Overview of Skill Building Sessions

Session I:

• Overview of the CSA investigation challenge
• Overview of the medical and forensic examination, mental health and advocacy challenges in CSA
• Overview of the CAC model, including examples both in the US and internationally
• Comparison of pre-CAC intervention vs. post-CAC intervention
• Introduction of ten CAC core components with accompanying rationale for each core component within the model
Overview of Skill Building Sessions

Session II

- Review of the ten CAC core components, rationale, and examples of implementation (continued)
- Strategies for engaging multidisciplinary partners, NGO’s, and governmental entities
- Outcome research regarding the CAC model
Overview of Skill Building Sessions

**Session III**

- Pilot project to national model – how to implement CAC model on a large scale and in culturally appropriate manner
- Considerations in developing and maintaining a network of Children’s Advocacy Centers
- Maintaining the integrity of the model as you grow the network of CACs
- Considerations in resource-allocation and funding strategies in CAC development
- Use of technology in building capacity – training and technical assistance resources available for child abuse professionals
Course Objectives

1. Participants will be able to identify the core components of the CAC/Barnahus model.

2. Participants will recognize the role of government and possibly NGO necessary for the successful implementation of the CAC model.

3. Participants will understand the critical role of the multidisciplinary response to child abuse and the evidence supporting the value of the CAC model.

4. Participants will review various program implementation challenges and strategies to address these challenges.

5. Participants will learn of online training and technical assistance resources to support the MDT response to child maltreatment.
Challenges of Investigating CSA

• No test to identify offenders
  ➢ MMPI profiles

• No symptom presentation which specifically proves CSA
  ➢ Excluding rare instances

• Rarely any eyewitnesses

• Shame and fear commonly seen in those affected – making them less likely to disclose or fully report

• Social stigma/repression of open dialogue

• It is a legal, civil society, medical, and mental health issue
  ➢ Diffusion of responsibility vs. Collaborative opportunity
Original Child Advocacy Center Philosophy

- Child sexual abuse is a serious issue which must be addressed
- The “system” intended to protect children should “help” children, not further traumatize or cause lack of trust
- The protection of children must involve all agencies involved in the investigation and intervention, and these agencies must work together
  - This collaboration will include both government and NGOs
- Programs should be flexible based on the community’s strengths
Challenges in Meeting the Mental Health and Medical Standard

JANE BRAUN
PROJECT DIRECTOR
MRCAC
Themes

- Geographic location
  - 50% located in rural areas
- Lack of Funding
  - Small budgets and difficult economic climate
- Capacity
  - General lack of trained professionals
- Expert Gap
  - Limited or no access to experts for peer review and/or quality improvement
CAC Environment: Who are we serving?

Geographic Location

- Rural: 51%
- Urban: 18%
- Suburban: 19%
- Other (Mixed): 12%
Percent of Children Receiving Medical Evaluations Based on Geographic Location

% Children receiving Medical Evaluation

- Rural
- Urban
- Suburban

MRCAC
Midwest Regional Children's Advocacy Center
Lack of Funding

- Small Operating Budgets
  - 42% of CACs operate on $100,000-$250,000 annually to serve on average 200-499 children
- Budget cuts in state and federal funding to provide services
- Restricted grant funding for specific programs
- Lack of support from partner/referral agencies
  - Professionals are unwilling to give up billable hours
Capacity

- Lack of trained professionals
  - CACs often rely on Emergency Departments to provide Medical Evaluations
  - Rural/Tribal CACs rely on community resources
- Additional Barriers
  - Fear of testifying in court
  - Unwillingness to give up billable hours
  - Uninterested and/or unable to obtain specialized child abuse training
70% of Emergency Doctors misdiagnose child sexual abuse

40% of Primary Care physicians could not identify prepubertal genital anatomy

Child Abuse Pediatricians have “greater knowledge and competence in interpreting medical and laboratory findings in children with Child Sexual Abuse” when compared with pediatric SANEs and advanced practice nurses (APN) in the field

i. Makoroff, Brauley, Brandener, et al, 2002
ii. Lentsch & Johnson, 2000
iii. Adams et al., 2012
Expert Gap

- Limited or no access to experts in the field
  - Hinders peer review and continuous quality improvement
  - Lack of appropriate supervision for medical and mental health providers
  - Little to no support for professionals specialized in child abuse
Expert Gap

- 264 Board Certified Child Abuse Pediatricians
  - 1 Board Certified Child Abuse Pediatrician for every 2,633 founded cases of child abuse
  - 7 states have no child abuse pediatricians
  - 16 states have fewer than 3 child abuse pediatricians
Medical Provider Trends

<table>
<thead>
<tr>
<th>Profession</th>
<th>2009</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (MD)</td>
<td>162</td>
<td>224</td>
</tr>
<tr>
<td>Physicians Assistant (PA)</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Nurse Practitioner (CNP)</td>
<td>59</td>
<td>102</td>
</tr>
<tr>
<td>SANE Nurse</td>
<td>84</td>
<td>239</td>
</tr>
<tr>
<td>Nurse (RN)</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>27</td>
</tr>
</tbody>
</table>

Of those who indicated a SANE nurse performs the medical evaluations, 40% are receiving supervision from a professional who has NOT received training specific to child abuse medical evaluations.
Recap

- Need services that span geographic distances
- Advocate for increased funding and efforts to make mental health and medical services affordable
  - Include affordable training and peer review
- Increase capacity to train professionals in rural/tribal areas
- Bridge the expert gap
  - Develop solutions to connect rural/tribal CACs with experts
Comparison of Intervention Pre- vs. Post-CAC Development

• Child Perspective
  ➢ *If I had it to do all over again*....

• System Perspective
  ➢ *System-induced trauma?*

• Public Awareness Perspective
  ➢ *Increased detection, reporting, and support*

• Media Perspective
  ➢ *High profile cases drive change*
  ➢ *McMartin and Little Rascals in USA*
Changing the Child Abuse System

WHAT HAPPENS TODAY WHEN KIDS NEED HELP FOR ABUSE

Robin tells her story, while a detective, CPS worker, and District Attorney listen as a team.

Robin can see a doctor.

Robin's mom talks to an advocate to help her understand the system.

Robin comes to the Advocacy Center with her mom.

Tells her teacher that she is being hurt by her mom's new boyfriend at home.

... Robin talks to 3 people

Start Here

Robin is referred to a counselor, who will help her heal.

Robin's mom talks to an advocate to help her understand the system.

Detective is assigned and brings Robin to a specialized hospital—where another Nurse, Social Worker, Doctor talks to her and is examined by another Doctor.

Who talks to Robin?
Nurse, Social Worker, Doctor
Who examines Robin?
Doctor

Police Officer talks to Robin.

School calls Hotline and Police

A Counselor needs to talk to Robin.

A Lawyer needs to talk to Robin.

A Child Protection Investigator needs to talk to Robin.

Why do I have to talk to so many people?

Robin had to talk to 15 people, but now...

(turn over)
Core Components of Children’s Advocacy Centers
Growth of CACs in the United States
Number of children seen in CACs by year

- 2000: 75,000
- 2002: 125,000
- 2004: 175,000
- 2006: 225,000
- 2008: 275,000
- 2010: 325,000
Resources:

- NCA Guidelines for Accreditation
- Annotated Bibliography
- A series of three videoconferences on the standards – [www.nationalchildrensalliance.org](http://www.nationalchildrensalliance.org)
- NCAn.e.t.
- CAC Director’s Guide to Mental Health Services
- Guidance on Cultural Competency Technical Assistance Manual
National Standards for Accreditation
NCA National Standards for Accreditation

- Multidisciplinary Teams
- Cultural Competency and Diversity
- Forensic Interviews
- Victim Support and Advocacy
- Medical Evaluation
- Mental Health
- Case Review
- Case Tracking
- Organizational Capacity
- Child Focused Setting
A multidisciplinary team for response to child abuse allegations includes representation from the following:

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

“This article critically reviewed the MDT research literature and summarizes the evidence concerning MDT benefits. The literature review sections cover Team Practice in Child Protection, Definitions of MDTs, Team Models and Compositions, and MDT Effectiveness. The extensive review of the research literature drew the following conclusions:

- agencies reviewed more suspected cases,
- missed fewer cases,
- resolved more cases successfully and
- they reduced fragmentation and duplication.
Synthesis of the research also revealed that team members reported the MDT approach helped

- bring a more positive view of working conditions,
- decreased stress, and
- improved client relations while providing moral support and confidence.
- Clients found services more accessible and less fragmented.”
“The literature also revealed several areas in which problems can occur.

- What may seem dysfunctional by one team member may be viewed as an [sic] objective by another.

- Among the most common barriers to team effectiveness were:
  (1) defining shared goals and objectives, (2) conflicting theories and ideologies about child abuse and neglect, (3) lack of consensus, (4) turf disputes, (5) agency territorialism, (6) power struggles, (7) confusion about leadership roles and the ownership of the case, and feelings of excessive case scrutiny, and (8) that interdisciplinary decision making is more time consuming than traditional approaches.”
Essential Components:

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

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

- The CAC/MDT’s written documents address information sharing that ensures the timely exchange of relevant information among MDT members, staff, and volunteers and is consistent with legal ethical and professional standards of practice.
Rated Criteria:

- The CAC provides routine opportunities for MDT members to provide feedback and suggestions regarding procedures/operations at the CAC/MDT.

- The CAC/MDT participates in ongoing and relevant training and educational opportunities, including cross-discipline, MDT, peer review and skills-based learning.
Culturally competent services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

“Two additional categories of deterrents to disclosure have been found in the literature.

- The first category was reporting costs, which vary by ethnic group and may inhibit disclosure. Reporting costs may include loss of privacy and family support as well as financial loss.

- The second issue was structural barriers to disclosure. These included linguistic barriers, lack of document in native languages, immigration laws, racism, and economic barriers.
The literature also revealed 14 positive effects of culture on disclosure. Strong mother-child relationships, intolerance of adult sexual practices with children, high value placed on women and children, strong social sanctions against abuse, and extended family supervision of children are some of the positive effects on probability of disclosure.

The literature also showed that people within the United States from different cultures may differ in how child sexual abuse is defined and understood.”
Essential Components:

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

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

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

- The CAC engages in community outreach with underserved populations.

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

- The CAC’s cultural competency plan has been implemented and evaluated.
Forensic Interviews Standard

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

“The results of this study mirrored previous studies by both Orbach, et al. (2000) and Sternberg, Lamb, Orbach, et al. (2001) which revealed that the quality of interviewing improved when forensic interviewers were trained to implement a protocol that operationalized the consensus recommendations of diverse professionals and scholars, practiced using that protocol, and received written and verbal feedback on their interviews.”

- Review of the research on the child advocacy center model provided these conclusions: (1) that repeated interviewing and repeatedly asking similar questions have both been associated with inaccurate reporting and recanting allegations, particularly if early interviews are conducted inappropriately and (2) that the CAC model approach to interviewing best serves the interests of the child, reduces number of interviews, and provides the victim with support.
Essential Components:

- Forensic interviews are provided by MDT/CAC staff who have specialized training in conducting forensic interviews.

The CAC must demonstrate that forensic interviewers meet at least ONE of the following Training Standards:

- Documentation of satisfactory completion of competency-based child abuse forensic interview training that includes child development.

- Documentation of 40 hours of nationally or state recognized forensic interview training that includes child development.
Essential Components:

- The CAC/MDT’s written documents describe the general forensic interview process including pre-and post-interview information sharing and decision making, and interview procedures.

Refer to the Rationale:

These guidelines or agreements must include criteria for choosing an appropriately trained interviewer (case specific), which personnel are to attend/observe the interview, preparation/information-sharing with the forensic interviewer, use of interview aids, use of interpreters, communication between the MDT and the interviewer, recording and/or documentation of the interview, and interview process/methodology.
Essential Components:

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

- MDT members with investigative responsibilities are present for forensic interviews.

- Forensic interviews are routinely conducted at the CAC.
Rated Criteria:

- The CAC/MDT’s written documents include:
  - Selection of an appropriate, trained interviewer.
  - Sharing of information among MDT members.
  - And, a mechanism for collaborative case planning.
Rated Criteria:

- The CAC and/or MDT provide opportunities for those who conduct forensic interviews to participate in ongoing training and peer review.

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who conduct forensic interviews to receive specialized training.

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

- Ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 3 hours per every 2 years of CEU/CME credits.
- Participation in a formalized peer review process for forensic interviewers.
Rated Criteria:

- The CAC/MDT coordinate information gathering *whether* through history taking, assessment or forensic interviews to avoid duplication.
Victim Support and Advocacy Standard

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

- “Some significant findings included
  - (1) As with children, parental satisfaction with investigations appears to increase with the perceived supportiveness of the involved professionals and when they have good access to information about what is happening with the investigation, and
  - (2) —’Caregivers reported higher rates of satisfaction when their case was investigated through a CAC compared to cases investigated in communities without a CAC. The difference was not due to the number of interview[s] or a specific case outcome per se, but was based on more intangible aspects of investigations, such as support from investigators and a greater sense of comfort and safety during interviews. . . .’’
“From the analysis, the authors argued that more professionals are needed who understand the system in its entirety, not just their own agency role.

It is important to know who can help guide victims, families and other professionals through the system.

The authors identified several areas for improvement, including the need for professionals to recognize how stressful certain aspects of the system can be for child victims.

In making these recommendations, the authors were again painting a vastly different picture of what occurs in the CAC model, suggesting that each child victim would greatly benefit from the services provided by someone who stays connected to a case for the duration of the child’s involvement with the system.”
Essential Components:

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

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

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

- The CAC/MDTs written documents include availability of victim support and advocacy services for all CAC clients.
Rated Criteria:

Designated, trained individual(s) provides comprehensive, coordinated victim support and advocacy services including, but not limited to:

- Information regarding dynamics of abuse and the coordinated multidisciplinary response;
- Updates on case status;
- Assistance in accessing/obtaining victims rights as outlined by law;
- Court education, support, and accompaniment; and
- Assistance with access to treatment and other services such as protective orders, housing, public assistance, domestic violence intervention, and transportation.

Procedures are in place to provide initial and ongoing support and advocacy with the child and/or non-offending family members.
Specialized medical evaluation and treatment services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

- “The study also concluded that except under circumstances where children refuse imaging, every examination should be recorded either by photograph, video, or digital imaging.

- This must be done in order to
  - preserve the evidence from the examination,
  - allow for peer review of examinations, and
  - allow the opposing counsel to secure their own expert review.

- From the review of the literature the authors further concluded that all examiners should have a method for oversight and peer review, due to the weight that abnormal examinations can carry as evidence and the risk of cases being lost or won upon the basis of medical findings.”
Essential Components:

- Medical evaluations are provided by health care providers with pediatric experience and child abuse expertise.

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

- Child Abuse Pediatrics Sub-board eligibility;
- Child Abuse Fellowship training or child abuse Certificate of Added Qualification;
- Documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations;
- Documentation of 16 hours of formal medical training in child sexual abuse evaluation.

The criteria outlined above apply to all examiners.
Essential Components:

- Specialized medical evaluations for the child client are routinely made available on-site or through linkage agreements with other appropriate agencies or providers.
- Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.
Essential Components:

- The CAC/MDT’s written documents include access to appropriate medical evaluation and treatment for all CAC clients.
Rated Criteria:

- The CAC/MDT’s written documents include:
  - The circumstances under which a medical evaluation is recommended.
  - The purpose of the medical evaluation.
  - How the medical evaluation is made available.
  - How medical emergency situations are addressed.
  - How multiple medical evaluations are limited.
  - How medical care is documented.
  - How the medical evaluation is coordinated with the MDT in order to avoid duplication of interviewing and history taking.
  - Procedures are in place for medical intervention in cases of suspected physical abuse and maltreatment, if applicable.
Rated Criteria:

- The CAC and/or MDT provide opportunities for those who conduct medical evaluations to participate in ongoing training and peer review.

*That must be demonstrated through the following Continuous Quality Improvement Activities:*

- **Ongoing education in the field of child sexual abuse consisting of a minimum of 3 hours per every 2 years of CEU/CME credits.**

- **Photo-documented examinations are reviewed with advanced medical consultants. Review of all exams with positive findings is strongly encouraged.**
Rated Criteria:

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

- Findings of the medical evaluation are shared with the MDT in a routine and timely manner.
Mental Health

Specialized trauma-focused mental health services, designed to meet the unique needs of the children and non-offending family members are routinely made available as part of the multidisciplinary team response.
“[The] authors provided a concise review of studies which have shown that TF-CBT is a superior treatment option when treating children who have been sexually abused.

In this study, their objective was to show that TF-CBT is not only an efficacious treatment for traumatized children, but how efficiently it works and how long the treatment effects [are] maintained after the treatment is completed. . . .

The authors concluded that TF-CBT was superior to NST in producing durable improvement in depressive, anxiety, and sexual concern symptoms over the course of a year following treatment.”
Essential Components:

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

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

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

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

- Mental health services are available and accessible to all CAC clients regardless of ability to pay.
Essential Components:

- The CAC/MDT’s written documents include access to appropriate mental health evaluation and treatment for all CAC clients.
Rated Criteria:

- The CAC/MDT’s written documents include:
  - The role of the mental health professional on the MDT including provisions for attendance at case review;
  - Provisions regarding sharing relevant information with the MDT while protecting the clients’ confidentiality;
  - How the forensic process is separate from mental health treatment;
Rated Criteria:

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

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

- Ongoing education in the field of child abuse consisting of a **minimum of 8 contact hours per year**.
Rated Criteria:

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

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

“The conclusions of this study were in agreement with previous studies such as Stevenson (1989), Reder and Duncan (2003), and Munro (2002) which found that a more rigorous approach and clearer use of expertise as well as capacity to be more open-minded and less insular would foster better outcomes for clients.
The role of the lead professional in case review was examined. The results suggested that the lead professional should

- have a key role in piecing information together,
- seeing gaps and coordinating expert knowledge.
- The lead professional should develop creative ways in which to seek specialist knowledge and incorporate it into assessment and planning.
- The study found similar to Reder and Duncan (2003), that an awareness of blocks caused by group dynamics is crucial to clear assessments and to the factors that ‘promote professional tension and cloud decision-making and actions.’
Essential Components:

- The CAC/MDT’s written documents include criteria for case review and case review procedures.

This must include: frequency of meetings; designated attendees; case selection criteria; designated facilitator and/or coordinator; mechanism for distribution of agenda and/or notification of cases to be discussed; procedures for follow-up recommendations to be addressed; and location of meeting.
Essential Components:

- A forum for the purpose of reviewing cases is conducted on a regularly scheduled basis.
- Case review is an informed decision making process with input from all necessary MDT members based on the needs of the case.
- A designated individual coordinates and facilitates the case review process, including notification of cases that will be reviewed.
Rated Criteria:

- Representatives routinely participating in case review include, at a minimum:
  - Law enforcement
  - Child protective services
  - Prosecution
  - Medical
  - Mental health
  - Victim advocacy
  - Children’s advocacy center
Rated Criteria:

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

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

Children’s Advocacy Centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.
“The researchers viewed the major findings of the study as the degree to which:

- (1) case processing mirrored prior studies in wide ranging jurisdictions,
- (2) physical abuse cases were prosecuted,
- (3) cases appropriate for CPS and known to law enforcement were not referred to CPS,
- (4) factors outside the case processing protocols affected actual referrals, and
- (5) case tracking across organizations was hindered by internal organizational systems.”
“One difference between this and earlier studies was that the rate of prosecution represents almost 10 times the rate of filings found in studies ten years earlier.

The authors further stated that systems which use cross-organizational case identification will need to develop more systematic methods for case identification. Without this ability, positive collaborative relationships will be meaningless.”
Essential Components:

- The CAC/MDT’s written documents include tracking case information until final disposition.
- The CAC tracks and minimally is able to retrieve NCA statistical information.
Rated Criteria:

- An individual is identified to implement the case tracking process.
- All MDT partner agencies provide their specific case information and disposition.
- MDT partner agencies have access to case information as defined by the CAC/MDT’s written documents.
A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.
“The study concluded that nonprofits should be audited by independent auditors such as that required by the California Nonprofit Integrity Act. The study found that to preserve integrity audits should not be staff members and must not have ‘a material financial interest in any entity doing business with the organization’. It was determined further that the independent auditor is required in order to be able to perform the audit with an oversight role free of personal conflict.”
Essential Components:

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

- The CAC maintains, at a minimum, current general commercial liability, professional liability, and Directors and Officers Liability insurance as appropriate to its organizational structure.

- The CAC has written administrative policies and procedures that apply to staff, MDT members, board members, volunteers, and clients.
Essential Components:

- The CAC has an annual independent financial review (Budget is equal to or less than $200,000) or financial audit (Budget exceeds $200,000).
- The CAC has personnel responsible for its operations and program services.
- The CAC has, and demonstrates compliance with, written screening policies for staff that include criminal background and child abuse registry checks and provides training and supervision.
Essential Components:

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

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

- The CAC has addressed its sustainability through the development of a strategic plan that includes a funding component.
Child Focused Setting Standard

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

“The authors emphasized that while the idea of a child-friendly environment seems deceptively simple, it is critically important, not only in

- increasing the comfort level for the victim, but also in
- promoting self-disclosure and
- improving the accuracy of the information provided, thereby
- facilitating the pathway to prosecution.”

- “Children and teens thought the best part of the clinic experience was a caring staff, helpful communication and clinic play experiences.

- The worst aspect was painful procedures, long waits, distance from home, and boredom.

The participants‘ discussions to the open-ended questions support the rationale behind the Child-Focused Setting Standard for NCA, provision of a comfortable and private setting which is also physically and psychologically safe for victims and their non-offending family members.”
Essential Components:

- The CAC is a designated, well-defined, task appropriate facility or contiguous space within an existing structure.
- The CAC has written policies and procedures that ensure separation of victims and alleged offenders.
- The CAC makes reasonable accommodations to make the facility physically accessible.
- The facility allows for live observation of interviews by MDT members.
Rated Criteria:

- The CAC is maintained in a manner that is physically safe and “child proof.”
- Children and families are observed or supervised by staff, volunteers, and/or MDT members.
- Separate and private area(s) are available for those awaiting services, for case consultation and discussion, and for meetings or interviews.
- The location of the CAC is convenient and accessible to clients and MDT members.
For more information:

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Children’s Advocacy Center Development in the USA and Internationally
Early Development of the CAC Model

• Model developed by Bud Cramer, Prosecutor in Huntsville, AL

• Early data points:
  ➢ Caseloads
  ➢ Demographics
  ➢ Prosecution Outcome
International CACs in Operation

- Australia – 1
- Canada – 5
- Croatia – 1
- Cuba – 3
- Denmark – 1
- Estonia – 1
- Greenland – 1
- Iceland – 1
- Israel – 3
- Latvia – 2
- Mexico – 1
- Norway – 8
- Philippines – 1
- Poland – 1
- South Africa – 1
- Sweden – 30
- Turkey – 3
- USA – 850+
Countries interested in implementing the CACs Model

- Belarus
- Brazil
- Finland
- Georgia
- Greece
- Guatemala
- Hong Kong, China
- India
- Japan
- Malawi
- Malaysia
- The Netherlands
- New Zealand
- Peru
- Portugal
- Russia
- Rwanda
- Tanzania
- Tiawan
- Trinidad and Tobago
What is the positive impact of the CAC/MDT model?

Multi-Site Evaluation of the Children’s Advocacy Center
Evaluating Children’s Advocacy Centers’ Response to Child Sexual Abuse

Theodore P. Cross, Lisa M. Jones, Wendy A. Walsh, Monique Simone, David J. Kolko, Joyce Szczepanski, Tonya Lippert, Karen Davison, Arthur Cryns, Polly Sosnowski, Amy Shadoin, and Suzanne Magnuson

Children’s Advocacy Centers (CACs) play an increasingly significant role in the response to child sexual abuse and other child maltreatment in the United States. First developed in the 1980s, CACs were designed to reduce the stress on child abuse victims and families created by traditional child abuse investigation and prosecution procedures and to improve the effectiveness of the response.
Multi-Site Evaluation of CACs

• Funded by the United States Department of Justice

• Designed to evaluate the impact of CACs on children, families, systems, and communities.

• Quasi-experimental design
  ➢ Data from over 1,000 cases were collected from four participating CACs and from communities without CACs.

• Global assessment of broader movement with extrapolation
Multi-Site Evaluation of CACs

• Goals and Objectives

➢ Examine the impact of CACs on children, families, agencies, the court system and communities.

➢ Sites consist of a Children's Advocacy Center (CAC) community with a matched comparison non-CAC community. The participating CACs are:
  • Dallas Children's Advocacy Center, Dallas, TX
  • The Pittsburgh Child Advocacy Center, Children's Hospital, Pittsburgh, PA
  • The Low Country Children's Center, Charleston, SC
  • The National Children's Advocacy Center, Huntsville, AL
What is the positive impact of the CAC/MDT model?

What did they find?
Coordinated Response

• CAC communities demonstrated:
  ➢ *significantly higher rates of coordinated investigations between law enforcement and CPS*
  ➢ *Team forensic interviews*
  ➢ *Case Review*
  ➢ *Recording of forensic interview*
  ➢ *Interviews in child-friendly settings*

Client Satisfaction

• Caregivers whose children were seen at the CAC:
  
  ➢ **Higher** rates of satisfaction than caregivers whose children were seen at the comparison sites
  
  ➢ **Significantly more satisfied** with the interview experience than caregivers from the comparison samples

• Children who were seen at the CAC:
  
  ➢ **Significantly more described themselves as being “not at all” or “not very” scared** versus kids from the comparison communities

Access to Medical Care

• Children served at CAC were much more likely to receive forensic medical exam:
  - *No penetration in abuse disclosure* - 4 times more likely
  - *Penetration in abuse disclosure* - 1.5 times more likely

Case Processing Time

• Charging decision in child sexual abuse cases:

  ➢ *Cases seen at the CAC had a significantly faster charging decision:*

  • CAC – 80% within 1-60 days
  • Comparison A – 49% within 1-60 days
  • Comparison B – 58% within 1-60 days

Impact on Prosecution Rates

• Significant use of the CAC approach for all cases:
  - Dramatic increase in number of felony prosecutions of child sexual abuse
    • District 1 – 196% increase
    • District 2 - 1% decrease
  - Despite increased prosecutions, the conviction rate did not change significantly between the districts over this time period.

Cost-Benefit Analysis

- Traditional investigations were 36% more expensive than CAC investigations. The average per-case cost:
  - CAC investigation - $2,902
  - Non-CAC investigation - $3,949

When you step here, you are Real!!

When you start here, you ARE LOVED

When you step here, you ARE NOT afraid.

When you step here, you Have & HOPE

When you step here, you Have FAITH.
Training and Technical Assistance Resources for Child Abuse Professionals
60+ languages
About National Conferences

Each year, we host two national conferences: the National Symposium on Child Abuse and the National Conference on Child Sexual Abuse and Exploitation Prevention.

29th National Symposium on Child Abuse - March 18-21, 2013


Both of these conferences feature an outstanding faculty who conduct training and share the latest knowledge and skills in child abuse prevention, intervention and treatment. Networking opportunities and access to Handouts Online provide added value.
Professional Training Classes

- Forensic Interviewing of Children
- Advanced Forensic Interviewing
- Extended Forensic Interviewing
- Spanish Speaking Forensic Interviewing of Children
- Victim Advocacy Training
- Advanced Victim Advocacy Training

➤ On-location or held in Huntsville, AL USA
NCAC Online Training

NCAC is currently implementing a new Online Training platform. Many of the Free Online Trainings, archived Webinars and Ask the Expert sessions are available and more are being added daily. Click the Free Online Trainings link to check the courses that are now available. Be sure to check back often for an updated list of trainings.

Train without leaving the office!

The NCAC's National Training Center (NTC) offers a wide range of online training opportunities for child abuse professionals. The NTC's online training includes live and archived Webinars and Ask the Expert sessions, and our recorded Online Training Courses including the Law Enforcement's Initial Response to Child Sexual Abuse (available at no charge).

Free Online Training courses are recorded training sessions synched with a PowerPoint Presentation. With 30 courses to choose from, these sessions feature some of the most respected names in the field as its faculty. These online training courses range in length from 1 hour to 3 ½ hours.

Free Webinars – The NTC offers live webinars on child maltreatment topics created and presented by subject matter experts. Each webinar includes a question and answer period at the end of the presentation. Webinars feature topics that support the adoption of evidence-based practices. Sessions last about one hour. Live webinars are recorded and archived on our website so anyone can access them later at their convenience.

Free Ask the Expert – Our Ask the Expert sessions allow participants to submit questions in advance to top experts in the field. An extended question and answer period is also included, allowing discussion of important current issues with experienced child maltreatment professionals. Sessions last about one hour. Live Ask the Expert sessions are recorded and archived on our website so
NCAC Online Training Metrics (April – August 2012)

- 1,399 unique users completed 2,715 courses
  - Users from 19 Countries

- Breakdown By Course Type
  - 334 Unique Users from 10 countries completed 537 “Ask the Expert” Sessions
  - 284 Unique Users from 7 countries completed 451 Webinars
  - 781 Unique Users from 11 countries completed 1,727 Online Trainings
72,644 people visited this site

Visits: 108,364
Unique Visitors: 72,644
Pageviews: 311,384
Pages / Visit: 2.87
Avg. Visit Duration: 00:02:52
Bounce Rate: 49.05%

162 different Countries accessed the resources on the NCAC website
## Google Analytics

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### Pageviews

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- % of Total: 100.00% (243,136)
- Site Avg: 00:01:32 (0.00%)

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**Period:** Jan 1, 2012 - Aug 27, 2012
Child Abuse Library Online (CALiO)
www.nationalcac.org
The Child Abuse Library Online (CALiO™)

- One of the largest professional resource collections in the USA of published knowledge, educational materials and educational resources related to child maltreatment.

- One stop resource for professionals seeking to improve evidence-supported practice on the frontlines

- Two research librarians to assist with information retrieval and library usage

- Translate research into practice
Evidence-Based Practice – The Children’s Advocacy Center Model

Annotated Bibliography of the Literature in Support of the NCA Standards for Accreditation

Annotated Bibliography of the Evidence-Based Literature Supporting the NCA Standards for Accreditation as Prepared the Research Library of The National Children’s Advocacy Center

This valuable resource, commissioned by The National Children’s Alliance and prepared by The National Children's Advocacy Center, explicates the foundations for the standards devised for accreditation by the National Children’s Alliance of children’s advocacy centers throughout the United States. The goal was to identify and explicate the existing research, scholarship, empirical data, formal theory, management practice, complementary professional standards, or other evidence that provides foundation for each of the standards.

This final compilation of 87 publications serves as a valuable resource for children’s advocacy centers seeking to obtain accreditation or preparing for re-accreditation. This also provides a snapshot of the strengths and limits of research and scholarship in areas related to child abuse. Many of the publications included in this collection are key works that every practitioner should be familiar.
International programs supported by CALiO information services

- International Society for the Prevention of Child Abuse and Neglect (ISPCAN)
- International Center for Missing and Exploited Children (ICMEC)
- Child Advocacy initiatives in:
  - Australia
  - Brazil
  - India
  - Japan
  - Norway
  - Russia
  - Sweden
  - Trinidad and Tobago
International Resources

Below is a collection of articles, government documents, reports, websites, and more from around the world. They are from government agencies, NGOs, and other research agencies and include resources in languages other than English. The National Children’s Advocacy Center cannot verify the veracity of evidence upon which the listed resources are based. Listing of documents here should not be interpreted as validation or recommendation. The resources are listed first by general international, then by continent, followed by country.

• International
• Africa
• Asia
• Australia & New Zealand
• Europe
• Brazil
• Canada
• China (Mandarin Language)
• Croatia
• Germany
• Iceland
• India
Open Access Research Databases

PubMed

PubMed holds over 20 million citations for biomedical literature from MEDLINE, life science journals, and online books. PubMed citations and abstracts include the fields of medicine, nursing, dentistry, veterinary medicine, the health care system, and preclinical sciences. PubMed also provides access to additional relevant Web sites and links to the other NCBI molecular biology resources.

MedlinePlus: Child Abuse

MedlinePlus is the National Institutes of Health's Web site for patients and their families and friends. Produced by the National Library of Medicine, it brings you information about diseases, conditions, and wellness issues in language you can understand. MedlinePlus offers reliable, up-to-date health information, anytime, anywhere, for free.

NIJ

The National Institute of Justice database provides topical and keyword searching of reports, the NIJ journal and more under headings including corrections, courts, crime prevention, justice system, juvenile justice, victims of crime, and more.

NCJRS

The National Criminal Justice Reference Service Abstracts Database contains summaries of the more than 200,000 criminal justice, juvenile justice, and substance abuse resources housed in the NCJRS Library collection.

ERIC

The Education Resources Information Center houses bibliographic records of education literature with a growing collection of full text documents.

PILOTS

The PILOTS (Published International Literature on Traumatic Stress) is the largest database of publications on PTSD and is a service of the U.S. Department of Veterans Affairs.

DOAJ

The Directory of Open Access Journals provides one stop, comprehensive access to open access, quality scientific and scholarly journals.
Professional Bibliographies

The NCAC Professional Bibliographies series provides guides to the literature for practitioners working with children and adolescents who have been sexually, emotionally or physically abused. New bibliographies are added to this website on an irregular basis, as they are completed.

These bibliographies provide references with abstracts to selected publications on the topic. Journal articles, books, chapters, and other publications that are reasonably available appear in the lists. In most cases, dissertations and audiovisual materials are not included.

The NCAC does not provide document delivery service at this time. However, there are successful strategies for obtaining copies of the publications. Every public, academic and health sciences library participates in InterLibrary Lending. Simply request photocopies of articles or loan of books from the Interlibrary Loan Service of the local library at which you have cardholder privileges. (There may be a charge, or not, depending on the library from which the material is obtained.)

The bibliographies are in Adobe Acrobat PDF format, and require Acrobat Reader, which can be downloaded free from the Adobe website.

NCAC Professional Bibliography Series

OF SPECIAL INTEREST:
Annotated Bibliography of the Evidence-Based Literature Supporting the Ten Standards for Accreditation by the National Children’s Alliance

No. 1 - Play Therapy for Sexually Abused Children
No. 2 - Recantation and False Allegations of Sexual Abuse
No. 3 - The Impact of Methamphetamine on Children
No. 4 - The Psychological Impact of Natural Disaster on Children
No. 5 - Multidisciplinary Teams
No. 6 - Cultural Competency
No. 7 - Child Sexual Abuse Allegations in Custody Cases
No. 8 - Interviewing Child Witnesses of Violent Crime
No. 9 - Effects of Interviewer Gender
No. 10 - Child Abuse Victims with Disabilities
No. 11 - The Sandy Wurtele Collection
No. 12 - The Tom Lyon Collection
No. 13 - Efficacy of Child Advocacy Centers
No. 14 - The David Finkelhor Collection
No. 15 - The Cordelia Anderson Collection
No. 16 - Domestic Violence Effects on Children
No. 17 - Adverse Affects/Economic Impact of Child Maltreatment
No. 18 - Declining Rates of Child Sexual Abuse
No. 19 - Nonoffending Caregivers of Abused Children
No. 20 - The Publications of Michael E. Lamb: A Bibliography
Full-Text Open-Access Publications

The e-publications collection of CALiO offers access to full-text of publications that do not require fee or password. Many of the publications included in this collection were published by state and federal government agencies, and are in the public domain. Others were funded by foundations or other organizations for open access. In most cases, publications in this collection have not undergone the same sort of peer review process employed for publication in professional journals. CALiO staff and the National Children’s Advocacy Center provide access to these publications as a convenience to readers, but do not verify or endorse the content of any publications linked in this collection. To search for journal publications, use a bibliographic database to identify articles. For registered CALiO users, retrieve restricted access journal articles from the CALiO Journals collections.

E-Publications Subject Organization (click a topic)

- General Publications on Child Abuse
- Advocacy
- Bullying
- CAC’s and Multidisciplinary Response
- Child Development
- Child Sexual Exploitation
- Child Welfare
- Co-Occurrence and Family Violence
- Courts and Law
- Disabilities
- Effects of Child Abuse
- First Responders
- Internet Victimization
- Interviewing, Assessment and Forensic Evaluation
- Medical
- Military
- Missing Children
- Parenting
- Perpetrators and Screening
- Physical Signs of Abuse
CALiO visitors January-August 2012

8,350 visits from 94 countries
Number of countries represented by CALiO visitors

<table>
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<td>94</td>
</tr>
</tbody>
</table>
Number of Persons receiving technical assistance from CALiO librarians
The Child Abuse Library Online (CALiO™) is a service of The National Children’s Advocacy Center

For further information, contact:

Muriel K. Wells, MA, MLIS
mwells@nationalcac.org

Cindy Markushewski, MA, MLIS
cmarkushewski@nationalcac.org

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We welcome additional resources on Child Abuse and Neglect to add to CALiO.

Please contact us at:
Libray@nationalcac.org
Agenda

- History
- Why technology?
- Distance Learning
  - NCA n.e.t.
  - Journal Club
  - Webinars
- THICM (Telehealth Institute for Child Maltreatment)
  - Anonymous Medical Peer Review
  - The Online Collaborative Conference Room (OCC)
- Into the future
- Technology Next Steps
History

- **1998 – Creation of RCACs**
  - Regional Children’s Advocacy Centers created to build the capacity of multidisciplinary child abuse professionals and the CAC movement

- **2000 – NCA n.e.t. Pilot**
  - 3 sites in the Midwest Region explore efficacy of videoconference equipment as a tool for collaboration on child abuse investigations

- **2003 – NCA n.e.t. Launched**
  - NCA n.e.t. becomes a national program for acquiring continuing education and peer review
• 2006 – Telehealth Institute for Child Maltreatment
  ○ Medical experts convene to develop solution to bridge the expert peer review gap

• 2008-2009 – Journal Club Calls
  ○ Creation of Journal Club calls to connect MDT professionals quarterly to review recent research in the field

• 2009 - Child Abuse Library Online (CALiO)

• 2010 – Webinar Library
  ○ MRCAC begins to build collection of training videos for MDT professionals including Forensic Interview and Medical training
History (cont)

- **2011 – CAC Extreme Makeover Podcast**
  - CAC Management podcast created for CAC directors
- **2012 – Online Collaborative Conference Room**
  - Real-time web-based collaboration for MDT professionals, Forensic Interview Peer Review, Medical Peer Review and Mental Health Clinical consultation
Why Technology?

- **Today’s Environment**
  - Time constraints?
  - Shrinking budgets?
  - Travel restrictions?
  - Data collection?

- **Geography**
  - 50% of CACs located in Rural settings
  - Experts concentrated in large metropolitan areas
NCA n.e.t. Education Calls

- **Need**
  - MDT professionals need to keep up on licensures and maintain best practices in the field

- **Growth**
  - NCA n.e.t. began in 2000 with only 3 participating sites. There are now 82 actively participating sites.
  - Free Online Streaming made available in 2005 to allow professionals to watch from their desks or home

- **Education Calls**
  - Offered 3 times per month via Videoconference and Online Streaming to provide continuing education.
  - Over 5,000 professionals trained per year
Value of Continuing Education

- 95% of participants indicated NCA n.e.t. education calls increase their knowledge

“I found the information very helpful and plan to implement it in my practice”

“The information was incredibly helpful, and will increase my expertise in Forensic Interviewing”

– NCA n.e.t Participants
NCA n.e.t. Peer Review

- **Need**
  - 50% of CACs located in Rural areas with lack of access to experts
  - NCA Standards require peer review
  - Peer review is a best practice and allows for continuous quality improvement

- **Growth**
  - Medical Peer Review – 4 calls per month
  - Forensic Interview Peer Review – 8 calls per month
  - MDT Case Review – Quarterly
Value of Peer Review

- 84% of participants indicated NCA n.e.t. peer review increased their knowledge

“I learn something every time and am continually amazed at the quality of the presentations. Being a part of this review process has been a challenge to have my work scrutinized by such a respected panel but I believe it makes me better. The knowledge and experience of the facilitators is amazing and I look forward to their input with each case”

– NCA n.e.t Medical Peer Review Participant
Technology Facilitated Peer Review Trends

- **14%** of CACs use technology to facilitate both *Forensic Interview* and *Medical Peer Review*
  - NCA n.e.t. videoconference peer review
    - 82 active sites participating
  - THICM
    - 141 providers from 41 states and 4 countries
- Rural CACs make up the majority of participants
Journal Club Calls

• **Need**
  - Support network for MDT professionals, especially those located in rural areas
  - Staying current with recent research, trends and developments in the field

• **Growth**
  - Forensic Interview Journal Club Call – 122 sites
  - Victim Advocate Journal Club Call – 56 sites
  - Mental Health Journal Club Call – 44 sites
  - CAC Director Journal Club Call – 102 sites
  - Chapter Coordinator Journal Club Call – 31 sites
Telehealth Institute for Child Maltreatment

What is THICM
- A technological initiative administered by MRCAC that provides anonymous, HIPAA compliant, internet-based educational and quality improvement services

Programs
- Anonymous Expert Medical Peer Review
- Online Collaborative Conference Room
“Telemedicine has significant implications for improving the quality of care received by the youngest victims in rural, underserved areas.”

- 2 Rural Underserved Hospitals
- Results
  - Change in interview methods (47%)
  - Use of multi-method examination techniques (86%)
  - Use of adjunct techniques (40%)

Supporting Research

- 70% of Emergency Doctors misdiagnose child sexual abuse \(^i\)
- 40% of Primary Care physicians could not identify prepubertal genital anatomy \(^ii\)
- 40% SANEs utilized by CACs as primary medical providers receive supervision from professionals who do NOT have child abuse medical evaluation expertise and/or training

\(^i\)Makoroff, Brauley, Brandener, et al, 2002
\(^ii\)Lentsch & Johnson, 2000
Anonymous Expert Medical Peer Review

- **Why**
  - Participation in THICM will provide a benchmark against which you can measure your level of diagnostic agreement with a Child Abuse Board Certified Pediatrician
    - **IMPORTANT:** THICM is not Second Opinion and is for education and quality improvement only

- **How**
  - Upload de-identified case information and photodocumentation (images) of your medical findings
  - Will receive anonymous expert feedback within 48 hours
What does it look like?

Software Requirements Checklist

✔ Supports Plugin Detection

✔ Supports Javascript

✔ Supports Flash for Image Viewing

⚠ Does not support Quicktime Video

Please upgrade to the latest version of Quicktime.
Peer Review

Case Name: bug test case
Gender: Male
Status: Active

Age:
Months: 0
Years: 0

Gender:

Ethnicity:

Save Demographics

Proceed to the next step: History
Return to Case Summary
Peer Review > Update History

Case Name: bug test case
Gender: Male
Status: Active

Chief Complaint:

Proceed to the next step: Physical Exam
Return to Case Summary

© Copyright 2005-2009 VisualShare, LLC All rights reserved.
Peer Review > Update Physical Exam

Case Name: power point
Gender: Male
Status: Active

General Physical Exam Findings:

Proceed to the next step: Genital Exam
Return to Case Summary
Peer Review > Update Anal Exam

Case Name: power point
Gender: Male
Status: Active

Anal Exam Findings:
Include detailed description of findings i.e. acute, non-acute, type of injuries, etc

Save Anal Exam

Proceed to the next step: Clinical/Radiology Images
Return to Case Summary

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Peer Review > Update Impression

Case Name: test case 2
Gender: Male
Status: Active

Explain your diagnostic impression of the exam findings in detail:

Your Diagnostic Impression:
(Choose one)

- Normal variants or findings normally caused by other medical conditions
- Indeterminate findings for sexual abuse
- Findings diagnostic of trauma and/or sexual contact

Save Impression

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<table>
<thead>
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<th><strong>Example Reviewer review</strong></th>
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<td><strong>Other Comment</strong></td>
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<tr>
<td><strong>Conclusion</strong></td>
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<tr>
<td><strong>Suggestion for Examiner</strong></td>
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</table>
Value of THICM Peer Review

- 68% of participants indicated that submitting cases to THICM peer review effectively increased their diagnostic skill base

“I was extremely thrilled to have someone review and mentor my findings. I appreciated the positive reinforcements as well as the tactful corrections of my interpretations”

– THICM User
Online Collaborative Conference Room

- HIPAA compliant technology
- Real time image, document, video and meeting collaboration entirely web-based
- Online meeting space for MDTs to conduct
  - Peer Review
  - Distance learning
  - Mentoring
What does it look like?
Forensic Interview Peer Review

- FI Peer Review Highlights
  - HIPAA Compliant
  - High quality video sharing
  - Ability to create/manage different groups (i.e., regions)
  - Ability to create/manage multiple users
  - NO travel required, only access to the internet!
Medical Peer Review

- Medical Peer Review Highlights
  - HIPAA Compliant
  - High quality video and image sharing
  - Tools to annotate images (arrows, zoom etc)
  - Ability to create/manage different groups (ie regions)
  - Ability to create/manage multiple users
  - NO travel required, only access to the internet!
Mental Health Clinical Consultation

- Clinical consultation and peer support for mental health providers
  - Many MH providers work in small communities with little support
  - 2012-2013 Cohort of 34 participants from 21 states

- Sample Topics
  - Why care about the caregiver?
  - CACs and Mental Health in the Courts
  - Confidentiality and the CAC Mental Health professional
  - Professional Ethics and the CAC Mental Health professional
Lessons Learned

- One step at a time
- Record/Archive everything for later viewing
- Make it as easy as possible
- Have technical support on hand
- Begin small and think BIG
Into the future...

- Quality Improvement Module
  - Hosted through THICM and available to physicians for MOC 4 credit and continuing education
  - Currently being certified by the American Board of Pediatrics

- Robust Online Collaboration through OCC
  - Webcam integration
  - Audio integration

- Online Learning expansion
  - Online Pediatric SANE training
  - Online management trainings
Next Steps

- **Survey your resources**
  - What is already available to you?
  - Don’t recreate the wheel

- **Survey your audience**
  - What does your audience want?
  - How experienced and/or comfortable is your audience with technology?

- **Are you ready?**
  - Do you have someone on staff that understands the ins and outs of technology?
  - Reach out to partners to build a support network
Questions???

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