, very unfamiliar to them.

Recommended Guideline

The working group deleted sentences from Ontario's draft guideline that explained the purpose of advocacy and support services and it is recommended this information be included in the rationale for the guideline. It is also proposed that the term "victim" be included in the guideline to emphasize the need to focus on victim support and to reflect the terminology adopted in the literature. The recommended guideline for advocacy and support services, as suggested by the CAC working group and supported by the research literature, is:

> *Victim advocacy and support services are neutral and available to all children, youth and families at the CAC/CYAC. Advocacy and support are offered to help reduce trauma for the child/youth and supporting family members and to improve outcomes.*

3.6 Medical Evaluation and Treatment

Ontario's draft guideline regarding medical evaluation and treatment states that:

> *Specialized medical evaluation and treatment services are routinely made available to all children/youth and coordinated with the multidisciplinary team response. All children/youth who are suspected victims of child abuse should be assessed to determine the need for a medical evaluation.*

The CAC working group on the development of national guidelines suggested rewording the second sentence of Ontario's guideline and making the guideline more directive by changing "should" to "shall." The suggested guideline from the working group is:

Specialized medical evaluation and treatment services are routinely made available to all children/youth and coordinated with the multidisciplinary team response. All cases of suspected child abuse shall be assessed to determine the need for a medical evaluation.

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

Rationale

A medical evaluation holds an important place in the multidisciplinary assessment of child abuse. Medical consultation with the MDT on cases of child abuse at the CYAC will assist in ensuring that all children/youth are provided with a medical evaluation when necessary. The goal of the medical evaluation is to reassure children/youth and caregivers about their well-being, identify and document necessary medical findings, screen for injuries/medical conditions and initiate treatment when necessary.

Guidelines [Key Components]

- *Medical evaluations should be offered to all children/youth as determined by skilled medical clinicians or by local MDTs that include qualified medical representation. Specialized medical evaluations can be provided in a number of ways. Some CYACs have a medical provider who comes to the centre on a scheduled basis, while in other communities the child is referred to a medical clinic or health care agency for this service. CYACs need not be the provider of primary care but CYACs must have protocols in place outlining the linkages to primary care and other needed healthcare services.*

- *The timing of the medical evaluation is key in many child abuse investigations.*

- *Immediate consultation with the MDT will allow for necessary decision making about the need for an exam and the timing. Timing should be based on the presence of physical signs and symptoms, need for medical treatment and collection of forensic evidence.*

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

- *Photographic documentation of examination findings (e.g., for physical injuries, etc.) is the standard for medical evaluations in child abuse cases. Photo documentation enables peer review, continuous quality improvement, and consultation. It may also obviate the need for a repeat examination of the child and is necessary for evidentiary purposes. Genital photo documentation (via colposcope or camera) in cases of sexual abuse should be strongly considered; however, issues of consent, storage and, access must be established.*

- *All medical clinicians who provide medical evaluations at a CYAC should have adequate training and ongoing continuing education. It is essential that the medical provider be familiar and keep up-to-date with published research studies on findings in children who have and have not been abused, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations.*

- *The medical clinician should have a system in place so that consultation with an established expert or experts in child abuse medical evaluation is available when a second opinion is needed in cases where physical or laboratory findings are felt to be abnormal. Regular peer review of cases should be conducted with colleagues and/or experts in the area.*

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

- *The medical evaluation is an important part of the response to suspected child abuse and neglect, and relevant findings of the medical evaluation should be shared with and explained to the MDT in a routine and timely manner so that case decisions can be made effectively.*

Evidence

The research literature supports the need for CAC clients to have access to medical evaluations and for medical personnel to have adequate training and ongoing continuing education in evaluating suspected cases of child abuse. Walsh et al. (2007) noted that forensic medical exams are an important component of the response to cases of suspected child sexual abuse. These authors stated that the exams serve three purposes: to identify medical evidence

that could be used in subsequent criminal proceedings; to identify any injuries suffered by the alleged victim and commence treatment if necessary; and to reassure the alleged victim and her or his parents regarding the child's physical well-being. An article by Adams et al. (2016) provides detailed guidelines for the medical examination of children who are suspected of having been sexually abused.

In their study of four CACs and comparison communities without CACs in the United States, Walsh et al. (2007) found that suspected victims of child sexual abuse who were seen at a CAC were twice as likely to receive a forensic medical exam as were children seen in non-CAC communities. Similar data were reported by Edinburgh, Saewyc and Levitt (2008), who found that 85% of suspected victims of child sexual abuse seen at a CAC received a physical examination, compared to 40% of suspected victims who were seen elsewhere in the community. The authors concluded that "the hospital-based CAC provided better assessments of abuse-related risk factors, the abuse experience, and management of the immediate sexual health needs of teens" (p. 1125).

A study by Lane and Dubowitz (2009) supported the need for medical personnel conducting child abuse assessments to have specialized training in this area. In a survey of primary care pediatricians, the authors found that respondents generally had very little direct experience in evaluating cases of child abuse and that less than one-half of them expressed confidence in their ability to evaluate suspected cases of child sexual abuse. Further, respondents said that they would like to have an expert available to whom they could refer the majority of suspected cases of sexual abuse. Similarly, Berkoff et al. (2008) recommended that medical personnel with little experience in assessing child sexual abuse should have any abnormal findings from a physical examination confirmed by an experienced examiner, and that all findings should be documented by photographs. In their mid-project report on the impact of CACs in Canada, Proactive Information Services (2015) reported that, for all but one CAC, medical evaluation is conducted at an off-site hospital or health centre. In some locations, medical staff has received specialized training in dealing with child and youth victims, while in other locations the child will be seen by whoever is on-call in the emergency department at the time.

A study by Adams et al. (2012) documented the importance of adequate training, experience and ongoing education for medical personnel who conduct medical evaluations in cases of suspected abuse. In a survey of physicians, sexual assault nurse examiners and advanced practice nurses, the authors found that the accuracy of identifying cases of abuse based on images and case information provided to the respondents positively correlated with the total number of sexual abuse evaluations performed and the average number of evaluations performed per month. Respondents who had their cases reviewed at least quarterly by a recognized child sexual abuse expert were also more likely to accurately identify cases of abuse. The authors concluded

that although correctly interpreting physical findings in a child abuse examination is very important, obtaining a detailed medical history in a developmentally appropriate fashion is also of importance.

Finkel and Alexander (2011) also discussed the necessity of obtaining a complete medical history from sexually abused children in addition to the physical exam. The authors noted that the history should be taken by skilled, compassionate and objective medical personnel who have an understanding of the forms of child abuse as well as the range of reactions that children may exhibit after being abused. Taking a complete medical history can also be therapeutic for the child and family because it can serve as an opportunity to address any worries or fears they may have regarding the process or examination. Leventhal, Murphy, and Asnes (2010) noted that, given the potentially damaging long-term effects of child sexual abuse, medical personnel need to deal with the concerns of the child and parents, rather than simply focusing on the forensic examination. This also argues for the need to take a full medical history, which can incorporate communication aimed at dealing with the worries and fears of the child and family.

Christian (2011) discussed the timing of the medical evaluation and presented arguments for immediate examination after the alleged abuse or for delaying the evaluation. She suggested that the appropriate timing depends on several factors. Reasons for immediate evaluation include:

- the need for collection of forensic evidence;
- identification of genital injury to provide support for the child's disclosure;
- pregnancy testing and prophylaxis; and
- testing and possible treatment for sexually transmitted infections.

Christian (2011) suggested that circumstances that may result in delaying the medical evaluation include:

- unavailability of qualified medical personnel;
- if the child's emotional state precludes an immediate examination; and
- if the disclosure of the abuse has been delayed and an immediate examination would be of little utility in corroborating the abuse.

Recommended Guideline

The recommended guideline for medical evaluation and treatment, as suggested by the CAC working group and supported by the research literature, is:

> *Specialized medical evaluation and treatment services are routinely made available to all children and youth and are coordinated with the multidisciplinary*

team response. All cases of suspected child abuse shall be assessed to determine the need for a medical evaluation.

3.7 Mental Health Evaluation and Treatment

Ontario's draft guideline regarding mental health evaluation and treatment states that:

> *Specialized counselling and trauma-focused mental health services, designed to meet the unique needs of children/youth and non-offending family members, are available as part of the MDT response.*

The CAC working group on the development of national guidelines discussed whether "specialized" should be replaced with "comprehensive," and whether "trauma-focused" should be "trauma-informed." Further, the working group suggested that the guideline should be worded more strongly and should state that mental health services are essential to the multidisciplinary team response. The suggested guideline from the working group is:

> *Comprehensive trauma–informed counselling and mental health services, designed to meet the unique needs of children/youth and family members, are essential to the MDT response.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

> *Rationale*
>
> *Healing may begin with the first contact with the MDT, the common focus of which is to minimize potential trauma to children/youth. However, without effective therapeutic intervention, many traumatized children/youth will suffer ongoing or long-term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetime. There are evidence-based assessment and treatments, and other practices with strong empirical support that will both reduce the impacts of trauma and the risk of future abuse. For these reasons, an MDT response must include trauma assessment and specialized trauma-focused mental health services for children/youth and non-offending family members.*
>
> *Family members are often the key to the child's recovery and ongoing protection. Their mental health is often an important factor in their capacity to support the child/youth. Therefore, family members may benefit from counselling and support to address the emotional impact of the abuse allegation, reduce or eliminate the risk of future abuse, and address issues that the allegation may trigger.*

Mental health treatment for non-offending parents or caregivers, many of whom may have victimization histories themselves, may focus on support and coping strategies for themselves and their child, information about abuse, coping with issues of self-blame and grief, family dynamics, parenting education, and abuse and trauma histories. Siblings and other children may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic relationship.

Guidelines [Key Components]

- *Counselling and mental health services are provided by professionals with child abuse and child development expertise.*

- *Specialized trauma-focused mental health services for the child/youth include but are not limited to:*

    - *crisis intervention services;*
    - *supportive counselling;*
    - *trauma-specific assessment, including full trauma history;*
    - *use of standardized measures (assessment tools) initially and periodically;*
    - *family/caregiver support;*
    - *an individualized treatment plan that is periodically re-assessed;*
    - *individualized evidence-informed treatment appropriate for the child/youth and family;*
    - *referral to other community services as needed; and*
    - *clinical supervision.*

- *A trained mental health professional should participate in case reviews so that the child/youth's treatment needs can be assessed and the child/youth's mental health can be monitored and taken into account as the MDT makes decisions. In some CYACs, this may be the child's treatment provider; in others, it may be a mental health consultant.*

- *The CYAC's written documents should include provisions about how mental health information is shared, and how client confidentiality and mental health records are protected.*

- *The forensic process of gathering evidentiary information and determining what the child may have experienced is separate from mental health treatment. Mental health treatment is a clinical process designed to assess and mitigate the possible 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.*

- *Mental health services for non-offending family members and/or caregivers may include onsite screening, assessment, and treatment, or by referral. It is important to consider the range of mental health issues that could impact the child/youth's recovery or safety with particular attention to the caregiver's mental health, substance use/misuse, family violence, and any other trauma history. Family members may benefit from 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.*

- *Siblings may also benefit from opportunities to discuss their own reactions and experiences, and to address family issues within a confidential therapeutic relationship.*

Evidence

The available research evidence provides support for the mental health services guideline drafted by the working group. The importance of readily-available mental health services for CAC clients and their families is widely acknowledged (Tavkar & Hansen, 2011), as is the finding that early intervention following a traumatic experience leads to better outcomes for children (Hahn et al., 2016). A 2016 survey of 38 CACs in New York state (Baker et al., 2016) found that all but two agencies reported that they provided mental health screening to at least some of their clients and approximately 70% of CACs reported that they provide on-site mental health screening to at least one-half of their clients. None of the agencies surveyed reported that all of their clients were screened, with the most common reasons being that the child or family refused mental health services, or that the child was thought to be too young to receive screening.

A 2016 study by Vanderzee et al. examined the frequency with which children of various ages were referred for mental health services in all CACs in Arkansas. As noted by these authors,

> *a common misperception among families-and even professionals who work in the field of trauma-is that very young children (i.e., children under 6) will not be affected by early stressful or traumatic events because they will not remember what happened, are resilient by nature, and/or will simply grow out of any emotional or behavioral problems that occur in early childhood.* (Vanderzee et al., 2016, p. 303)

However, these authors note that a growing body of research suggests that very young children may experience substantial negative effects arising from trauma experienced in the first few years of their lives. In keeping with the common misperception outlined above, Vanderzee et al. (2016) found that 74% of child clients aged 0 to 2 years at Arkansas CACs were not referred for mental health services, compared to 28% of clients

aged 3 to 5, and 24% of clients 6 years and older. These authors conclude that increased education about the effects of trauma and abuse on very young children and the availability of mental health services for them is needed for professionals who work with them.

Despite the recognition of the importance of mental health assessment and treatment for CAC clients, little research has examined the type of on-site mental health services provided at CACs or whether counsellors implement evidence-based treatments (Staudt & Williams-Hayes, 2011). Evidence-based practices are defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

One study examined the availability of mental health services at 117 CACs in the United States, of which 71 centers were members of the National Children's Alliance and 46 were non-members (Jackson, 2004b). Findings indicated that all centers provided mental health services for children and that 93% of member centers and 92% of non-member centers also had mental health services for non-offending caregivers. One-half of the member centers (51%) and one-quarter of the non-member centers (27%) provided mental health services on-site, while the remaining centers referred clients and caregivers to mental health resources in the community. The mid-project report on the impact of CACs in Canada (Proactive Information Services, 2015) reported that, for all of the CACs examined, mental health services are provided off-site, although one CAC was in the process of hiring an in-house therapist. Depending on the community and local resources, there may be lengthy waiting lists and gaps in services for children and youth may exist.

The limited research that is available on the specific types of mental health services offered by CACs points to the efficacy of trauma-focused cognitive behavioural therapy (TF-CBT) for child victims of sexual abuse and cases of post-traumatic stress disorder more generally (Cary & McMillen, 2012; Kenny et al., 2017; Mannarino et al., 2012; Tavkar & Hansen, 2011). According to the National Crime Victims Research and Treatment Center (n.d.), TF-CBT has proved successful with children aged 3-18 who are experiencing significant emotional problems related to traumatic life events. TF-CBT has the following characteristics:

- *It is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.*

- *It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques.*

- *Children and parents learn new skills to help process thoughts and feelings related to traumatic life events, manage and resolve distressing thoughts, feelings, and behaviors related to traumatic life events and enhance safety, growth, parenting skills and family communication*. (National Crime Victims Research and Treatment Center, n.d.)

Connors-Burrow et al. (2012) examined mental health screening and referral practices in 13 CACs in Arkansas and found that practices were inconsistent and undocumented. In an attempt to strengthen the mental health services offered through CACs and enhance the consistency of mental health services across CACs, the authors implemented a new protocol that involved collecting demographic information on the CACs' clients and alleged perpetrators, conducting appropriate emotional and behavioural screening for mental health issues and collecting follow-up data on the status of mental health interventions. Follow-up forms, completed with the parent or guardian at one week, one month and three months post-intake, collected information on services received, barriers to receiving services, and the needs of the family.

A review of the protocol one year after implementation involved obtaining feedback from CAC staff regarding the new process. This review indicated that while over one-half of staff expressed reservations about the protocol prior to its implementation, one year later almost three-quarters reported fewer concerns and most thought that the protocol helped them better understand the needs of the victims. The authors concluded that having a standardized protocol in place to collect information about mental health screening and referral may be helpful to staff in better understanding and meeting the needs of their clients.

Tavkar and Hansen (2011) discussed the implementation of Project SAFE (Sexual Abuse Family Education) at a CAC in Nebraska. The authors noted that "given the diverse needs of child victims and/or their non-offending family members, a continuum of accessible treatments is imperative" (p. 196). Project SAFE is a cognitive-behavioural treatment program that offers four interventions designed to meet the mental health needs of both victims and their families. The first intervention in Project SAFE is a 12-week cognitive-behavioural group treatment program for youth aged 7 to 18 and their non-offending caregivers. Youth and their caregivers meet concurrently in separate groups. The second intervention is designed for non-abused siblings aged 7 to 18 and is a six-week group treatment that meets for 90 minutes per week. Project SAFE Crisis Intervention is the third intervention offered in the program and provides a single crisis session to non-offending caregivers ranging from one to three hours in length designed to assist with coping and immediate issues that arise following disclosure of abuse. The fourth intervention in Project SAFE is Brief Family Intervention that provides three to six one-hour individual and family counselling sessions that are individualized for families who are already involved in group treatment.

Summarizing the benefits offered by Project SAFE over other available community resources, the authors conclude that:

> *Project SAFE offers several unique advantages for families, including: free multiple-session therapy, parallel group therapy for non-offending family members, education tailored to help prevent revictimization, free child care for younger children, and flexible scheduling for appointments that include evenings.* (Tavkar & Hansen, 2011, p. 197).

One 2014 study evaluated the implementation of Project SAFE with a group of 97 victims of child sexual abuse and their non-offending caregivers at a CAC in the Midwest United States (Hubel et al., 2014). The authors noted that victims of child sexual abuse are a heterogeneous group, with children exhibiting varying levels of emotional and behavioural symptoms or, in approximately one-third of cases, little or no symptoms. Findings of the evaluation "demonstrated significant improvements in behavioral and psychological functioning in a heterogeneous population of families seeking treatment following [child sexual abuse] … both symptomatic and subclinical children demonstrated significant improvements following Project SAFE treatment" (p. 320). The study also found that both the children and their caregivers rated the therapy positively and felt that it was beneficial.

Recommended Guideline

The revised guideline adopted by the National Children's Alliance (2017b) has added the term "evidence-based" to describe the mental health services provided at CACs to emphasize the need to implement, to the extent possible, mental health assessment and treatment services that have been shown to have efficacy for child clients of CACs and their families. While the research on the types of mental health services provided at CACs is somewhat limited at this time, there is some work pointing to the effectiveness of certain interventions. The recommended guideline for mental health evaluation and treatment, is:

> *Comprehensive evidence-based and trauma–informed counselling and mental health services, designed to meet the unique needs of children, youth and their family members, are essential to the multidisciplinary team response.*

3.8 Case Review

Ontario's draft guideline regarding case review states that:

> *Case Review is a formal process in which multidisciplinary discussion and information sharing with respect to the investigation, case status and services needed by the child/youth and family occur on a routine basis. Case review offers the CYAC the opportunity to review active/current cases, provide updated case information, and coordinate interventions. It is a planned meeting of all relevant MDT members and occurs on a regular basis for cases coming from the CYACs primary service area. Case review is in addition to informal discussions and pre- and post-interview debriefings.*

At the CAC working group's visioning session on the development of national guidelines, participants discussed whether the guideline should state that the process is mandatory, or perhaps essential. Further, the working group discussed whether an actual timeframe should be specified in place of "routine." The working group also proposed shortening the guideline by deleting the sentences explaining the purpose of case review. The suggested guideline from the working group is:

> *A case review is a mandatory process that supports information sharing and decision making with respect to the investigation, case status and services needed by the child, youth and family and occur at minimum once per month. Participants will include police, child protection services, medical, mental health and victim services.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

> *Rationale*
>
> *Case reviews are intended to monitor current cases and are not meant as retrospective case studies. This is a formal process by which knowledge, experience and expertise of MDT members is shared so that informed decisions can be made, collaborative efforts are nurtured, formal and informal communication is promoted, mutual support is provided, and protocols/procedures are reviewed.*
>
> *Guidelines* [Key Components]
>
> - *Case reviews encourage mutual accountability and help to assure that children/youth's needs are met sensitively, effectively and in a timely manner.*

- *Case review is not meant to pre-empt ongoing discussions, and ongoing discussions are not meant to take the place of formal case review. Every CYAC must have a process for reviewing cases. Depending on the size of the CYAC's jurisdiction or caseload, the method/timing of case review may vary to fit the unique CYAC community. Some CYACs review every case, while others review only complex or problematic cases. Representatives from each core discipline should attend and/or provide input at a case review. Confidentiality must be addressed in the interagency agreements.*

- *In order to make informed case decisions, essential information and professional expertise are required from all disciplines. The process should ensure that no one discipline dominates the discussion, but rather all relevant team members have a chance to adequately address their specific case interventions, questions, concerns and outcomes.*

- *Generally, the case review process should:*

    - *review interview outcomes;*
    - *assess the family's reactions and response to the child/youth's disclosure and involvement in the criminal justice/child protection systems;*
    - *discuss, plan and monitor the progress of the investigation;*
    - *review medical evaluations;*
    - *discuss child protection and other safety issues;*
    - *discuss emotional support and treatment needs of the child/youth and non-offending family members and strategies for meeting those needs;*
    - *make provisions for court preparation and court support; and*
    - *discuss other issues relevant to the case.*

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

- *Relevant MDT representation at case reviews promotes an informed process through the contributions of diverse professional perspectives. Case reviews should be attended by the identified agency representatives capable of participating on behalf of their specific profession. CYACs should establish policies addressing those required to attend case reviews. All those*

participating should be familiar with the CYAC process, as well as purpose and expectations of case reviews.

- *A process is defined to communicate recommendations or MDT decisions from a case review to the appropriate individuals for implementation.*

- *CYACs should strive to create an environment where complex issues can be raised and discussed. Case reviews should provide an opportunity for MDT members to increase their knowledge of the dynamics of child abuse cases. Discussions may include, but not be limited to: relevant theories; research; agency interventions, limitations, or service gaps; issues of family dynamics; developmental and/or emotional disabilities; parenting styles and child-rearing practices; gender roles; religious beliefs; socioeconomics; and cultural dynamics and behaviors.*

Evidence

The research literature supports the guideline proposed above. According to Jackson (2004b, p. 417), case review is a process during which members of the multidisciplinary team "regularly convene to discuss the family's well-being, to share information efficiently, to determine what additional information is needed, and to assign specific tasks to the appropriate individuals." The case review allows the participants to draw on the knowledge and expertise of the other members of the MDT. Chandler (2000) cites many benefits of a case review, including: providing an opportunity for team members to become acquainted with each other and the case process; allowing individual team members to retain their own agencies' mandate while learning about the other agencies involved; helping to prevent cases from "falling through the cracks"; and enables participants to identify gaps in resources and conflicts in service provision.

In a study examining the factors that influence the effectiveness of child protection teams, Kistin et al. (2010) established that the team performance should be evaluated based on whether the involvement of the team resulted in: more timely investigations of cases; the provision of more services to families; and better child abuse and neglect education of medical professionals. The variables that participants ranked as most important to achieve these goals were active interdisciplinary collaboration, a sense of team collegiality, and mutual trust and respect.

Researchers in the United Kingdom (Brandon, Dodsworth & Rumball, 2005) theorized that effective communication and common understanding is difficult to achieve between professionals, policy-makers, and the children they were serving. They analyzed 20 serious child abuse case reviews and found that all cases exhibited "inadequacies of assessment, agencies' inability to communicate with each other

effectively, poor supervision arrangements, and lack of attention to the voice of the child" (p. 162). They also found that the expertise of the professionals was rarely brought together systematically, and that professionals displayed insularity and a reluctance to trust other professional groups. They concluded that the role of the lead professional in coordinating the expert knowledge and identifying gaps was critical to incorporating shared knowledge into assessment and planning.

Similarly, a 2011 study by Smith for her doctoral dissertation explored the roles and relationships of team leaders and team members on child abuse case review teams at five CACs in Pennsylvania. Using multiple data sources including program documents, surveys, interviews and observations, Smith identified six themes:

1. *Alignment of written documents with the operations of the CAC is important.*
2. *Trust was experienced at different levels between team members and team leaders.*
3. *Quality of facilitation and communication skills varied among team leaders.*
4. *Attendance at and participation in team meetings is highly valued.*
5. *CAC Director and team leader boundaries can become blurred.*
6. *Meeting location may affect participation*. (p. 165)

Smith identified three essential concepts to optimize team member and team leader interactions:

> *a sense of trust by both team leaders and team members in each other and the case review process that shared goals will be achieved; respect for members and leaders as demonstrated by acceptance of each other's differences in beliefs, perceptions and experiences and acknowledgement that team goals will be achieved through collaborative efforts; and, commitment to working as a multidisciplinary team and holding others accountable for their level of engagement in the case review process and CAC model.* (pp. 164-165)

In her survey of program services provided by American CACs, Jackson (2004b) interviewed directors of both member (complied with the National Children's Alliance standards) and non-member CACs. She found that 92% of member centers and 84% of non-member centres had case review procedures. The vast majority of CACs review cases during the investigation to expedite the case and ensure that family members are being referred for appropriate services (90% of member centres and 97% of non-member centres). The frequency of the meetings varied widely from twice a week to every other month, although non-member centres tended to meet less frequently than member centres.

A Canadian study examining the impact of CACs found in its mid-project report that the frequency of case reviews also varied considerably among the six sites included

in the study (Proactive Information Services, 2015), supporting the working group's recommendation to specify a timeframe in the guideline. One site held case review meetings twice a week, one site met every two weeks, two sites met once a month, one site met quarterly and, for one site, the frequency of case review meetings was reported as not applicable. The researchers interviewed MDT team members across the sites regarding their lessons learned, and their recommendation was to schedule frequent case meetings:

> *Frequent case meetings are supported by co-location, but these can occur regardless of who is actually situated at the CAC. A review of all open cases can be done quickly and those cases which require more in-depth attention can be dealt with by the key MDT members for that case. Clients are well served when their issues and needs can be addressed in a timely manner.* (Proactive Information Services, 2015, p. 23)

Jackson (2012) surveyed MDT members and centre staff from 16 CACs in Virginia to examine their knowledge, philosophy and perceptions of case review meetings. She found some differences among the professional groups in how case review meetings were perceived. The CAC staff, usually CAC directors, reported that while they attended all case review meetings, they perceived the meetings were not well attended. Investigators thought case review meetings were too long and that observing interviews was more informative for them, while service providers did not think the meetings were too long and thought they were useful for obtaining case information. Differences were also noted between supervisors and frontline workers, with frontline workers feeling they had less status in decision making. To level the perceptions of status of MDT members, Jackson recommended holding meetings in a neutral location and restricting the group size. She also suggested that CAC directors receive more training on managing MDTs and case reviews.

An Australian study examined the processes involved when multidisciplinary cancer teams used technology to conduct team meetings in hospital settings (Li & Robertson, 2011). The researchers observed meetings held by videoconference, and interviewed the team members. They observed that the spatial arrangement of the team members influenced interaction patterns, and that participation was enhanced when team members were more visible to each other. They concluded that "factors such as room size, team size, seating arrangements, display configuration and variations in preparing and presenting medical information clearly influence the dynamics of the conversation and information sharing in distributed multidisciplinary team meetings" (p. 443).

An early study out of Hong Kong sought to provide practical suggestions for medical practitioners who were members of multidisciplinary teams for cases of child abuse (Lee, Li & So, 2005), and the findings are applicable for CAC case reviews. The

authors determined that preparation is a key factor for more effective meetings. Documentation should be complete, and reports should be circulated to participants prior to the meeting to save time. Team members should be respectful, objective, resourceful, and helpful to each other. Finally, a follow-up plan with an objective assessment should be determined.

Recommended Guideline

At the CAC working group's visioning session on the development of national guidelines, participants discussed whether the guideline should state that the process is mandatory, or perhaps essential. Since the guidelines are not mandatory at this time, it is suggested that essential might be the better choice. The working group also deleted sentences from Ontario's draft guideline that explained the purpose of case review and it is recommended this information be included in the rationale for the guideline.

The recommended guideline for case review, suggested by the working group and supported by the research literature, is:

> *A case review is an essential process that supports information-sharing and decision-making with respect to the investigation, case status and services needed by the child/youth and family, and should occur at least once per month. Participants will include all members of the multidisciplinary team.*

3.9 Case Tracking

Ontario's draft guideline regarding case tracking states that:

> *Case tracking is an important component of a CYAC. Case tracking refers to a systematic method where specific data is routinely collected on each case served by the CYAC. CYACs must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.*

The CAC working group on the development of national guidelines discussed this guideline and decided that no changes were necessary.

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

> *Rationale*
>
> *Case tracking systems provide essential demographic information, case information and investigation/intervention outcomes. It can also be used for*

program evaluation (e.g., identifying areas for continuous quality improvement, ongoing case progress and outcomes) and generating statistical reports.

Effective case tracking systems can enable MDT members to accurately inform children/youth and families about the current status and disposition of their cases. There are additional reasons for establishing a case tracking system; one is the usefulness and ease of access to data that is frequently requested for grants and other reporting purposes. When collected across centres, data can be used to assemble local, regional, provincial and national statistics that are useful for advocacy, research and legislative purposes in the field of child maltreatment.

Guidelines [Key Components]

- *Each CYAC needs to determine the type of case tracking system that will suit its needs. Case tracking must be compliant with all applicable privacy and confidentiality requirements.*

- *CYACs should collect and demonstrate the ability to retrieve case specific information for all CYAC clients. Statistical information should include the following data:*

    - *demographic information about the child/youth and family;*
    - *type(s) of abuse;*
    - *relationship of alleged offender to child/youth;*
    - *MDT involvement and outcomes;*
    - *charges laid and case disposition in criminal court;*
    - *child protection outcomes;*
    - *medical and mental health referrals; and*
    - *any other services provided.*

- *Case tracking is an important function of the CYAC and can be a time consuming task depending on case volume. Accuracy is important and for this reason, an individual should be identified to implement and/or oversee the case tracking process.*

- *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. Identifying case tracking procedures in CYAC's written documents underscores its importance and helps to ensure accountability in this area.*

- *MDT partner agencies should have access to case information as defined by the CYAC's written documents. Since case data may be useful to MDT members for a variety of purposes, it is important that they have access to aggregate and/or specific case information. Centres should also develop*

policies addressing how this data may be released to participating agencies or parties other than the MDT, which adhere to confidentiality requirements.

Evidence

The research evidence supports the need for child advocacy centres to systematically track cases. A study conducted by Gragg, Cronin and Schultz (2006) used a case tracking methodology to examine the processing and outcomes of child abuse and neglect cases in three American communities. Data were collected from each site on agency involvement, service referrals and delivery, case processing, and outcomes, and the tracking method allowed each community to examine case handling and outcomes across agencies. The advantages of this methodology were twofold: it allowed the MDTs to better understand the impact of their services and identify areas for improvement; and it assisted the communities with assessing their policies, practices and procedures to enhance service delivery and improve case outcomes. Based on their study and lessons learned, the researchers made the following recommendations:

> *First, they recommended that local and national partnerships for case tracking studies should be forged early in the process so that all parties can contribute to study design. Second, outcome evaluation efforts need to be developed and funded earlier. Third, communities should determine whether some case tracking data could be collected on an ongoing basis. The final recommendation was the development of a realistic timeline for change that should help schedule the research and reduce frustrations of those working on the reform.* (Gragg et al., 2006 as cited in National Children's Alliance, 2013, p. 146)

In 2004 in the United States, The Duke Endowment, a granting agency for CACs, noted that CACs lacked agreement on what constitutes a good outcome for a CAC as well as how to measure outcomes (Pankaj & Shah, 2008). In partnership with Innovation Network and 32 CACs, they conducted a multi-year study to develop a logic model, a common set of outcomes and a set of standardized data collection instruments to be used by all CACs. The instruments included: the Multi-Disciplinary Team Questionnaire; the Caregiver Self Assessment; the Caregiver Satisfaction Survey; and the Trauma Symptom Checklist. When asked how the data collection process was relevant to their work, the majority of CACs indicated that they would be able to use the evaluation data to improve their services and better serve their clients and many said it allowed them to learn about their service delivery and address potential gaps. For example, one CAC discovered local agencies were not referring reported cases to the CAC, so they focused on strengthening agency buy-in to the CAC model. Another CAC learned that their turn-around time between the initial referral and the first visit was not optimal, and subsequently made adjustments to address the problem. The CACs also reporting using the evaluation data in grant requests to other funders.

A very comprehensive resource guide for evaluating CACs was produced by Jackson (2004a) for the National Institute of Justice in the United States. According to Jackson (2004a, p. 1), the benefit of a CAC evaluation resource "is that it introduces standard procedures and instruments, thereby producing consistency across evaluations." A standardized evaluation system enables CAC administrators to learn from each other about how to implement the evaluation protocols, as well as to learn which systems are effective and under what conditions.

In 2005, the National Children's Alliance developed NCAtrak, a computerized, web-based case tracking system designed to help CACs track case specific information in a user-friendly, reliable manner (National Children's Alliance, 2008). NCAtrak is a comprehensive system for entering case data such as referral information, victim and offender characteristics, mental health and medical services, and criminal justice outcomes. As reported by Walsh, Jones and Swiecicki (2014), as of November 2013, 360 CACs in the United States were using the system, with approximately 887,000 cases in the system and an average of 500 new cases being entered daily. Walsh and her colleagues recognized that these data could be an important resource for examining criminal justice outcomes for child abuse cases, and used the data from one CAC to examine criminal disposition timeframes. The objective of their study was to examine how long it took it took to criminally resolve three types of child abuse cases: physical abuse; sexual abuse with adult perpetrators; and sexual abuse with juvenile perpetrators. Using a one-year timeframe as a key measurement of efficient case-flow management, the researchers used the NCAtrak data to examine case characteristics associated with cases that took longer than one year to be criminally resolved. They found that child physical abuse cases with younger victims were significantly more likely to exceed the one-year timeframe than those with older victims, suggesting that these cases are more difficult to resolve. No differences in disposition time were found in child sexual abuse cases with adult offenders by various case characteristics, but child sexual abuse cases with juvenile offenders were more likely to take longer than one year to resolve if they involved a nonfamily offender compared to a family offender. All three types of child abuse cases were more likely to be resolved by trial than by plea or dropped charges.

Walsh et al. (2014, p. 212) believe that the NCAtrak system holds great potential for child abuse research:

> *Such systems consolidate a lot of details about individual child abuse cases over time, including case characteristics, investigation procedures and dates, and criminal justice outcomes. The NCAtrak system also permits modifications that could allow a site to collect data on additional variables in order to answer a specific research question. It would be fairly straightforward, for example, to add fields to track the type and level of evidence available during prosecution. Also, given the breadth of data in CAC case tracking systems, there is an opportunity to*

pursue additional areas of child abuse research, such as questions on forensic interviewing, medical service, and mental health access.

However, Walsh and her colleagues did note that missing data was a significant challenge in using the NCAtrak data for research, and were unable to use some variables in their analyses because of the amount of missing data. They found that few CACs were regularly completing data on criminal justice outcomes, even though the capability was there. Similarly, Pankaj and Shah (2008) discovered that CACs faced challenges with the data collection process in their study for The Duke Endowment CAC evaluation. Understaffed CACs struggled to understand the importance of the task, difficulties were encountered in administering surveys in terms of timing and follow-up, and client participation was not always favourable. They concluded that, "in the long run, it is hoped that this information will help CACs improve service delivery and better serve their clients. This data can also be used to make the case for additional funding and to promote the CAC practice model" (p. 21).

One study out of Australia discussed the challenges involved in case tracking using administrative databases for child sexual abuse research (Leach, Baksheev, & Powell, 2015). Because administrative databases are often created for functional purposes, such as case management, there can be significant problems in using the data for robust research and evaluation. Challenges include inconsistency in data recording, particularly where there are many users responsible for inputting data, datasets that are limited to the needs of a particular agency, and missing data. The authors recommend that policy-makers pay careful attention to the way in which data are "collected, stored and integrated across agencies to enhance their application and utility in evaluating and informing policy" (p. 8). This study suggests that the development of a common case tracking system designed for CACs in Canada may be beneficial.

Recommended Guideline

The recommended guideline for case tracking, as suggested by the CAC working group and supported by the research literature, is:

Case tracking refers to a systematic method where specific data are routinely collected on each case served by the CAC/CYAC. CACs/CYACs must develop and implement a system for monitoring case progress and tracking case outcomes for all multidisciplinary team components.

3.10 Organizational Capacity

Ontario's draft guideline regarding the organizational capacity of a CAC states that:

> *A designated legal entity responsible for program and fiscal operations is established and implements basic sound administrative policies and procedures. Every CYAC 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 CYAC, including setting and implementing administrative policies, hiring and managing personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.*

The CAC working group on the development of national guidelines supported adopting the first two sentences of Ontario's draft guideline without changes. However, there was discussion that the guideline might pose challenges for some CACs that are integrated in government or physically housed in law enforcement, so the guideline may need to be more broadly defined. The working group also deleted the sentence describing the role of the legal entity.

In addition, there was discussion at the visioning session whether an additional guideline should be added on the health of CAC employees and the MDT to address vicarious or secondary trauma or compassion fatigue. In personal communication with Jan Dunn, Director of Accreditation for the National Children's Alliance in the United States (29 September 2015), we were informed that the NCA had recently released revised Standards for Accreditation that became effective January 2017, a process that occurs every 5 to 6 years. In response to current research in the field, the NCA added an essential component within its Organizational Capacity standard that specifically addresses vicarious trauma and resiliency. The current research and the NCA's revisions are discussed below.

The suggested guideline from the CAC working group is:

> *A designated legal entity responsible for program and fiscal operations is established and implements basic sound administrative policies and procedures. Every CYAC must have a designated legal entity responsible for the governance of its operations.*

According to Ontario's draft guidelines, the rationale and key components for this guideline are as follows:

Rationale

There are many options for a CYAC organizational structure, depending upon the unique needs of its community. Ultimate success requires that, irrespective 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. A CYAC may be an independent non-profit agency, a program affiliated with an umbrella organization, such as a hospital or other non-profit social service agency, or part of a governmental entity, such as child protection services, law enforcement, or victim services. Each of these options has its advantages and limitations, as they relate to implications for collaboration, planning, governance, community partnerships and resource development.

Guidelines [Key Components]

- *The CYAC is an incorporated, non-profit organization or government-based agency or a component of such an organization or agency. The CYAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight.*

- *Every CYAC must provide appropriate insurance for the protection of the organization and its personnel. Non-profit CYACs, including those that are a component of an umbrella non-profit or non-profit hospital, must carry, at a minimum, general commercial liability, professional liability, and Directors and Officers liability insurance. Government-based CYACs must carry, at a minimum, general commercial liability and professional liability insurance or comparable coverage through self-insurance. CYACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed, such as renters, property owners, and automobile insurance.*

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

- *Confidence in the integrity of the fiscal operations of the CYAC 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 CYACs with annual actual expenses equal to or less than $500,000.

- *All centres with annual actual expenses in excess of $500,000 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.*

- *All centres with annual actual expenses equal to or less than $500,000 are required to have a review of their financial statements. If a management letter is prepared by the independent accountant (CPA), it should be included with the review report.*

- *In order to ensure that children/youth receive the services they require, CYACs should have personnel responsible for coordinating its operations and program services. The CYAC should have sufficient staffing to support all program components. Efforts must be made to secure reliable and ongoing sources of funding for these positions.*

- *Due to the sensitive and high-risk nature of CYAC work, it is necessary that, at a minimum: the CYAC conducts a formal screening process for staff that includes a satisfactory Vulnerable Sector Police Criminal Reference Check for each staff member; an orientation; ongoing training; and regular supervision.*

- *The CYAC has, and demonstrates compliance with, written screening policies for onsite volunteers that include a satisfactory Vulnerable Sector Police Criminal Reference Check for every volunteer, and provides orientation, training and supervision.*

- *The CYAC provides education and community awareness on child abuse issues. One component of CYAC work is education and outreach to the community about child abuse, its effects, legal and moral responsibilities if child abuse is suspected, and services provided by the CYAC. Community education and outreach may be provided by staff, or MDT members.*

- *In an effort to ensure long-term viability of the organization, the CYAC should regularly undertake strategic planning process. This planning process should explore program needs, staffing levels, and funding for future growth and sustainability.*

Evidence

The research literature supports the draft guideline as proposed, and does not preclude CACs from being incorporated into or housed within other organizations. In

Proactive Information Services' (2015) mid-project report on understanding the impact of CACs in Canada, the researchers found that all six centres included in their study operationalize their objectives in different ways and have varying governance structures. One is sponsored by a registered charitable society, for example, and an agency's volunteer board governs another, but both have their own steering committees. One CAC is a partnership between police and social services, and one operates as a demonstration project within a health centre. One is a governmental collaboration with an agreed upon Terms of Reference and Memoranda of Understanding, and the sixth CAC has a Board of Directors consisting of representatives from the partner agencies, as well as a three-member Executive Committee. All six CACs, however, use the multidisciplinary approach. When MDT team members were asked about the lessons learned, they advised other CACs to develop their own protocols and processes: "Through developing Terms of Reference and Memoranda or Letters of Understanding, not only can partners be clear on their roles, but also on how they can work together collaboratively" (p. 22).

In a commentary on whether the use of child advocacy centres in the United States leads to positive case outcomes, Faller and Palusci (2007) summarized the results of a national evaluation conducted by the University of New Hampshire Crimes Against Children Research Center. The researchers evaluated four well established programs: the National Children's Advocacy Center in Huntsville; the Dallas Children's Advocacy Center; the Pittsburgh Children's Hospital Child Advocacy Center; and the Dee Norton Lowcountry Children's Center in Charleston. All four centres were established under the leadership of different professions and services—prosecution, law enforcement, medicine, and psychology—and therefore their structures for service delivery varied considerably. The research results suggested, however, that there is no single "best" model for structuring CACs. As stated by Faller and Palusci (2007, pp. 1027-1028):

> *Although the National Children's Alliance has attempted to set standards and hence achieve uniformity among CACs, perhaps uniformity should not be an overriding goal. Indeed, research on community and program development suggests that organizations that are developed from the ground up, rather than from the top down, are more viable….*

Varying forms of governance and regulations are also observed in the Nordic countries. Johansson (2012) studied the diffusion and governance of the Barnahus ("children's house") model. In a Barnahus, similar to CACs, governmental agencies related to social services, law enforcement and health care collaborate in one location to investigate suspected crimes against children. Johansson noted that the model varies according to the interplay of the formal and informal actors involved, *formal* meaning governmental agencies, and *informal* meaning voluntary organizations and private associations; this formal and informal balance influences the balance between criminal and welfare law. Even among the Nordic countries, the formal governmental

department responsible for the Barnahus varies. In Iceland, the specified authority is the Government's Agency for Child Protection. In Norway, it is the Department of Justice, with administrative ties to the police, and in Finland it is the Ministry of Social Affairs and Health. These different players have resulted in each country establishing their own national guidelines for Barnahus.

One of the key components for the proposed national guideline for organizational capacity is that the CAC be non-profit and, in Canada, such organizations are governed either by the *Canada Not-for-Profit Corporations Act* (S.C. 2009, c. 23) or the related provincial or territorial legislation. Non-profit organizations are generally viewed by the public as more trustworthy because they are constrained from distributing profits to managers or directors for personal gain (Lam et al., 2013). Moore (2000) states that non-profit organizations help to create social capital by providing valuable channels for donors' charitable aspirations, and some research indicates that non-profit centres are more sustainable in times of economic uncertainty because they generate revenue streams from a variety of sources (Besel, Williams & Klak, 2011; Lam et al., 2013; Schuh & Leviton, 2006).

A national survey of non-profit governance of charitable agencies in the United States examined the factors associated with a board's performance in overseeing and supporting the organization's mission (Ostrower, 2007). Surveying a national database of public charities with revenue exceeding $25,000 annually, Ostrower found that six practices are becoming more common in the public sector: external audit; independent audit committee; rotating audit firms and/or lead partners every five years; conflict of interest policy; formal complaint process for employees; and document destruction and retention policy.

Reiser (2007) reviewed the literature regarding the important components of non-profit directorship and concluded that, in addition to being led by independent directors, non-profits should be audited by independent auditors to preserve the integrity of the audit. Likewise, in developing a framework to build non-profit capacity, De Vita, Fleming & Twombly (2001) concluded that non-profits must show greater transparency and accountability in their financial operations. A Canadian publication, *The Effective Not-for-Profit Board* (Deloitte, 2013) emphasizes the importance of good governance and provides best practice guidelines for non-profit organizations. According to Deloitte, non-profit organizations must not only be well governed, but be seen to be well governed.

In addition to good governance, it is important for CACs to assess their liability and obtain appropriate liability insurance. Agatston and his colleagues (2010) describe two scenarios where a lawsuit might occur following a forensic investigation: an alleged offending parent might sue when a child's disclosure results in the filing of unfounded criminal charges or a civil protection suit; and a child who has been abused does not

disclose the abuse during an interview, or the disclosure is discounted, and no protective action is taken. To limit potential liability, the authors recommend that the interviews be videotaped and documented, and that CACs supervise forensic interviews and the interview process. They also recommend that CACs be familiar with the national and professional standards that govern their work and that CACs have access to legal counsel on liability issues.

In a review of liability issues with volunteer organizations, Martinez (2003) states that organizations that rely on volunteers have a stronger incentive to minimize liability through effective risk management practices than do for-profit organizations. While he acknowledges that non-profits do not seem to be sued in greater numbers, he states that because non-profits are undercapitalized, even a minor lawsuit could have detrimental financial consequences.

Another component of Ontario's draft guidelines is that CACs should regularly undertake strategic planning processes. In examining adaptive tactics used by human service non-profit managers facing financial uncertainty, Mosley, Maronick & Katz (2012) found having a strategic plan assisted organizations in implementing complex new activities; organizations with a strategic plan were 81% more likely to expand or start a joint program. Similarly, Moore (2000, p. 183) has suggested that non-profit managers should focus on three key issues when developing a sustainable strategic plan: "public value to be created; sources of legitimacy and support; and operational capacity to deliver the value."

Ontario's draft guidelines state that one component of CACs' work is community education and outreach by CAC staff or MDT members. In Proactive Information Services' (2015) mid-project report on understanding the impact of CACs in Canada, the researchers found that some of the CACs in their study had taken an active role in community education, but this was not always the case. According to the authors, a few CACs have been involved in organizing workshops and conferences, and one has reached out to the surrounding small and First Nations communities. In terms of training staff, Proactive Information Services found that very little formalized training was available to team members; the training that team members most often received was related to forensic interviewing. A number of the sites in the study, however, did provide opportunities for staff to attend conferences or visit other CACs (Proactive Information Services, 2015).

Related to the issue of training staff is maintaining the health of the staff, which was discussed by the CAC working group on the development of national guidelines at the visioning session held in March 2015. In its revised Standards for Accreditation, which became effective for all accreditation in the United States starting January 2017, the National Children's Alliance (2017b) added two essential components to its

Organizational Capacity standard. The first, intended to reduce employee burnout and improve employee retention, states:

> *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 upon staff*. (National Children's Alliance, 2017b, p. 50)

The second essential component recognizes the important role that CACs have in strengthening the functioning of the MDT. It also recognizes that the health of the MDT can directly impact service delivery, thus addressing the issue can ultimately improve outcomes for children and their families. It states:

> *The CAC promotes MDT well-being by providing access to training and information on vicarious trauma and building resiliency to MDT members.* (National Children's Alliance, 2017b, p. 50)

In its mid-project report on understanding the impact of CACs in Canada, Proactive Information Services (2015) found that "very little formalized training and support was available to help the MDT members cope with the 'realities of the job'" (p. 20). Rather, the only formal supports available to MDT members were employee assistance plans available through their employer. One site did offer train-the-trainer support on compassion fatigue to the victim advocate, but it had not yet been offered to other team members.

The term *secondary traumatic stress* (STS) was defined by Figley (1999, p. 10) as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or] the stress resulting from helping or wanting to help a traumatized or suffering person." To measure symptoms and the prevalence of secondary trauma among professionals who work with trauma victims, Bride et al. (2004) developed a Secondary Traumatic Stress Scale. Given the job responsibilities of forensic interviewers in CACs and their potential for STS, Bonach and Heckert (2012) used this scale to examine the relationship between organizational satisfaction, organizational buffers, and job support and secondary traumatic stress in a population of human service workers. They found that organizational satisfaction and job buffers were not associated with secondary trauma among forensic interviewers in CACs, but job support was negatively associated with secondary trauma. They further found that two other variables were predictive of STS. First, forensic interviewers who had experienced a significant loss in the past year reported higher levels of STS, suggesting that an accumulation of stressors may make workers more vulnerable to STS. Second, the older the forensic interviewer, the lower the level of STS, suggesting that as workers age on the job, they may "develop the necessary positive and healthy coping

skills to diminish the impact or build a resistance to STS" (Bonach & Hecker, 2012, p. 310). In terms of practice implications, the researchers argue that it is critical that workers are made aware of the potential negative effects of interviewing children and their families about sexual abuse and, just as important, that supervisors educate forensic interviewers about stress management and positive coping strategies.

Recommended Guideline

The CAC working group proposed deleting the sentence regarding the role of the legal entity, and it is recommended that this information be included in the guideline. Further, it is important to acknowledge that a CAC can be integrated into another institution and to address the issue of the health of CAC employees. Therefore, it is suggested that the guideline be revised as follows:

> *Every CAC/CYAC 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/CYAC, including setting and implementing administrative policies, hiring and managing personnel, providing training and support to personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.*

In addition, it is recommended that the key components for the guideline include two new components addressing the issue of secondary traumatic stress as proposed by the National Children's Alliance.

4.0 RECOMMENDED GUIDELINES

This chapter presents the recommended guidelines for child advocacy centres (CACs) in Canada, as supported by the research literature. It is important to note, however, that the guidelines are not standalone; in order to be informative and useful for organizations, the guidelines must be considered together with their rationale and key components. Accordingly, this chapter also presents the rationale and key components for each guideline, which are largely based on the work done by Boost Child and Youth Advocacy Centre. These guidelines are currently in the discussion stage and have not yet been adopted as the Canadian standards.

In reviewing the recommended guidelines in 2015, the research team conducted a national and international literature review to identify the evidence base for each of the ten guidelines proposed by the CAC working group, as well as any other guidelines that would be appropriate for Canada. Literature both in support and contrary to the proposed guidelines was critically analyzed, and representatives from the National Children's Alliance in the United States were consulted regarding their experience with the American standards. Based on this information, suggested wording and content changes were made, and then each guideline was reviewed by the legally-trained members of the research team to ensure their applicability to the Canadian legal context.

The 2018 revision to this report involved reviewing any new literature related to the guidelines and determining if this literature suggested any revisions to the guidelines. Consideration was also given to the recently revised guidelines from the National Children's Alliance (2017b) in the United States and the discussions at a Canadian CAC/CYAC training session held in February 2017. The recommended national guidelines, together with their rationale and key components, are presented below.

4.1 Child-focused Setting

Recommended Guideline: The CAC/CYAC provides services to diverse populations of children, youth and their supporting family members in a physically and psychologically safe, neutral and comfortable child-friendly setting.

Rationale

Children, youth and their supporting family members require a safe, friendly and comfortable setting to meet with professionals when child abuse is reported. A child-focused setting that is appropriate for diverse populations of children and their families can help alleviate the child's fear and anxiety and help to promote his or her involvement and comfort in the process.

Key Components

- The waiting room and interview spaces should be safe, welcoming, comfortable and neutral, and investigative interviews should be conducted using up-to-date recording equipment. All other child and family spaces within the centre should likewise promote safety and comfort, and reduce anxiety.

- The CAC must be physically and psychologically safe for children. If a CAC shares space with an existing agency that provides services to offenders, there must be a separation between children and non-offending family members and offenders, such as seeing alleged offenders on different floors or at different times of day.

- The CAC must have policies and procedures that address the separation of victims and alleged offenders during the investigative process, and as necessary throughout delivery of the full array of CAC services. In addition, CACs that serve children with sexual behaviour problems must also make provisions to ensure the physical and psychological safety of all children who visit the centre.

- Children and families must be supervised by CAC staff, MDT members, or volunteers to ensure that clients are within sight and hearing distance at all times while at the CAC.

- Whenever possible, clients involved in different investigations should be kept separate to respect the confidentiality of families and investigations.

- Confidentiality and respect for privacy is of primary concern. It is not acceptable for team members or CAC staff to discuss cases with client children or families, with each other where they may be overheard by anyone not directly involved with the case, with anyone not affiliated with the CAC, and whenever consent to share information has not yet been given or has been withheld.

4.2 Multidisciplinary Team

Recommended Guideline: The CAC/CYAC will include an integrated, multidisciplinary team from the core disciplines and agencies involved in the case, usually police, child protection services, medical and mental health assessment and treatment, prosecution, and advocacy and support.

Rationale

The purposes of interagency collaboration are to: coordinate intervention so as to reduce potential trauma to children and families; increase the likelihood that investigations and

prosecutions will be concluded as quickly as possible; and increase the likelihood that prosecutions have successful outcomes. A functioning and effective multidisciplinary team approach, where members have skills and expertise specific to child, youth and family, is the foundation of a CAC.

MDTs work collaboratively to provide the most effective coordinated response possible for every child and family. MDT interventions, particularly when provided in a child-focused CAC setting, are associated with less anxiety, fewer interviews, increased support, and more appropriate and timely referrals for needed services. In addition, non-offending parents are empowered to protect and support their children throughout the investigation, prosecution and beyond. Police may find that when the support and advocacy needs of the child and family are appropriately addressed, they have more time to focus on forensically relevant aspects of the case. Police work more effectively with child protection workers on child protection issues and benefit from other MDT members' training and expertise in communicating with children and understanding family dynamics.

A coordinated MDT approach: facilitates the efficient gathering and sharing of information; broadens the knowledge base with which decisions are made by including information from many sources; and improves communication among agencies. More thorough and shared information, and improved and timely evidence-gathering from the beginning stages of the case may contribute to a more successful outcome. A MDT response also fosters necessary education, support and treatment for children and families that may enhance their willingness to participate and their ability to be effective witnesses.

Key Components

- Ideally, the core MDT should include the following disciplines and agencies:

    - police;
    - child protection services;
    - medical;
    - mental health;
    - advocacy for child and family; and
    - crown prosecution.

    In addition to these core partners, MDTs can expand to include other professionals when helpful, such as teachers and probation officers. It is recognized that it is not always feasible to have all members of the MDT, such as crown prosecutors and medical and mental health professionals, co-located with the rest of the team; this does not necessarily pose a serious impediment to the effective functioning of the team.

- 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 advocate. Community resources may limit personnel and require some to fulfill multiple roles. What is important, however, is that each of the above-mentioned functions be performed by a specific member of the MDT while maintaining clear boundaries for each function.

- Written agreements formalizing interagency cooperation and commitment to the CAC practice and policy are essential and may also be helpful to ensure continuity of practice even when agency personnel change. Written agreements may take different forms, such as memoranda of understanding, protocols or guidelines, and may be signed by the leadership of participating agencies. These documents should be developed with input from the MDT, reviewed regularly and updated as needed to reflect current practice and current agency leadership.

- Advocacy personnel are able to provide crisis intervention, support, information and case updates, and advocacy in a timely fashion. These services help the MDT anticipate and respond to the needs of children and their families more effectively.

- As a result of more effective information sharing, child protection workers are often in a better position to monitor the child's safety and parental support, evaluate non-offending parents, and make recommendations with respect to placement and visitation. Protocols often exist to allow for information sharing between child protection and police; other organizations will likely require signed consent from the youth or family in order to share information with each other and ensure privacy and confidentiality of information is maintained.

- Medical providers are available to consult about the advisability of a specialized medical evaluation, and to interpret medical findings and reports.

- Mental health professionals can provide the MDT with valuable information with respect to the child's emotional state and treatment needs. Having a mental health professional on the MDT helps to ensure that assessment, treatment and related services are more routinely offered and made available to children and families.

- The purpose of multidisciplinary involvement in all interventions is to ensure that the unique needs of each child are recognized and met. This means that informed decision-making will occur at all stages of the case so that children and families optimally benefit from a coordinated response. Multidisciplinary intervention begins at the initial report and includes, but is not limited to, pre- and post-interview debriefings, forensic interviews, consultations, advocacy, medical evaluation,

treatment, case reviews and prosecution. The MDT follows an agreed-upon process for collaborative intervention throughout the trajectory of the case.

- CACs should have both formal and informal mechanisms, such as staff meetings, for MDT members to regularly provide feedback with respect to the operations of the CAC. These mechanisms can address both operational matters, such as transportation for clients, use of the facility and equipment upgrades, and MDT issues, such as communication, case decision-making, documentation and record keeping.

- MDT members participate in continuing training and educational opportunities, including cross-discipline peer review and skills-based learning. Ongoing learning is critical to the successful operation of CACs. The CAC identifies and provides relevant educational opportunities. These should include topics that are relevant to all disciplines, are MDT-focused and enhance the skills of the MDT members.

- CACs should strive to create an atmosphere of trust and respect that fosters opportunities for open communication and enables MDT members to share ideas and raise concerns.

4.3 Cultural Sensitivity

Recommended Guideline: Culturally competent and socially inclusive services are available to all children, youth and their families and caregivers at the CAC/CYAC.

Rationale

An inclusive attitude and approach is essential to the CAC philosophy. Issues related to inclusion influence nearly every aspect of work with children and families, such as welcoming a child and their family to the centre, employing effective forensic interviewing techniques, gathering information to determine the likelihood of abuse, selecting appropriate mental health providers, and securing help for the family in a manner in which it is likely to be utilized.

Proactive planning and outreach should consider culture, ethnicity, religion, socioeconomic status, disability, gender, and sexual orientation. These factors contribute to an individual's worldview, unique perceptions and experiences throughout the investigation, and should influence intervention and case management processes. By addressing these factors in an inclusive environment, children and families of all backgrounds feel welcomed, valued, respected, and acknowledged by staff, MDT members and volunteers.

Key Components

- To effectively meet the needs of children and families, the CAC must be willing and able to understand each client's worldview, adapt practices as needed and offer help in a manner in which it can be utilized. Striving toward inclusivity is an important and ongoing endeavor.

- The CAC must ensure that throughout the investigation process, provisions are made for non-English speaking and Deaf or hard of hearing children and their supporting family members. Language barriers can significantly impact the ability to obtain accurate information from the child and family, and hinder the ability of the MDT to convey their roles, expectations, concerns, and decisions with respect to the investigation and intervention services. Language barriers may compound already existing possibilities for miscommunication between children and adults. In order to protect the integrity of the process, care should be taken to ensure that appropriate interpreters are utilized, including American Sign Language interpreters for Deaf or hard of hearing clients; CACs should not rely on children or family members as interpreters.

- All children and families who come to the CAC should feel welcome. While there are many ways of accomplishing this, materials such as dolls, toys, books, magazines, and artwork should reflect the different interests, ages, developmental stages, ethnicities, religions, and genders of the children and families served.

- It is the responsibility of the MDT members to understand the background of the child being served and what languages the child speaks or is comfortable speaking. Understanding the child's and family's background will help to: effectively elicit relevant history; understand decisions made by the child and family; understand the perception of the abuse and attribution of responsibility made by the child, family and community; understand the family's comprehension of laws; address any religious or cultural beliefs that may affect the disclosure; and recognize the impact of prior experience with police and government authorities both in this country and in other countries of origin. With knowledge and preparation, the MDT should structure services to obtain the most complete and accurate information and more effectively interpret and respond to the needs of the child and family.

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

4.4 Forensic Interviews

Recommended Guideline: Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, follows leading practices and are conducted jointly by police and child protection services to avoid duplicative interviewing.

Rationale

Forensic interviews are the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution, and may be the beginning of a process of healing for many children/youth and families. The manner in which a child/youth is treated during any interview may significantly impact his/her understanding of, and ability to respond to the investigation process and/or criminal justice system, as well as potentially affecting the reliability of statements from the child.

The purpose of a forensic interview in a CAC is to obtain a statement from a child in a developmentally and culturally sensitive, unbiased and fact-finding manner that will support accurate and fair decision-making by the involved MDT members for the criminal justice and child protection systems. Quality interviewing includes: an appropriate, neutral setting; effective communication among MDT members; employment of legally sound interviewing techniques; and the selection, training and supervision of interviewers, focusing on child-specific expertise.

Key Components

- Some communities have formal protocols that describe the steps involved in the investigative and interview process, and where these exist they must be followed in the CAC. CACs without community protocols should develop and document the process and steps that will be followed in the centre, in consultation with crown, police and child protection agencies, to ensure appropriate consent is obtained and protection of privacy is guaranteed.

- Forensic interviewers must have formal, specialized training in order to conduct interviews in the CAC. Following research-based guidelines will help ensure a sound process. These guidelines should be monitored over time to ensure that they reflect current practice.

- The CAC should offer an environment and an interview protocol that enhance free recall, minimize interviewer influence and gather the information needed to avoid duplication of the interview process.

- Forensic interviews of children should be conducted at the CAC whenever possible rather than at other settings, such as a police station. The CAC is the setting where the MDT is best equipped to meet the child's needs during an interview. When interviews must take place outside the CAC, steps should be taken to utilize appropriate forensic interview guidelines.

- The CAC should provide ongoing, specialized training opportunities for professionals who conduct forensic interviews. Suitable training may include: attendance at workshops or conferences; reading current research and literature on forensic interviewing; role playing; interviewing children on non-abuse related topics; review of recorded interviews; observations of interviews; peer review; and ongoing supervision.

4.5 Advocacy and Support Services

Recommended Guideline: Victim advocacy and support services are neutral and available to all children, youth and their families at the CAC/CYAC. Advocacy and support are offered to help reduce trauma for the child/youth and supporting family members and to improve outcomes.

Rationale

Advocacy is a necessary component of the CAC/CYAC and encourages child and family participation in investigation, prosecution, assessment, treatment, and support services. Up-to-date information and ongoing support is critical to a child's and family's comfort and ability to participate in intervention and treatment. Support and advocacy for children and families is integral and fundamental to the MDT response. The manner in which services are provided must be clearly defined to avoid role confusion. The support and advocacy functions may be filled by a designated advocate or by another member of the MDT. Appropriately trained individuals need to be identified to fulfill these responsibilities.

Children and families need support to navigate the various systems they encounter that may be unfamiliar to them. A crisis may reoccur at times of financial hardship, child placement, arrest, and changes or delays in court proceedings. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide some of these services through support groups for non-offending family members or access to mental health services either at the CAC or through other community agencies or providers.

Often families have never been involved with the systems that respond to child abuse allegations. In the aftermath of victimization, the child and family may feel a loss of control; education provides information that is empowering for children and their

families. Education is an ongoing process because families may be unable to process all information at one time and their needs often change over time. Many are in crisis, including dealing with immediate safety issues, and are coping with the emotional impact of the initial report and the ensuing process, including economic impacts. As family needs and case dynamics change, these changes must be assessed so that additional relevant information and services can be offered.

Key Components

- An advocate is available to the child and the family to ensure a consistent and comprehensive network of support. Children and families in crisis need assistance in navigating through the responses of different systems. Although more than one person may perform advocacy functions at different points in time, coordination that promotes continuity and consistency is the responsibility of the CAC. While some CACs may have dedicated advocates, others may have other staff, like care coordinators, victim advocates, victim services workers, and child life specialists, that perform advocacy functions.

- Advocacy and support may include but is not limited to:

    - crisis intervention and support at all stages of investigation;
    - attendance at and coordination of interviews and case reviews;
    - greeting and orientation of children to the CAC;
    - providing education about the coordinated multidisciplinary response;
    - providing updates to the family on case status, court dates, dispositions, and sentencing;
    - assistance with services such as housing, food, transportation, and public assistance; and
    - providing referrals for medical and mental health services and court preparation for the criminal justice process.

- It is important that individuals be informed with respect to their rights as victims of crime, including information about victims' compensation programs. Non-offending family members who are affected by the crime may also be entitled to services. Many children and their families are unfamiliar with their rights. This information should be provided by a professional who is knowledgeable about the criminal justice system and has some familiarity with other legal responses, including civil, child protection and family law proceedings. In some CACs, this role may be filled by specialized child victim witness professionals or court-based victim or witness assistance programs.

4.6 Medical Evaluation and Treatment

Recommended Guideline: Specialized medical evaluation and treatment services are routinely made available to all children and youth and are coordinated with the multidisciplinary team response. All cases of suspected child abuse shall be assessed to determine the need for a medical evaluation.

Rationale

A medical evaluation often holds an important place in the multidisciplinary assessment of child abuse. Medical consultation with the MDT on cases of child abuse at the CAC will assist in ensuring that children are provided with a medical evaluation when necessary. The goal of the medical evaluation is to reassure children and families about their well-being, identify and document the necessary medical findings, screen for injuries and medical conditions, and initiate treatment when necessary.

Key Components

- Medical evaluations should be offered to children as determined by skilled medical clinicians or by local MDTs that include qualified medical representation. Specialized medical evaluations can be provided in a number of ways. Some CACs have a medical provider who comes to the centre on a scheduled basis, while in other communities the child is referred to a medical clinic or health care agency for this service. CACs need not be the provider of primary care but CACs must have protocols in place outlining the linkages to primary care and other needed healthcare services. It is important that appropriate consent for medical evaluation and treatment be obtained.

- The timing of the medical evaluation is key in many child abuse investigations. Immediate consultation with the MDT will allow for necessary decision-making about the need for an examination and its timing. Recommendations as to the timing of medical examinations should be based on the presence of physical signs and symptoms, the need for medical treatment and the need to collect forensic evidence.

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

- Photographic documentation of examination findings is standard for medical evaluations in child abuse cases. Photographic documentation enables peer review,

continuous quality improvement and consultation. It may also obviate the need for a repeat examination of the child and is necessary for evidentiary purposes. Genital photo documentation, via colposcope or camera, in cases of sexual abuse should be strongly considered; however, issues of consent, storage and access must be adequately addressed.

- All medical clinicians who provide medical evaluations at CACs should have adequate training and ongoing continuing education. It is essential that medical clinicians be familiar and up-to-date with current research on findings in children who have and have not been abused, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations.

- Medical clinicians should have systems in place so that consultations with established experts in child abuse medical evaluation are available when a second opinion is needed in cases where physical or laboratory findings are felt to be abnormal. Regular peer review of cases should be conducted with colleagues and experts in the area.

- Medical evaluations often cause significant anxiety for children and their families, and there may be misconceptions about how the exam is conducted and what findings, or lack of findings, mean. In some CAC settings, the client is introduced to the exam by non-medical personnel. It is essential for MDT members and CAC staff to be trained about the nature and purpose of medical evaluations so that they can competently respond to common questions, concerns and misconceptions.

- The medical evaluation is an important part of the response to suspected child abuse and neglect, and relevant findings of the medical evaluation should be shared with and explained to the MDT in a routine and timely manner so that case decisions can be made effectively. Policy and procedures regarding privacy and confidentiality must be followed.

4.7 Mental Health Evaluation and Treatment

Recommended Guideline: Comprehensive evidence-based and trauma–informed counselling and mental health services, designed to meet the unique needs of children, youth and their family members, are essential to the multidisciplinary team response.

Rationale

Healing may begin with the first contact with the MDT, the common focus of which is to minimize potential trauma to children. However, without effective therapeutic

intervention, many traumatized children will suffer ongoing or long-term adverse social, emotional and developmental outcomes that may impact them throughout their lifetime. There are evidenced-based assessment and treatments, and other practices with strong empirical support, that will both reduce the impacts of trauma and the risk of future abuse. For these reasons, a MDT response must include trauma assessment and specialized trauma-focused mental health services for children and non-offending family members.

Family members are often the key to children's recovery and ongoing protection. Their mental health is often an important factor in their capacity to support the child. Therefore, family members may benefit from counselling and support to address the emotional impact of the abuse allegation, reduce or eliminate the risk of future abuse, and address issues that the allegation may trigger.

Mental health treatment for non-offending parents or caregivers, many of whom may have victimization histories themselves, may focus on support and coping strategies for themselves and their child, information about abuse, coping with issues of self-blame and grief, family dynamics, parenting education, and abuse and trauma histories. Siblings and other children may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic relationship.

Key Components

- Counselling and mental health services are provided by professionals with child abuse and child development expertise.

- Specialized trauma-focused mental health services for the child include but are not limited to:

    - crisis intervention services;
    - supportive counselling;
    - trauma-specific assessment, including full trauma history;
    - use of standardized assessment tools initially and periodically thereafter;
    - family and caregiver support;
    - an individualized treatment plan that is periodically re-assessed;
    - individualized evidence-based treatment appropriate for the child and family;
    - referral to other community services as needed; and
    - clinical supervision.

- A trained mental health professional should participate in case reviews so that the child's treatment needs can be assessed and that the child's mental health can be

monitored and taken into account as the MDT makes decisions. In some CACs, this may be the child's treatment provider; in others, it may be a mental health consultant.

- The CAC's procedural documentation should include provisions about how mental health information is shared, and about how client confidentiality and mental health records are protected.

- The forensic process of gathering evidence and determining what the child may have experienced is separate from mental health treatment. Mental health treatment is a clinical process designed to assess and mitigate the possible 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.

- Mental health services for non-offending family members and caregivers may include onsite screening, assessment and treatment, or screening, assessment and treatment by referral. It is important to consider the range of mental health issues that could impact the child's recovery or safety, with particular attention being paid to the family's mental health, substance use or misuse, family violence, and any other trauma history. Family members may benefit from 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.

- Siblings may also benefit from opportunities to discuss their own reactions and experiences, and to address family issues within a confidential therapeutic relationship.

4.8 Case Review

Recommended Guideline: A case review is an essential process that supports information-sharing and decision-making with respect to the investigation, case status and services needed by the child/youth and family, and should occur at least once per month. Participants will include all members of the multidisciplinary team.

Rationale

Case review offers the CAC the opportunity to review active/current cases, provide updated case information, and coordinate interventions. Case review occurs on a regular basis and is in addition to informal discussions and pre- and post-interview debriefings. Case reviews are intended to monitor current cases and are not intended to function as retrospective case studies. This is a formal process in which the knowledge, experience and expertise of all MDT members is shared so that: informed decisions can be made; collaborative efforts are nurtured; formal and informal communication is promoted; mutual support is provided; and protocols and procedures are reviewed.

Key Components

- Case reviews encourage mutual accountability and help to ensure that children's needs are met sensitively, effectively and in a timely manner.

- Case review is not meant to pre-empt ongoing discussions between MDT members, and ongoing discussions are not meant to take the place of formal case review. Every CAC must have a process for reviewing cases. Depending on the size of the CAC's jurisdiction or caseload, the method and timing of case review may vary to fit the unique CAC community. Some CACs review every case, while others review only complex or problematic cases. Representatives from each core discipline should attend and provide input at a case review. Confidentiality must be addressed in the interagency agreements.

- In order to make informed case decisions, essential information and professional expertise are required from all disciplines. The process should ensure that no one discipline dominates the discussion, but rather all relevant team members have a chance to adequately address their specific case interventions, questions, concerns and outcomes.

- Generally, the case review process should:

    - review interview outcomes;
    - assess the family's reactions and response to the child's disclosure and involvement in the criminal justice and child protection systems;
    - discuss, plan and monitor the progress of the investigation;
    - review medical evaluations;
    - discuss child protection and other safety issues;
    - discuss emotional support and treatment needs of the child and non-offending family members and strategies for meeting those needs;
    - make provisions for court preparation and court support; and
    - discuss other issues relevant to the case.

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

- Relevant MDT representation at case reviews promotes an informed process through the contributions of diverse professional perspectives. Case reviews should be attended by agency representatives able to participate on behalf of their respective agencies. CACs should establish policies addressing who is required to attend case reviews. All those participating should be familiar with the CAC process, as well as the purpose and expectations of case reviews.

- Processes should be defined to communicate recommendations or MDT decisions arising from a case review to the appropriate individuals for implementation.

- CACs should strive to create an environment where complex issues can be raised and discussed. Case reviews should provide an opportunity for MDT members to increase their knowledge of the dynamics of child abuse cases. Reviews may include, but not be limited to, discussion of: relevant theories; research; agency interventions, limitations, or service gaps; issues of family dynamics; developmental and emotional disabilities; parenting styles and child-rearing practices; gender roles; religious beliefs; socioeconomics; and cultural dynamics and behaviours.

4.9 Case Tracking

Recommended Guideline: Case tracking refers to a systematic method where specific data are routinely collected on each case served by the CAC/CYAC. CACs/CYACs must develop and implement a system for monitoring case progress and tracking case outcomes for all multidisciplinary team components.

Rationale

Case tracking systems provide essential demographic information, case information and investigation or intervention outcomes, and can also be used for program evaluation, such as identifying areas for continuous quality improvement, ongoing case progress and monitoring outcomes, and for generating statistical reports.

Effective case tracking systems will enable MDT members to accurately inform children and families about the current status and disposition of their cases. They also enable ease of access to data that are frequently requested for grants and other reporting purposes. When collected across centres, data can be used to assemble local, regional, provincial or territorial, and national statistics that are useful for advocacy, research and legislative purposes in the field of child maltreatment.

Key Components

- Each CAC needs to determine the type of case tracking system that will suit its needs. Case tracking must be compliant with all applicable privacy and confidentiality

requirements. For case tracking data to be used for research purposes, appropriate consent should be obtained at the outset of the case.

- CACs should collect and demonstrate the ability to retrieve case specific information for all CAC clients. Statistical information should include the following data:

  - demographic information about the child and family;
  - types of abuse alleged;
  - relationship of alleged offender to child;
  - MDT involvement and outcomes;
  - charges laid and case disposition in criminal court;
  - child protection outcomes;
  - medical and mental health referrals; and
  - any other services provided.

- Case tracking is an important function of the CAC and can be a time-consuming task depending on case volume. Accuracy is important and, for this reason, an individual should be identified to implement and oversee the case tracking process.

- 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. Defining case tracking procedures in CACs' procedural documentation underscores the importance of case tracking and helps to ensure accountability in this area. CACs should consider implementing a standardized tool such as NCAtrac to facilitate consistency in case tracking.

- MDT partner agencies should have access to case information as defined by the CAC's written documents. Since case data may be useful to MDT members for a variety of purposes, it is important that they have access to aggregate and specific case information. Centres should also develop policies addressing how these data may be released to participating agencies or parties other than the MDT that adhere to confidentiality requirements.

4.10 Organizational Capacity

Recommended Guideline: Every CAC/CYAC 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/CYAC, including setting and implementing administrative policies, hiring and managing personnel, providing training and support to personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.

Rationale

There are many options for a CAC's organizational structure, depending upon the unique needs of its community. Success ultimately requires that, regardless of where the program is housed or under what legal auspices it is established, all agencies in the collaborative effort have equal investment in and ownership of the program. A CAC may be an independent non-profit agency, a program affiliated with an umbrella organization, such as a hospital or other non-profit social service agency, or part of a governmental entity, such as child protection services, law enforcement or victim services. Each of these options has its advantages and limitations as they relate to collaboration, planning, governance, community partnerships and resource development.

Key Components

- CACs are incorporated, non-profit organizations or government-based agencies, or a component of such an organization or agency. CACs have a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight.

- Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Non-profit CACs, including those that are a component of an umbrella non-profit hospital, must carry, at a minimum, general commercial liability, professional liability, and directors' and officers' liability insurance. Government-based CACs must carry, at a minimum, general commercial liability and professional liability insurance or comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed, such as renters', property owners' or automobile insurance.

- Every CAC should have written policies and procedures that govern its administrative operations. Administrative policies and procedures may address: job descriptions, personnel policies and related staffing procedures; non-discrimination; grievance policies; fiscal management; documentation and record-keeping; how the work of the CAC should be evaluated; privacy and confidentiality requirements; health and safety policies and emergency procedures; security policies; and use of CAC facilities and equipment. These policies and procedures may be found in various organizational documents, such as board policies, hiring policies, employee handbook and MDT protocols.

- 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 rather than full audit will usually be sufficient for CACs with annual actual expenses equal to or less than $500,000.

  - All CACs with annual actual expenses in excess of $500,000 must have their financial statements audited. If a management letter is prepared by the accountant conducting the audit, the letter should be included with the audit report.

  - All centres with annual actual expenses equal to or less than $500,000 are required to have a review of their financial statements. If a management letter is prepared by the accountant conducting the review, it should be included with the review report.

- In order to ensure that children receive the services they require, CACs should have personnel responsible for coordinating its operations and program services. The CAC should have sufficient staffing to support all program components. Efforts must be made to secure reliable and ongoing sources of funding for these positions.

- Due to the sensitive and high-risk nature of CAC work, it is necessary that, at a minimum, CACs conduct a formal screening process for staff that includes a satisfactory vulnerable sector police criminal reference check for each staff member. CACs should also provide an orientation, ongoing training and regular supervision to all staff members.

- CACs must have, and demonstrate compliance with, written screening policies for onsite volunteers that include a satisfactory vulnerable sector police criminal reference check for every volunteer and provides orientation, training and regular supervision.

- CACs should promote 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 upon staff.

- CACs should promote the well-being of MDT members by providing access to training and information on vicarious trauma and building resiliency.

- CACs should provide education and community awareness on child abuse issues. One component of CAC work is education and outreach to the community about child abuse, its effects, legal and moral responsibilities if child abuse is suspected and the services provided by the CAC. Community education and outreach may be provided by staff and MDT members.

- In an effort to ensure long-term viability of the organization, CACs should regularly undertake a strategic planning or planning review process. This process should explore program needs, staffing levels and funding for future growth and sustainability.

REFERENCES

Adams, J.A., Kellogg, N.D., Farst, K.J., Harper, N.S., Palusci, V.J., Frasier, L.D., Levitt, C.J., Shapiro, R.A., Moles, R.L., & Starling, S.P. (2016). Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused. *Journal of Pediatric and Adolescent Gynecology*, *29*(2), 81-87.

Adams, J.A., Starling, S.P., Frazier, L.D., Palusci, V.J., Shapiro, R.A., Finkel, M.A., & Botash, A.S. (2012). Diagnostic Accuracy in Child Sexual Abuse Medical Evaluation: Role of Experience, Training, and Expert Case Review. *Child Abuse & Neglect*, *36*(5), 383-392.

Agatston, A.H., Kutulakis, J.R., Leclair, T.J., Smith, S., & Vieth, V.I. (2010). When a Parent Sues the CAC: Tips for Forensic Interviewers and Children's Advocacy Centers Facing Litigation. *Centerpiece*, *2*(9), 1-5.

American Professional Society on the Abuse of Children. (2002). *Investigative Interviewing in Cases of Alleged Child Abuse*. Charleston, SC: APSAC. Practice Guideline Series.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-Based Practice in Psychology. *American Psychologist*, *61*, 271-285.

Anderson, J., Ellefson, J., Lashley, J., Miller, A.K., Olinger, S., Russell, A., Stauffer, J., & Weigman, J., (2010). The CornerHouse Forensic Interview Protocol: RATAC. *Thomas M. Cooley Journal of Practical and Clinical Law*, *12*, 193-331.

Baker, A.J.L., Lenane, A., Cahill, L., Hess, T., Schneiderman, M., & Dimick, C. (2016). The Provision and Utilization of Mental Health Screenings in New York State Child Advocacy Centers: A Statewide Survey. *APSAC Advisor*, *28*(1), 1-6.

Berkoff, M.C., Zolotor, A.J., Makoroff, K.L., Thackeray, J.D., Shapiro, R.A., & Runyan, D.K. (2008). Has This Prepubertal Girl Been Sexually Abused? *Journal of the American Medical Association*, *300*(23), 2779-2792.

Besel, K., Williams, C.L., & Klak, J. (2011). Nonprofit Sustainability During Times of Uncertainty. *Nonprofit Management and Leadership*, *22*(1), 53-65.

Bonach, K. & Heckert, A. (2012). Predictors of Secondary Traumatic Stress Among Children's Advocacy Center Forensic Interviewers. *Journal of Child Sexual Abuse*, *21*, 295-314.

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

Bracewell, T. (2015). *Children's Advocacy Centers' Effect on the Prosecutorial Decision to Accept or Reject Cases of Child Sexual Abuse*. (Doctoral dissertation). Texas State University.

Brandon, M. Dodsworth, J., & Rumball, D. (2005). Serious Case Reviews: Learning to Use Expertise. *Child Abuse Review*, *14*(3), 160-176.

Bride, B.E., Robinson, M.M., Yegidis, B., & Figley, C. (2004). Development and Validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, *14*(1), 27-35.

Brzozowski, J.-A., Taylor-Butts, A., & Johnson, S. (2006). Victimization and Offending among the Aboriginal Population in Canada. *Juristat*, *26*(3). Ottawa, ON: Canadian Centre for Justice Statistics.

Cary, C.E., & McMillen, J.C. (2012). The Data Behind the Dissemination: A Systematic Review of Trauma-focused Cognitive Behavioral Therapy for Use with Children and Youth. *Children and Youth Services Review*, *34*(4), 748-757.

Cassady, C., Kellogg, N., MacDonald, M., Mounty, J., & Northrup, K. (2006). *Guidelines on Children's Advocacy Center Services for Children Who Are Deaf/Hard of Hearing*. (Nancy Chandler, Ed.). Available online: www.nationalcac.org/professionals/images/stories/pdfs/cc%20standard%20chandler%20hearing%20impaired.pdf

Chand, A. (2005). Do You Speak English? Language Barriers in Child Protection Social Work with Minority Ethnic Families. *British Journal of Social Work*, *35*, 807-821.

Chandler, N. (Ed.). (2000). *Best Practices for Establishing a Children's Advocacy Center Program*. National Children's Alliance in Cooperation with the Regional Children's Advocacy Centers.

Child Welfare Information Gateway. (2016). *Racial Disproportionality and Disparity in Child Welfare*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Institute. (2017). *Boost Child and Youth Advocacy Centre – Evaluation Report: October 2013 – June 2015*. Toronto, ON: Children's Aid Society of Toronto.

Christian, C.W. (2011). Timing of the Medical Examination. *Journal of Child Sexual Abuse*, *20*(5), 505-520.

Cohen, J.A., Deblinger, E., Mannarino, A.P., & de Arellano, M.A. (2001). The Importance of Culture in Treating Abused and Neglected Children: An Empirical Review. *Child Maltreatment*, *6*(2), 148-157.

Collin-Vézina, D., Dion, J., & Trocmé, N. (2009). Sexual Abuse in Canadian Aboriginal Communities: A Broad Review of Conflicting Evidence. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, *7*, 27-48.

Connors-Burrow, N.A., Tempel, A.B., Sigel, B.A., Church, J.K., Kramer, T.L., & Worley, K.B. (2012). The Development of Systematic Approach to Mental Health Screening in Child Advocacy Centers. *Children and Youth Services Review*, *34*(9), 1675-1682.

Cross, T.P., Jones, L.M., Walsh, W.A., Simone, M., & Kolko, D. (2007). Child Forensic Interviewing in Children's Advocacy Centers: Empirical Data on a Practice Model. *Child Abuse & Neglect*, *31*(10), 1031-1052.

Cross, T.P., Jones, L.M., Walsh, W.A., Simone, M., Kolko, D.J., Szczepanski, J., Lippert, T., Davison, K., Cryns, A., Sosnowski, P., Shadoin, A., & Magnuson, S. (2008). Evaluating Children's Advocacy Centers' Response to Child Sexual Abuse. *Juvenile Justice Bulletin*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Cyr, M. (2014). *Recueillir la parole de l'enfant témoin ou victim: De la théorie à la pratique.* Paris: Dunod.

Deloitte. (2013). *The Effective Non-for-Profit Board: A Value-driving Force*. Available online: www.corpgov.deloitte.ca/en-ca/Documents/RolesAndResponsibilities/Effective-NPO-Board_052013.pdf.

Deloitte. (2017). *Reducing Trauma, Improving Lives: The Social Value of Boost Child and Youth Advocacy Centre – Final Report*. Toronto, ON: Deloitte LLP.

Department of Justice Canada. (2017). *Understanding the Development and Impact of Child Advocacy Centres (CACs)*. Ottawa, ON: Department of Justice Canada.

Dettlaff, A.J., & Earner, I. (2012). Children of Immigrants in the Child Welfare System: Characteristics, Risk, and Maltreatment. *Families in Society*, *93*(4), 295-303.

De Vita, C.J., Fleming, C., & Twombly, E. (2001). Building Nonprofit Capacity: A Framework for Addressing the Problem. In C.J. De Vita & C. Fleming (Eds.),

Building Capacity in Nonprofit Organizations. Washington, DC: Urban Institute Press.

Edinburgh, L., Saewyc, E., & Levitt, C. (2008). Caring for Young Adolescent Sexual Abuse Victims in a Hospital-based Children's Advocacy Center. *Child Abuse & Neglect*, *32*, 1119-1126.

Faller, K.C. (2015). Forty Years of Forensic Interviewing of Children Suspected of Sexual Abuse, 1974-2014: Historical Benchmarks. *Social Sciences*, *4*, 34-65.

Faller, K.C. & Palusci, V.J. (2007). Children's Advocacy Centers: Do they Lead to Positive Case Outcomes? *Child Abuse and Neglect*, *31*, 1021-1029.

Fashola, S. (2012). *Services Similar to Child Advocacy Centres in Other Countries*. Ottawa, ON: Department of Justice Canada.

Figley, C.R. (1999). Compassion Fatigue: Toward a New Understanding of the Costs of Caring. In B.H. Stamm (Ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran.

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

Finkelhor, D., Cross, T.P., & Cantor, E.N. (2005). The Justice System for Juvenile Victims: A Comprehensive Model of Case Flow. *Trauma, Violence, & Abuse*, *6*(2), 83-102.

Finkelhor, D., & Williams, L.M. (1988). *Nursery Crimes: Sexual Abuse in Daycare*. Newbury Park, CA: Sage.

Fontes, L.A. (2010). Interviewing Immigrant Children for Suspected Child Maltreatment. *The Journal of Psychiatry and Law*, *38*(3), 283-305.

Fontes, L.A., & Plummer, C. (2010). Cultural Issues in Disclosure of Child Sexual Abuse. *Journal of Child Sexual Abuse*, *19*(5), 491-518.

Fontes, L.A., & Tishelman, A.C. (2016). Language Competence in Forensic Interviews for Suspected Child Sexual Abuse. *Child Abuse & Neglect*, *58*, 51-62.

Friedman, M.S., Marshal, M.P., Guadamuz, T.E., Wei, C., Wong, C.F., Saewyc, E.M., & Stall, R. (2011). A Meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, *101*(8), 1481-1494.

Gjuric, M. (2016). *Snowflake Place for Children and Youth: Evaluation Report 2016*. Winnipeg, MB: University of Manitoba.

Gragg, F., Cronin, R., & Schultz, D. (2006). *National Evaluation of the Safe Kids/Safe Streets Program: Processing and Outcomes of Child Abuse and Neglect Cases in Three Sites*. Rockville, MD: Westat.

Gudjonsson, G., Sveinsdottir, T., Sigurdsson, J.F., & Jonsdottir, J. (2010). The Ability of Suspected Victims of Childhood Sexual Abuse (CSA) to Give Evidence. Findings from the Children's House in Iceland. *The Journal of Forensic Psychiatry and Psychology*, *21*(4), 569-586.

Hahn, H., Oransky, M., Epstein, C., Stover, C.S., & Marans, S. (2016). Findings of an Early Intervention to Address Children's Traumatic Stress Implemented in the Child Advocacy Center Setting Following Sexual Abuse. *Journal of Child and Adolescent Trauma*, *9*, 55-66.

Herbert, J.L. & Bromfield, L. (2016). Evidence for the Efficacy of the Child Advocacy Center Model: A Systemic Review. *Trauma, Violence, & Abuse*, *17*(3), 341-357.

Herbert, J.L., & Bromfield, L (2017). Better Together? A Review of Evidence for Multi-disciplinary Teams Responding to Physical and Sexual Child Abuse. *Trauma, Violence & Abuse*. Prepublished March 6, 2017. DOI:10.1177/1524838017697268.

Herbert, J.L., Walsh, W., & Bromfield, L. (in press). A National Survey of Characteristics of Child Advocacy Centers in the United States: Do Flagship Models Match Those in Broader Practice? *Child Abuse & Neglect*.

Hill, J.R. (2008). *Prosecuting Child Sexual Abuse Offenders: A Case Study of Victim, Family, Offender, Incident, and Evidentiary Characteristics*. A dissertation presented to the Graduate School of the University of Missouri-St. Louis.

Hubel, G.S., Campbell, C., West, T., Friedenberg, S., Schreier, A., Flood, M.F., & Hansen, D.J. (2014). Towards Strengthening Social and Family Relationships in Child Sexual Abuse Victims: Child Advocacy Center Based Group Treatment for Child Sexual Abuse. *Journal of Child Sexual Abuse*, *23*, 304-325.

Jackson, S.L. (2004a). *A Resource for Evaluating Child Advocacy Centers*. Special Report from the National Institute of Justice.

Jackson, S.L. (2004b). A USA National Survey of Program Services Provided by Child Advocacy Centers. *Child Abuse and Neglect*, *28*, 411-421.

Jackson, S.L. (2012). Results from the Virginia Multidisciplinary Team Knowledge and Functioning Survey: The Importance of Differentiating by Groups Affiliated with a Child Advocacy Center. *Children and Youth Services Review*, *34*(7), 1243-1250.

Joa, D., & Edelson, M.G. (2004). Legal Outcomes for Children Who Have Been Sexually Abused: The Impact of Child Abuse Assessment Center Evaluations. *Child Maltreatment*, *9*, 263-276.

Johansson, S. (2012). Diffusion and Governance of 'Barnahus' in the Nordic Countries: Report from an On-going Project. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, *13*, 69-84.

Jones, L.M., Cross, T.P., Walsh, W.A., & Simone, M. (2005). Criminal Investigations of Child Abuse: The Research Behind "Best Practices." *Trauma, Violence, & Abuse*, *6*(3), 254-268.

Jones, L.M., Cross, T.P., Walsh, W.A., & Simone, M. (2007). Do Children's Advocacy Centers Improve Families' Experiences of Child Sexual Abuse Investigations? *Child Abuse & Neglect*, *31*, 1069-1085.

Kenny, M.C., Vazquez, A., Long, H., & Thompson, D. (2017). Implementation and Program Evaluation of Trauma-informed Care Training across State Child Advocacy Centers: An Exploratory Study. *Children and Youth Services Review*, *73*, 15-23.

Kistin, C.J., Tien, I., Bauchner, H., Parker, V., & Leventhal, J.M. (2010). Factors That Influence the Effectiveness of Child Protection Teams. *Pediatrics*, *126*(1), 94-100.

Kolbo, J.R., & Strong, E. (1997). Multidisciplinary Team Approaches to the Investigation and Resolution of Child Abuse and Neglect: A National Survey. *Child Maltreatment*, *2*(1), 61-72.

Kouyoumdijian, H., Perry, A.R., & Hansen, D.J. (2009). Nonoffending Parent Expectations of Sexually Abused Children: Predictive Factors and Influence on Children's Recovery. *Journal of Child Sexual Abuse*, *18*(1), 40-60.

Lalayants, M., & Epstein, I. (2005). Evaluating Multidisciplinary Child Abuse and Neglect Teams: A Research Agenda. *Child Welfare*, *84*(4), 433-458.

Lam, M., Klein, S., Freisthler, B., & Weiss, R.E. (2013). Child Center Closures: Does Nonprofit Status Provide a Comparative Advantage? *Children and Youth Services Review*, *35*(3), 525-534.

Lamb, M.E., Orbach, Y., Hershkowitz, I., Esplin, P.W., & Horowitz, D. (2007). A Structured Forensic Interview Protocol Improves the Quality and Informativeness of Investigative Interviews with Children: A Review of Research Using the NICHD Investigative Interview Protocol. *Child Abuse & Neglect*, *31*(11-12), 1201-1231.

Lamb, M.E., Sternberg, K.J., Orbach, Y., Esplin, P.W., & Mitchell, S. (2002a). Is Ongoing Feedback Necessary to Maintain the Quality of Investigative Interviews with Allegedly Abused Children? *Applied Developmental Science*, *6*(1), 35-41.

Lamb, M.E., Sternberg, K.J., Orbach, Y., Hershkowitz, I., Horowitz, D., & Esplin, P. (2002b). The Effects of Intensive Training and Ongoing Supervision on the Quality of Investigative Interviews with Alleged Sex Abuse Victims. *Applied Developmental Science*, *6*(3), 114-125.

Lane, W.G., & Dubowitz, H. (2009). Primary Care Physicians' Experience, Comfort and Competence in the Evaluation and Management of Child Maltreatment: Do We Need Child Abuse Experts? *Child Abuse & Neglect*, *33*(2), 76-83.

Lawrence, C., Zuckerman, M., Smith, B.D., & Liu, J. (2012). Building Cultural Competence in the Child Welfare Workforce: A Mixed-methods Analysis. *Journal of Public Child Welfare*, *6*(2), 225-241.

Leach, C., Baksheev, G.N., & Powell, M. (2015). Child Sexual Abuse Research: Challenges of Case Tracking Through Administrative Databases. *Psychiatry, Psychology and Law*, 2015, 1-8.

Lee, C.W., Li, C.H., & So, K.T. (2005). Going to the Multidisciplinary Case Conference for Child Abuse: A Review and Guide to the Medical Practitioner. *Hong Kong Journal of Emergency Medicine*, *12*(1), 50-58.

Leventhal, J.M., Murphy, J.L., & Asnes, A.G. (2010). Evaluations of Child Sexual Abuse: Recognition of Overt and Latent Family Concerns. *Child Abuse & Neglect*, *34*(5), 289-295.

Li, J. & Robertson, T. (2011). Physical Space and Information Space: Studies of Collaboration in Distributed Multi-Disciplinary Medical Team Meetings. *Behaviour & Information Technology*, *30*(4), 443-454.

Lightfoot, E.B., & LaLiberte, T.L. (2006). Approaches to Child Protection Case Management for Cases Involving People with Disabilities. *Child Abuse & Neglect*, *30*(4), 381-391.

Malott, K.M. & Paone, T.R. (2008). Using Interpreters in Mental Health Counseling: A Literature Review and Recommendations. *Journal of Multicultural Counseling and Development*, *36*(3), 130-142.

Mannarino, A.P., Cohen, J.A., Deblinger, E., Runyon, M.K., & Steer, R.A. (2012). Trauma-focused Cognitive-behavioral Therapy for Children: Sustained Impact of Treatment 6 and 12 Months Later. *Child Maltreatment*, *17*(3), 231-241.

Martinez, J. (2003). Liability and Volunteer Organizations: A Survey of the Law. *Nonprofit Management and Leadership*, *14*(2), 151-169.

Miller, A., & Rubin, D. (2009). The Contribution of Children's Advocacy Centers to Felony Prosecutions of Child Sexual Abuse. *Child Abuse & Neglect*, *33*(1), 12-18.

Moore, M.H. (2000). Managing for Value: Organizational Strategy in For-profit, Nonprofit, and Governmental Organizations. *Nonprofit and Voluntary Sector Quarterly*, *29*(1), 183-204.

Mosley, J.E., Maronick, M.P, & Katz, H. (2012). How Organizational Characteristics Affect the Adaptive Tactics Used by Human Service Nonprofit Managers Confronting Financial Uncertainty. *Nonprofit Management & Leadership*, *22*(3), 281-303.

National Children's Alliance. (2008). *NCAtrak: Frequently Asked Questions About Getting on NCAtrak*. Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice.

National Children's Alliance. (2013). *Accreditation Guidelines for Children's Advocacy Centers*. Washington, DC: National Children's Alliance.

National Children's Alliance. (2015). *Standards for Accredited Members Revised Effective 2017*. Washington, DC: National Children's Alliance.

National Children's Alliance. (2017a). *Putting Standards into Practice: A Guide to Implementing the 2017 Standards for Accredited Members*. Washington, DC: National Children's Alliance.

National Children's Alliance. (2017b). *Standards for Accredited Members – 2107 Edition*. Washington, DC: National Children's Alliance.

National Crime Victims Research and Treatment Center. (n.d.). *What is TB-CBT?* Available online: http://academicdepartments.musc.edu/projectbest/tfcbt/tfcbt.htm

Newlin, C., Steele, L.D., & Wells, M.K. (2013). *Bibliography of the Empirical and Scholarly Literature Supporting the Ten Standards for NCA Accreditation* (2nd ed.). Washington, DC: National Children's Alliance.

Newman, B.S., Dannenfelser, P.L., & Pendleton, D. (2005). Child Abuse Investigations: Reasons for Using Child Advocacy Centers and Suggestions for Improvement. *Child and Adolescent Social Work Journal*, *22*(2), 165-181.

Orbach, Y., Hershkowitz, I., Lamb, M.E., Sternberg, K.J., Esplin, P.W., & Horowitz, D. (2000). Assessing the Value of Structured Protocols for Forensic Interviews of Alleged Abuse Victims. *Child Abuse & Neglect*, *24*, 733-752.

Ostrower, F. (2007). *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*. Washington, DC: The Urban Institute Center on Nonprofits and Philanthropy.

Pankaj, V. & Shah, S.C. (2008). *The Duke Endowment: Child Advocacy Center Evaluation. Year 3 Final Report*. Washington, DC: Innovation Network, Inc.

Pence, D.M., & Wilson, C.A. (1994). Reporting and Investigating Child Sexual Abuse. *The Future of Children*, *4*, 70-83.

Pipe, M.-E., Orbach, Y., Lamb, M.E., Abbott, C.B., & Stewart, H. (2012). Do Case Outcomes Change When Investigative Interviewing Practices Change? *Psychology, Public Policy, and Law*, *19*(2), 179-190.

Proactive Information Services. (2015). *Understanding the Impact of Child Advocacy Centres (CACs): Mid-Project Report*. Ottawa, ON: Department of Justice Canada.

Rasmusson, B. (2011). Children's Advocacy Centers (Barnahus) in Sweden: Experiences of Children and Parents. *Child Indicators Research*, *4*(2), 301-321.

Reiser, D.B. (2007). Director Independence in the Independent Sector. *Fordham Law Review*, *76*(2), 795-832.

Ruggieri, C.L. (2005). *Child Advocacy Centers and Child Sexual Abuse in Nevada* (Masters thesis). University of Nevada, Las Vegas.

Saewyc, E.M., Skay, C.L., Pettingell, E.A., Reis, L.B., Bearinger, L., Resnick, M., Murphy, A., & Combs, L. (2006). Hazards of Stigma: The Sexual and Physical Abuse of Gay, Lesbian, and Bisexual Adolescents in the United States and Canada. *Child Welfare*, *85*(2), 195-213.

Schuh, R.G. & Leviton, L. (2006). A Framework to Assess the Development and Capacity of Non-profit Agencies. *Evaluation and Program Planning*, *29*(2), 171-179.

Simone, M., Cross, T.P., Jones, L.M., & Walsh, W.A. (2005). Children's Advocacy Centers: Understanding the Impact of a Phenomenon. In K. Kendall-Tackett & S.M. Giacomoni (Eds.), *Child Victimization* (pp. 1-24). Kingston, NJ: Civic Research Institute, Inc.

Smith, N., & Harrell, S. (2013). *Sexual Abuse of Children with Disabilities: A National Snapshot*. New York: Vera Institute of Justice Center on Victimization and Safety. Available online: www.vera.org/pubs/sexual-abuse-of-children-with-disabilities-national-snapshot

Smith, D.W., Witte, T.H., & Fricker-Elhai, A.E. (2006). Service Outcomes in Physical and Sexual Abuse Cases: A Comparison of Child Advocacy Center-based and Standard Services. *Child Maltreatment*, *11*(4), 354-360.

Smith, T.M. (2011). *Case Studies of Multidisciplinary Child Abuse Case Review Teams and their Leaders in Children's Advocacy Centers in Pennsylvania*. Doctoral dissertation available from Proquest Dissertations and Theses (3453625).

Statistics Canada. (2015). Self-reported Victimization, 2014. *The Daily*, November 23, 2015. Available at: http://www.statcan.gc.ca/daily-quotidien/151123/dq151123a-eng.htm.

Staudt, M., & Williams-Hayes, M. (2011). A State Survey of Child Advocacy Center Therapists; Attitudes toward Treatment Manuals and Evidence-based Practice. *Journal of Child Sexual Abuse*, *20*, 1-13.

Sullivan, P.M., & Knutson, J.F. (2000). Maltreatment and Disabilities: A Population-based Epidemiological Study. *Child Abuse & Neglect*, *24*(10), 1257-1273.

Tavkar, P., & Hansen, D.J. (2011). Interventions for Families Victimized by Child Sexual Abuse: Clinical Issues and Approaches for Child Advocacy Center-based Services. *Aggression and Violent Behavior*, *16*(3), 188-199.

Tjaden, P.G., & Anhalt, J. (1994). *The Impact of Joint Law Enforcement-Child Protective Services Investigations in Child Maltreatment Cases*. Denver, CO: Center of Policy Research.

Vanderzee, K.L., Pemberton, J.R., Conners-Burrow, N., & Kramer, T.L. (2016). Who Is Advocating for Children under 6? Uncovering Unmet Needs in Child Advocacy Centers. *Children and Youth Services Review*, *61*, 303-310.

Walsh, W.A., Cross, T.P., Jones, L.M., Simone, M., & Kolko, D.J. (2007). Which Sexual Abuse Victims Receive a Forensic Medical Examination? The Impact of Children's Advocacy Centers. *Child Abuse & Neglect*, *31*, 1053-1068.

Walsh, W.A., Jones, L.M., & Swiecicki, C.C. (2014). Using Child Advocacy Center Tracking Data to Examine Criminal Disposition Times. *Journal of Child Sexual Abuse*, *23*, 198-216.

Walsh, W.A., Lippert, T., Cross, T.P., Maurice, D.M., & Davison, K.S. (2008). How Long to Prosecute Child Sexual Abuse for a Community Using a Children's Advocacy Center and Two Comparison Communities? *Child Maltreatment*, *13*(1), 3-13.

Whitcomb, D. (1992). *When the Victim is a Child* (2nd ed.). Washington, DC: US Department of Justice, Office of Justice Programs, National Institute of Justice.

Wiener, E.S. & Rivera, M.I. (2004). Bridging Language Barriers: How to Work With an Interpreter. *Clinical Pediatric Emergency Medicine*, *5*, 93-101.

Yuille, J.C., Hunter, R., Joffe, R., & Zaparniuk, J. (1993). Interviewing Children in Sexual Abuse Cases. In G.S. Goodman & B.L. Bottoms (Eds.), *Child Victims, Child Witnesses* (pp. 95-115). New York: Guilford Press.