Child Advocacy Center Statewide Plan Development: Technical Assistance to the Commonwealth of Pennsylvania

The Field Center

for Children's Policy, Practice & Research

The University of Pennsylvania

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Executive Summary

A Child Advocacy Center (CAC) is a child-friendly facility where multidisciplinary teams, including representatives from child welfare and law enforcement, can collaborate on child sexual abuse investigations and case planning. In the wake of the Sandusky case, it was recommended that child advocacy centers (CACs) be developed throughout the Commonwealth of Pennsylvania such that a CAC would be within reach of every child victim in the state. The Field Center was selected by the Pennsylvania Commission on Crime and Delinquency (PCCD) to conduct research and make recommendations for the development of new CACs.

The Field Center gathered data from the Department of Public Welfare (DPW), Pennsylvania CAC Directors, medical stakeholders, the Health Research Services Administration (HRSA), the Administrative Office of Pennsylvania Courts (AOPC), and the United States Census. This data was analyzed using GIS mapping and quantitative and qualitative analysis. The results of this analysis were used to select locations for CACs based on the following criteria:

- A caseload sufficient to maintain the skills of forensic interviewers and medical providers
- A caseload sufficient to meet economies of scale
- A reasonable driving distance (less than one hour) for the majority of families and MDT members
- A local population sufficient to protect the anonymity of the child
- Potential to meet the resource needs of the center

The final recommendations were to establish three types of new CACs:

1. New Regional CACs: New CACs that will serve two or more counties
2. New Countywide CACs: New CACs that will serve single counties
3. New Affiliations with Existing Accredited CACs: Existing CACs that will serve a new county

This report recommends that in order to meet the needs of child victims of sexual abuse in Pennsylvania, the state should support the establishment of:

- 10 New Regional CACs
- 2 New Countywide CACs
- 7 New Affiliations with Existing Accredited CACs

This plan is based on quantitative and qualitative data collected over the course of one year. The recommendations are driven by the best data available. However, CACs are comprised by people, and not data points. It is understood that community stakeholders have expert knowledge of their communities, and that the data alone may not always point to the most reasonable solution. This plan is intended as a starting point so that communities may, to the best of their ability, incorporate the data into their planning.

Introduction

In the wake of the Sandusky case in 2011, Pennsylvania Governor Tom Corbett convened the Task Force on Child Protection, a group of experienced and prominent members of the child welfare community drawn from around the Commonwealth. This Task Force was charged with reviewing and suggesting improvements to Pennsylvania child welfare laws and policy. During the Task Force hearings, Bucks County District Attorney and Task Force Chair David Heckler stated that, if there had been a child advocacy center in Centre County at the time that Sandusky perpetrated his crimes, he would have been apprehended sooner and more victims would have been spared. One of the recommendations made by the Task Force was that Child Advocacy Centers (CACs) should be developed throughout the Commonwealth such that a CAC would be within reach of every child victim of sexual abuse in Pennsylvania.

The Pennsylvania Commission on Crime and Delinquency (PCCD) selected The Field Center for Policy, Practice, and Research to conduct quantitative and qualitative research with the goal of creating a Statewide CAC Development Plan. The Field Center approached this research as a two-phase study. Phase One included data collection, the identification of existing CACs, and the identification of other support resources. Phase Two, conducted in collaboration with the Cartographic Modeling Lab at the University of Pennsylvania, focused on spatial optimization mapping using Geographic Information Systems (GIS) and data analysis.

Throughout the study, efforts were made to include input from all potential stakeholders. The team reached out to and received substantive input from:

- All current Pennsylvania CAC Directors
- Cathy Utz, Acting Deputy Secretary of the Department of Public Welfare Office of Children, Youth and Families (OCYF)
- Teresa Olsen, Director of the Pennsylvania American Academy of Pediatrics (PA AAP) Suspected Child Abuse and Neglect Program
- Administrative Office of Pennsylvania Courts
- Pennsylvania District Attorneys Association
- Pennsylvania Sentencing Commission
- Northeast Regional Children's Advocacy Center (NRCAC)
- The Pennsylvania Chapter of Children's Advocacy Centers and Multidisciplinary Teams
- Dr. Cindy Christian, Chair of the American Academy of Pediatrics Child Abuse and Neglect Committee
- Sue Stockwell, Director of Systems and Data Management Section Department of Public Welfare Office of Children, Youth and Families

- Brittany Strandell, Alan Lerner Fellow in Child Welfare Policy at the University of Pennsylvania Field Center
- David Heckler, Bucks County District Attorney and Chair of the Pennsylvania Task Force on Child Protection
- Dr. Rachel Schwab, Child Abuse Pediatric Specialist in Centre County

This plan makes recommendations with the goal of optimizing access to the services provided by a CAC through the use of new regional CACs, countywide CACs, and the formalization of existing relationships.

This plan is based on quantitative and qualitative data collected over the course of one year. The recommendations are driven by the best data available. However, CACs are comprised by people, and not data points. It is understood that community stakeholders have expert knowledge of their communities, and that the data alone may not always point to the most reasonable solution. This plan is intended as a starting point so that communities may, to the best of their ability, incorporate the data into their planning.

Terminology

Some of the terminology in this report can have different meanings depending upon the context. Other terms may be unfamiliar to some readers. The following provides clarification for usage in this report.

Multidisciplinary Team (MDT) - A team comprised of law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and the children's advocacy center. This is the team that collaborates on investigations in the CAC model. Pennsylvania child welfare agencies, under the direction of the Department of Public Welfare, convene MDTs to review certain cases. MDTs referenced in this report refer only to the MDTs described in the National Children's Alliance standards for CACs.

Multidisciplinary Investigative Team (MDIT) - In Pennsylvania, each county is mandated to establish an MDIT, whose membership will fluctuate depending on the type of case being investigated and the information available. Each MDIT is required to establish protocols for receiving and reviewing reports, coordinating investigations and developing a system for sharing information obtained in interviews, to minimize the trauma of multiple interviews of a child and to avoid duplication with other fact-finding efforts

CPIP MDIT - CPIP MDITs are those MDITs which have elected to participate in the Pennsylvania Chapter of CACs and MDTs' Continuing Practice Improvement Program. This program is designed to help strengthen MDITs through training and mentorship.

National Children's Alliance (NCA) - A professional membership organization dedicated to helping local communities respond to allegations of child abuse in ways that are effective and efficient, putting the needs of child victims first, that has established Standards of Practice for Child Advocacy Centers. NCA is the national accrediting body for CACs. National Children's Alliance was founded in 1987 by former Congressman Bud Cramer, then District Attorney of Madison County Alabama, in response to the needs of a growing number of facility-based child abuse intervention programs and the demand for guidance from grassroots organizations working with child victims. Today, NCA is a membership organization providing services to more than 750 children's advocacy centers across the United States, as well as numerous developing centers, multidisciplinary teams, and child abuse professionals.

Child Protective Services (CPS) - Child Protective Service reports are those reports whose allegations correspond to the definition of child abuse in the Child Protective Services Law of the Commonwealth of Pennsylvania (Title 23 PA C.S.A. Chapter 63). The child abuse case data in this report comes from a CPS database and includes only CPS reports.

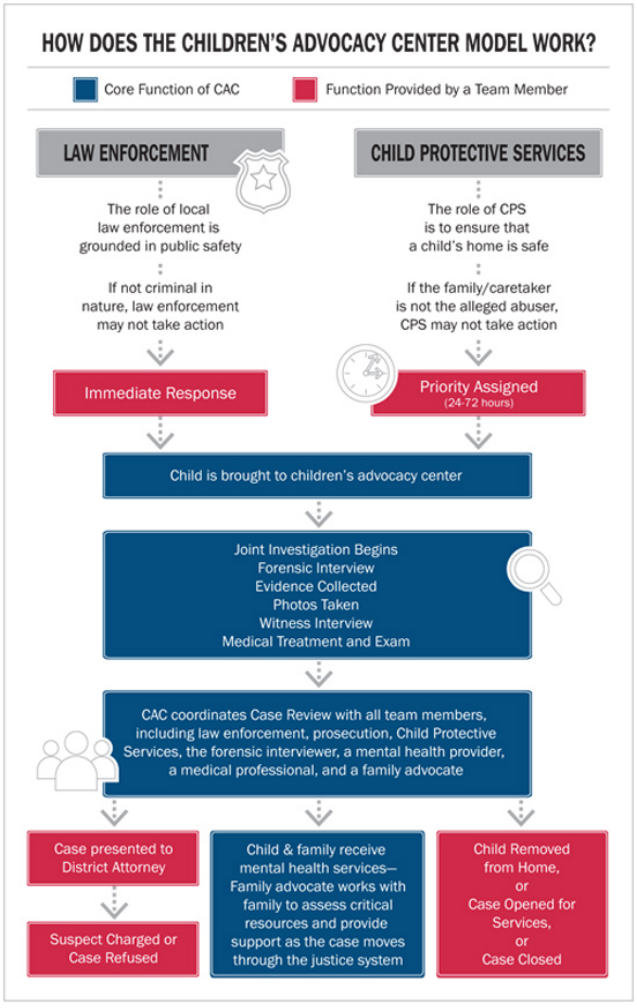
General Protective Services (GPS) - General Protective Service (GPS) reports, unique to Pennsylvania, are reports of neglect, the potential for harm, or issues of dependency whose allegations fail to meet the definition of child abuse the Child Protective Services Law of the Commonwealth of Pennsylvania (Title 23 PA C.S.A. Chapter 63). Some cases of sexual abuse fall under the umbrella of general protective services, such as a sibling perpetrator under the age of 14 years.

The CAC Model

Background

A Child Advocacy Center (CAC) is a child-friendly facility where multidisciplinary teams, including representatives from child welfare and law enforcement, can collaborate on child abuse investigations and case planning. This model arose out of a need to limit the additional traumatization of victims of child abuse caused by redundant and repetitive interviewing by an uncoordinated group of investigators. Since its inception in the 1980s, the CAC model has fostered collaborations on cases of child abuse throughout the country, and there are currently 750 accredited CACs in the U.S.

Figure 1. How The Model Works (www.nationalchildren'salliance.org)



The CAC model brings together child protective services, law enforcement, prosecution, medical providers, mental health providers, and victim advocates to ensure that the systems designed to protect children do not further traumatize them. The majority of CACs respond to allegations of child sexual abuse. However, some have also added on services for the victims of severe physical abuse and child witnesses to violence. Investigations typically begin with a forensic interview conducted by a trained forensic interviewer, which is viewed by the multidisciplinary team via a one-way mirror or closed circuit video (CCTV.) This interview is recorded to prevent the need for multiple interviews of the child and can be made available for evidence in the potential prosecution of perpetrators. The child should also receive a forensic medical exam from a trained, experienced, and qualified medical professional. The medical exam component is necessary not only for the collection of evidence, but is also often the first step in healing for the child. The team then collaborates on case planning, including potential prosecution, and makes referrals for needed services, such as mental health treatment. Team members participate in multidisciplinary case reviews to assure that the investigation is proceeding and that the victim is receiving needed services to foster the healing process.

CAC Outcomes

Though research on the CAC model is relatively new, there is evidence supporting the superiority of the CAC model over other methods of child abuse investigations. Research shows that child advocacy centers (CACs) increase interagency coordination on cases of suspected child abuse, increase the number of child sexual abuse victims who receive forensic medical exams, and improve family experiences of child sexual abuse investigations. A study conducted by Cross et al. in 2007 showed that CAC cases were more likely to feature multidisciplinary team (MDT) interviews, video or audio taping of interviews, case reviews, police involvement, and joint police/CPS investigation than the non-CAC comparison cases (Cross et al., 2007). Suspected child abuse victims at CACs were twice as likely to have forensic medical exams as those seen in comparison communities (Walsh et al., 2007). These exams are invaluable both to ensure appropriate care for the child and to support legal decision-making (Walsh et al., 2007). Non-offending caregivers of children involved in investigations reported a higher level of satisfaction with the investigations when they took place through a CAC and reported that they felt more supported and safe in the CAC (Jones et al., 2007). CACs also reduce the number of interviews which take place in environments which have been shown to be undesirable, such as the child's home, a police department, or CPS (Newman, 2005).

Standards for Accreditation

In order for CACs to be effective, they must meet certain minimum standards for planning, training, and service delivery. Like other professional organizations, child advocacy centers have a national accrediting body that seeks to promote quality service delivery by establishing minimum standards of practice. The National Children's Alliance is the national accrediting body for CACs, and their standards are based on the premise that all CACs should provide effective, efficient, and compassionate services for child abuse victims. Understanding that not all communities are equipped with many resources, the NCA standards for accreditation are flexible enough to ensure that even communities with limited resources may achieve accreditation. While most child advocacy centers are developed as independent 501(c)3 non-profit agencies, multiple models are acceptable under NCA standards. A 2011 annual survey reported that 62% of child advocacy centers were independent non-profit agencies, 15% affiliated with a governmental entity, 13% under a larger umbrella non-profit, 9% hospital-affiliated, and 1% "other." To ensure that the CAC services provided to Pennsylvania's children are of the highest quality, all CACs should be in full compliance with the NCA standards. The following summary of standards is intended only as a snapshot of the elements required to meet the standards. The full set of standards may be found in Appendix I.

The standards are broken down into ten categories:

1. **Multidisciplinary Team (MDT)**
2. **Cultural Competency and Diversity**
3. **Forensic Interview**
4. **Victim Support and Advocacy**
5. **Medical Evaluation**
6. **Mental Health**
7. **Case Review**
8. **Case Tracking**
9. **Organizational Capacity**
10. **Child-Focused Setting**

1. Multidisciplinary Team (MDT)

Standard: The multidisciplinary team response to child abuse allegations includes representation from the following – law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and the children's advocacy center.

An allegation of child abuse must be met with a multidisciplinary team response and the team must include representation from law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, and the children's advocacy center.

The multidisciplinary team is the foundation of the CAC and such an approach fosters interagency collaboration and coordination which limits trauma for children and families as they navigate the investigation process.

Community resources may limit staff and so a CAC might employ one staff member to fill multiple roles. However, it is important that each function be performed by a member of the MDT while maintaining clear boundaries for each function.

Essential Components:

- The CAC provides routine opportunities for MDT members to provide feedback and suggestions regarding procedures/operations of the CAC/MDT.
- All members of the MDT including appropriate CAC staff, as defined by the needs of the case, are routinely involved in investigations and/or MDT interventions.
- The 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.
- The CAC/MDT participates in ongoing and relevant training and educational opportunities, including cross-discipline, MDT, peer review and skills-based learning.

2. Cultural Competency and Diversity

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

Cultural competency is defined by the NCA as "the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community". Cultural competency is as integral to the CAC model as developmentally appropriate and child friendly practice, therefore culturally competent services must be routinely made available to all CAC clients and be coordinated with the multidisciplinary team response.

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.

3. Forensic Interview

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 purpose of conducting a forensic interview at a CAC is to obtain a statement from a child in a manner that is developmentally appropriate and culturally sensitive while remaining unbiased and focused on fact-finding. A quality forensic interview will support accurate and fair decision-making by the multidisciplinary team. Forensic interviews should be child-centered and coordinated in order to reduce redundant interviewing.

CACs vary with regard to who conducts the interview. However, the interviewer must meet at least one of two Training Standards:

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

OR

2.) Documentation of 40 hours of nationally or state recognized forensic interview training that includes child development.

Essential Components:

- Forensic interviews are provided by MDT/CAC staff who have specialized training in conducting forensic interviews.
- 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.
- 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 the forensic interview(s).
- Forensic interviews are routinely conducted at the CAC.

4. Victim Support and Advocacy

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

Victim support and advocacy is meant to mitigate trauma for the child and non-offending family members by helping families to navigate the investigation process. Examples of victim support and advocacy include, but are not limited to: crisis intervention and support throughout all stages of investigation and prosecution, provision of education about the coordinated, multidisciplinary response, providing updates to the family on case status, continuances, dispositions, sentencing, and offender release from custody, and assistance in procuring concrete services.

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.
- 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/MDT's written documents include availability of victim support and advocacy services for all CAC clients.

5. Medical Evaluation

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

Medical evaluations should be made available either on site or through linkages with the community. All CAC clients must have access to medical services, regardless of their ability to pay. The CAC must document the circumstances under which medical evaluations are recommended, how emergency situations are addressed, and the purpose of the medical evaluation. The CAC must address how the medical evaluation is coordinated with the MDT in order to avoid duplicative evaluations and promote information sharing.

Physicians, nurse practitioners, physician assistants, and nurses may all engage in medical evaluation of child abuse. However, research shows that the medical professional's training, clinical experience, and discipline are strongly affiliated with the medical professional's ability to identify and interpret findings in cases of child sexual abuse. Evaluations must be conducted by a pediatric health care provider with child abuse expertise and the CAC's medical provider must meet as 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 completion of competence-based training in child abuse evaluations
- Documentation of 16 hours of formal medical training in child sexual abuse evaluation.

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

It is important to note that medical exams do not serve only an evidence-finding or clinical purpose. The medical exam is an opportunity for providers to assure the child that their bodies are normal and that the abuse has not damaged them physically. It is often the first step in the healing process for the child and it is crucial the experienced and compassionate providers be available to conduct these medical exams.

Essential Components:

- Medical evaluations are provided by health care providers with pediatric experience and child abuse expertise.
- 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.
- The CAC/MDT's written documents include access to appropriate medical evaluation and treatment for all CAC clients.

6. Mental Health

Standard: 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.

CACs seek to minimize trauma to the child and to help the child heal. Therefore, the MDT response must include trauma assessment and specialized trauma-focused mental health services for child victims and non-offending family members. Without effective therapeutic intervention, many traumatized children will suffer ongoing or long term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetimes. Children should be referred to evidence-based treatment and other practices with strong empirical support that will both reduce the impact of trauma and the risk of future abuse.

Essential Components:

- Mental health services are provided by professionals with pediatric experience and child abuse expertise.
- 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.
- The CAC/MDT's written documents include access to appropriate mental health evaluation and treatment for all CAC clients.

7. Case Review

Standard: 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.

According to NCA Standards, case review is an informed decision-making process that requires input from all members of the multidisciplinary team. Case review should be utilized at the CAC in order to monitor the progress of an investigation, provide input for prosecution and sentencing, review criminal and dependency case disposition, and discuss providing court support for children and their non-offending family members. In addition to focusing on the legal aspects of the case, case review should also be used to review interviews and medical evaluations, as well as discuss the family's reactions to a child's disclosure and the supports and services that the child or family members may need on a case-by-case basis.

The case review process at the CAC must involve multidisciplinary discussion and information sharing on a routine basis. It is integral that all aspects of the multidisciplinary team be represented in the case review process. Written documentation for the CAC must include criteria for case review that includes the frequency of meetings, the designated attendees, and the designated coordinator.

Essential Components:

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

8. Case Tracking

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

All CACs must develop and implement a system for tracking case progress and outcomes. Case tracking, according to the NCA, must be "a systematic method in which specific data is routinely collected on each case served by the CAC." The CAC must designate an individual to oversee case tracking, and case information needs to be made available to all members of the MDT. In order to meet this standard, the CAC needs to track and to be able to retrieve NCA Statistical Information. Statistical information minimally includes demographic information about the child and family, demographic information about the alleged offender, the type of abuse, the relationship of the alleged offender to the child, MDT involvement and outcomes, charges filed and case disposition in criminal court, child protection outcomes, and status/outcome of medical and mental health referrals.

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.

9. Organizational Capacity

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

In order to meet the standard for organizational capacity, the CAC must designate a legal entity that is responsible for the governance of the CAC's operations. The CAC must be an incorporated private non-profit or government based agency, or a component of such an agency. At a minimum, the CAC must maintain current general commercial liability insurance, professional liability, and Directors and Officers liability as is appropriate.

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 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.
- 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.
- 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.

10. Child-Focused Setting

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

The tenth standard mandates the development of a child-focused setting at the CAC. Children and their non-offending family members should feel physically and psychologically safe at all times. In a study conducted by Newman et al (2005), researchers found that a child-focused setting is integral because it increases the child's comfort level, thereby improving their ability to self-disclose accurate information about their experiences. The facility must have private waiting areas for children and their non-offending family members. The facility must also have space for private interviews that can be observed by members of the MDT either through a video feed or one-way mirrors.

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.

Levels of Accreditation

The National Children's Alliance defines four different types of CAC accreditation or membership:

1. **Accredited Membership:** Accredited Membership is available to those CACs which are able to fully meet the ten standards.
2. **Associate/Developing Membership:** Children's Advocacy Centers that are working toward but have not yet achieved implementation of all standards for accreditation may be granted Associate/Developing CAC status.
3. **Affiliate Membership:** Affiliate membership is offered to multidisciplinary teams that are working to improve services for abused children through a collaborative approach to intervention.
4. **Satellite Membership:** Satellite Membership is available to child friendly facilities offering onsite forensic interviews and victim advocacy services under the sponsorship and oversight of an NCA Accredited Child Advocacy Center.

With the flexibility of NCA's standards to accommodate the differences in communities and resources, it is expected that all new CACs in Pennsylvania strive to meet these standards.

Provision of Required Services

Forensic Medical Exams

Forensic medical exams provided at or in collaboration with a CAC are not only an important component of the investigative process, but also the initial step in healing from the trauma of abuse. A trained and experienced medical provider will not only look for evidence during an exam, but will also reassure the child that they have not been changed or "damaged" by the abuse. For this reason, it is recommended that all child victims have the opportunity to be examined by a trained, experienced, and qualified medical professional.

Training and experience are important for several reasons. It takes appropriate training and field experience to develop the skills necessary to look for evidence of abuse and also to reassure and heal the child. Furthermore, those with underdeveloped skills might struggle when providing testimony or their testimony may be called into question, which could jeopardize the conviction of the offender. Pediatricians with special training and experience in child abuse are the desirable providers of forensic medical exams. Sexual Assault Nurse Examiners with special training in Pediatrics and experience under the supervision of a pediatrician may also provide forensic medical exams.

Unfortunately, the provision of forensic medical exams poses a major challenge to expansion of CACs across the Commonwealth. Pennsylvania trains child abuse pediatricians through a fellowship program offered by the Pennsylvania Chapter of the American Academy of Pediatrics (SCAN Program). This is a 60-hour continuing medical education program to train physicians on the thorough evaluation and diagnosis of physical and sexual abuse. The program accepts three participants each year, with special consideration given to those in geographic locations that are a significant distance from major medical centers and those affiliated with a Child Advocacy Center. Though approximately 30 providers have completed the fellowship, only about 20% actively provide forensic medical exams. Reasons for this might be fear of being called to testify in court or concern that working with a CAC might interfere with private practice work.

Though Pennsylvania has more child abuse pediatric specialists than most other states, linking providers with CACs, particularly in rural counties, presents a challenge. Telemedicine has been proposed as a method of addressing this problem in rural areas. However, it is unlikely that the more refined aspects of child abuse pediatric care, such as reassuring the child, can be achieved through telecommunication. Concerted efforts need to be made at the state level to encourage the education and training of child abuse pediatric specialists and to develop capacity across the commonwealth to meet this critical need.

Mental Health

The mental health standard for accreditation dictates that victims must be referred to trauma-informed mental health therapy providers. These providers offer evidence-based treatment such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The provision of needed mental health services can be a challenge, particularly in rural areas that face mental health professional shortages (MHPSAs). Mental health professional shortage areas are designated by the federal government as areas in which the ratio of psychiatrists to patients is 1: 30,000. Pennsylvania currently has 53 counties with designated MHPSAs. Although treatment for victims would not be provided by a psychiatrist, this data demonstrate the challenges faced by communities in providing appropriate mental health services as mandated by both good practice and NCA standards.

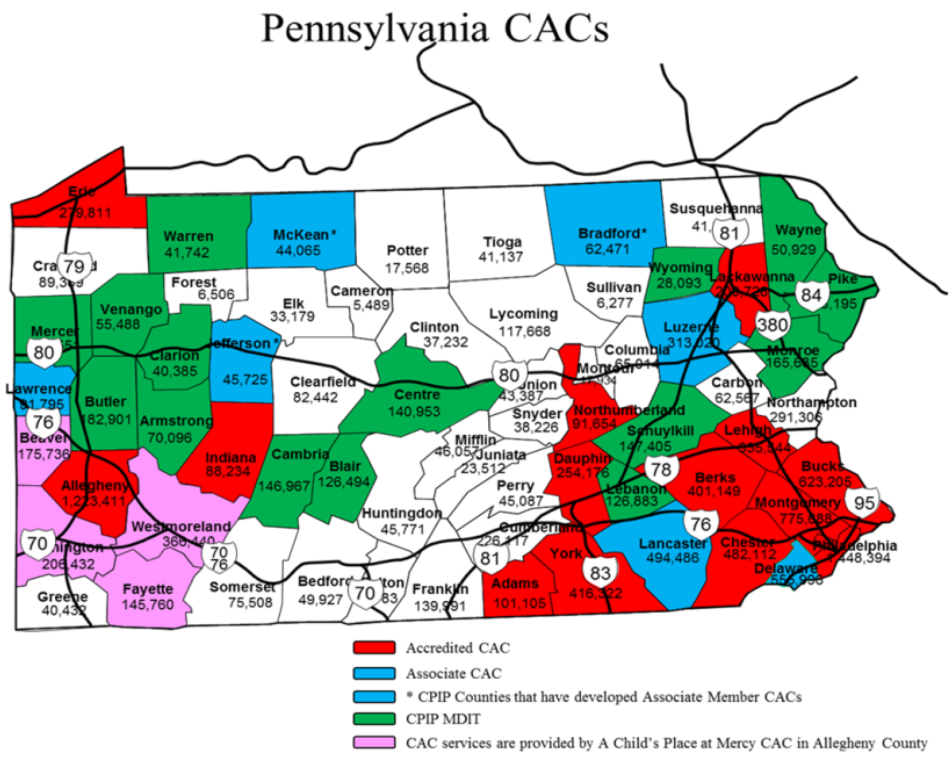
Victim Advocacy

Victim advocates provide crisis intervention, information and case updates, and advocacy. They help children and families navigate the process by securing transportation to interviews, court, treatment and other case-related meetings, assisting in procuring concrete services such as housing, and providing referrals for mental health and medical treatment. Each MDT should develop the capacity for victim advocacy services to serve their community. Victim advocacy services may be provided by more than one individual or entity. For example, court accompaniment can be provided by victim services in the local community while referrals for services can be offered through a CAC-based victim advocate.

Overview of Pennsylvania

CACs in Pennsylvania

Figure 2. PA Chapter of CACs and MDTs Map of CACs in Pennsylvania (as of October 29, 2013)



In Pennsylvania, of April 2014, there are 22 CACs in 21 counties, with 15 fully accredited centers and 7 associate/developing members. Fifteen counties are participating in the Continuing Practice Improvement Program (CPIP) to strengthen their multidisciplinary teams.

The Task Force on Child Protection recommended that a CAC be located within two hours of each child in Pennsylvania. However, a two hour drive may correspond to very different distances depending on whether it is highway, a rural road, or a city street. Furthermore, in practice, a two hour drive may be prohibitive for families or even for MDT members. NCA standards mandate participation of MDT members in the investigation process so that too great a driving distance could place a significant hardship on MDT members' ability to be present for forensic interviews and subsequent case reviews. In order to develop a reasonable drive-time parameter, the Field Center worked with the University of Pennsylvania Cartographic Modeling Lab (CML). Using GIS, the CML can estimate drive-times for

different locations. These estimates show that Pennsylvania can locate CACs such that the majority of families and team members would be able to reach the CAC within a **one-hour drive**.

Data and Methodology

- **DPW Child Abuse Case Data:** The Field Center contracted with the Pennsylvania Department of Public Welfare to procure child abuse case data spanning five years, from 2007 to 2011. This statewide data included the zip code of the child victim's residence, the age and gender of the child, and the type of abuse. This data was analyzed to estimate the number of child sexual abuse investigations each county in Pennsylvania could expect annually. This data is important for planning because, as research has shown, experience is the single most important predictive factor in the quality of child investigations (Adams, 2012). Medical providers and forensic interviewers must see a sufficient number of cases per month in order to maintain their skill sets. The data was further analyzed to estimate the age and gender breakdown in each county so that appropriate child-friendly interview rooms might be designed in each community. It is important to note that the data set provided by DPW contains only substantiated cases due to state law that mandates expunging unsubstantiated cases after one year. The data also refer only to CPS cases and do not take General Protective Services (GPS) cases or "law enforcement-only cases" (LEO), those cases of sexual abuse that fail to fall under the jurisdiction of the child protection system, into account. For example, under current definitions, cases of sibling sexual abuse are considering GPS not CPS cases. If the alleged perpetrator is a neighbor or other community member rather than a member of the household or caretaker, CPS does not have jurisdiction of the case, making it a LEO case. The Field Center was able to estimate the number of investigations by applying one-year county substantiation rates for sexual abuse cases and the average of the local range of law enforcement-only cases. Due to the lack of complete data and revised laws and definitions expected to be enacted in 2015, it is quite possible that the estimated projections in this report may underpredict what will be experienced by CACs in the future. Furthermore, experience tells us that once a CAC is open and the community sees its value, utilization will increase. For example, Montgomery County's Mission Kids Child Advocacy Center increased from 300 cases its first year to 450 cases its fourth.

- **Survey of CAC Directors:** The Field Center conducted an online survey of the directors of existing CACs in order to determine catchment areas, pre-existing inter-county collaborations, interest in and capacity for expansion, and the percentages of law enforcement-only cases. This information is invaluable to the process of selecting the locations for new CACs, as it provides a ground-level view of existing interactions among communities.

- **Medical Background Research:** The Field Center conducted qualitative background research by interviewing pediatric child abuse experts, including those involved with the Pennsylvania American Academy of Pediatrics Suspected Child Abuse and Neglect (SCAN) Program. SCAN is a statewide continuing medical education program that aims to increase the recognition and reporting of suspected child abuse and neglect. The Field Center also identified Pediatric Sexual Assault Nurse Examiner (SANE-P) programs around the state.

- **Mental Health Background Research:** The Field Center examined publicly available federal data from the Health Research Services Administration (HRSA) to identify those counties that might experience difficulty in identifying mental health service providers in their communities.

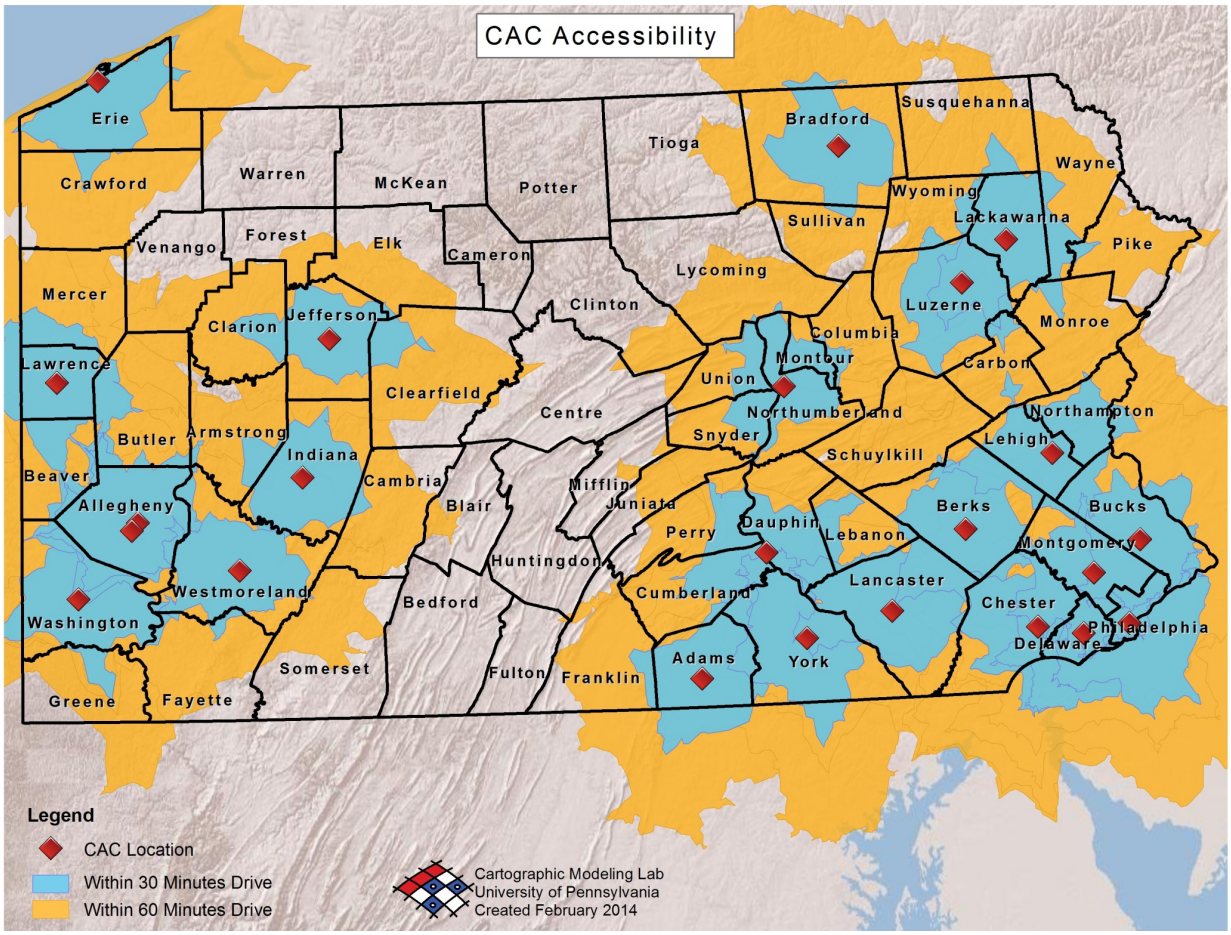
- **Census Research:** The Field Center utilized census data to identify population levels in suggested CAC locations to ensure that recommended locations would not endanger the anonymity of the child victim.

- **GIS Mapping:** The Field Center contracted with the University of Pennsylvania Cartographic Modeling Lab (CML). Using the child abuse case location data that was procured from DPW, along with CML's database to predict drive-times based on roads and speed limits, the CML optimized the location for a new set of CACs, selecting locations for new CACs based on access for the highest number of cases in the shortest amount of time.

- **AOPC Charging Data:** The Field Center procured five years of county-level charging data for sexual abuse offenses spanning from 2007 to 2011. Statutes relating to sexual abuse were identified from the PA Criminal Code. However, the use of this data is limited for a variety of reasons, including the absence of data on perpetrators under the age of 18 because of confidentiality in the juvenile justice system.

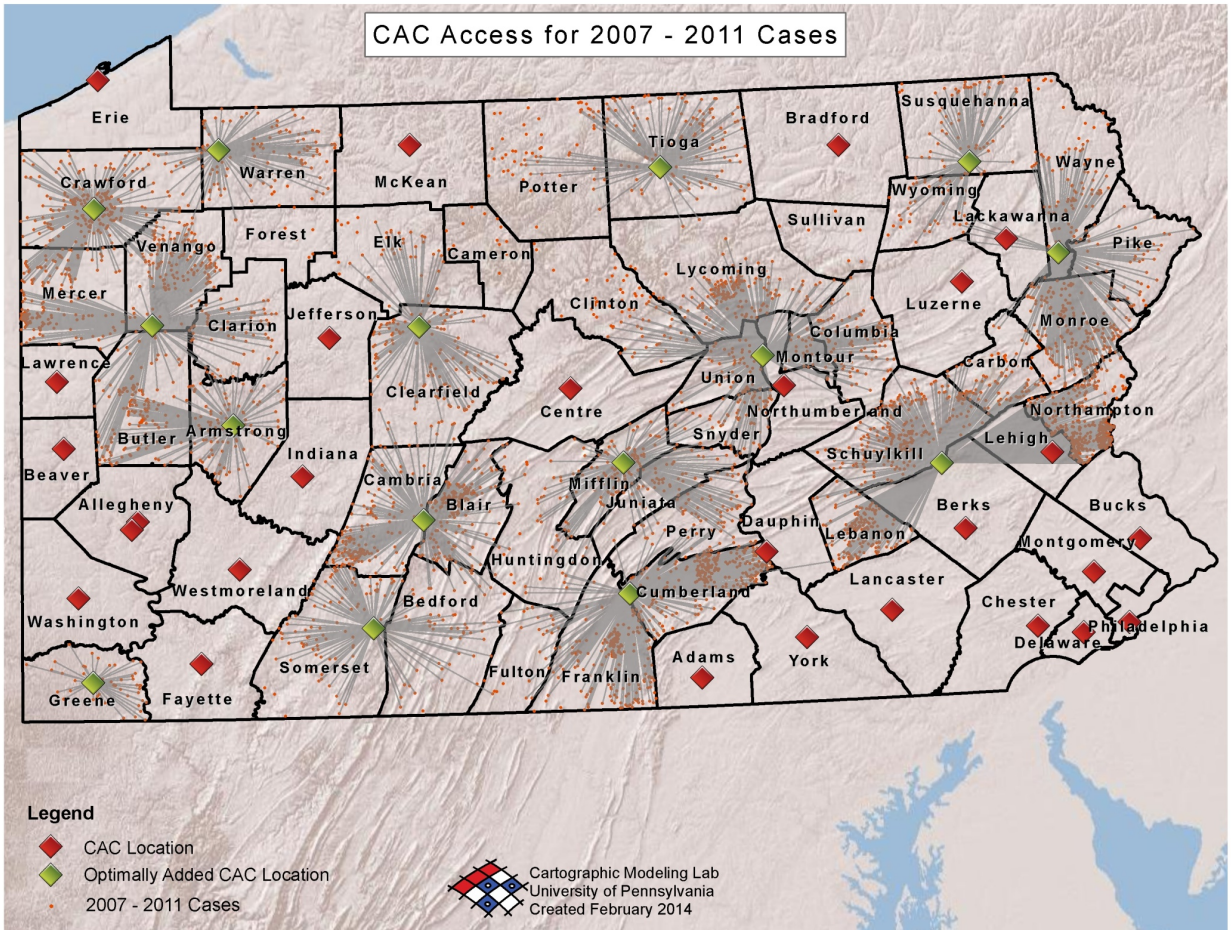
Maps

Figure 3. CAC Accessibility Prior to Planning



This map shows existing CACs as of October 2013 with color-coded areas corresponding to 30-minute and 60-minute drive times from those CACs. From this map, it is evident that a large portion of the state lacks access to the services of a CAC within a reasonable drive time.

Figure 4. Computer-Generated Optimal Locations for New CACs with Cases Attributed



*Note that although the computer algorithm occasionally splits counties and attributes cases from one county to more than one CAC, the Field Center has chosen to override this in its recommendations, as it is not feasible to have one MDT traveling to more than one CAC.

Figure 4 shows the GIS-generated map of optimized new CAC locations, along with lines showing which cases have been attributed to each new CAC. The GIS program selected these locations by maximizing the number of cases served while minimizing the drive times. This map does not take into account the populations of the selected communities, proximity to medical providers, or proximity to mental health services. Data includes five years of DPW reports to account for year-to-year variation in reporting.

Figure 5. CAC Optimization

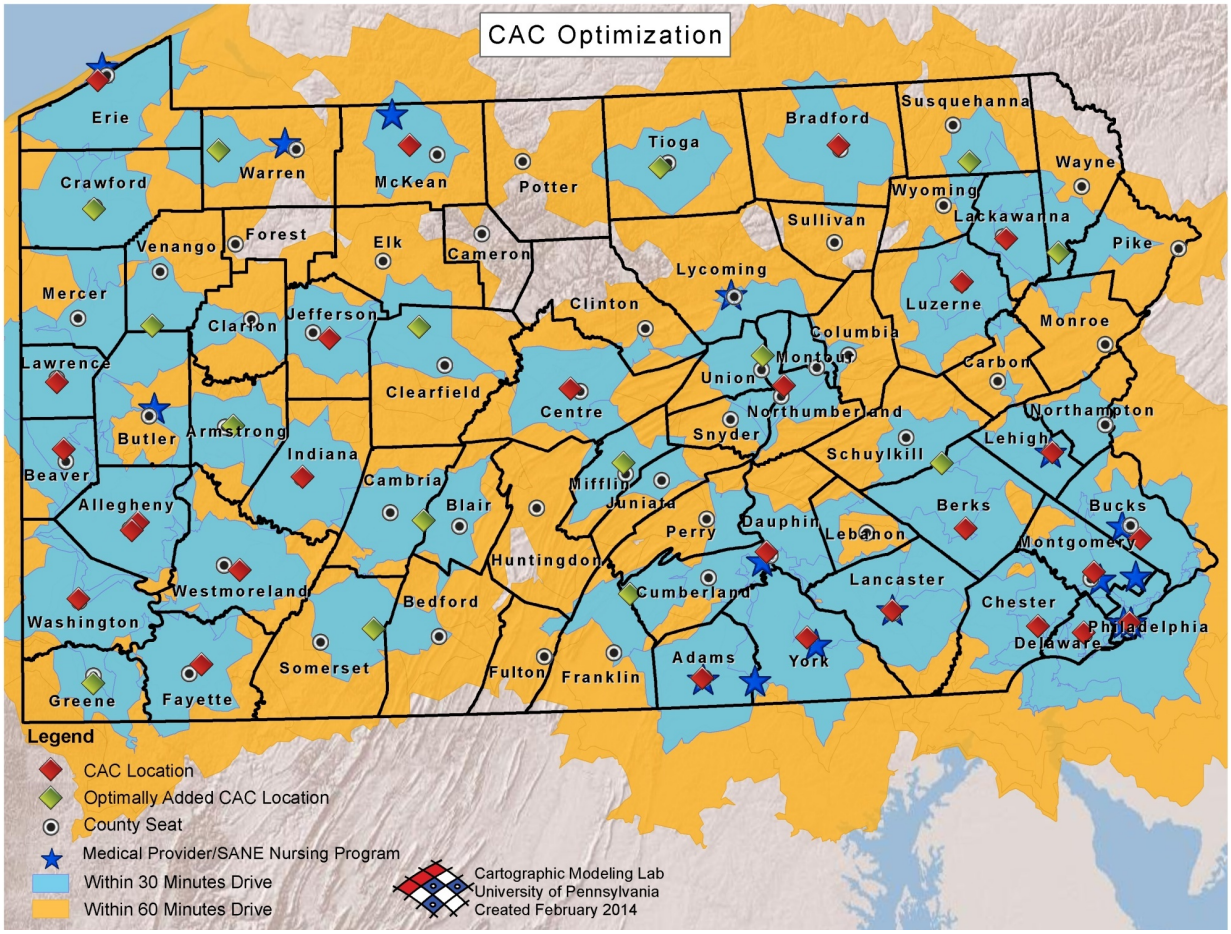


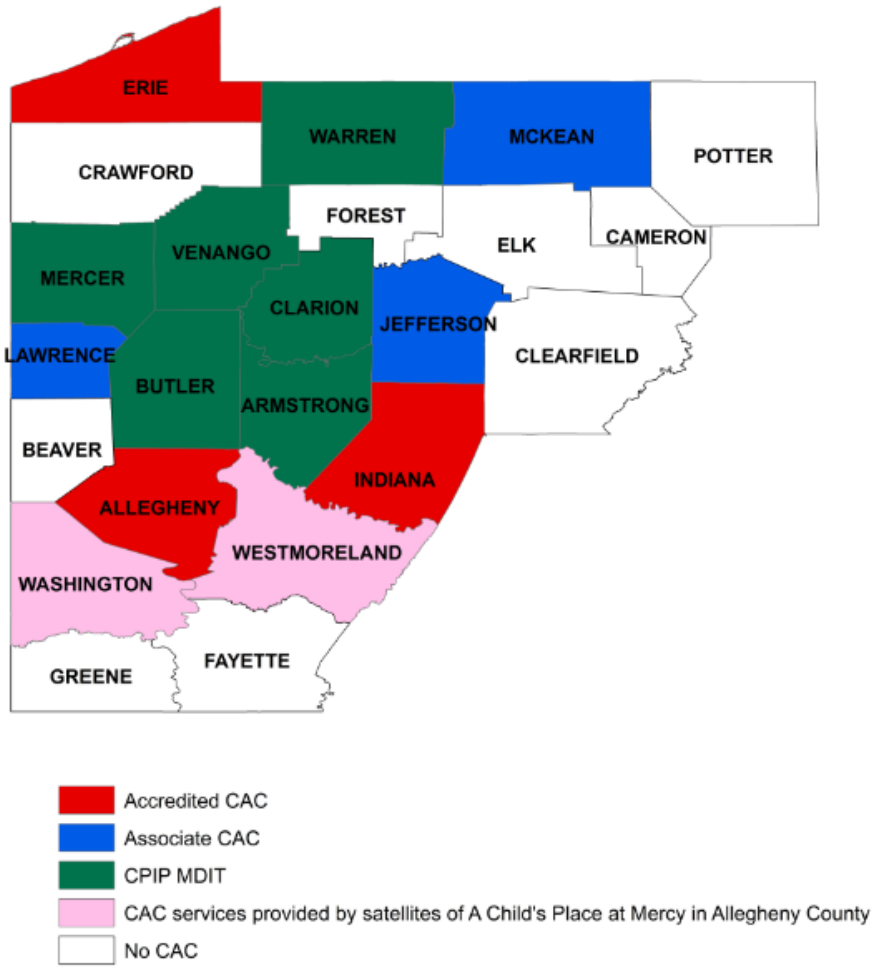
Figure 5 shows the optimized locations, along with existing locations and the location of some medical providers and SANE-P Nursing Programs. From this map, It can be seen that the new optimized centers can reach the majority of the state within a 60-minute drive.

No map or single source of data is sufficient in the planning of new CACs. The selection of new locations must take into account all variables, including predicted caseloads, economies of scale, proximity to the county seat (which is typically the location of the district attorney and the child welfare agency), the location of other necessary resources, pre-existing collaborative relationships, and a population density that does not endanger the anonymity of the child.

For clarity, the results of the mapping, caseload data analysis, background research and CAC survey are broken down by major Pennsylvania regions, as defined by the Department of Public Welfare. Discussed are existing accredited and associate CACs, their catchment areas, and the percentage of law enforcement only cases, as well as local child sexual abuse case data, and recommendations for

the development of new CACs. In order to meet the criteria, some new centers cross the DPW regions. These regions are presented simply for clarity and organization.

Western Region



*Note: At the writing of this report, Washington and Westmoreland counties each have a satellite location of *A Child's Place at Mercy*, while Beaver and Fayette do not. Beaver and Fayette counties are served at the Allegheny County location of *A Child's Place at Mercy*.

Western Pennsylvania is comprised of Allegheny, Armstrong, Beaver, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren, Washington, and Westmoreland counties.

There are 15 counties in the Western Region which currently do not have CACs: Clearfield, Cameron, Crawford, Elk, Mercer, Venango, Potter, Butler, Clarion, Forest, Armstrong, Warren, Beaver, Fayette and Greene counties.

The Western Region of Pennsylvania contains 7 accredited children's advocacy centers:

The Bradley H. Foulk Children's Advocacy Center of Erie County

- **County:** Erie
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** Provides medical exams for Crawford and McKean counties when requested; provides forensic interviews for Venango and Clarion counties when requested.

A Child's Place at Mercy

- **County:** Allegheny
- **Status:** Accredited
- **Type:** Hospital Based
- **County Collaboration:** *A Child's Place at Mercy* has accredited satellite locations in Washington and Westmoreland counties and provides services to Beaver and Fayette counties.

UPMC Children's Hospital Child Advocacy Center

- **County:** Allegheny
- **Status:** Accredited
- **Type:** Hospital Based
- **County Collaboration:** Provides services to Blair, Washington, Armstrong, Butler, Bedford and Somerset counties.

The CARE Center of Indiana County

- **County:** Indiana
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** Provides forensic interview services for Cambria, Westmoreland, Mifflin, Jefferson, Lycoming, and Clearfield counties.

The Western PA CARES for Kids Child Advocacy Center

- **County:** Jefferson
- **Status:** Associate
- **Type:** Nonprofit
- **County Collaboration:** Provides forensic interview services for Jefferson, Clearfield, Clarion and Forest counties.

Children's Advocacy Center of McKean County

- **County:** McKean
- **Status:** Associate
- **Type:** Government Based
- **County Collaboration:** Provides forensic interview and victim advocacy services for Potter, Elk and Cameron counties.

Children's Advocacy Center of Lawrence County

- **County:** Lawrence
- **Status:** Associate
- **Type:** Nonprofit
- **County Collaboration:** Provides forensic interview and medical evaluations for Mercer County.

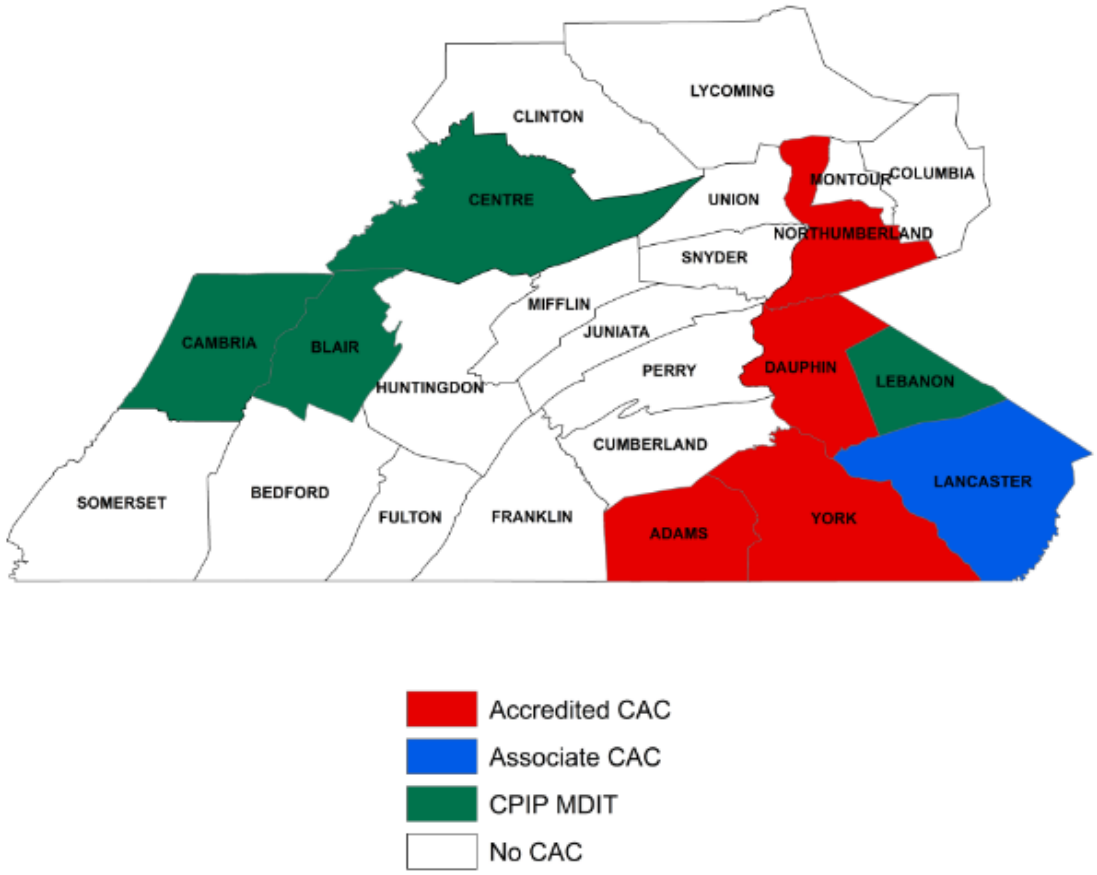
The following table shows the estimated number of projected investigations for sexual abuse per county in the DPW Western Region. These estimates are based on CPS data only, and therefore cannot account for GPS cases, law enforcement-only cases, or the potential increase of cases under revisions in the laws. The number of law enforcement-only cases for existing CACs in the Western Region range from **14 percent to 46 percent**. Due to these factors, the estimated projections may in reality be larger than they appear in this table.

Table 1. Estimated Yearly Number of Sexual Abuse Investigations in DPW Western Region

Western Region County	Projected Range of CPS Investigations
Allegheny	298 - 345
Armstrong	13 - 39
Beaver	56 - 72
Butler	64 - 100
Cameron	0 - 3
Clarion	11 - 24
Clearfield	25 - 47
Crawford	72 - 95
Elk	3 - 8
Erie	315 - 432
Fayette	53 - 74
Forest	0 - 5
Greene	9 - 17
Indiana	21 - 47
Jefferson	11 - 26
Lawrence	25 - 35
McKean	22 - 38
Mercer	56 - 94
Potter	5 - 16
Venango	29 - 63
Warren	18 - 29
Washington	62 - 109
Westmoreland	238 - 308

The 13 counties in the Western Region that currently have no children's advocacy center would respond to a total of approximately **305 to 540** CPS sexual abuse investigations per year. Based on this estimate it would be recommended that **at least 3** new CACs be added in this region to establish access for child victims in this part of the commonwealth.

Central Region



The DPW Central Region is comprised of Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, Union, and York counties.

There are 18 counties in central Pennsylvania that do not have CACs. These counties are Bedford, Blair, Cambria, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lycoming, Mifflin, Montour, Perry, Snyder, Somerset, and Union counties.

The Central Region of Pennsylvania contains 5 accredited CACs:

The Children's Resource Center

- **County:** Dauphin
- **Status:** Accredited
- **Type:** Hospital Based
- **County Collaboration:** Provides services for Dauphin, Perry, Cumberland, Lebanon, Schuylkill, Mifflin, Juniata, Blair, Fulton, and Bedford counties. *The Children's Resource Center* will be opening a satellite office in Lebanon County in July of 2014.

The CAC of the Central Susquehanna Valley

- **County:** Northumberland
- **Status:** Accredited
- **Type:** Hospital Based
- **County Collaboration:** Provides services for Union, Snyder, Montour, Columbia, Lycoming, Clinton, Tioga, Centre, Clearfield, and Huntington counties.

The Adams County Children's Advocacy Center

- **County:** Adams
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** Provides forensic interview and medical exams to neighboring Franklin County.

York County Children's Advocacy Center

- **County:** York
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None indicated.

Lancaster County Children's Alliance

- **County:** Lancaster
- **Status:** Associate
- **Type:** Umbrella Hospital
- **County Collaboration:** None indicated.

Centre County is in the process of opening its first CAC and does not currently intend to provide services outside of that county, therefore they were excluded from planning in this report.

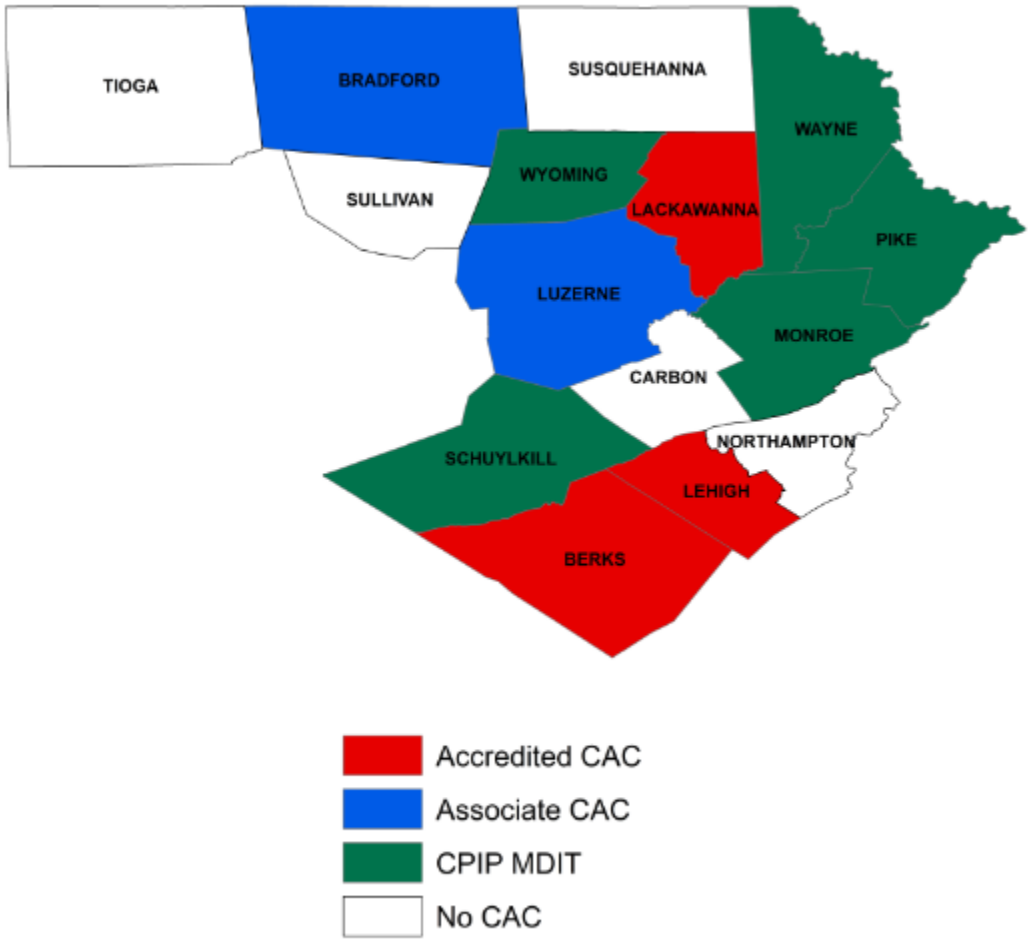
The following table shows the projected number of CPS sexual abuse investigations per county per year for the DPW Central Region of Pennsylvania. These estimates are based on CPS data only, and therefore cannot account for GPS cases, law enforcement-only cases, or the potential increase of cases under revisions in the laws. The percentage of law enforcement-only cases in the Central Region ranges from **10 to 30 percent**. Due to these factors, the estimated projections may in reality be larger than they appear in this table.

Table 2. Estimated Yearly Number of Sexual Abuse Investigations in DPW Central Region

Central	Projected Number of CPS Investigations
Adams	33 - 56
Bedford	13 - 17
Blair	39 - 70
Cambria	52 - 92
Centre	25 - 43
Clinton	7 - 19
Columbia	26 - 47
Cumberland	76 - 107
Dauphin	330 - 448
Franklin	41 - 56
Fulton	2 - 10
Huntingdon	14 - 20
Juniata	7 - 18
Lancaster	486 - 616
Lebanon	60 - 93
Lycoming	64 - 108
Mifflin	20 - 24
Montour	4 - 14
Northumberland	36 - 81
Perry	18 - 39
Snyder	7 - 18
Somerset	21 - 45
Union	8 - 16
York	319 - 407

The counties that do not contain CACs would expect to see approximately **809 to 1,262** investigations per year. Based on these estimates, we would recommend opening **at least 4 to 6** new CACs in the Central Region of Pennsylvania.

Northeast Region



The DPW Northeast Region is comprised of Berks, Bradford, Carbon, Lackawanna, Lehigh, Luzerne, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties.

Most counties in northeastern Pennsylvania do not host CACs. These counties are Carbon, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming counties.

The Northeast Region of Pennsylvania contains 5 accredited CACs:

The CAC of Lehigh County

- **County:** Lehigh
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None indicated.

Children's Alliance Center of Berks County

- **County:** Berks
- **Status:** Accredited
- **Type:** Umbrella
- **County Collaboration:** None indicated.

The Children's House

- **County:** Bradford
- **Status:** Associate
- **Type:** Nonprofit
- **County Collaboration:** Has provided services for Wyoming, Sullivan, Tioga and Susquehanna counties.

Luzerne County CAC

- **County:** Luzerne
- **Status:** Associate
- **Type:** Government Based
- **County Collaboration:** None Indicated

Children's Advocacy Center of Northeastern PA (NEPA)

- **County:** Lackawanna
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None indicated

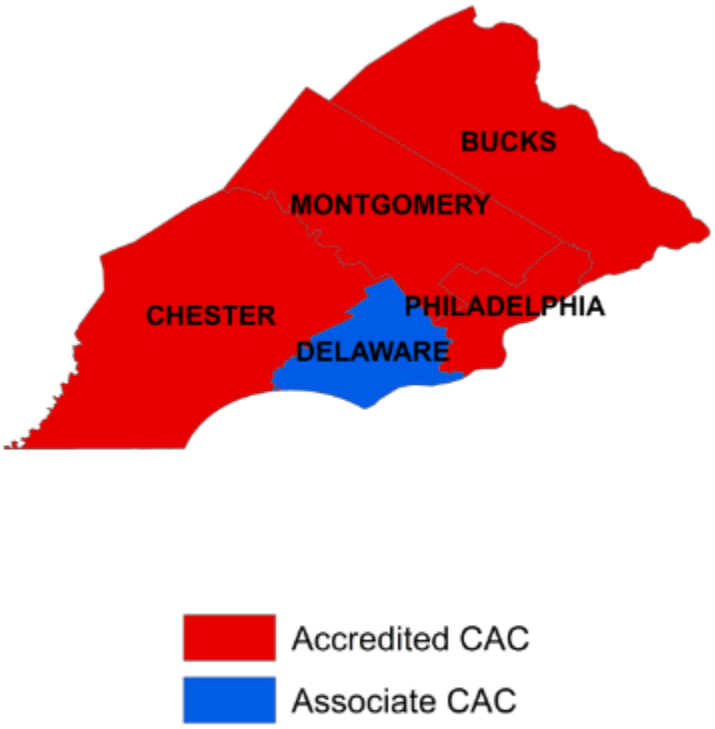
The following table shows the projected number of investigations per county per year in the DPW Northeast Region of PA. These estimates are based on CPS data only, and therefore cannot account for GPS cases, law enforcement-only cases, or the potential increase of cases under revisions to the laws. The percentage of law enforcement cases in the Northeast Region ranges from **27 to 35 percent**. Due to these factors, the estimated projections may in reality be larger than they appear in this table.

Table 3. Estimated Yearly Number of Sexual Abuse Investigations in DPW Northeast Region

Northeast	Projected Number of CPS Investigations
Berks	136 - 171
Bradford	31 - 48
Carbon	17 - 29
Lackawanna	96 - 123
Lehigh	204 - 345
Luzerne	274 - 355
Monroe	57 - 89
Northampton	245 - 350
Pike	5 - 19
Schuylkill	61 - 77
Sullivan	0 - 2
Susquehanna	16 - 24
Tioga	14 - 36
Wayne	21 - 31
Wyoming	2 - 15

The counties which do not contain CACs would expect approximately **655 to 938** investigations per year. Based on these numbers, we would project **3 to 5 new centers** in the Northeast Region.

Southeast Region



The DPW Southeast Region is comprised of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. All counties in the Southeast Region contain either accredited or associate CACs. Due to the high level of coverage, these CACs provide services to their own communities, with occasional courtesy interviews provided for outside communities.

The Southeast Region of Pennsylvania contains 5 accredited CACs:

Mission Kids

- **County:** Montgomery
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None Indicated

The Philadelphia Children's Alliance

- **County:** Philadelphia
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None Indicated

The Bucks County Children's Advocacy Center

- **County:** Bucks
- **Status:** Accredited
- **Type:** Nonprofit
- **County Collaboration:** None Indicated

Delaware County Children's Advocacy Center

- **County:** Delaware
- **Status:** Dormant Associate Member
- **Type:** Former Associate Membership under Governmental Agency; plans to reapply for new Associate Membership as a Nonprofit
- **County Collaboration:** None indicated

Chester County Children's Advocacy Center

- **County:** Chester
- **Status:** Accredited
- **Type:** Government Based
- **County Collaboration:** None Indicated

The following table shows the projected number of investigations per county per year in the Southeast Region of Pennsylvania. These estimates are based on CPS data only, and therefore cannot account for GPS cases, law enforcement-only cases, or the potential increase of cases under new laws. The percentage of law enforcement cases in the Southeast Region ranges from **25 to 50 percent**. Due to these factors, the estimated projections may in reality be larger than they appear in this table.

Table 4. Estimated Yearly Number of Sexual Abuse Investigations in DPW Southeast Region

Southeast	Projected Number of CPS Investigations
Bucks	177 - 242
Chester	195 - 324
Delaware	84 - 129
Montgomery	209 - 301
Philadelphia	697 - 900

Recommendations

Based on the Field Center's comprehensive research, incorporating multiple data sources, qualitative and quantitative analyses, and GIS mapping technology, the Field Center recommends the establishment of 12 new child advocacy centers in order to meet the needs of all children in Pennsylvania. In addition, the Field Center is recommending that an additional 7 counties formalize existing partnerships with specific accredited CACs who will provide comprehensive services to their populations. These locations have been selected based on the geographically optimal locations while also factoring in predicted caseloads, economies of scale, and local resources. The recommendations fall into three categories: New Regional CACs, New Countywide CACs, and Counties Affiliating with an Existing Accredited CAC.

Figure 6. Recommended CAC Locations

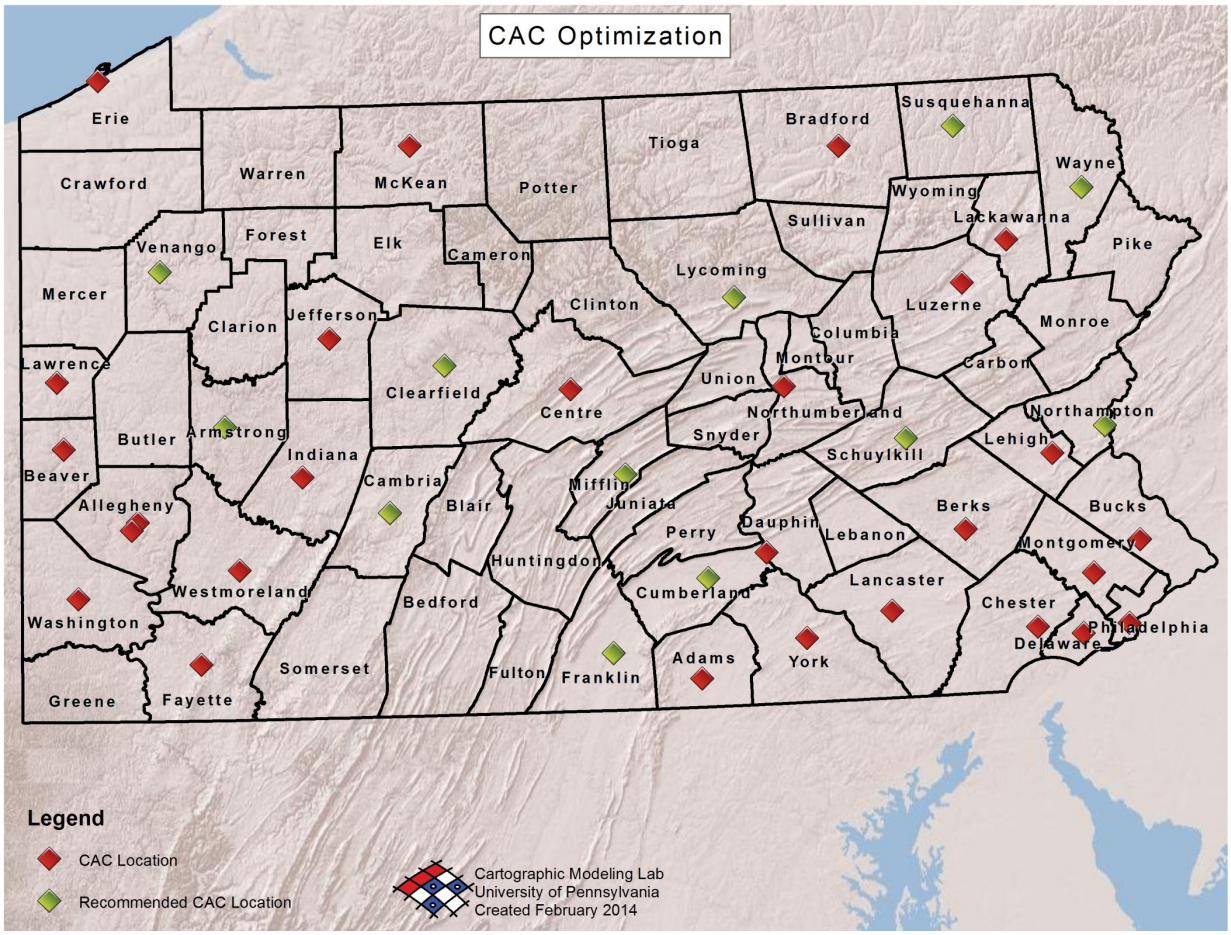


Figure 6 shows the recommended additional CAC locations, as well as existing CAC locations in Pennsylvania. This set of 12 new CACs, along with the formalization of existing relationships with current CACs, will expand access to CACs for children in Pennsylvania. Approximately 95% of children will be able to access a CAC within a one-hour drive.

New Regional CACs

All counties served by new regional CACs will develop their own county-based MDT comprised of the local child welfare agency, the District Attorney's Office, and all law enforcement agencies within the county. These MDTs will utilize the infrastructure, forensic interviewer(s), and medical provider(s) of the new regional CAC. It is hoped that each county will be able to meet capacity for mental health services and victim advocacy in their own communities, rounding out the NCA required disciplines.

1. Location: Schuylkill County
Counties Served: Schuylkill, Columbia, and Carbon Counties

Based on the results of the study, a new Regional CAC serving Schuylkill, Columbia, and Carbon Counties should be established in the Pottsville area. This CAC would respond to between **105 and 153** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 5. Local Snapshot for Schuylkill, Columbia, and Carbon Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Schuylkill County	Yes	No	Yes
Columbia County	No	No	No
Carbon County	No	No	Yes

Table 5 is intended to provide a snapshot of the resources for this CAC. Though Schuylkill County is listed as having a Pediatric Child Abuse Expert, this indicates only that a pediatrician who has completed the SCAN program is working in Schuylkill County. Information about this pediatrician can be found in Appendix II. Schuylkill and Carbon Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

2. Location: Venango County
Counties Served: Venango, Mercer, Forest, and Clarion Counties

Based on the results of the study, a new Regional CAC serving Venango, Mercer, Forest, and Clarion Counties should be established in the Franklin area. This CAC would respond to between **96 and 185** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 6. Local Snapshot for Mercer, Venango Forest and Clarion Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Mercer County	No	No	Yes
Venango County	No	No	Yes
Forest County	No	No	Yes
Clarion County	No	No	Yes

Table 6 is intended to provide a snapshot of the resources for this CAC. Mercer, Venango, Forest and Clarion are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

3. Location: Cambria County
Counties Served: Cambria, Blair, Somerset and Bedford Counties

Based on the results of the study, a new Regional CAC serving Cambria, Blair, Somerset, and Bedford Counties should be established in Cambria County. If it considered appropriate by the community, this CAC could be located in Cresson which would provide the most geographically central location. If the county stakeholders don't feel that Cresson has adequate infrastructure to host a CAC, it should be located in the Ebensburg area. This CAC would respond to between **125 and 224** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 7. Local Snapshot for Cambria, Blair, Somerset and Bedford Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Cambria County	Yes	No	Yes
Blair County	No	No	Yes
Somerset County	No	No	Yes
Bedford County	No	No	Yes

Table 6 is intended to provide a snapshot of the resources for this CAC. Though Cambria County is listed as having a Pediatric Child Abuse Expert, this indicates only that a pediatrician who has completed the SCAN program is working in Cambria County. Information about this pediatrician can be found in Appendix II. Cambria, Blair, Somerset and Bedford are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

4. Location: Lycoming County
Counties Served: Lycoming, Union, Montour, and Clinton Counties

Based on the results of the study, a new Regional CAC serving Lycoming, Union, Montour, and Clinton Counties should be established in Lycoming County. This CAC should be established in the Williamsport area. This CAC would respond to between **82 and 157** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 8. Local Snapshot for Lycoming, Union, Montour and Clinton Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Lycoming County	No	Yes	Yes
Union County	No	No	Yes
Montour County	Yes	No	No
Clinton County	No	No	Yes

Table 8 is intended to provide a snapshot of the resources for this CAC. Though Montour County is listed as having a Pediatric Child Abuse Expert, this indicates only that a pediatrician who has completed the SCAN program is working in Montour County. Information about the Montour County pediatrician can be found in Appendix II. All four counties have previously utilized the medical services of *The CAC of the Central Susquehanna Valley* in Northumberland County. *The CAC of the Central Susquehanna Valley* is hospital-based, and could potentially serve as a medical resource for the new CAC. Lycoming County also has a SANE-P Program. Lycoming, Union, and Clinton Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

5. Location: Wayne County
Counties Served: Wayne, Pike and Monroe Counties

Based on the results of the study, a new Regional CAC serving Wayne, Pike, and Monroe Counties should be established in Wayne County. This CAC could be established in the Honesdale area. This CAC would respond to between **83 and 139** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 9. Local Snapshot for Wayne, Pike, and Monroe Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Wayne County	No	No	Yes
Pike County	No	No	Yes
Monroe County	No	No	No

Table 9 is intended to provide a snapshot of the resources for this CAC. Wayne and Pike Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

6. Location: Mifflin County
Counties Served: Mifflin, Juniata, Perry, Snyder, and Huntingdon Counties

Based on the results of the study, a new Regional CAC serving Mifflin, Juniata, Perry, Snyder, and Huntingdon Counties should be established in Mifflin County. This CAC should be established in the Lewistown area. This CAC would respond to between **65 and 119** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 10. Local Snapshot for Mifflin, Juniata, Perry, Snyder, and Huntingdon Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Mifflin County	No	No	Yes
Juniata County	No	No	Yes
Perry County	No	No	No
Snyder County	No	No	No
Huntingdon County	No	No	Yes

Table 10 is intended to provide a snapshot of the resources for this CAC. Though there are no pediatric child abuse experts in these counties, all five counties have previously utilized the medical services of *The Children's Resource Center* in Dauphin County. *The Children's Resource Center* is hospital-based, and could potentially serve as a medical resource for the new CAC. Mifflin and Juniata Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

7. Location: Clearfield County
Counties Served: Clearfield and Elk Counties

Based on the results of the study, a new Regional CAC serving Clearfield and Elk Counties should be established in Clearfield County. This CAC should be established in the Clearfield area. This CAC would respond to between **28 and 55** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need to approach a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale. In this case, although a small number of cases are predicted, any other option would have significantly increased the driving time for both families and MDT members.

Table 11. Local Snapshot for Clearfield and Elk

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Clearfield County	No	No	Yes
Elk County	No	No	Yes

Table 11 is intended to provide a snapshot of the resources for this CAC. Clearfield and Elk Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers in their counties. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

8. Location: Armstrong County
Counties Served: Armstrong and Butler Counties

Based on the results of the study, a new Regional CAC serving Armstrong and Butler Counties should be established in Armstrong County. This CAC should be established in the Kittanning area. This CAC would respond to between **77 and 140** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need for a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale.

Table 12. Local Snapshot for Armstrong and Butler Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Armstrong County	No	No	Yes
Butler County	No	Yes	No

Table 12 is intended to provide a snapshot of the resources for this CAC. Butler County has a SANE-P program. Armstrong County is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

9. Location: Susquehanna County
Counties Served: Susquehanna and Wyoming Counties

Based on the results of the study, a new Regional CAC serving Susquehanna and Wyoming Counties should be established in Susquehanna County. This CAC should be established in the Montrose area. This CAC would respond to between **18 and 39** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need to approach a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale. In this case, although a small number of cases are predicted, any other option would have significantly increased the driving time for both families and MDT members.

Table 13. Local Snapshot for Susquehanna and Wyoming Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Susquehanna County	No	No	Yes
Wyoming County	No	No	No

Table 13 is intended to provide a snapshot of the resources for this CAC. Susquehanna County is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

10. Location: Franklin County
Counties Served: Franklin and Fulton Counties

Based on the results of the study, a new Regional CAC serving Franklin and Fulton Counties should be established in Franklin County. This CAC should be established in the Chambersburg area. This CAC would respond to between **43 and 66** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This location was selected for the CAC based on the GIS spatial optimization, as well as the need to approach a minimum number of investigations to sustain the skillsets of forensic interviewers and medical providers, and to meet economies of scale. In this case, although a small number of cases are predicted, any other option would have significantly increased the driving time for both families and MDT members.

Table 14. Local Snapshot for Franklin and Fulton Counties

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Franklin County	No	No	Yes
Fulton County	No	No	Yes

Table 14 is intended to provide a snapshot of the resources for this CAC. Franklin and Fulton Counties are designated MHPSAs, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in these counties can be found in Appendix III, and may be useful in planning this CAC.

New Countywide CACs

1. Location: Cumberland County

A new CAC should be established in Cumberland County serve that county's cases. This new CAC should be located in the Carlisle area. This CAC would respond to between **76 and 107** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to support its own countywide CAC because the estimated projected number of cases indicates that a single countywide CAC would be sustainable and meet requirements for maintaining professional skills and economies of scale. However, Cumberland County does have a strong existing relationship with *The Children's Resource Center* in Dauphin County. If the community feels it is appropriate, it may instead seek to establish a formal relationship with *The Children's Resource Center in Dauphin County.*

Table 15. Local Snapshot for Cumberland County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Cumberland County	No	Yes	Yes

Table 15 is intended to provide a snapshot of the resources for this CAC. Cumberland has a SANE-P Program. Cumberland is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning this CAC.

2. Location: Northampton County

A new CAC should be established in Northampton County serve that county's cases. This new CAC should be located in the Easton area. This CAC would respond to between **245 and 350** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. With this volume of projected cases, Northampton County has the largest number of projected cases in any currently unserved county in Pennsylvania and can easily sustain its own CAC

Table 16. Local Snapshot for Northampton County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Northampton County	Yes	No	No

Table 16 is intended to provide a snapshot of the resources for this CAC. Though Northampton County is listed as having a Pediatric Child Abuse Expert, this indicates only that a pediatrician who has completed the SCAN program is working in Northampton County. Information about this provider can be found in Appendix II. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning this CAC.

New Formal Affiliations with Existing Accredited CACs

1. County: Tioga County
Served By: *The Children's House* in Bradford County

Based on the results of the study, Tioga County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *The Children's House* in Bradford County. This could be done in one of two ways. If there is capacity and interest, *The Children's House* could establish an accredited satellite location in Tioga County. Otherwise, the Tioga County MDT could travel to Bradford to utilize their infrastructure, forensic interviewer(s), and medical exams. Tioga County would account for between **14 and 36** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *The Children's House* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 17. Local Snapshot for Tioga County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Tioga County	No	No	Yes

Table 17 is intended to provide a snapshot of the resources for this County. Tioga is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

2. County: Sullivan County
Served By: *The Children's House* in Bradford County

Based on the results of the study, Sullivan County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *The Children's House* in Bradford County. This could be done in one of two ways. If there is capacity and interest, *The Children's House* could establish an accredited satellite location in Sullivan County. Otherwise, the Sullivan County MDT could travel to Bradford to utilize their infrastructure, forensic interviewer(s), and medical exams. Sullivan County would account for **up to 2** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *The Children's House* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 18. Local Snapshot for Sullivan County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Sullivan County	No	No	Yes

Table 18 is intended to provide a snapshot of the resources for this County. Sullivan is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

3. County: Crawford County
Served By: *The Bradley H. Foulk Children's Advocacy Center of Erie County*

Based on the results of the study, Crawford County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *The Bradley H. Foulk Children's Advocacy Center of Erie County.* This could be done in one of two ways. If there is capacity and interest, *The Bradley H. Foulk Children's Advocacy Center* could establish an accredited satellite location in Crawford County. Otherwise, the Crawford County MDT could travel to Erie to utilize their infrastructure, forensic interviewer(s), and medical exams. Crawford County would account for between **72 and 95** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *The Bradley H. Foulk Children's Advocacy Center of Erie County* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 19. Local Snapshot for Crawford County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Crawford County	No	No	Yes

Table 19 is intended to provide a snapshot of the resources for this County. Crawford is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

4. County: Potter County
Served By: *Children's Advocacy Center of McKean County*

Based on the results of the study, Potter County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *Children's Advocacy Center of McKean County*. This could be done in one of two ways. If there is capacity and interest, *Children's Advocacy Center of McKean County* could establish an accredited satellite location in Potter County. Otherwise, the Potter County MDT could travel to McKean to utilize their infrastructure, forensic interviewer(s), and medical exams if their local Pediatric Child Abuse Expert is unable to accommodate CAC needs. Potter County would account for between **5 and 16** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *Children's Advocacy Center of McKean County* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 20. Local Snapshot for Potter County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Potter County	Yes	No	Yes

Table 20 is intended to provide a snapshot of the resources for this County. Though Potter County is listed as having a Pediatric Child Abuse Expert, this indicates only that a pediatrician who has completed the SCAN program is working in Potter County. Information about this provider can be found in Appendix II. Potter is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

5. County: Cameron County
Served By: *Children's Advocacy Center of McKean County*

Based on the results of the study, Cameron County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *Children's Advocacy Center of McKean County*. This could be done in one of two ways. If there is capacity and interest, *Children's Advocacy Center of McKean County* could establish an accredited satellite location in Cameron County. Otherwise, the Cameron County MDT could travel to McKean to utilize their infrastructure, forensic interviewer(s), and medical exams if their local Pediatric Child Abuse Expert is unable to accommodate CAC needs. Cameron County would account for **up to 3** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *Children's Advocacy Center of McKean County* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 21. Local Snapshot for Cameron County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Cameron County	No	No	Yes

Table 21 is intended to provide a snapshot of the resources for this County. Cameron is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

6. County: Warren County
Served By: *The Bradley H. Foulk Children's Advocacy Center of Erie County*

Based on the results of the study, Warren County should form its own MDT and participate in the full complement of CAC services through its existing relationship with *The Bradley H. Foulk Children's Advocacy Center of Erie County.* This could be done in one of two ways. If there is capacity and interest, *The Bradley H. Foulk Children's Advocacy Center* could establish an accredited satellite location in Warren County. Otherwise, the Warren County MDT could travel to Erie to utilize their infrastructure, forensic interviewer(s), and medical exams, if it does not utilize its local SANE-P Program. Warren County would account for between **18 and 29** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *The Bradley H. Foulk Children's Advocacy Center of Erie County* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 22. Local Snapshot for Warren County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Warren County	No	Yes	Yes

Table 22 is intended to provide a snapshot of the resources for this County. Warren County has a SANE-P Program. Warren is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

7. County: Greene
Served By: *A Children's Place at Mercy* (Allegheny County) through its Accredited Satellite CAC in Washington County

A Child's Place at Mercy in Allegheny County is engaged in active discussions with Greene County to provide CAC services. We recommend that, if possible, Green County utilize the accredited Satellite CAC of *A Child's Place at Mercy* located in Washington County, shortening the driving time for Greene County residents. Greene County alone would account for approximately **9 to 17** CPS investigations of sexual abuse per year. These numbers do not take into account GPS cases, law-enforcement only cases, or increasing cases due to revisions to Pennsylvania laws that may go into effect. This county was selected to utilize its existing relationship with *A Child's Place at Mercy* because it cannot sustain a CAC with so few cases and it is geographically too isolated to participate in a new Regional CAC.

Table 23. Local Snapshot for Greene County

County	Pediatric Child Abuse Expert	SANE-P Program	M-HPSA
Greene County	No	No	Yes

Table 23 is intended to provide a snapshot of the resources for this County. Greene is a designated MHPSA, meaning that they might face a significant challenge in finding mental health providers. Age and gender breakdowns for cases in this county can be found in Appendix III, and may be useful in planning services.

Special Notes

Lebanon County will be served by a new satellite of *The Children's Resource Center* in Dauphin County as of July, 2014. Due to this development, it has been excluded from this analysis.

A new CAC in **Centre County** is due to open its doors very soon. As such, it has also been excluded from this analysis.

However, case data for these and all other counties throughout the state, as well as snapshot data are available in the appendices of this report.

Summary of Recommendations and Special Considerations

In sum, this report recommends the establishment of:

- 10 New Regional CACs
- 2 New Countywide CACs
- 7 Counties establishing formal affiliations with existing accredited CACs

New Regional CACs

1. Location: Schuylkill County (Pottsville)
   - Counties Served: Schuylkill, Columbia, and Carbon
   - 105 to 153 CPS Investigations
2. Location: Venango County (Franklin)
   - Counties Served: Venango, Mercer, Forest, and Clarion
   - 96 to 185 CPS Investigations
3. Location: Cambria County (Cresson or Ebensburg)
   - Counties Served: Cambria, Blair, Somerset and Bedford
   - 125 to 224 CPS Investigations
4. Location: Lycoming County (Williamsport)
   - Counties Served: Lycoming, Union, Montour, and Clinton
   - 82 to 175 CPS Investigations
5. Location: Wayne County (Sterling or Honesdale)
   - Counties Served: Wayne, Pike and Monroe Counties
   - 83 to 139 CPS Investigations
6. Location: Mifflin County (Lewistown)
   - Counties Served: Mifflin, Juniata, Perry, Snyder, and Huntingdon
   - 65 to 119 CPS Investigations
7. Location: Clearfield County (Clearfield)
   - Counties Served: Clearfield and Elk Counties
   - 28 to 55 CPS Investigations
8. Location: Armstrong County (Kittanning)
   - Counties Served: Armstrong and Butler Counties
   - 77 to 140 CPS Investigations
9. Location: Susquehanna County (Montrose)
   - Counties Served: Susquehanna and Wyoming Counties
   - 18 to 39 CPS Investigations
10. Location: Franklin County (Chambersburg)
    - Counties Served: Franklin and Fulton Counties
    - 43 to 66 CPS Investigations

New Countywide CACs

1. Location: Cumberland County (Bridgeton)
   - 76 to 107 CPS Investigations
2. Location: Northampton County (Easton)
   - 245 to 350 CPS Investigations

New Formal Affiliations with Existing Accredited CACs

1. County: Tioga County
   - Served By: *The Children's House* in Bradford County
2. County: Sullivan County
   - Served By: *The Children's House* in Bradford County
3. County: Crawford County
   - Served By: *The Bradley H. Foulk Children's Advocacy Center* (Erie)
4. County: Potter County
   - Served By: *Children's Advocacy Center of McKean County*
5. County: Cameron County
   - Served By: *Children's Advocacy Center of McKean County*
6. County: Warren County
   - Served By: *The Bradley H. Foulk Children's Advocacy Center* (Erie)
7. County: Greene County
   - Served By: *A Children's Place at Mercy* (Allegheny County) through its Accredited Satellite CAC in Washington County

It should be noted that many existing CACs have been valiantly supporting surrounding counties in an effort to bring services to underserved areas. Though these efforts are commendable, and many CACs expressed interest in expanding, in many cases it will be more appropriate for new CACs to be developed, as described in the recommendations.

Some small counties may want to establish individual countywide CACs. We recommend against this, because most counties that currently do not have CACs do not see enough child sexual abuse cases to sustain the infrastructure of a CAC nor maintain the skill sets of forensic interviewers and medical providers. However, it is highly encouraged that each county move toward developing a strong MDT with representation from child welfare, the District Attorney's office, and law enforcement, so that these MDTs may utilize the new Regional CACs.

The importance of being in compliance the NCA's standards has been described many times throughout this report. In keeping with this, it is recommended that all new CACs and satellites actively pursue accreditation. Both the Northeast Regional Children's Advocacy Center (NRCAC) and the Pennsylvania Chapter of Children's Advocacy Centers and Multidisciplinary Teams dedicate significant resources to the development of new CACs, including training, support, and mentorship, with the goal of a full complement of nationally accredited centers.

Planning

Starting a New Child Advocacy Center

Communities must carefully plan in order to successfully launch a new child advocacy center. Without a strategic process for engagement and planning, initiatives can fall short of meeting the goals of the child advocacy center and fail to achieve the necessary requirements for accreditation. Therefore, it is recommended that the first year is dedicated to community planning and MDT team and center development. This will serve to set the stage for a fully functioning and successful child advocacy center that meets the complex needs of child victims and is best positioned to meet national standards of practice.

Hosting a New Child Advocacy Center

Once a community/county, or in the case of a regional center, a group of communities or counties, decide that they are interested in opening a child advocacy center, a decision needs to be reached on who will host it. Child advocacy centers can be established as private non-profit organizations, associated with a hospital, under the umbrella of an existing not-for-profit entity, or affiliated with a governmental agency. While most child advocacy centers are developed as independent 501(c)3 non-profit agencies, all models are acceptable under NCA standards. A 2011 annual survey reported that 62% of child advocacy centers were independent non-profit agencies, 15% affiliated with a governmental entity, 13% under a larger umbrella non-profit, 9% hospital-affiliated, and 1% other. (http://www.nationalcac.org/images/pdfs/CALiO/annual-survey-current-trends-2012.pdf)

Communities to need to weigh the advantages and disadvantages of each and determine which fit is best for their particular needs and resources while assuring that the NCA standards for organizational capacity are met.

Community Development

The principles behind a child advocacy center are rooted in a multidisciplinary, collaborative model of practice. The mandatory partners, including law enforcement, child welfare, and prosecution, are typically "siloed" entities, making decisions independently rather than collaboratively. The child advocacy center model presents a significant shift in approach, and can be met with resistance by potential community partners who may be less than comfortable with a collaborative model or reluctant to change how they have historically investigated cases of child abuse.

Engaging community partners in this shift in practice is key to the model's success. Without buy-in from all entities, child advocacy centers face significant challenges. It is critical for partners to understand the approach, see how the model supports their individual mandates, and agree to work collaboratively across systems for the benefit of child victims. Memoranda of Understanding (MOUs) are a required component and can only be promulgating after the newly formed partnership reaches consensus. It cannot be stressed enough how important it is for communities to invest the time and attention needed for collaborative development prior to opening the child advocacy center's doors.

Child advocacy centers develop their own community protocols for the investigation of cases of child abuse. Members of the multidisciplinary team (MDT) determine eligibility for services, agree on a referral process, and develop protocols for team investigation of cases. Team members need to understand and acknowledge the individual roles and responsibilities of MDT partners as well as agree on the collaborative process.

This process is even more complex for regionalized child advocacy centers. When new CACs are developed to serve multiple communities, each community may choose to form and operationalize its own MDT, forming a partnership in a regional center that can offer a shared infrastructure and comprehensive services. For example, as recommended in this report, multiple smaller counties may each develop their own community-based multidisciplinary team consisting of the district attorney's office, county child welfare agency, and all law enforcement agencies within the county, while sharing other CAC resources including forensic interviewers, medical providers, child-friendly facility, and agency infrastructure. In this instance, not only would each MDT work to develop team relationships and protocols, all of the teams would need to come together to develop models of collaboration under the umbrella of the regional center. Structuring governance and fiduciary responsibility and establishing policies and protocols can be even more challenging in this model.

Costs of Opening a New Child Advocacy Center

Facility

NCA standards require child advocacy centers to be child-friendly facilities. To achieve this, CACs must provide waiting rooms that are comfortable for children who are awaiting interviews, with separate entrances for families and MDT members. Interview rooms must be developmentally appropriate for victims and offer either one-way mirrors for observation by team members or video feed into a nearby conference room. Soundproofing in the facility is critical to assure the privacy of children as well as help them feel safe. The facility must also be a perpetrator-free environment. New centers should build the cost of renovations into their planning budgets.

The center's location must be easily accessible to children and families while simultaneously offering privacy and anonymity. In determining location, convenience for MDT members should also be taken into consideration to promote full participation in forensic interviews and subsequent case staffings. There needs to be adequate parking available. The location of the center within the community must be one that families find safe and comfortable at all hours.

New child advocacy centers must outfit child-friendly waiting rooms, interview rooms (preferably one for young children and a second for older children and adolescents), a multidisciplinary team conference room, a private space to meet with family members, and staff offices. Rest room facilities and snacks for children should be convenient to the waiting area.

New Child Advocacy Center Staffing

Child advocacy centers require a dedicated administrator who will represent the CAC in the larger community, work on developing CAC funding, convene MDT partners, take the lead on developing protocols, maintain personnel responsibility, and provide fiscal oversight. This individual will need to be brought on board as soon as feasible as part of the planning process.

Child advocacy center staff must meet the minimum requirements for experience and training as delineated in the standards. Ongoing peer review and continuing education is also required for specialized staff.

Forensic interviewers must complete NCA-approved initial training as well as undergo extensive skills training first observing and then, under mentorship, conducting forensic interviews in order to be qualified to serve as forensic interviewers. This extensive training must be completed prior to the child advocacy center accepting referrals. Completion of a course or attendance at a conference is not in itself sufficient to train a forensic interviewer.

Child advocacy centers must have staff to meet and greet families, schedule appointments, and monitor the waiting room. These duties can be supplemented by clerical and data entry support and record maintenance.

NCA standards require victim advocacy. This may be accomplished by a dedicated CAC staff member or in partnership with an existing community-based organization, as long as the standards of practice are met.

Medical and behavioral health components may be provided by either CAC staff or through formal community-based partnerships, as long as the providers of service meet the criteria for training, experience, and continuing education delineated in NCA standards.

Communication and Technology Requirements

Data tracking is a requirement for child advocacy centers. New centers need to identify and plan for data tracking which may be met by the optional purchase of NCATrak, the National Children's Alliance's data tracking system developing specifically for CAC use. As in any organization, a plan for data collection is critical to demonstrate program utilization and determine outcomes.

Technology support is critical to the interview process. CAC practice includes video recording of forensic interviews. This process provides unequivocal documentation of the interview process, creates evidence for court proceedings, and prevents children from having to tell their story again which may result in secondary trauma. New child advocacy centers need to invest in a video recording system that can meet the specific needs of a CAC model. Any recording system must also have capacity for a closed circuit video display feed so that MDT members can observe the interview in a separate conference room. The costs to purchase, install, and maintain this equipment needs to be built into CAC budgets.

In addition to recording equipment and closed circuit video display, start-up costs also include telephone systems, computer, fax and copying equipment, internet access for staff and guests, and conference call and videoconferencing equipment. Additional needs may include equipment to copy video recordings and DVD encryption equipment.

Final Consideration

The recommendations in this report are supported by research, including quantitative and qualitative analysis. But, in the long run, CACs are comprised of people, not numbers. If collaborative relationships cannot be established among prospective MDT members, the CAC will be unable to achieve its goal, of improving the investigation of and services to victims of child sexual abuse.

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Standards for Accredited Members
Revised 2011

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NATIONAL CHILDREN'S ALLIANCE

STANDARDS FOR ACCREDITED MEMBERS

MULTIDISCIPLINARY TEAM (MDT)

STANDARD: A MULTIDISCIPLINARY TEAM FOR RESPONSE TO CHILD ABUSE ALLEGATIONS INCLUDES REPRESENTATION FROM THE FOLLOWING:

- LAW ENFORCEMENT
- CHILD PROTECTIVE SERVICES
- PROSECUTION
- MEDICAL
- MENTAL HEALTH
- VICTIM ADVOCACY
- CHILDREN'S ADVOCACY CENTER

Rationale

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

Six disciplines; law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, together with CAC staff, comprise the core MDT. Some CACs, including those in small, rural communities, may employ one person to fill multiple roles. For example, the CAC Director may also serve as

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

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

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

CRITERIA

Essential Components

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

Written agreements formalize interagency cooperation and commitment to MDT/CAC practice and policy ensuring continuity of practice even when personnel, heads of departments, and elected officials change. Written agreements may be in different forms such as memoranda of understanding (MOUs), protocols and/or guidelines, and are signed by the leadership of participating agencies (e.g. police chiefs, prosecuting attorney, agency department heads, supervisors, etc.) or their designees. These documents should be developed with input from the MDT, reviewed annually and updated as needed to reflect current practice and current agency leadership.

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

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

C. 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.

Effective communication and information sharing happen at many points in a case. Both are key dynamics for MDTs in order to minimize duplicative efforts, enhance decision making, and maximize the opportunity for children and caretakers to receive the services they need. The CAC/MDT's written documents must delineate how pertinent information is communicated and how confidential information is protected. Most professions represented on the MDT have legal, ethical and professional standards of practice with regard to confidentiality, but they may differ among disciplines. States may

have laws such as the Health Information Portability and Accountability Act (HIPAA) that govern this practice. The CAC/MDT must create written confidentiality and information sharing policies that specifically apply to the MDT, staff and volunteers.

Rated Criteria

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

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

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

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

CULTURAL COMPETENCY AND DIVERSITY

STANDARD: CULTURALLY COMPETENT SERVICES ARE ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND COORDINATED WITH THE MULTIDISCIPLINARY TEAM RESPONSE.

Rationale

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

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

CRITERIA

Essential Components

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

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

strategies are developed to ensure that CAC services are delivered to those children and families in need.

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

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

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

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

It is the responsibility of the CAC and MDT members to know the ethnic and cultural background of the child being served and what languages they speak and/or comfortable speaking. From the moment of first contact with the child and family, the CAC and MDT should identify any cultural or linguistic issues that may affect service delivery. Understanding the child and family's background will help to: effectively elicit relevant history; understand decisions made by the child and family; understand the perception of the abuse and attribution of responsibility made by the child, family and community; understand the family's degree of acculturation and comprehension of laws; address any religious or cultural beliefs which may affect the disclosure; and recognize the impact of prior experience with police and government authorities both in this country and in other countries of origin. With knowledge and preparation, the CAC and MDT can structure services to obtain the most complete and accurate information and more effectively interpret and respond to the child and family's needs.

Rated Criteria

D. The CAC engages in community outreach with underserved populations.

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

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

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

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

In order to serve a community in a culturally competent manner, a CAC must have a cultural competency plan. Such a plan should include several components: community assessment, goals, strategies, implementation and evaluation. Included in the plan's goals and strategies may be things such as formal and informal training for staff, MDT members, volunteers, and board members; production and distribution of informational materials; outreach to underserved populations; protocol and policy changes; innovative recruitment practices; etc. An evaluation component is necessary to determine the success of the plan and implement any needed changes.

FORENSIC INTERVIEWS

STANDARD: FORENSIC INTERVIEWS ARE CONDUCTED IN A MANNER THAT IS LEGALLY SOUND, OF A NEUTRAL, FACT FINDING NATURE, AND ARE COORDINATED TO AVOID DUPLICATIVE INTERVIEWING.

Rationale

Forensic interviews create an environment that provides the child an opportunity to talk to a trained professional regarding what the child has experienced or knows that resulted in a concern about abuse. Forensic interviews are typically the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution, and may be the beginning of the road toward healing for many children and families. The manner in which a child is treated during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to the intervention process and/or criminal justice system. Quality interviewing involves: an appropriate, neutral setting; effective communication among MDT members; employment of legally sound interviewing techniques; and the selection, training and supervision of interviewers.

The purpose of a forensic interview in a Children's Advocacy Center is to obtain a statement from a child, in a developmentally and culturally sensitive, unbiased and fact-finding manner that will support accurate and fair decision making by the involved multidisciplinary team in the criminal justice and child protection systems. Forensic interviews should be child-centered and coordinated to avoid duplication. When a child is unable or unwilling to provide information regarding any concern about abuse, other interventions to assess the child's experience and safety are required.

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

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

CRITERIA

Essential Components

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

The CAC must demonstrate that the forensic interviewer(s) meets 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.

A system must be in place to provide initial training on forensic interviewing for anyone conducting a forensic interview at the CAC. Many CACs use a combination of MDT members and CAC staff to fulfill this role. While many of the members of the MDT may have received interview training, forensic interviewing of alleged victims of child abuse, and in the context of an MDT response, is considered specialized interviewing and thus requires additional specialized training.

B. 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.

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

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

Following research-based guidelines will help ensure a sound process. These guidelines as recognized by the members of the MDT should be monitored over time to ensure that they reflect current day practice. Guidelines should be developed and followed to create an interview environment that enhances free recall, minimizes interviewer influence and gathers information needed by all the MDT members involved to avoid duplication of the interview process.

D. MDT members with investigative responsibilities are present for the forensic interview(s).

MDT members, as defined by the needs of the case, are routinely present for the forensic interview. This practice provides each MDT member access to the information necessary to fulfill their professional role and ensures that their respective informational needs are met. Members may include local, state, federal or tribal child protective services, law enforcement and prosecution; they may vary based on case assignments but these parties are routinely present. Observation of interviews does not have to be limited to these parties; the unique needs of the case may require others to observe.

E. Forensic interviews are routinely conducted at the CAC.

Forensic interviews of children, as defined in the CAC/MDT's written documents, will be conducted at the CAC rather than at other settings. The CAC is the setting where the MDT is best equipped to meet the child's needs during the interview.

On rare occasions when interviews take place outside the CAC, steps must be taken to utilize appropriate forensic interview guidelines. Some CACs have established other interview spaces such as a satellite office. MDT members must assure the child's comfort and privacy and protection from alleged offenders or others who may unduly influence the child.

Rated Criteria

F. 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.***

The CAC/MDT's written documents should outline in writing how these tenets are assured. In doing so, the documents provide for a defined, proactive process for decision making in regards to the forensic interview.

G. 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. 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.

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.

H. The CAC/MDT coordinate information gathering whether through history taking, assessment or forensic interview(s) to avoid duplication.

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

VICTIM SUPPORT AND ADVOCACY

STANDARD: VICTIM SUPPORT AND ADVOCACY SERVICES ARE ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND THEIR NON-OFFENDING FAMILY MEMBERS AS PART OF THE MULTIDISCIPLINARY TEAM RESPONSE.

Rationale

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

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

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

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

- crisis intervention and support at all stages of investigation and prosecution
- attendance and/or coordination of interviews and/or case review
- greeting and orientation of children to the CAC
- provision of education about the coordinated, multidisciplinary response
- providing updates to the family on case status, continuances, dispositions, sentencing, offender release from custody

- assessment of the child's/family's attitudes and feelings about participation in the investigation/prosecution
- provision of court education/support/accompaniment
- providing tours of the courthouse/courtroom
- securing transportation to interviews, court, treatment and other case-related meetings
- assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, crime victims compensation, transportation, public assistance etc.)
- providing referrals for mental health and medical treatment, if not provided at the CAC.

CRITERIA

Essential Components

A. 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.

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

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

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

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

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

D. The CAC/MDT's written documents include availability of victim support and advocacy services for all CAC clients.

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

Rated Criteria

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

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

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

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

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

MEDICAL EVALUATION

STANDARD: SPECIALIZED MEDICAL EVALUATION AND TREATMENT SERVICES ARE ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND COORDINATED WITH THE MULTIDISCIPLINARY TEAM RESPONSE.

Rationale

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

A medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate history is essential in making the medical diagnosis and determining appropriate treatment of child abuse. Recognizing that there are several acceptable models that can be used to obtain a history of the abuse allegations and that forensic interview techniques are specialized skills that require training, information gathering must be coordinated with the MDT. Because children learn early the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators.

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

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

CRITERIA

Essential Components

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

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

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

The criteria outlined above apply equally to all examiners. Nurses must practice within the scope of their applicable state Nurse Practice Acts.

B. 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 can be provided in a number of ways. Some CACs have a medical provider that comes to the center on a scheduled basis while in other communities the child is referred to a medical clinic or health care agency for this service. CACs need not be the provider of primary care but CACs must have protocols in place outlining the linkages to primary care and other needed healthcare services.

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

In many communities, the cost of the medical evaluation is covered by public funds. In other settings, limited public funding requires that those who can pay or are insured cover the cost of their own exam, or apply for reimbursement through victim compensation. In either scenario, ability to pay should never be a factor in determining who is offered a medical evaluation.

D. The CAC/MDT's written documents include access to appropriate medical evaluation and treatment for all CAC clients.

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

Rated Criteria

E. The CAC/MDT's written documents include:

- ***the circumstances under which a medical evaluation is recommended;***
  All children who are suspected victims of child sexual abuse should be offered a medical evaluation. The timing and detail of the evaluation should be based on specific screening criteria developed by qualified

medical providers or by local multidisciplinary teams which include qualified medical representation.

The CAC should have protocols in place to identify those children in need of medical care for suspected or possible injury or illness resulting from the abuse or unmet medical needs.

- ***the purpose of the medical evaluation;***
  The purposes of a medical evaluation in suspected child abuse include:
  - Help ensure the health, safety, and well-being of the child;
  - Diagnose, document, and address medical conditions resulting from abuse;
  - Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions;
  - Diagnose, document, and address medical conditions unrelated to abuse;
  - Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary; and
  - Reassure and educate the child and family.

- ***how the medical evaluation is made available;***
  CACs differ in their practices of how the medical evaluation is made available. The MDT's written protocol or agreement must include qualified medical input to define the referral process and how, when, and where the exam is made available.

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

  Reasons for emergency evaluation include, but are not limited to:
  - Medical intervention is needed emergently to assure the health and safety of the child;
  - The alleged assault may have occurred within the previous 72 hours (or other state-mandated time interval) and the transfer of trace evidence may have occurred which will be collected for later forensic analysis;
  - The need for emergency contraception;
  - The need for post-exposure prophylaxis for STI (sexually transmitted infections) including HIV;
  - The child complains of pain in the genital or anal area;

- There is evidence or complaint of anogenital bleeding or injury; and
- The child is experiencing significant behavioral or emotional problems and needs evaluation for possible suicidal ideation/plan.

- ***how multiple medical evaluations are limited;***
  Multiple evaluations should be avoided by identifying the best location and timing for the evaluation. This often requires initial conversations with emergency departments and primary care providers to develop a process for referral to the specialized medical provider as defined by the needs of the child. In addition, exams should be performed by experienced examiners and photodocumented to minimize repeat examinations.

- ***how medical care is documented;***
  All medical records are also legal documents. The medical history and physical examination findings must be carefully and thoroughly documented in the medical record. Diagnostic-quality photographic documentation using still and/or video documentation of examination findings is the standard of care, and is particularly important if the examination findings are thought to be abnormal. Photographic documentation allows for peer review, for obtaining an expert or second opinion, and may also obviate the need for a repeat examination of the child.

  Detailing procedures for the documentation and preservation of evidence (labeling, processing and storing) in written protocols and agreements can help to assure the quality and consistency of medical evaluations. Such protocols can also serve as a "checklist" and training document for new examiners. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

- ***how the medical evaluation is coordinated with the MDT in order to avoid duplication of interviewing and history taking****;*
  Coordination with the MDT is important both in reducing duplicative interviewing and utilizing information from the medical evaluation to assure appropriate follow-up treatment and referrals, often coordinated by other MDT members.

  Medical diagnosis and treatment of child abuse includes obtaining a medical history. Information needs to be gathered from the parent or other caretakers as well as from the child regarding past medical history and signs or symptoms that may be relevant to the medical assessment.

- ***procedures are in place for medical intervention in cases of suspected physical abuse and maltreatment, if applicable.*** Many CACs provide medical evaluation of child physical abuse and neglect in addition to sexual abuse. These CACs must have written protocols and agreements for all types of medical evaluations performed. CACs that provide medical evaluations for sexual abuse but not specifically for physical abuse need written procedures for medical intervention when there are also physical injuries, including how to obtain treatment for injuries and the management of emergency or life-threatening conditions that may become evident during a sexual assault exam.

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

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

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

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

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

G. 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.

The medical evaluation often raises significant anxiety for children and their families, usually due to misconceptions about how the exam is conducted and what findings, or lack of findings, mean. In many CAC settings, the client is

introduced to the exam by non-medical personnel. Therefore, it is essential for MDT members and CAC staff to be trained about the nature and purpose of a medical evaluation so that they can competently respond to common questions, concerns and misconceptions.

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

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

MENTAL HEALTH

STANDARD: 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.

Rationale

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

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

CRITERIA

Essential Components

A. 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)

B. 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.

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

- crisis intervention services
- trauma-specific assessment including full trauma history
- use of standardized measures (assessment tools) initially and periodically
- family/caregiver engagement
- individualized treatment plan that is periodically re-assessed
- individualized evidence-informed treatment appropriate for the children and family seen
- referral to other community services as needed
- clinical supervision

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

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

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

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

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

Rated Criteria

E. The CAC/MDT's written documents include:

- ***the role of the mental health professional on the MDT including provisions for attendance at case review;***

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

- ***provisions regarding sharing relevant information with the MDT while protecting the clients' right to confidentiality***

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

- ***how the forensic process is separate from mental health treatment***

The forensic process of gathering evidentiary information and determining what the child may have experienced to account for the allegation is separate from mental health treatment. Mental health treatment is a clinical process designed to assess and mitigate the long term adverse impacts of trauma or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

F. 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

G. 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.

Mental health services for non-offending family members and/or caregivers include screening, assessment, and treatment on-site or by referral. It is important to consider the range of mental health issues that could impact the child's recovery or safety with particular attention to the caregiver's mental health, substance abuse, domestic violence, and other trauma history.

Family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues which the allegations may trigger. Siblings and other children may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic relationship.

CASE REVIEW

STANDARD: 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.

Rationale

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

Every CAC must have a process for reviewing cases. Depending on the size of the CAC's jurisdiction or caseload, the method/timing of case review may vary to fit the unique CAC community. Some CACs review every case, while other programs review only complex or problematic cases or cases involved in prosecution. Representatives from each core discipline must attend and/or provide input at case review. Confidentiality should be addressed in the interagency protocol. State and/or federal law may govern information sharing among MDT members, including during case review.

CRITERIA

Essential Component

A. The CAC/MDT's written documents include criteria for case review and case review procedures.

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

The CAC/MDT's written documents must include:

- frequency of meetings;
- designated attendees;
- case selection criteria;

- designated facilitator and/or coordinator;
- mechanism for distribution of agenda and/or notification of cases to be discussed;
- procedures for follow-up recommendations to be addressed; and
- location of the meeting.

B. A forum for the purpose of reviewing cases is conducted on a regularly scheduled basis.

Case review affords the CAC/MDT the opportunity to review active/current cases, provide updated case information, and coordinate interventions. It is a planned meeting of all MDT partners and occurs not less than once a month for cases coming from the CACs primary service area. Case review is in addition to informal discussions and pre- and post- interview debriefings.

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

In order to make informed case decisions, essential information and professional expertise are required from all disciplines. This means that decisions are made with as much information as available, interventions receive the support of all involved professionals (or provides an opportunity for discussion if dissention exists), efforts are coordinated and non-duplicative, and all aspects of the case are covered. The process should ensure that no one discipline dominates the discussion, but rather all relevant team members have a change to adequately address their specific case interventions, questions, concerns and outcomes.

Generally, the case review process should:

- review interview outcomes;
- discuss, plan and monitor the progress of the investigation;
- review medical evaluations;
- discuss child protection and other safety issues;
- provide input for prosecution and sentencing decisions;
- discuss emotional support and treatment needs of the child and non-offending family members and strategies for meeting those needs;
- assess the family's reactions and response to the child's disclosure and involvement in the criminal justice/child protection systems;
- review criminal and civil (dependency) case disposition;
- make provisions for court education and court support; and
- discuss cross-cultural issues relevant to the case.

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

Proper planning and preparation for case review including notification of cases to be reviewed, maximizes the quality of the discussions and decision making. A process for identifying and adding cases to the agenda must be

articulated and understood by all MDT members. The skill with which case review meetings are facilitated directly impacts on the success of the case review process and team functioning. The person designated to lead and facilitate the meetings should have training and/or experience in facilitation.

Rated Criteria

E. Representatives routinely participating in case review include, at a minimum:

- **law enforcement**
- **child protective services**
- **prosecution**
- **medical**
- **mental health**
- **victim advocacy and**
- **Children's Advocacy Center**

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

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

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

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

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

CASE TRACKING

STANDARD: CHILDREN'S ADVOCACY CENTERS MUST DEVELOP AND IMPLEMENT A SYSTEM FOR MONITORING CASE PROGRESS AND TRACKING CASE OUTCOMES FOR ALL MDT COMPONENTS.

Rationale

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

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

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

CRITERIA

Essential Components

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

Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response. Often MDT members will have a system to collect their own agency data, however, the MDT response requires sharing of this information to better inform decision making. The CAC/MDT's written documents must include a process for case tracking.

B. The CAC tracks and minimally is able to retrieve NCA Statistical Information.

CACs are required to collect and demonstrate the ability to retrieve case specific information for all CAC clients. This includes basic demographic information, services provided and outcome information from MDT partner agencies.

NCA statistical information minimally includes the following data:

- demographic information about the child and family;
- demographic information about the alleged offender;
- type(s) of abuse;
- relationship of alleged offender to child;
- MDT involvement and outcomes;
- charges filed and case disposition in criminal court;
- child protection outcomes; and
- status/outcome of medical and mental health referrals.

Rated Criteria

C. An individual is identified to implement the case tracking process.

Case tracking is an important function of the CAC and can be a time-consuming task depending on case volume. Accuracy is important and for this reason, an individual is identified to implement and/or oversee the case tracking process. Some CACs define case tracking as part of the MDT coordinator's or case manager's job. Some dedicate a position, part- or full-time, for data collection and database maintenance or assign the responsibility to an administrative assistant. Other programs utilize trained volunteers (who have signed confidentiality agreements) to input data.

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

An, accurate, comprehensive case tracking system is only possible when all MDT members support the need to submit data in a thorough and timely fashion. Codifying case tracking procedures in CAC/MDT's written documents underscores its importance and helps to assure accountability in this area.

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

Because case data may be useful to MDT members for a variety of purposes, it is important that they have access to aggregate and/or specific case information. Centers should also develop policies regarding how this data may be released to participating agencies or parties other than the MDT that adheres to confidentiality requirements.

ORGANIZATIONAL CAPACITY

STANDARD: A DESIGNATED LEGAL ENTITY RESPONSIBLE FOR PROGRAM AND FISCAL OPERATIONS HAS BEEN ESTABLISHED AND IMPLEMENTS BASIC SOUND ADMINISTRATIVE POLICIES AND PROCEDURES.

Rationale

Every CAC must have a designated legal entity responsible for the governance of its operations. The role of this entity is to oversee ongoing business practices of the CAC, including setting and implementing administrative policies, hiring and managing personnel, obtaining funding, supervising program and fiscal operations, and long term planning.

There are many options for CAC organizational structure depending upon the unique needs of its community. CACs may be an independent non-profit agency, affiliated with an umbrella organization such as a hospital or other non-profit human service agency, or part of a governmental entity, such as prosecution, social services, law enforcement, or victim services. Each of these options has its limitations, and implications for collaboration, planning, governance, community partnerships and resource development. Ultimate success requires that, regardless of where the program is housed or under what legal auspices, all agencies in this collaborative effort feel equal investment in and ownership of the program.

CRITERIA

Essential Components

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

The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This can be an independent not-for-profit, a component of such an entity, or a government-based entity.

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

Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Nonprofit CACs, including those that are a

component of an umbrella nonprofit or nonprofit hospital, must carry, at a minimum, general commercial liability, professional liability, and Directors and Officers liability insurance. Government-based CACs must carry, at a minimum, general commercial liability and professional liability insurance or comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed such as renters, property owners, and automobile insurance.

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

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

D. The CAC has an annual independent financial review (Budget is equal to or less than $200,000) or financial audit (Budget exceeds $200,000).

Confidence in the integrity of the fiscal operations of the CAC is critical to the long term sustainability of the organization. An annual independent audit is one tool to assess for fiscal soundness and internal controls for financial management. A financial review is sufficient for those CACs with annual actual expenses equal to or less than $200,000.

Reporting Requirements for Audited Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) in excess of $200,000 are required to have an audit of their financial statements. If a management letter is prepared by the independent accountant (CPA), it should be included with the audit report.

Reporting Requirements for Reviewed Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) equal to or less than $200,000 are required to have a review of their financial statements. The review must be in compliance with SSARS 19. If a management letter is prepared by the independent accountant (CPA), it should be included with the review report.

E. The CAC has personnel responsible for its operations and program services.

In order to ensure that children receive the services they are entitled, CACs must have personnel responsible for coordinating its operations and program

services. The CAC must assure that there is sufficient staffing to support all program components. Efforts must be made to ensure reliable and ongoing sources of funding for these positions.

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

Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts a formal screening process for staff. This process should be documented in a written policy. Staff must receive initial and ongoing training and supervision relevant to their role.

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

Volunteers perform a wide variety of functions within CACs. Sometimes, CACs can attract people who may not be emotionally prepared for the activities of the CAC and/or may attract potential or actual offenders. Due to the sensitive and high-risk nature of CAC work, it is imperative that, at a minimum, the CAC conducts a formal screening process for onsite volunteers. This process should be documented in a written policy. Volunteers must receive training and supervision relevant to their role.

Rated Criteria

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

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

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

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

CHILD-FOCUSED SETTING

STANDARD: THE CHILD-FOCUSED SETTING IS COMFORTABLE, PRIVATE, AND BOTH PHYSICALLY AND PSYCHOLOGICALLY SAFE FOR DIVERSE POPULATIONS OF CHILDREN AND THEIR NON-OFFENDING FAMILY MEMBERS.

Rationale

A Children's Advocacy Center (CAC) requires a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other CAC services can be provided for children and families. While every center may look different, the criteria below help to define some specific ways that the environment can help children and families feel physically and psychologically safe and comfortable. These include attending to the physical setting and assuring it meets basic child safety standards, ensuring that alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating an environment that reflects the diversity of clients served.

There is no one "right" way to build, design or decorate a CAC. The CAC should have adequate square footage and conform to generally-accepted safety and accessibility guidelines, fire codes, etc. Consideration should be given to future growth and the need for additional space as case loads increase and additional program components are needed. Care should be taken to ensure that MDT members have access to work space and equipment onsite to carry out the necessary functions associated with their role on the Multidisciplinary Team (MDT) including, but not limited to, meeting with families and appropriate exchange of necessary information.

Special attention should be given to designing and decorating the client service areas. The appearance of the CAC can help facilitate children's and families' participation in the process, largely by helping to alleviate anxiety and instill confidence and comfort in the intervention system. It should communicate, through its design, decor and materials, that the CAC is a welcoming and child-oriented place for all children and their non-offending family members.

CRITERIA

Essential Components

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

The CAC has an identified location that is a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other services can be provided for children and families. CACs range from small, refurbished houses, to a renovated wing of a county office building or community hospital, to newly built facilities.

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

The CAC has a setting that is physically and psychologically safe for child clients and separation for children and alleged offenders is ensured. During the investigative process, logic dictates that children may not feel free to disclose abuse if an alleged offender accompanied them to the interview and was sitting just down the hall in the waiting room. This separation of children from alleged offenders should also extend to children and perpetrators in unrelated cases. If a CAC shares space with an existing agency that provides services to offenders, facility features must assure separation between children and non-offending family members and alleged offenders.

The CAC has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and as appropriate throughout delivery of the full array of CAC services. In addition, CACs that serve sexually reactive children should also make provisions to assure physical and psychological safety of all children who visit the center.

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

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

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

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

Rated Criteria

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

A center that is physically safe for children is central to the creation of a child-focused setting. This can be a challenge as centers are host to children of a variety of ages and developmental stages. Materials and center furnishings should be selected with this in mind. Any areas where children may be present should be "childproofed" and cleaned to be as safe as possible for infants and toddlers. Toys and materials should be sanitized on a regular basis.

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

To assure a physically and psychologically safe environment, children and families must be observed or supervised by CAC staff, or MDT members, or volunteers ensuring that they are within sight and hearing distance at all times. Some CACs are built so that the waiting room can be seen from the receptionist's desk. Other CACs have volunteers scheduled to supervise play in the waiting room whenever the center is open for clients.

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

Confidentiality and respect for client privacy is of paramount concern in a CAC. It is not acceptable for team members or CAC staff to discuss cases with children or families where it may be overheard by other visitors or others not directly involved with the case. Separate areas should also be made available for private family member interviews and so that individual family members may privately discuss aspects of their case. Care should be taken to assure that segregated meeting areas are not only physically separate, but also sound-proofed so that conversations cannot be overheard. Some centers have placed soundproofing materials in walls when building or refurbishing their centers. Others have placed stereos or "white noise" machines in rooms to block sound.

H. The location of the CAC is convenient and accessible to clients and MDT members.

When planning the location of a center, it is important to evaluate the site's accessibility for clients and MDT partner agencies. Considerations should include transportation assistance, travel distances, availability of parking, and public transportation, and how welcoming a particular neighborhood is for clients of diverse cultural and socioeconomic backgrounds. Additionally, planning should include consideration for clients who will return to the center for ongoing services such as follow-up meetings, medical appointments, or therapy services.

Appendix II
Medical Resources- Child Abuse Experts and SANE-P Programs

Child Abuse Experts

Name	Street Address	City	State	Zipcode	Group
Andrea C Taroli, MD	500 University Drive, PO Box 850	Hershey	PA	17033	Expert
C. Eve J. Kimball, MD, FAAP	132 S. 5th Street	Reading	PA	19602	Preceptorship Participant
C. Eve J. Kimball, MD, FAAP	301 Penn Avenue #200	Reading	PA	19611	Preceptorship Participant
Carol A. Bilinski, MD	690 Kimmels Road	Orwigsburg	PA	17961	Preceptorship Participant
Cindy Christian, MD, FAAP	34th Street and Civic Center Boulevard	Philadelphia	PA	19104	Expert
Donald Gibbon, DO	P.O. Box 788, Hospital Road	Indiana	PA	15701	Preceptorship Participant
Donna L. Balewick, MD	626 Phillips Road	Blairsville	PA	15717	Preceptorship Participant
Harry Bramley, MD	PO Box 850	Hershey	PA	17033	Preceptorship Participant
Heather Rozzi, MD	1001 South George Street	York	PA	17405	Preceptorship Participant
Janet Squires, MD	3705 5th Ave	Pittsburgh	PA	15213	Preceptor
Jennifer Wolford, MD	4401 Penn Avenue, Floor 2	Pittsburgh	PA	15224	Expert
Joanne Wood, MD	34th Street and Civic Center Boulevard	Philadelphia	PA	19104	Expert
John VanBrakle, MD	17th & Chew Street	Allentown	PA	18105	Preceptorship Participant
Kathryn R. Crowell, MD	500 University Drive	Hershey	PA	17033	Preceptorship Participant
Kevin Waninger, MD	153 Brodhead Road	Bethlehem	PA	18017	Preceptorship Participant
Kisha M. Martin, MD	1400 Redwood Lane	Wyncote	PA	19095	Preceptorship Participant
Laura Brennan, MD	34th Street and Civic Center Boulevard	Philadelphia	PA	19104	Expert
Laura M. Duda, MD	500 University Drive	Hershey	PA	17033	Preceptorship Participant
Lawrence Rosenberg, MD, FAAP	1086 Franklin Street	Johnstown	PA	15905	Expert
Maria Conwell, MD	3509 North Broad Street	Philadelphia	PA	19140	Preceptorship Participant
Maria McColgan, MD, FAAP	Erie Avenue at Front Street	Philadelphia	PA	19134	Preceptorship Participant
Mario Cruz, MD	5501 Old York Road	Philadelphia	PA	19141	Preceptorship Participant
Marla C. Farrell, MD	323 North Abington Road	Clarks Green	PA	18411	Preceptorship Participant
Marlene Wust-Smith, MD, FAAP	1001 East Second Street	Coudersport	PA	16915	Preceptorship Participant
Marlene Wust-Smith, MD, FAAP	45 Pine Street	Port Allegany	PA	16743	Preceptorship Participant

Mary Ann Rigas, MD, FAAP	1001 East Second Street	Coudersport	PA	16915	Preceptorship Participant
Monique Fountain Hanna, MD., MPH., MBA	150 South Independence Mall West	Philadelphia	PA	19106	Preceptorship Participant
Olapeju Simoyan, MD, MPH, BDS	525 Pine Street	Scranton	PA	18509	Preceptorship Participant
Pat Bruno, MD	100 N Academy Ave	Danville	PA	17822	Expert
Paula George, MD, FAAP	2645 North Third Street	Harrisburg	PA	17110	Preceptorship Participant
Philip V. Scribano, DO, MSCE, FAAP	34th Street and Civic Center Boulevard	Philadelphia	PA	19104	Expert
Rachel Berger, MD	4401 Penn Avenue, Floor 2	Pittsburgh	PA	15224	Preceptor
Rachel Schwab, MD	125 Holly Ridge Drive	State College	PA	16801	Preceptorship Participant
Renee E. Riddle, MD	Sixth Avenue and Spruce Street,	West Reading	PA	19611	Preceptorship Participant
Stephanie Flora Russo, MD, FAAP	5810 Pebblestone Court	Erie	PA	16506	Preceptorship Participant
Yvonne Siwek, MD	5 Sandstone Drive	Stevens	PA	17578	Preceptorship Participant

SANE-P Programs					
Hospital	**Street Address**	**City**	**State**	**Zip**	**Type of Program**
Abington Memorial Hospital	1200 Old York Rd	Abington	PA	19001	Pediatric Sexual Assault
Bradford Regional Medical Center	116 Interstate Parkway	Bradford	PA	16701	Pediatric Sexual Assault
Butler Memorial Hospital	311 East Brady Street	Butler	PA	16001	Pediatric Sexual Assault
Children's Hospital of Philadelphia	34th and Civic Center Blvd	Philadelphia	PA	19104	Pediatric Sexual Assault
Doylestown Hospital	595 West State Street	Doylestown	PA	18901	Pediatric Sexual Assault
Gettysburg Hospital	147 Gettys Street	Gettysburg	PA	17325	Pediatric Sexual Assault
Hanover Hospital	300 Highland Ave	Hanover	PA	17331	Pediatric Sexual Assault
Holy Spirit Hospital	503 North 21st Street	Camp Hill	PA	17011	Pediatric Sexual Assault
Lancaster General Health	555 N Duke St	Lancaster	PA	17604	Pediatric Sexual Assault
St. Luke's University Health Network	1736 Hamilton Street	Allentown	PA	18104	Pediatric Sexual Assault
Saint Vincent Health Center	232 W. 25th Street	Erie	PA	16544	Pediatric Sexual Assault
Susquehanna Health	700 High Street	Williamsport	PA	17701	Pediatric Sexual Assault
Thomas Jefferson University Hospital	111 S 11th St	Philadelphia	PA	19107	Pediatric Sexual Assault
Warren General Hospital	2 Crescent Park West	Warren	PA	16365	Pediatric Sexual Assault
WellSpan Health York Hospital	1001 South George St	York	PA	17405	Pediatric Sexual Assault

APPENDIX III
Age and Gender Breakdown of Substantiated Cases by County

County	Male						Female					
	Age 0-1	Age 1-4	Age 5-9	Age 10-14	Age 15-17	Age>17	Age 0-1	Age 1-4	Age 5-9	Age 10-14	Age 15-17	Age>17
Adams	0.00%	0.00%	5.38%	5.38%	1.08%	2.15%	0.00%	10.75%	15.05%	31.18%	29.03%	0.00%
Allegheny	0.00%	2.07%	4.38%	5.07%	3.46%	0.23%	0.00%	4.84%	19.59%	38.48%	20.05%	1.84%
Armstrong	0.00%	1.72%	10.34%	3.45%	3.45%	0.00%	0.00%	1.72%	24.14%	31.03%	24.14%	0.00%
Beaver	0.00%	1.94%	12.62%	7.77%	0.97%	0.97%	0.00%	8.74%	19.42%	26.21%	19.42%	1.94%
Bedford	0.00%	2.70%	2.70%	10.81%	5.41%	0.00%	0.00%	2.70%	8.11%	48.65%	18.92%	0.00%
Berks	0.00%	2.49%	6.05%	6.41%	3.56%	0.71%	0.71%	3.91%	19.93%	37.37%	17.79%	1.07%
Blair	0.00%	4.42%	8.85%	5.31%	7.08%	0.00%	0.00%	5.31%	25.66%	23.89%	18.58%	0.88%
Bradford	0.00%	1.14%	3.41%	9.09%	1.14%	0.00%	0.00%	10.23%	29.55%	26.14%	17.05%	2.27%
Bucks	0.00%	0.98%	5.85%	5.37%	3.90%	0.00%	0.49%	3.41%	13.66%	34.15%	29.76%	2.44%
Butler	0.00%	0.83%	5.83%	11.67%	6.67%	3.33%	0.00%	2.50%	12.50%	34.17%	22.50%	0.00%
Cambria	0.00%	1.77%	4.42%	7.96%	3.54%	0.00%	0.00%	4.42%	29.20%	26.55%	20.35%	1.77%
Cameron	0.00%	0.00%	16.67%	16.67%	0.00%	0.00%	0.00%	16.67%	33.33%	16.67%	0.00%	0.00%
Carbon	0.00%	2.08%	6.25%	8.33%	6.25%	2.08%	0.00%	10.42%	27.08%	29.17%	8.33%	0.00%
Centre	0.00%	5.97%	11.94%	2.99%	0.00%	0.00%	0.00%	4.48%	22.39%	25.37%	26.87%	0.00%
Chester	0.00%	2.60%	4.33%	9.96%	6.93%	0.87%	0.00%	5.63%	16.88%	31.60%	19.48%	1.73%
Clarion	0.00%	2.38%	4.76%	14.29%	0.00%	0.00%	0.00%	4.76%	16.67%	38.10%	16.67%	2.38%
Clearfield	0.00%	1.30%	12.99%	5.19%	5.19%	0.00%	0.00%	9.09%	28.57%	19.48%	15.58%	2.60%
Clinton	0.00%	0.00%	11.43%	2.86%	5.71%	0.00%	0.00%	0.00%	28.57%	28.57%	22.86%	0.00%
Columbia	0.00%	5.71%	11.43%	4.29%	1.43%	0.00%	0.00%	7.14%	12.86%	44.29%	11.43%	1.43%
Crawford	0.00%	1.22%	6.71%	8.54%	1.83%	0.00%	0.61%	9.76%	19.51%	31.10%	20.73%	0.00%
Cumberland	0.00%	2.14%	9.09%	10.16%	2.14%	0.00%	0.00%	9.63%	14.97%	29.41%	20.86%	1.60%
Dauphin	0.00%	0.35%	5.28%	9.86%	3.52%	1.41%	0.00%	2.82%	19.01%	33.10%	23.59%	1.06%

Delaware	0.00%	2.59%	8.62%	4.31%	3.02%	0.00%	0.00%	6.90%	23.28%	30.60%	18.10%	2.59%
Elk	0.00%	0.00%	10.00%	10.00%	0.00%	0.00%	0.00%	0.00%	35.00%	25.00%	20.00%	0.00%
Erie	0.00%	2.37%	8.47%	7.46%	3.05%	1.02%	0.00%	6.78%	21.36%	26.10%	22.03%	1.36%
Fayette	0.00%	0.00%	7.84%	7.84%	0.98%	0.00%	0.00%	6.86%	28.43%	32.35%	14.71%	0.98%
Forest	0.00%	0.00%	25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.50%	62.50%	0.00%	0.00%
Franklin	0.00%	0.85%	5.08%	3.39%	3.39%	0.85%	0.00%	5.08%	28.81%	35.59%	16.95%	0.00%
Fulton	0.00%	0.00%	0.00%	11.11%	11.11%	0.00%	0.00%	0.00%	16.67%	50.00%	11.11%	0.00%
Greene	0.00%	0.00%	13.33%	10.00%	0.00%	0.00%	0.00%	6.67%	16.67%	36.67%	16.67%	0.00%
Huntingdon	0.00%	2.78%	5.56%	11.11%	2.78%	0.00%	0.00%	2.78%	27.78%	38.89%	8.33%	0.00%
Indiana	0.00%	1.35%	10.81%	6.76%	1.35%	0.00%	0.00%	6.76%	24.32%	25.68%	22.97%	0.00%
Jefferson	0.00%	4.00%	6.00%	12.00%	2.00%	0.00%	0.00%	18.00%	10.00%	32.00%	16.00%	0.00%
Juniata	0.00%	0.00%	5.13%	5.13%	5.13%	0.00%	0.00%	0.00%	23.08%	38.46%	20.51%	2.56%
Lackawanna	0.00%	2.65%	5.29%	5.29%	1.59%	0.00%	0.00%	6.88%	19.05%	38.10%	19.58%	1.59%
Lancaster	0.00%	1.16%	6.28%	5.81%	3.26%	0.47%	0.00%	5.58%	18.37%	36.98%	20.70%	1.40%
Lawrence	0.00%	2.70%	6.76%	8.11%	1.35%	0.00%	0.00%	6.76%	21.62%	28.38%	24.32%	0.00%
Lebanon	0.00%	2.83%	4.72%	5.66%	3.77%	1.89%	0.00%	0.94%	20.75%	38.68%	19.81%	0.94%
Lehigh	0.00%	0.89%	4.00%	9.78%	3.56%	0.00%	0.00%	1.78%	17.33%	35.11%	25.33%	2.22%
Luzerne	0.00%	2.00%	9.60%	6.80%	2.80%	0.40%	0.00%	10.40%	18.80%	30.40%	17.60%	1.20%
Lycoming	0.00%	3.25%	6.50%	18.70%	6.50%	0.00%	0.00%	4.07%	13.82%	26.83%	18.70%	1.63%
McKean	0.00%	1.69%	0.00%	8.47%	3.39%	0.00%	0.00%	1.69%	20.34%	45.76%	18.64%	0.00%
Mercer	0.00%	0.81%	8.13%	8.13%	4.07%	0.81%	0.00%	2.44%	17.89%	26.83%	30.08%	0.81%
Mifflin	0.00%	3.33%	6.67%	10.00%	6.67%	0.00%	0.00%	1.67%	18.33%	41.67%	11.67%	0.00%
Monroe	0.00%	1.74%	9.57%	10.43%	1.74%	0.87%	0.00%	9.57%	23.48%	21.74%	20.87%	0.00%
Montgomery	0.00%	2.17%	10.11%	5.05%	2.53%	0.72%	0.00%	4.69%	21.30%	30.69%	21.66%	1.08%
Montour	0.00%	9.09%	4.55%	4.55%	13.64%	0.00%	0.00%	9.09%	0.00%	13.64%	36.36%	9.09%
Northampton	0.00%	2.73%	8.18%	8.18%	3.64%	0.00%	0.00%	9.09%	15.91%	31.36%	18.64%	2.27%
Northumberland	0.00%	3.03%	8.08%	6.06%	8.08%	1.01%	0.00%	9.09%	20.20%	20.20%	22.22%	2.02%
Perry	0.00%	3.39%	8.47%	5.08%	10.17%	1.69%	0.00%	11.86%	18.64%	22.03%	16.95%	1.69%

Philadelphia	0.06%	2.45%	7.82%	5.72%	1.69%	0.12%	0.12%	6.30%	20.32%	33.39%	20.90%	1.11%
Pike	0.00%	6.90%	13.79%	13.79%	0.00%	0.00%	0.00%	0.00%	24.14%	24.14%	17.24%	0.00%
Potter	0.00%	0.00%	3.70%	22.22%	3.70%	0.00%	0.00%	7.41%	22.22%	18.52%	22.22%	0.00%
Schuylkill	0.00%	3.82%	6.87%	8.40%	3.82%	0.00%	0.00%	3.05%	23.66%	33.59%	16.03%	0.76%
Snyder	0.00%	0.00%	13.89%	8.33%	2.78%	0.00%	0.00%	2.78%	27.78%	22.22%	22.22%	0.00%
Somerset	0.00%	1.41%	8.45%	11.27%	4.23%	0.00%	0.00%	5.63%	30.99%	19.72%	16.90%	1.41%
Sullivan	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.00%	0.00%	60.00%	20.00%	0.00%
Susquehanna	0.00%	2.08%	0.00%	8.33%	2.08%	0.00%	0.00%	12.50%	22.92%	27.08%	25.00%	0.00%
Tioga	0.00%	1.72%	8.62%	5.17%	0.00%	0.00%	0.00%	12.07%	17.24%	20.69%	31.03%	3.45%
Union	0.00%	0.00%	2.86%	20.00%	17.14%	0.00%	0.00%	5.71%	11.43%	25.71%	14.29%	2.86%
Venango	0.00%	4.76%	5.95%	4.76%	2.38%	1.19%	0.00%	2.38%	17.86%	35.71%	22.62%	2.38%
Warren	0.00%	3.57%	3.57%	10.71%	1.79%	0.00%	0.00%	8.93%	14.29%	39.29%	16.07%	1.79%
Washington	0.00%	2.13%	7.09%	9.22%	5.67%	0.71%	0.00%	2.84%	19.15%	26.95%	24.82%	1.42%
Wayne	0.00%	0.00%	13.24%	8.82%	1.47%	1.47%	0.00%	5.88%	19.12%	33.82%	14.71%	1.47%
Westmoreland	0.00%	0.96%	9.13%	6.73%	4.33%	0.48%	0.48%	2.40%	22.60%	24.52%	26.92%	1.44%
Wyoming	0.00%	0.00%	4.55%	13.64%	9.09%	0.00%	0.00%	9.09%	18.18%	31.82%	13.64%	0.00%
York	0.00%	1.59%	6.15%	6.38%	3.19%	0.00%	0.00%	2.96%	23.46%	35.76%	19.13%	1.37%
Total	0.01%	2.07%	7.10%	7.17%	3.23%	0.41%	0.07%	5.67%	20.02%	32.10%	20.83%	1.32%

*** These percentages are based on substantiated CPS reports only and do not take into account differences in the age and gender breakdown of law enforcement only cases or GPS cases**

APPENDIX IV
Charges Filed for Sexual Abuse Offenses 2007-2011

County	Number of Charges Filed					Number of Charges Disposed				
	2007	**2008**	**2009**	**2010**	**2011**	**2007**	**2009**	**2009**	**2010**	**2011**
Adams	135	234	140	304	383	118	455	201	148	324
Allegheny	963	955	1344	895	973	601	739	805	760	1061
Armstrong	3033	94	102	108	122	89	2158	77	105	95
Beaver	237	441	201	167	335	154	170	281	96	150
Bedford	878	251	179	1201	121	78	994	173	219	1054
Berks	442	511	748	544	353	337	590	296	518	414
Blair	185	201	263	282	321	81	259	103	257	302
Bradford	231	421	320	401	517	93	202	266	320	633
Bucks	497	467	1111	429	473	386	442	874	467	297
Butler	1087	424	1111	226	1634	829	331	297	516	199
Cambria	548	346	260	240	537	419	276	304	134	357
Cameron	4	11	Missing	81	9	7	9	2	8	80
Carbon	194	70	64	264	127	100	67	155	53	233
Centre	570	11623	88	138	780	513	6269	1273	47	150
Chester	2085	789	949	2246	776	724	1268	706	1001	1258
Clarion	84	58	859	1095	272	66	28	58	854	1073
Clearfield	410	324	215	142	116	688	114	314	46	88
Clinton	14	45	134	52	41	16	7	48	79	59
Columbia	846	94	1076	198	66	48	850	54	90	89
Crawford	219	120	242	140	214	272	145	166	189	230
Cumberland	436	605	1714	1610	381	304	573	347	1437	1310
Dauphin	580	549	685	1472	624	490	463	594	1225	641
Delaware	6741	1891	2068	4952	1936	3228	4140	1715	3029	3566

Elk	104	17	46	44	13	9	99	37	14	42
Erie	235	285	222	210	268	279	234	181	213	151
Fayette	243	159	92	140	122	123	174	93	104	133
Forest	8	21	11	4	11	11	18	9	3	9
Franklin	132	121	117	452	175	39	61	61	103	70
Fulton	52	60	164	92	408	16	52	152	67	405
Greene	59	42	24	28	187	71	36	33	12	27
Huntingdon	54	69	550	171	152	66	42	42	83	738
Indiana	89	72	132	98	111	59	73	69	77	84
Jefferson	427	189	272	906	4320	2054	289	283	427	738
Juniata	461	160	269	2247	174	16	227	136	1145	12
Lackawanna	307	197	278	403	222	378	172	211	341	265
Lancaster	668	376	650	775	1642	236	648	245	513	1148
Lawrence	82	107	169	432	127	78	296	84	87	338
Lebanon	379	192	274	424	268	138	179	180	193	353
Lehigh	139	199	252	249	258	162	173	171	217	238
Luzerne	263	185	2016	1915	416	131	176	312	3273	273
Lycoming	178	265	633	249	507	138	214	143	531	404
McKean	84	110	176	78	706	97	51	138	44	584
Mercer	173	216	203	204	312	91	115	151	111	173
Mifflin	445	59	32	68	43	100	44	56	57	37
Monroe	212	589	1720	272	478	39	157	447	98	130
Montgomery	1018	1660	1244	1266	1738	839	929	1437	1065	1231
Montour	33	50	46	1	7	20	20	44	34	3
Northampton	301	387	197	476	7	255	206	345	288	436
Northumberland	65	135	138	79	617	65	89	109	61	98
Perry	93	125	35	50	147	544	141	49	28	87
Philadelphia	4304	4700	5303	3614	157	2738	3523	4514	3273	2981

Pike	205	37	109	23	3235	175	37	45	58	100
Potter	395	128	143	134	86	252	123	26	61	109
Schuylkill	197	114	195	329	86	170	162	121	146	342
Snyder	20	117	39	77	202	50	81	36	81	38
Somerset	103	362	124	306	52	55	237	174	78	183
Sullivan	16	15	8	9	687	34	15	Missing	15	Missing
Susquehanna	37	81	61	183	214	31	54	23	20	20
Tioga	50	58	116	246	214	22	26	54	122	370
Union	65	52	36	53	12	41	40	39	51	39
Venango	63	54	224	133	149	1001	100	52	205	118
Warren	75	76	63	240	131	72	81	54	250	66
Washington	288	454	885	303	218	72	421	1009	145	317
Wayne	94	91	85	60	69	61	81	50	50	55
Westmoreland	353	580	346	312	609	353	414	311	266	313
Wyoming	56	27	54	45	39	25	49	17	46	76
York	643	844	1052	577	461	822	485	974	510	416
TOTAL	33687	34361	32678	35164	31168	21669	31393	21826	26164	27413

*This data is for the charges filed for child sexual abuse offenses from 2007 to 2011. Juvenile offenders are not reflected. Data Is collected from the Administrative Office of Pennsylvania Courts.