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IN THIS ISSUE

Children's Advocacy Centers:

One Philosophy, Many Models

Wendy Walsh, PhD,
Lisa Jones, PhD, and
Theodore Cross, PhD

The National Children's Advocacy Center was established in Huntsville, Alabama, in 1985 as the first CAC in the United States. By 2003, there were 460 full or associate CACs in 49 states. Although the original function of CACs was to respond to cases of child sexual abuse, most centers now also interview alleged child victims of serious physical abuse and child witnesses to other crimes. Based on a current multisite evaluation of child advocacy centers led by the Crimes Against Children Research Center at the University of New Hampshire and funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), this article describes what is fundamental and consistent across CACs and discusses important ways in which CACs differ.

3

Substance Abuse and Child Maltreatment Prevention

Steven J. Ondersma, PhD
Sara K. Chase, MA

Substance abuse is correlated with child physical abuse and neglect in between one-third and two-thirds of substantiated child protective services cases. This paper proposes utilizing a motivationally informed public health approach to large numbers of parents potentially at risk for substance abuse, rather than utilizing intensive and expensive interventions with parents for whom substance abuse is an obvious problem. Research has shown that when compared with substance abusers who have received no intervention, substance abusers who received brief (even single session) motivational interventions were more likely to quit or reduce substance use. To have a community-wide effect and to have at least some contact with the "silent majority" of at-risk parents who never cross the paths of child maltreatment professionals, we may need to adopt these public health approaches.

8

What Teachers Can Do to Prevent Sexual Abuse in Schools

Pegi Taylor
Milwaukee, WI

Sexual abuse in schools can include sex crimes by adult staff against students, students sexually abusing other students, and students sexually assaulting staff. As prevention efforts, teachers can be vigilant about their own behavior, identify a specific staff person to handle sexual abuse complaints, and monitor other staff for warning signs that might signal improper contact. Teachers can also work to reduce juvenile sex offenses by addressing the "callous sexual attitudes" of many students, curb student impulsivity, and help students develop positive self-esteem. The author has written a number of other articles about sexual abuse issues.

12

APSAC Amicus Brief on Child Sexual Abuse in the United States Supreme Court

Tom Lyon, JD, PhD

This brief, coauthored by APSAC associate editor Thomas Lyon, JD, PhD, is available in full at <http://www.psyclaw.org/stogner-v-california.pdf>. The brief reviews the research about why most child sexual abuse victims never disclose their abuse and how child molesters do not "age out" of their behavior, thus presenting a continuing risk to children. The brief also reviews research on the long-term effects of child sexual abuse.

14

REGULAR FEATURES:

News of the Organization.....	15
About the Contributors.....	16
Washington Update.....	22
Journal Highlights.....	24

ALSO IN THIS ISSUE:

Message From the President.....	2
Letters to the Editor.....	17
APSAC Professional Publications Order Form.....	20
Conference Calendar.....	21

Children's Advocacy Centers: One Philosophy, Many Models

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The growth of Children's Advocacy Centers (CACs) in the United States has been extraordinary. These innovative programs work to improve child abuse investigations and reduce stress on children and families. CACs aim to eliminate repetitive interviews for child victims, provide a child-friendly environment for the investigation, use well-trained interviewers, and coordinate forensic investigations by multiple agencies (Sheppard & Zangrillo, 1996). The first CAC, the National Children's Advocacy Center, was established in Huntsville, Alabama, in 1985 (see Cramer, 1985), but CACs have increased from 50 registered centers in 1994 to more than 460 full or associate centers in 49 states in 2003 (<http://www.nca-online.org>). These centers are everywhere, from Brooklyn to Alaska; Cape Cod to Native American Tribes; the corporate, suburban landscape of Marietta, Georgia, to the Appalachian Children's Center in Ellijay, Georgia. CACs appear as independent centers, units in hospitals, and departments in district attorney's offices. Even where CACs have not been established, there are programs that follow many of the same principles and program models as CACs, but have not yet affiliated with the National Children's Alliance (NCA), the national membership organization of CACs.

This article describes what is fundamental and consistent across CACs and also discusses important ways in which CACs differ. We explore how these differences may affect what outcomes we should expect from different CACs. Understanding what is fundamental about these programs and how they adapt to different communities and situations can help us develop more effective centers and improve community response to suspected child abuse.

This article is based in part on our findings from a current multisite evaluation of CACs, led by the Crimes Against Children Research Center (CCRC) at the University of New Hampshire. Supported by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), this evaluation is designed to measure the impact of CACs on children, families, and communities. The four sites participating in the evaluation are the Dallas Children's Advocacy Center; the Pittsburgh Children's Advocacy Center; the Dee Norton Lowcountry Children's Center (LCC) in Charleston, South Carolina; and the National Children's Advocacy Center (NCAC) in Huntsville, Alabama. Other research has contributed to our thinking as well, including studies of the Collin County (Texas) CAC, the Massachusetts CACs and other multidisciplinary teams (Cross & Spath, 1998), the Children's Safe House in Albuquerque (Steele, Norris, & Komula, 1994), the Florida CACs (Williams, 2002), and the Seacoast Child Advocacy Center in Portsmouth, New Hampshire (Simone, Grey & Adler, 2003).

The CAC Approach

The CAC philosophy draws from a core set of beliefs that the intervention system should respond to the individual needs of the alleged child victim and family and that the most effective response builds upon the expertise of multiple agencies (Chandler, 2000). The original function of CACs was primarily to respond to cases of child sexual abuse. Most CACs today have broadened their target population to include suspected child victims of serious physical abuse, child witnesses to domestic violence, and children affected by other forms of victimization.

The National Children's Alliance (NCA), a nonprofit, CAC-membership organization, was established in 1988 to support the implementation and development of CACs nationally. Although CACs vary, a standard set of components defines participating agencies. Table 1 lists ten specific CAC-program components necessary for full membership with the NCA. These standards can be considered a consensus among CACs regarding their key services.

Probably the most defining and universal of the items listed here is the multidisciplinary team (MDT). The MDT consists of law enforcement officers, child protective service investigators, prosecutors, mental health and medical professionals, and others who provide a coordinated response designed to increase the effectiveness of investigations while reducing the stress and risk of secondary traumatization to children. To this end, CACs work to create a positive experience in a child-friendly location. For example, the CAC building is located in a welcoming environment geographically separate from police stations, child protective service, and court houses (to reduce families' fears of participating) and is designed to provide a child and family-friendly environment for interviews and family meetings.

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Another defining element of CACs is providing forensic interviews. CACs typically make available specialized interviewers or specific team members, such as law enforcement officers and CPS workers, with education and experience in child development and training in forensic child interviewing. Forensic interviewers are trained to understand children's communication, talk with them clearly, and put them at ease, while still collecting sound investigative information. During the interview process, a professional typically interviews the child while multiple team members watch through a one-way mirror or closed circuit television. The one interview will serve the information needs of multiple agencies. Any additional interviews, if necessary, are conducted to allow children to disclose information at their own pace or go into more depth as needed, but they avoid asking children to "tell their story" repeatedly. Without the MDT and the related forensic interview method, children may be asked about their abuse again and again by multiple interviewers who are not working together.



cont'd on page 4

Following the interview, the team develops a coordinated plan for pursuing the investigation, if indicated, and for responding to the child and family's needs for protection and services. Child protective service and law enforcement investigators usually coordinate their plans for interviewing the alleged perpetrator, nonoffending parents, and others, and prosecutors and law enforcement will collaborate on plans to pursue additional evidence. Because CACs have formal links with medical professionals as well as agreements and protocols in place for conducting medical examinations, a plan for a forensic medical evaluation with direct feedback to investigators is often appropriate; sometimes the exams are done on-site to coincide with the forensic interview. Case-review meetings in the weeks after the initial interview give professionals further opportunities to refine planning, share new information, engage in team problem solving regarding obstacles in investigations and service delivery, and refer a child for additional services. Team members can provide details on what is alleged and how it was disclosed; data on the crime scene and victims' and perpetrators' behavior; and insight about the relationships and responses of victims, perpetrators, and family members.

CAC involvement with the family extends well beyond the interview, however. The team and CAC professionals work with families to support them through the difficult process of investigation. They continue to help families through the challenges of prosecution, if that is pursued. The CAC also works with the family to secure needed services, such as child psychotherapy, shelter, victims' compensation, and medical care—helping the child and family stabilize and begin to recover is a priority.

The reported influence of CACs also extends to the community as a whole (Cramer, 1985; Cross & Spath, 1998) and arguably changes the entire system of response to suspected child victimization. CAC staff are often among the best trained and most experienced in their communities regarding alleged child victimization, and they can influence the competence of the community through consultation, case review meetings, professional training, and community education. CACs have been active in communities developing programs and services, advocating for children's issues, and even lobbying for new legislation or regulations. They can increase interagency coordination and investigation effectiveness at the level of system structure and policy as well as in individual cases. CACs can also mobilize general community support and commitment to child abuse response through community auxiliary groups, volunteer efforts, and fundraising. Clearly, CACs play multiple roles within each community.

Variations Among CACs

CACs share the same philosophy, but the settings, populations, and program models with which it is used vary tremendously. As the NCA notes, "No single model for an ideal multidisciplinary program exists, because each community's approach must reflect its unique characteristics" (Chandler, 2000, p. 7). Below we identify seven areas in which CACs differ. These differences are important to understand because variations in implementation affect who CACs serve, what CACs do, and what outcomes they might have.

Community Characteristics

Characteristics of the community, such as the size, diversity, and setting (rural, suburban, urban), affect the nature and development of a CAC. CACs located in rural settings are often faced with the problem of how to provide coordinated services to isolated locations over a large geographic area. The typical model of a centrally located CAC can be impractical there. For example, CACs that serve Native American populations have had to find creative ways to bring services to families who often live hours away from the host organization (U.S. Department of Justice, 2000). Instead of a stationary center, some have developed mobile units that travel to different locations in the service area as needed. Urban CACs face different challenges, such as coordinating services for a large, diverse, and often multilingual clientele. Client volume can affect the scope and nature of service provision. The Dallas CAC, for example, faces requests for forensic interviews—a skill in short supply—in hundreds of cases for the city of Dallas, making it difficult to apply the full CAC model to referrals from other municipalities throughout the county.

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In addition to demographic and geographic factors, developing CACs also must take the structure and politics of existing services into account. Even prior to widespread implementation of CACs, states and communities were developing a number of different models for coordinated investigation procedures and multidisciplinary teams (Kolbo & Strong, 1997). Florida has instigated statewide Child Protection Teams (CPTs), medically directed multidisciplinary teams available to supplement child protection investigations. CACs developing in Florida communities with a CPT must identify the best process for adapting to the existing service structure in the community and avoid overlapping efforts. Some have chosen to emphasize different multidisciplinary components, serving as partners with their local CPTs. Other communities have integrated the CPT into a single, more comprehensive CAC.

Organizational Base

CACs vary greatly in the way they are organized. Some CACs are independent, nonprofit organizations, whereas others are located within hospitals, district attorney's offices, child protective service agencies, or larger nonprofit human service agencies. Organizational base has an effect on the pattern of agency involvement, referral process, and emphasis on and development of available services. The Pittsburgh CAC, for instance, is located within Children's Hospital of Pittsburgh. One obvious outcome of this setting is that the medical component of the CAC is likely to be a major focus of the program. Less obvious is the impact that the setting of this CAC has on the nature of its cases. Because of direct referrals from the emergency department and other health care providers, initial data suggest that nearly a half of child victims are under 6 years old. In contrast, initial data at the NCAC in Huntsville show the majority of child victims are between the ages of 10 and 15 years old. Moreover, such case differences have an obvious effect on child protection and criminal justice outcomes, such as arrest and prosecution rates.

Developmental Stage

It is also important to recognize the developmental stages of CACs: the start up, structuring, cooperation, productive, and completion phases (Chandler, 2000). As CACs progress through these phases, their size, capacity, and services expand and interventions are refined. There may not be a natural progression through these phases, however, and some CACs may remain small and specific in the services they provide. Because CACs vary greatly in the portion of the eligible population they can serve, their organizational complexity, budgets, and expected outcomes must shift accordingly. Like a number of CACs, the new Seacoast Child Advocacy Center in Portsmouth, New Hampshire, began small. It operates in a suite of two rooms, and, until recently, it had a staff of one, who was simultaneously forensic interviewer, CAC coordinator, and office manager. In contrast, a few longstanding CACs (e.g., in Charleston, Dallas, Huntsville, and Plano, Texas) have staffs in the dozens, multiple services, and more ambitious agendas.

Referral Process

The CAC referral process varies greatly and influences who is served and what outcomes should be expected. In some communities, referrals come from multiple sources and in others, only from CPS and law enforcement. In some states, legislation may guide which cases are referred. According to our initial data, the Dallas CAC and the NCAC in Huntsville receive approximately two-thirds of their referrals from CPS and one-third from law enforcement. In contrast, the Dee Norton LCC receives approximately one-third from mental health providers, one-third from CPS, and one-tenth each from law enforcement and medical providers. A broader referral base leads to a greater variety of cases and is associated with differences in services. Referral processes can also be mandatory or discretionary. DCAC sees a subset of all cases of severe physical abuse and sexual abuse in Dallas County on the basis of DCAC's criteria. All cases in Dallas in which the alleged victim is younger than 15 and has made an outcry of sexual abuse or severe physical abuse are referred to the Dallas CAC. At the Dee Norton LCC, on the other hand, professionals refer only those cases they consider appropriate. Mandatory referrals bring an entire cross-section of a certain population to a CAC, but discretionary referrals may tend to give CACs a selected segment, perhaps more severe or less, younger or older—but not a cross-section.

Interagency Involvement and Relationships

To be a full member of the NCA, CACs must have a multidisciplinary team with representation from at least seven different agencies or disciplines (see Standard 2), but agency participation, interagency relationships, and team activity still vary considerably even though the existence of the team is inherent to a CAC. The extent to which participating disciplines are actively involved with the leadership and sponsorship of the CAC shape, in part, the procedures most emphasized, the services offered to victims and families, and ultimately the expected outcomes.

In addition to team composition, the relationships between partner agencies and the CAC influence the nature of the CAC procedures and outcomes. At some CACs, prosecutors play a primary role in

overseeing the direction of a case throughout the investigation process. At other CACs, the prosecutor's office may be only peripherally involved or participate only when the criminal justice case reaches a certain level of development. Complicating things further, election cycles affect the participation of certain officials, such as district attorneys, who are elected to their position. Fluctuations in partner involvement can have a direct impact on the types of criminal justice outcomes that can be anticipated. Therefore, outcomes such as prosecution rates and conviction rates are often dependent on the overall philosophy, interest, and commitment of the prosecutor and available resources.

Finally, the degree of interaction among team members is also important. This depends in part upon the historic interagency conflicts and turf issues, which influence the manner and time necessary for the building of a multidisciplinary team. The degree of interaction is also influenced by whether child protection and law enforcement workers are co-located, having their offices in the same building. Our discussions with professionals working at the NCAC

in Huntsville, the Dallas CAC, and other CACs with co-location indicate that having a law enforcement investigator right down the hall from a child protection investigator increases the level of communication.

Agency Objectives

Like many other ambitious social programs (see McLaughlin, 1985), CACs have a number of objectives. They aim to protect children, conduct accurate assessments, further justice when a crime has been committed, and help child victims toward recovery, among other things. Though CACs carry out many different functions, especially as they develop, some objectives are emphasized more in some programs than in others. This is partially a result of the inability to do ev-

everything at once, given limited resources. The needs are many and centers have to choose their priorities. Varying objectives also reflect philosophical differences that are echoed in child abuse professional fields as a whole. Given that experts, professionals, and communities may disagree on many of the issues, it is not surprising that variations in practice exist among CACs.

For example, there is consensus that prosecution should play a role in the response to child abuse, but there is disagreement about how important this is and the range of cases that should be prosecuted, particularly with juvenile and intrafamilial perpetrators. Another example points to philosophical differences about medical response. In some CACs, a medical examination is provided for almost every child, whereas other CACs are more selective. Some CACs have medical examination rooms on site and part-time medical professionals on staff, but others rely on private pediatricians or pediatric departments in hospitals. Some CACs use specially trained nurses; in others, only physicians conduct examinations. These choices vary because of different judgments and tradeoffs about how best to engage families and reduce intrusiveness and stress, what type of information to gather and who is qualified to gather it, and how best to allocate limited resources. Differences in the emphasis on objectives would naturally lead to CACs with varying roles in the community and with different outcomes.

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CAC Outcomes

Although CACs have been in existence for over twenty years and are increasingly considered to be a leading model for agency collaboration in investigating suspected child victimization, systematic evaluation of these centers is lacking. Interest in such evaluation research is growing as funding agencies look for evidence of effectiveness and agencies themselves seek to improve their services. An important preliminary step to evaluating the effectiveness of the CAC model is to understand better what outcomes are most important to examine.

In reviewing the literature on CACs and by talking with a number of CAC professionals, we identified more than 75 specific outcomes that CACs might hope to see resulting from their program (Cross & Jones, 2001). In survey research we conducted, CAC professionals were asked to rank these outcomes according to their relative importance. Sixty-nine professionals responded out of 171. The outcomes that received the highest relative ratings included the following: More effective investigations; More thorough investigations; Increased child safety; Decreased child stress; More accurate decision making; and Increased community resources for victims.

Although we noted general consensus about what outcomes CAC professionals valued, there were still differences of opinion. For example, most professionals in one site rated the outcome, increased availability of needed services during investigation as very important, but one quarter of the respondents gave this item a relatively low score. However, some items, such as improved coordination with domestic violence investigations, were rated as relatively less important by most professionals, but extremely important by a few. Clearly, there are many important outcomes of CAC effectiveness.

The influence that a particular CAC hopes to make will be driven by the goals and expectations of the involved professionals. A CAC located in a district attorney's office, with a strong focus on coordinating law enforcement activities with child protection, for example, can expect to see different outcomes than an independent CAC with comprehensive service options for victims and frequent collaboration from a broad array of community member agencies. The first CAC might expect to see a notable effect on the quality and success of its criminal prosecution of child victimization, and the second, improved satisfaction with the availability of services. Both of these CACs may offer a good example of "a CAC model"; nevertheless, one-size-fits-all assumptions about CACs may lead to unrealistic expectations.

Implications

What are the "take home" messages of understanding CACs as the same but different? First, a core philosophy truly has captured the imagination of a wide range of professionals dedicated to helping children and has spurred tremendous growth and change in how we respond to allegations of child victimization. This philosophy is manifest in basic elements of CACs and consistent across the organizations. Every CAC we have examined has a facility that appears to be built and set up to be substantially more comfortable to children than the alternatives. Each CAC has interviewing professionals with substantially more training and experience in child development and child forensic interviewing than the typical investigating officer or CPS worker of years past. Consistently, investigations are conducted in a manner that is more coordinated than in the past, and duplicative interviewing is never standard procedure for cases coming through the CAC. Although there is still work ahead

of us to improve interviewing, coordination, and service delivery, much has been accomplished in developing a consistent, professional model in hundreds of communities across the country and in defining a national standard of care that dominates professional opinion.

Second, the differences among CACs mean that we cannot adopt a "cookie cutter" approach in any aspect of their development, operation, or evaluation. CACs must be implemented in ways that are responsive to the needs of their communities and that "knit" them together with the existing service and justice systems. That alone would create variation in how CACs are structured and operate, but it also must be recognized that different CACs are going to interpret and respond differently to the many broad goals inherent in the CAC philosophy. Thus, CACs will be pursuing somewhat different goals in various ways, the biggest difference being the broad, and often divergent, goals of criminal justice and human services. It is inevitable that CACs will embody some of the philosophical differences in the field about how best to respond to alleged child victimization. Given the close link and indeed dependence on other organizations for participation and in many cases sponsorship, CACs will inevitably be affected by and reflect the orientations and structure of the organizations underlying them. Evaluation of CACs, both formal and informal, must take into account their variability, measuring each CAC by somewhat different yardsticks and focusing on different outcomes, depending on the organization, orientation, and stage of development of the CAC.

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Table 1

National Children's Advocacy (NCA) Full Membership Standards for Children's Advocacy Centers (CACs)*

- 1. Child-Appropriate/Child-Friendly Facility:** A children's advocacy center provides a comfortable, private, child-friendly setting that is both physically and psychologically safe for clients.
- 2. Multidisciplinary Team (MDT):** A multidisciplinary team for response to child abuse allegations includes representation from the following: law enforcement, child protective services, prosecution, mental health and medical providers, victim advocacy services, and a children's advocacy center.
- 3. Organizational Capacity:** A designated legal entity responsible for program and fiscal operations has been established and implements basic, sound administrative practices.
- 4. Cultural Competency and Diversity:** The CAC promotes policies, practices, and procedures that are culturally competent. Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to appreciate, understand, and interact with members of diverse populations within the local community.
- 5. Forensic Interviews:** Forensic interviews are conducted in a manner that is of a neutral, fact-finding nature and coordinated to avoid duplicative interviewing.
- 6. Medical Evaluation:** Specialized medical evaluation and treatment are to be made available to CAC clients as part of the team response, either at the CAC or through coordination and referral with other specialized medical providers.
- 7. Therapeutic Intervention:** Specialized mental health services are to be made available as part of the team response, either at the CAC or through coordination and referral with other appropriate treatment providers.
- 8. Victim Support/Advocacy:** Victim support and advocacy are to be made available as part of the team response, either at the CAC or through coordination with other providers, throughout the investigation and subsequent legal proceedings.
- 9. Case Review:** Team discussion and information sharing regarding the investigation, case status, and services needed by the child and family are to occur on a routine basis.
- 10. Case Tracking:** CACs must develop and implement a system for monitoring case progress and tracking case outcomes for team components.

*—<http://www.nca-online.org/network.html>

