NORTH CAROLINA CHILDREN'S ADVOCACY CENTERS

ACCREDITATION STANDARDS

2023

Table of Contents

MULTIDISCIPLINARY TEAM: Standard 1

A multidisciplinary team for response to child maltreatment allegations includes mandatory representation from the following and may include other community and/or state disciplines:

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

RATIONALE

A CAC is an agency or organization that facilitates the interagency coordinated response. All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate response that is relevant and accessible to its clients. A committed and effective multidisciplinary team (MDT) with a shared common goal is the foundation of a Children's Advocacy Center (CAC). An MDT is a group of professionals from specific and distinct disciplines that collaborates from the point of report and throughout a child and family's involvement with the CAC. MDTs coordinate investigations and service delivery to mitigate potential trauma to children and families. In addition, this collaborative partnership keeps the lines of communication open, maintains transparency, fosters trust, and helps optimize a quality response while preserving and respecting the rights of the clients. The CAC honors the mandates and obligations of each agency while protecting the positive outcomes to families through our collective partnership.

The core MDT must be composed of representatives from law enforcement, child protective services, prosecution, medical providers, mental health providers, victim advocates, and CAC staff. CAC staff may provide any of the above functions, or additional functions, such as forensic interviewers. Some CACs, including those in small or otherwise under-resourced rural communities, may employ one person to fill multiple roles. For example, the CAC director may also serve as the victim advocate, or a CPS worker may function as a forensic interviewer and a caseworker. What is important is that clear boundaries are maintained between each function, and that the MDT response is comprehensive and utilizes all of the required functions outlined in these Standards. As the center grows, centers are encouraged to consult with Children's Advocacy Centers of North Carolina (CACNC) staff to assess capacity and growth needs.

MDTs may be expanded to include professionals with other relevant roles and responsibilities, including Guardians ad Litem, adult, and juvenile probation officers, dependency (civil) attorneys, out-of-home care licensing personnel, federal investigators, school personnel, domestic violence/sexual assault providers and others as deemed necessary and appropriate for an individual child, family, or community on a case-by-case or routine basis.

Generally, a coordinated MDT approach results in efficient interagency communication and information sharing with ongoing collaboration of key individuals who form a network of support for children and families. Each agency benefits from the knowledge and expertise of MDT colleagues through shared information, improved and timely gathering of evidence, improved safety planning, thorough investigations for prosecution, ensures timely referrals for treatment, and assures the most effective outcomes for children and families. CACs function within a trauma-informed framework designed to reduce harm and support healing. MDT interventions in a neutral, child-focused CAC setting are associated with clients experiencing less anxiety, having to undergo fewer interviews, and seeing more appropriate and timely referrals for needed services and meaningful participation by clients in the protective services,

criminal justice, and other systems where applicable. In addition, a coordinated MDT response can empower caregivers to protect and support their children throughout the life of the case and beyond.

BENEFITS OF THE MDT APPROACH BY MDT FUNCTION

Law Enforcement

- May generate additional evidence to create a stronger case that is less reliant on only the child's disclosure.
- Support and advocacy functions are attended to by other MDT partners, leaving law enforcement personnel more time to focus on their investigatory role.
- Enhanced collaboration between investigative partners results in a better understanding of family dynamics and improved response to child safety issues.

CPS

- Contributes historical family information, which enhances MDT's abilities to foster child safety and provide parental support and assistance with service plans, minimizing need for escalated CPS interventions.
- Provides additional support and intervention in cases where safety cannot be assured.
- Enhanced collaboration between investigative partners results in a better understanding of family dynamics and improved response to child safety issues.

Medical Providers

- History and other information obtained during the coordinated forensic interview prevents unnecessary duplication of effort and guides medical decisions.
- Provide consultation on specialized medical evaluations and interpretation of medical findings and reports.

Mental Health Providers

- Contribute valuable information to the MDT regarding the child's emotional state/needs and are able to participate in the investigative process and other systems where necessary.
- Help ensure that trauma assessments, treatment, and related services are routinely made available/accessible to children and families.

Victim Advocates

- Lessen the stress on children and families by providing crisis assessment and intervention, safety planning, referrals for additional services, ongoing support, information, case updates, and court advocacy where necessary in a timely manner.
- Help ensure the MDT's ability to anticipate and respond effectively to the specific needs of children and their families.
- Afford legal rights and meaningful participation in, various systems and the court process.

- Increase access to services and resources for the child and family, including crime victims' compensation.

Prosecutors
- Provide information about the criminal justice process, victim rights, and seek input from children and families to inform decisions.
- Integrate input from MDT members to optimize ability to hold offenders accountable and ensure community safety.

Children's Advocacy Center
- Coordinates the MDT response to ensure the child and family are receiving non- duplicative services.
- Offers a child-focused setting where trained professionals conduct forensic interviews and other needed services.
- Coordinates ongoing education and training for the MDT partners and CAC Staff.

CRITERIA - Essential Components

A. THE MDT COORDINATOR/FACILITATOR COORDINATES AND FACILITATES THE DAY-TO-DAY INFORMATION SHARING AND ACTIVITIES OF THE MDT. THE MDT FACILITATOR/COORDINATOR MUST COMPLETE TRAINING THAT INCLUDES A MINIMUM OF EIGHT HOURS OF INSTRUCTION. (THIS MAY BE THE SAME OR DIFFERENT FROM THE PERSON WHO FACILITATES CASE REVIEW SESSIONS, AS SOME CASE REVIEWS ARE FACILITATED BY MDT MEMBERS.)

TRAINING TOPICS WHICH COVER THE FUNCTION OF THE MDT COORDINATOR/FACILITATOR MAY INCLUDE:

- **Developing and maintaining relationships with and among MDT members**
- **Defining roles and responsibilities of team members**
- **Defining mission, vision, and values of the MDT**
- **Managing change and turnover on the MDT**
- **Navigating and resolving conflict**
- **Knowledge of evidence-informed team development models**
- **Facilitating shared decision-making**
- **Ensuring adherence to MDT agreements and protocols**
- **Understanding of the various meeting structures that support effective teams**
- **Facilitating effective communication processes**
- **Creating psychological safety**

- **Personal bias and vicarious trauma and how they impact the MDT**
- **Role of the medical and mental health provider on the MDT and nature of these services**
- **Building resilience for the MDT**

STATEMENT OF INTENT

The person designated to coordinate and facilitate the MDT must have training experience in team facilitation to ensure a complete and participatory process that will ultimately benefit the child and family. MDT coordinators/facilitators may come from a variety of professional backgrounds. Often, they have subject matter expertise in child maltreatment, child maltreatment investigations, or other human services occupations. However, facilitating a team of multidisciplinary professionals is a unique skill set. It requires an understanding of group dynamics, conflict resolution techniques, and team problem- solving. This requires specialized training to set the MDT Facilitator/Coordinator up for success. The MDT Facilitator/Coordinator may be a person employed by the CAC who has another role in addition (such as an Executive Director, forensic interviewer, or victim advocate) or may exclusively act as the MDT Coordinator/Facilitator. In some CACs this person also facilitates case review. In others, an MDT member may facilitate case review while the MDT Coordinator/Facilitator is responsible for coordinating day to day information-sharing. However, it is constructed the CAC must be able to identify this role, who fills, it and the role must be viewed by the team as the go-to by MDT members for case coordination, information-sharing among team members, and addressing team functioning. The CAC employee who fills this role must have the required baseline training. In the rare instance in which someone outside the CAC plays this vital role, the training requirement does not apply (though is highly encouraged).

B. The designated MDT facilitator must demonstrate participation in continued education in the field of child maltreatment and/or MDT facilitation for a minimum of eight contact hours every two years.

STATEMENT OF INTENT

The CAC must provide ongoing opportunities for the MDT facilitator/coordinator employed by the CAC to receive ongoing training. It is important that team facilitators remain current on developments in facilitation and other relevant fields of practice to further enhance their expertise.

C. The CAC/MDT has, and facilitates, a written interagency agreement/MOU signed by authorized representatives of all MDT components that clearly commits the signed parties to its collaborative multidisciplinary response to reports of child maltreatment and the needs of children and families it serves. The agreement will be reviewed and signed annually. The interagency agreement should be a part of the protocol and must include signatures from:

1. **Law Enforcement**
2. **Child Protective Services**
3. **Prosecution**
4. **Mental Health**
5. **Medical**
6. **Forensic Interview**
7. **Victim Advocacy**
8. **Children's Advocacy Center**

STATEMENT OF INTENT

Written agreements formalize interagency cooperation and commitment to CAC/MDT policy, ensuring continuity of practice. Written agreements are to be reviewed and signed by the current leadership of participating agencies or their designees.

D. Written protocols address the functions of the MDT, the roles and responsibilities of each discipline/role, and their interaction with the CAC throughout the life of the case, including the role of the MDT facilitator/coordinator. Protocols are developed with input from the MDT, reviewed/signed annually, and updated to reflect current practice.

STATEMENT OF INTENT

The active involvement and commitment of all MDT agency leaders and their representatives are critical to ensuring that the policies and protocols by which investigations are conducted and services provided are consistently followed.

NOTE: *Most CACs choose to combine the interagency agreement/MOU and the protocol into one document.*

E. All core members of the MDT, including appropriate CAC staff, are routinely and actively supporting collaborative investigations, evaluations, advocacy, case management and other services throughout the life of the case, in accordance with the defined needs of children, families, and the case.

STATEMENT OF INTENT

The purpose of multidisciplinary involvement for all interventions is to ensure the unique needs of children and families are assessed and addressed. Coordination and collaboration among MDT

members allow for informed decision-making to occur at all stages of the case to ensure optimal benefit to children and families. Multidisciplinary intervention begins at initial report and includes, but is not limited to, child protection and/or law enforcement response; forensic interviews to include pre- and post- forensic interview meetings; consultations; child and family advocacy; medical and mental health screening, assessment, and treatment; referrals for other services; case review; and prosecution.

F. CAC staff and MDT members participate in effective information sharing that is consistent with legal, ethical, and professional standards of practice and ensures the timely exchange of case information within the MDT.

STATEMENT OF INTENT

Regular and effective communication and information sharing minimizes duplicative efforts, enhances decision-making and maximizes the opportunity for children and caregivers to receive the services they need. Understanding issues of confidentiality, privacy, and relevant legal and ethical obligations must be considered and respected.

G. The CAC has written documentation, within their protocol, describing how information sharing is communicated among MDT members and how confidential information is protected.

STATEMENT OF INTENT

Most professions represented on the MDT have legal, ethical, and professional standards of practice with regard to child and family privacy, confidentiality, and privileged communications. These may differ across disciplines. North Carolina has laws such as the Health Information Portability and Accountability Act (HIPPA) that govern this practice. The CAC/MDT must create written confidentiality and information sharing policies that align to these standards and specifically apply to the MDT members, CAC staff, board, and volunteers.

H. The CAC provides routine opportunities for MDT members to give feedback and suggestions regarding procedures and operations of the CAC/MDT. North Carolina uses Outcome Measurement Systems (OMS) as the formal process for reviewing and assessing the information provided. For developing centers, check with CACNC for information on OMS.

STATEMENT OF INTENT

CACs should have both formal and informal mechanisms for eliciting regular feedback from MDT members regarding the operations and administration of the CAC (e.g., transportation of clients, use of the facility, equipment upgrades, etc.) and MDT issues (e.g., communication, case decision-making, documentation and record keeping, conflict resolution, training, etc.).

CACs should foster opportunities for open communication to create an atmosphere of trust and respect and to enable MDT members to share responsibility for enhancing the quality of the MDT response with their ideas and concerns. Various methods for eliciting feedback and/or suggestions from MDT members may be utilized, including the Outcome Measurement Survey (OMS) tool team satisfaction survey, suggestion boxes and MDT meetings specifically scheduled for this purpose, among others.

I. The CAC/MDT annually provides and/or facilitates relevant training or other educational opportunities focused on issues relevant to investigation, prosecution, and service provision to children and their nonoffending caregivers. The CAC retains documentation (certificates of completion and/or case review sign-in sheets with training agenda) of MDT member participation in annual professional development.

STATEMENT OF INTENT

Ongoing learning is critical to the successful operation of the CAC/MDT. The CAC identifies and/or provides relevant educational opportunities for MDT members, including topics that enhance the knowledge and skills of MDT members, collaborative work across disciplines, and a deeper understanding of each discipline's role in service provision. This may include directly providing training to MDT members and/or facilitating opportunities to attend conferences or online trainings offered by the State Chapter, Regional CACs, or state/national training providers.

J. The CAC/MDT provides formal orientation for new MDT members regarding CAC/MDT process, policies and procedures, and code of conduct.

STATEMENT OF INTENT

New MDT members arrive experienced in their profession but often inexperienced with multidisciplinary team principles and practice. Providing an orientation for new MDT members ensures that they understand how the team functions, what is expected of their role, and how each member of the team contributes to the case and to better child outcomes. Orienting team members well at the beginning can reduce confusion and conflict and contribute to better overall team function.

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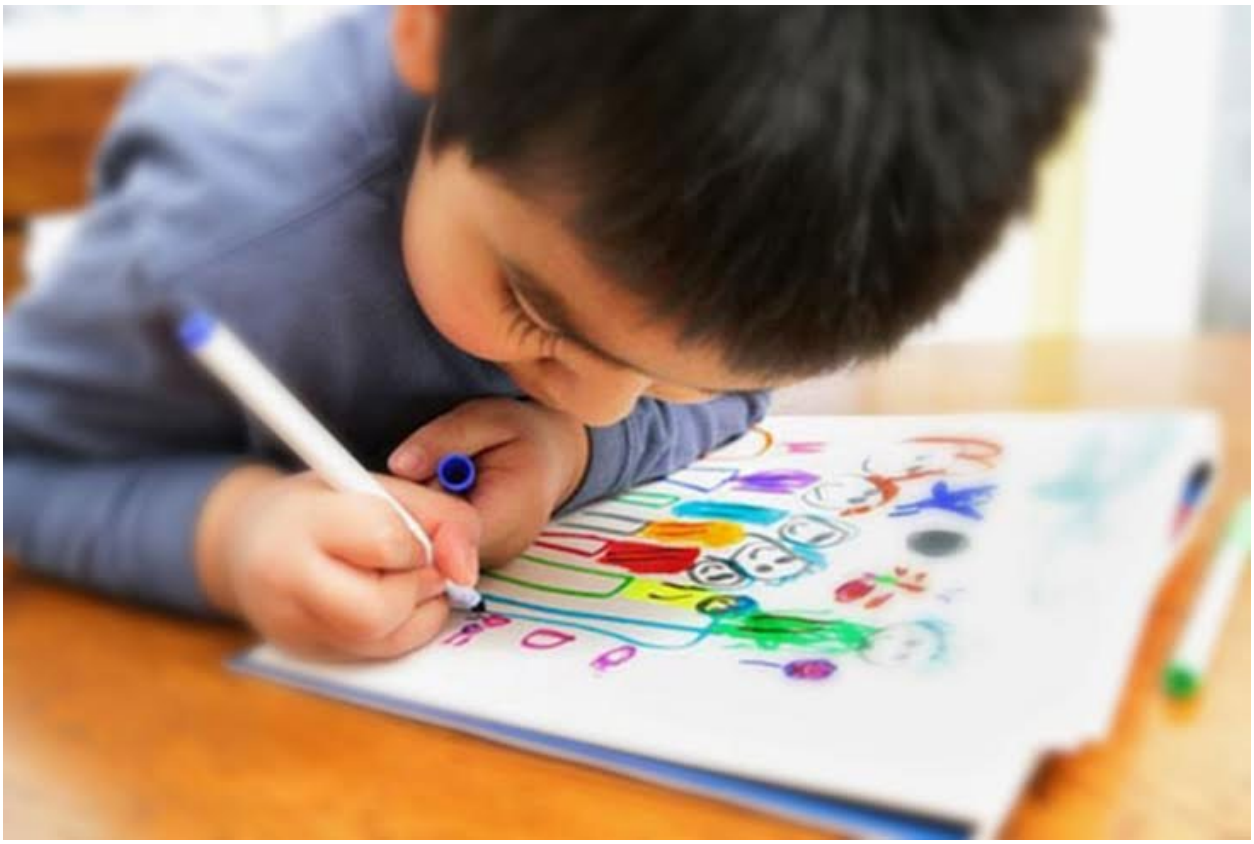
FORENSIC INTERVIEWS: Standard 3



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

RATIONALE

The purpose of a CAC forensic interview is to facilitate information gathering from children to determine whether maltreatment occurred and, if so, the nature of the allegations. This information is intended to contribute to accurate and fair decision making by the MDT members relative to criminal justice, child protection and relevant service delivery systems. Forensic interviews are conducted in a manner that is developmentally responsive, unbiased, fact-finding, and legally sound. When a child is unable to provide information regarding any concern of maltreatment through the forensic interview process, other interventions to assess the child's safety and well-being are required.

The CAC/MDT must adhere to research-based forensic interview guidelines that create an interview environment that enables free recall, minimizes interviewer influence, and gathers information needed by all the MDT members to avoid duplication of the interview process. The CAC/MDT must monitor these guidelines over time to ensure they reflect current research-based practice, and CAC/MDT protocols and practices need to be congruent.

Forensic interviews are the foundation for multiple CAC/MDT functions, including child protection and criminal investigations, prosecution, and implementation of services critical to helping ensure children and families' paths toward safety, healing, and justice. The child's experience during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to, the ensuing steps in the various aspects of the intervention process.

Skilled forensic interviewing by appropriately trained individuals requires an appropriate neutral setting and effective communication among MDT members. While CACs vary regarding who conducts the forensic interview, the role must be fulfilled by an appropriately trained, qualified, supervised professional who engages in peer review and ongoing professional development. This may include a CAC-employed forensic interviewer, law enforcement officers (local/state, and/or federal), CPS workers, or others determined by the CAC/MDT in accordance with the resources available in their respective communities. At a minimum, any professional in the role of a forensic interviewer must have initial and on-going formal forensic interviewer training that is approved by National Children's Alliance (NCA} for purposes of accreditation. North Carolina laws may also dictate which professionals can or should conduct forensic interviews.

The CAC/MDT's protocol must include the general interview process, guidelines for selecting an appropriately trained interviewer, specifications for sharing of interview information among MDT members, and a mechanism for collaborative case planning, peer review and continuing education. Additionally, for CACs that conduct Extended Forensic Evaluations, an additional protocol for this purpose must also be articulated.

CRITERIA - Essential Components

A. Forensic interviews are provided by CAC staff and/or MDT members with specialized training in conducting forensic interviews. The CAC must demonstrate that all forensic interviewer(s) have successfully completed training that includes the following elements:

- **Minimum of 32 hours of instruction and practice**
- **Evidence-supported interview protocol**
- **Pre- and Post-testing that reflects understanding of the principles of legally sound interviewing.**
- **Child development; question design; implementation of protocol; dynamics of maltreatment; disclosure process; and suggestibility**
- **Practice component with a standardized evaluation process**
- **Required reading of current articles specific to the practice of forensic interviewing**

Curriculum must be included on NCA's approved list of nationally or state-recognized forensic. interview trainings or submitted with the accreditation application for review and approval.

STATEMENT OF INTENT

The CAC must have a process to ensure initial forensic interview training for anyone conducting a forensic interview at the CAC. While MDT members may have received general interview training, conducting forensic interviews of children in the context of an MDT response requires specialized and qualifications.

B. Individuals who conduct forensic interviews must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing for a minimum of eight contact hours every two years.

STATEMENT OF INTENT

The CAC/MDT must provide ongoing opportunities for professionals who conduct forensic interviews to receive specialized training. It is vitally important that forensic interviewers remain current on developments in forensic interviewing and other relevant fields of practice to further enhance their expertise.

C. Forensic Interviews are provided by CAC staff and MDT members with specialized training in conducting forensic interviews. Emergent forensic interviews, as defined by MDT agencies, shall be conducted within 24 hours of request. Non-emergent forensic interviews shall be conducted at MDT agencies and families' convenience with best practice being completion within 5 business days.

STATEMENT OF INTENT

The CAC recognizes the importance of scheduling interviews quickly to best meet the needs of

children and families as well as the needs of the MDT agencies. CACs should educate their MDT on best practices regarding response time and have within their protocols a way to respond within 24 hours to an emergent request from their MDT members taking into account children and family's safety and well-being. While not all cases will require a response within 24 hours, cases deemed as non-emergent should be completed within one week's time to meet the needs of children, families, and MDT agencies.

D. CAC/MDT forensic interview protocols must reflect the following items:

- **Case acceptance criteria**
- **Circumstances under which a case would be defined as emergent.**
- **Criteria for choosing an appropriately trained interviewer (for a specific case)**
- **CAC staff/MDT members expected to attend/observe the interview on-site, specifically including those with investigative responsibilities for the case.**
- **Information sharing and communication between case-involved MDT members and the forensic interviewer before, during and after the interview.**
- **Use of interview aids**
- **Use of interpreters**
- **Recording, documentation, and storage of the interview**
- **Interview methodology (i.e., state or nationally recognized forensic interview training model(s)**
- **Introduction of evidence in the forensic interviewing process**
- **Sharing of information among MDT members**
- **A mechanism for collaborative case coordination**
- **Criteria and process for conducting a multi-session or subsequent interview.**
- **The use of technology for remote live observation of forensic interviews using a secure method (if applicable)**
- **The criteria and process for the use of tele-forensic interviews (if applicable)**

STATEMENT OF INTENT

The forensic interview process must be described in comprehensive detail in the agency's written guidelines or agreements. These guidelines help ensure consistency and quality of interviews, inform MDT discussions pre and post interview, and support subsequent decision making. Technology now makes it possible to both conduct and observe (in real time) forensic interviews online and remotely. Centers that wish to do either or both should clearly identify in the written guidelines or agreements the circumstances in which this is allowed and the process for doing so. Children who receive a tele-forensic interview must be afforded the full range of CAC services and MDT interventions as with any other clients. Care must be taken that the use of remote live observation does not result in the need for repeated interviews or miscommunication between team members. And any use of remote live observation requires the team's written guidelines and agreements to outline who may do so, and under what circumstances.

E. The CAC allows for real-time observation of forensic interviews by case-involved MDT members.

STATEMENT OF INTENT

To create a psychologically safe space and lessen or eliminate the need for duplicative interviews, interviewers should be observed by case-involved MDT members in a space other than the interview room. The case-involved MDT members should also have the ability to communicate with the interviewer in some manner to provide input and feedback during the real-time interview with the child to reduce the need for additional interviews.

F. MDT members with investigative responsibilities on a case must participate in live/real time observation of forensic interview(s) to ensure necessary preparation, MDT member and Interviewer coordination, and information sharing throughout the interview and post-interview process.

STATEMENT OF INTENT

MDT members with involvement in the case are present to observe the forensic interview and participate in pre and post interview discussions. This practice provides MDT members with access to the information necessary to fulfill their respective investigatory and related professional roles. MDT members who are present for forensic interviews typically include local, state, federal or tribal child protective services, and law enforcement; others may vary based on the circumstances of each case.

G. Cases meeting the CAC case acceptance criteria, as outlined in the MDT protocol, have forensic interviews conducted at the CAC, or through a secure tele-forensic method. Under rare circumstances, CACs in partnership with their MDT, may decide to complete interviews outside of standard protocol operations. CACs must document that a minimum of 75% of all interviews meeting the CAC case acceptance criteria are interviewed at or by the CAC and maintain a log of the reasons why cases were handled outside of the protocol.

STATEMENT OF INTENT

Forensic interviews of children, as defined in the CAC/MDT's written protocols, will be conducted at the CAC, where the MDT is best equipped to meet the child's needs during the interview.

Written protocols must also address the rare occasions when interviews may need to take place outside the CAC with the agreed-upon forensic interview guidelines utilized. Some CACs have established interview rooms outside of the primary CAC, such as at a satellite office. In an alternate setting, MDT members must assure the child's comfort, privacy, and protection from alleged offenders and others who may unduly influence the child. Remote or tele-forensic interviews may also occur when appropriate and/or necessary to increase access and utilization of CAC forensic interviews. All such alternatives must be agreed upon by the MDT and codified

in the written protocols. And any alternative must continue to afford children and families with the full range of CAC services.

CACs are encouraged to develop policies that will provide the most comprehensive services and benefits to all children in their communities. Case acceptance criteria may include various types of maltreatment, other forms of direct or indirect exposure to violence/trauma, jurisdictional issues, and the ages of children, among others.

H. Individuals who conduct forensic interviews must participate in a structured forensic interviewer peer review process a minimum of four times per year, with two of those being completed by an external group approved by CACNC. Every interviewer must complete one peer review by an external group approved by CACNC, annually, utilizing their own work.

Peer review is a quality assurance mechanism that reinforces the methodologies utilized and provides support and problem-solving for participants. Structured peer review includes:

- **Ongoing opportunities to network with and share learning and challenges with peers.**
- **Review and performance feedback on actual interviews in a professional and confidential setting**
- **Discussion of current relevant research articles and materials and implications for forensic interview practice**
- **Training opportunities specific to forensic interviewing of children and CAC - specific modalities**

STATEMENT OF INTENT

Participation in peer review is vital for quality assurance of forensic interviewers and allows for further development and enhancement of their skills based on new research and developments in the field. Peer review is a compliment, not a substitute, for supervision, as well as multidisciplinary case review and case planning.

I. The CAC/MDT coordinates information gathering, including history taking, assessments, and forensic interview(s) to avoid duplication.

STATEMENT OF INTENT

All CAC staff/MDT members need information to complete their respective assessments and evaluations. Whether it is initial information gathered prior to the forensic interview, or where applicable, history taken by the medical provider, or intake by the mental health or victim services provider, every effort should be made to avoid unnecessary duplication of information gathering from the child and family members and ensure effective information sharing among MDT members.

VICTIM SUPPORT AND ADVOCACY: Standard 4

Victim Support and Advocacy Services are provided to all CAC children and families as part of the multidisciplinary team response.

RATIONALE

Research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members. Client access to, and participation in, investigation, prosecution, treatment, and support services are core components of MDT response, and are informed and supported by coordinated victim advocacy services. Up-to-date information and ongoing access to comprehensive services are critical to a child and family's well-being and ability to participate in an ongoing investigation, possible prosecution, intervention, and treatment.

Victim support and advocacy responsibilities are implemented consistent with legal and, North Carolina victims' rights legislation, and the complement of services in the CACs coverage area. Many MDT members may advocate for children and families within their discipline systems or agencies. However, victim advocacy is a discipline unto itself with a distinct and central role on the MDT. Victim advocates provide services and resources to ensure a consistent and coordinated comprehensive network of support for each child and family.

Children and families in crisis need assistance in navigating the multiple systems involved in the CAC response. More than one victim advocate may perform these functions at different points throughout a case, requiring continuity and consistency in service delivery. Coordination of victim support is the responsibility of the CAC and must be defined in the CAC/MDT's written documents including understanding of relevant states and ethics regarding confidentiality and privilege. Specific victim support services may be provided in a variety of ways, as dictated by the needs of the CAC children and families and their case, such as:

- Collaborating with local community-based advocates, including, but not limited to domestic violence advocates, rape crisis counselors, Guardians Ad Litem/Court Appointed Special Advocates, etc.
- Collaborating with system-based advocates (e.g., law enforcement victim advocates, prosecutor-based victim witness coordinators)
- Coordinating victim support services depending upon the individual needs of children and families

All advocates who provide the constellation of services to CAC children and families must meet the prescribed training and supervision requirements. This includes advocates on staff at the CAC and/or advocates from outside organizations.

CRITERIA - Essential Components

A. Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training that includes a minimum of 24 hours of instruction. NC Victim Advocates must provide certificates of completion that demonstrate a minimum of 24 hours training as well as inclusion of each criterion. For

those attending the NC/SC VSP training the certificate of completion will satisfy this component. Training must include the following topics:

1. **Dynamics of child maltreatment**
2. **Trauma-informed services**
3. **Crisis assessment and intervention**
4. **Risk assessment and safety planning**
5. **Professional ethics and boundaries**
6. **Understanding the coordinated multidisciplinary response**
7. **Understanding, explaining, and affording of victim's legal rights**
8. **Understanding and explaining the CAC-specific referral and/or specialized medical evaluation process for non-emergency evaluations**
9. **Understanding and explaining the CAC-specific trauma-focused, evidence-supported mental health referral, assessment, and treatment process**
10. **Court education, support, and accompaniment**
11. **Knowledge of available community and legal resources, referral methods and assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, and interpreters, among others as determined for individual children and families.**
12. **Personal inclination in service delivery.**
13. **Caregiver resilience**
14. **Domestic violence, family violence, and/or children's exposure to domestic violence and poly-victimization**

STATEMENT OF INTENT

Victim support and advocacy is fundamental to the MDT response. These professional responsibilities may be filled by a designated victim advocate who is an employee of the CAC, another MDT member, or another victim-serving agency. Regardless of whom is serving in the advocate role, they must have appropriate experience and training in victim advocacy. If an advocate, employed by the CAC or an external agency, is providing any of the constellation of services to the child and family then they must demonstrate completion of initial victim advocacy training. The victim advocate may only provide advocacy services to an assigned child or family; while the advocate may be cross trained, they may not conduct the forensic interview or medical evaluation, provide mental health treatment, or perform any other required MDT role for the assigned child and family.

B. Individuals who provide victim advocacy services for the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who

provide advocacy services to receive specialized training and peer support. As with all other disciplines represented on the MDT and serving CAC children and families, it is vitally important that victim advocates remain current on developments in the fields relevant to their delivery of services to children and families.

C. Victim Advocates serving CAC children and families must provide the following constellation of services:

1. **Crisis assessment and intervention, risk assessment, and safety planning and support for children and family members at all stages of involvement with the CAC**
2. **Assessment of individual and family needs to ensure those needs are being addressed in concert with the MDT and other service providers.**
3. **Presence at the CAC during the forensic interview in order to participate in information sharing with other MDT members, inform and support the family regarding the coordinated, multidisciplinary response, and assess needs of children and non-offending caregiver.**
4. **Provision of education and assistance in ensuring access to victims' rights and crime victims' compensation**
5. **Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance, other legal services etc.)**
6. **Provision of education about specialized medical treatment and trauma-focused, evidence-supported mental health assessment and treatment**
7. **Support referrals for specialized medical treatment and trauma-focused, evidence-supported mental health assessment and treatment**
8. **Monitor family compliance with referrals for specialized medical treatment and participation in trauma-focused, evidence-supported mental health assessment and/or treatment (onsite or offsite)**
9. **Facilitating access to transportation to interviews, court, treatment, and other case-related meetings**
10. **Engagement with the child and family to help them understand the investigation and prosecution processes and help ensure understanding of crime victims' rights.**
11. **Participation in case review to communicate and discuss the unique needs of the child and family and associated services planning; and help ensure the coordinator of identified services, and that the child and family's concerns are heard and addressed.**
12. **Provision of case status updates to the family, including investigations, court date, continuances, dispositions, sentencing, and inmate status notification (including offender release from custody)**
13. **Provision of court education and support, including court orientation and accompaniment**

STATEMENT OF INTENT

While the constellation of services required will vary based upon the child and family's unique needs and the legal requirements of any civil and/or criminal cases, all children and families

need support in navigating the various systems they encounter that are often unfamiliar to them. Crisis and risk assessments and intervention, advocacy and support services will help to identify the child and family's unique needs, reduce fear and anxiety, and expedite access to appropriate services and resources. Crises may recur with various precipitating or triggering events, including, but not limited to, financial hardships, child placement, arrest, change/delay in court proceedings and preparation for court testimony. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including victims of child maltreatment, are informed of their rights as crime victims, including information about, and eligibility for, crime victim compensation. Caregivers who are affected by the crime may also be entitled to services and may be eligible for victim compensation. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained at the outset of their involvement with the CAC/MDT and made available to all children and their caregivers.

D. Outreach, provision of support services, and case management for children and caregivers consistently occurs throughout the life of the case. Post case intake contact should be made every 30 days throughout the first year unless the family request otherwise. Following year 1, contact should be made minimally every quarter. Contact can include phone calls/texts from a CAC work phone, emails, letters/cards, in person appointments. The life of a case is defined by final disposition for all MDT partners (LE, CPS, Prosecutor) and at the expiration of services/support requested by the family.

STATEMENT OF INTENT

Often, families have never been involved in this multi-system response, which can prove intimidating and confusing. Outreach requires follow-up with families beyond initial investigation, assessment, and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case and the family no longer requires services.

In the aftermath of victimization, the child and family typically feel a significant loss of control. Support services including education are empowering. Services and education must be ongoing and repeated as needed, as families may be unable to process so much information at one time, particularly during a crisis. The family may be dealing with immediate safety issues and may be coping with the emotional impact of the initial report and ensuing forensic interview and investigation process. They may need a variety of concrete medical, mental health, and social services. As the case dynamics change, and as the case proceeds through the various systems, the needs of the child and family will also change. It is important their needs continue to be assessed, so that additional relevant information, support, and services can be offered.

E. The CAC/MDT's written protocols include availability of victim support and advocacy services for all CAC children and families throughout the life of the case and participation of the victim advocate(s) in the MDT case review. The life of a case is defined by final disposition for all MDT partners (LE, CPS, Prosecutor) and at the expiration of services/support requested by the family. Victim advocates should provide the MDT with an open case list quarterly and allow for case discussion as needed.

STATEMENT OF INTENT

Because victim support and advocacy are a central function of the CAC response, the availability and provision of ongoing victim support and advocacy by designated, trained individuals must be included in the CAC/MDT's written documents. Service coordination, both within and outside the CAC, must be clearly defined, including the role of the victim advocate during the interview process, follow-up, and case review.

The protocol must include specific guidelines for the MDT and victim advocacy providers regarding what and how information can be shared during case review in accordance with state laws and professional ethical practice standards.

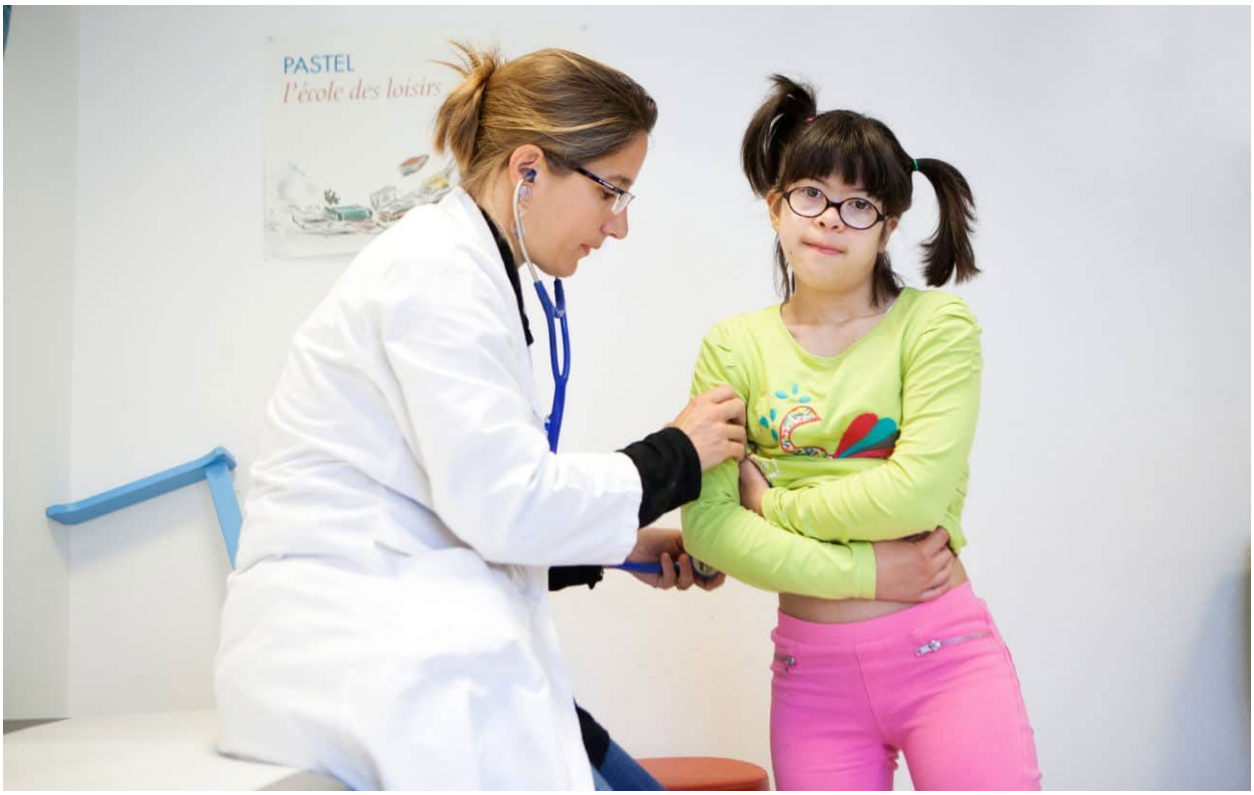
F. Coordinated case management must be defined within the protocol and occur when multiple individuals are providing any of the constellation of victim advocacy services to CAC children and families.

STATEMENT OF INTENT

If multiple advocacy agencies share the delivery of services, the CAC is responsible for establishing protocols and linkage agreements as indicated, that clearly define the victim advocacy roles and ensure seamless coordination of victim advocacy services.

In any community or jurisdiction, a CAC serves, there may be various agencies and programs providing advocacy and support services to child and adult victims and survivors who have experienced maltreatment and trauma. In addition to victim advocates who may be employed by the CAC, there may be advocates on staff in law enforcement agencies, prosecutors' offices, domestic and sexual violence community-based agencies, hospitals, and GAL/CASA programs, among others. While specific job titles may vary, children and families engaged with the CAC/MDT may also be receiving services from some or all of these agencies/programs. To better understand each other's roles, optimize cross-referrals for CAC children and families, avoid unnecessary duplication and ensure meaningful coordination of services, the CAC must develop a process for achieving these goals in collaboration with one another. This process will need to include understanding and respect for issues of confidentiality and methods for sharing case-specific information accordingly.

MEDICAL EVALUATION: Standard 5



Specialized medical evaluation and treatment services are available to all CAC children/patients and are coordinated as part of the multidisciplinary team response.

RATIONALE

All children referred to a CAC and who meet CAC case acceptance criteria, are entitled to, and should be offered, a high quality, specialized medical evaluation. CAC protocol, linkage agreements and contracts must include how evaluations are offered at no cost to the family, minimally, in all cases meeting the case acceptance criteria. Additionally, the protocol, linkage agreement and contracts must include clinical criteria whereby children are referred by the MDT for a medical evaluation at no cost to the family. Medical evaluations must be conducted by medical providers with specialized training and expertise in the field of child maltreatment, as well as appropriate licensure and credentialing.

A medical evaluation holds an important place in the multidisciplinary assessment of child maltreatment. An accurate and complete medical history is essential in making medical diagnoses, determining appropriate treatment of child maltreatment, and making safety recommendations. Because many children are familiar with the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators. In fact, some children describe residual physical symptoms to medical providers even when no injury is seen. If a nonmedical member of the MDT is obtaining the in-depth forensic interview, further medical history will likely be needed from the caregiver and child to complete the medical evaluation. Information gathering across disciplines must be coordinated to avoid duplication and help ensure a comprehensive response.

In general, child maltreatment medical evaluations are conducted for the purposes of:

- Assisting with clinical aspects of the intake process for individual children/patients
- Identifying and addressing urgent clinical need or responding to emergent needs
- Evaluating maltreatment concerns referred by the MDT or partner agency, and/or requested by a non-offending caregiver.
- Screening for and/or evaluating other areas of maltreatment and psychosocial risk.
- Screening for and/or evaluating general medical, dental/oral, developmental, and mental health concerns.
- Screening for and/or evaluating the impact of maltreatment and psychosocial risk on a child and family.
- Forensic evidence collection and documentation
- Exploring potential child/patient and family concerns and answering questions
- Providing reassurance about the child/patient's body, physical health, thoughts, feelings, and behaviors
- Formulating clinical conclusions and establishing a medical diagnosis(es)
- Developing clinical recommendations and a treatment plan that address child and family safety and well-being (The medical provider may recommend follow-up medical evaluation or treatment at the CAC or with a primary care provider, subspecialist, or other professionals. Children/patients are often referred for mental health assessment and treatment. In rare circumstances, a child/patient may disclose a history of

previously unknown maltreatment, necessitating a follow-up forensic interview.)

- Clinical documentation of findings and conclusions, medical diagnosis(es), safety and well-being recommendations, and the treatment plan
- Communication of clinical findings and conclusions, medical diagnosis(es), safety and well-being recommendations, and the treatment plan to children/patients, families, CAC staff, MDT partners, courts, and other professionals, as appropriate
- Introducing mental health treatment and instilling hope about positive treatment outcomes, as appropriate
- Expert medical testimony (based on training, ongoing education, and experience) in response to subpoenas to district court, superior court, and courts martial, to include:
    - Clinical findings and conclusions, medical diagnosis(es), safety and well-being recommendations, and the treatment plan
    - Explanation and/or clarification regarding the written medical record
    - Explanation and/or clarification regarding child development and the impact of trauma on the developing child in the context of maltreatment concerns
    - Explanation and/or clarification regarding the interface of clinical and legal issues, including the disclosure process, coaching and suggestibility, memory, recantation, and others.

The clinical content of a medical evaluation must be developed, ultimately, by child maltreatment medical experts, with input from the CAC and MDT partners. Content must reflect clinical best practices, professional standards, requirements or limitations of respective clinical licensing boards, the role of a medical provider as a member of a larger multidisciplinary team, and the clinical needs of the population served.

CRITERIA - Essential Components

A. Medical evaluations must be conducted by healthcare professionals with specialized training and expertise in the field of maltreatment, as well as appropriate licensure, credentialing, and medical malpractice coverage.

1. **Child abuse pediatricians (CAP MDs) must have a medical license in good standing with the North Carolina Medical Board (NCMB). Additionally, they must demonstrate completion of subspecialty training through the American Board of Pediatrics' certification program. Finally, they must be rostered through the North Carolina Child Medical Evaluation Program (NC CMEP) (see below); NC CMEP requires physicians to complete 10 AMA PRA Category 1 Credit(s)™ in child maltreatment every 2 years.**
2. **Physicians (MDs) without child abuse pediatrics certification must have a medical license in good standing with the NCMB. Additionally, they must demonstrate a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse and an additional 16 hours of formal didactic training in other aspects of**

child maltreatment. Finally, they must be rostered through NC CMEP (see below); NC CMEP requires physicians to complete 10 AMA PRA Category 1 Credit(s)™ in child maltreatment every 2 years.

3. **Physician assistants (PAs) must have a physician assistant license in good standing with the NCMB. PAs must have a primary supervising physician who accepts full responsibility and liability for their medical activities and professional conduct at all times (per terms established by NCMB). The PA must designate a mentor in child maltreatment when rostering with the NC CMEP. The mentor may be different from the supervising physician. The PA must demonstrate a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse and an additional 16 hours of formal didactic training in other aspects of child maltreatment. The physician assistant must be rostered through NC CMEP (see below); NC CMEP requires physicians to complete 10 AMA PRA Category 1 Credit(s)™ in child maltreatment every 2 years.**
4. **Nurse practitioners (NPs) must hold a North Carolina Registered Nurse (RN) license or another Compact State Registered Nurse license which is valid for practice in North Carolina and obtain certification (or recertification) to practice through the NPs specific credentialling body. NPs must have a physician supervisor through a collaborative practice agreement approved by the North Carolina Board of Nursing (NC BON). The NP must designate a mentor who has expertise in child maltreatment when rostering with the NC CMEP. The mentor in child maltreatment may be different from the supervising physician. The nurse practitioner must be rostered through NC CMEP (see below); NC CMEP requires physicians to complete 10 AMA PRA Category 1 Credit(s)™ in child maltreatment every 2 years. Nurse practitioners may submit official nursing contact hours as well.**

In North Carolina, medical professionals providing services to CAC children/patients must be rostered through the North Carolina Child Medical Evaluation Program (NC CMEP) as part of the credentialing process. Medical providers who serve as "advanced medical consultants" must also meet all NC CMEP rostering criteria.

Initial NC CMEP rostering criteria addresses specific licensure and training. Annual rostering requirements include ongoing education (or delivery of approved child maltreatment training), participation in continuous quality improvement (CQI) activities, and a signature on the annual Letter of Agreement signature. NC CMEP rostering criteria can be found at: https://www.med.unc.edu/pediatrics/cmep

In North Carolina, Sexual Assault Nurse Examiners (SANEs) must complete North Carolina Board of Nursing approved adolescent pediatric sexual assault nurse examiner training to perform forensic evidence collection during an acute medical examination for suspected maltreatment. SANEs without advance practice nursing licensure may not conduct a child medical evaluation, nor formulate a diagnosis or treatment plan, for CAC children/patients.

STATEMENT OF INTENT

All children referred to a CAC for suspected sexual abuse or who meet case acceptance criteria are entitled to, and should be offered, a high quality, specialized medical evaluation. Additionally, the CAC protocol may include clinical criteria whereby children with concerns for other forms of maltreatment are offered a medical evaluation. Evaluations may be performed onsite by CAC medical personnel (employee or contracted) or through a linkage agreement with an outside provider who meets all NCA and CACNC medical standards. It should be noted that the content of the medical evaluation (see below) is based on best practice standards; content and quality should not vary based on the referral source or evaluation site.

Medical evaluations for suspected maltreatment must be conducted by healthcare professionals with specialized training in the field of maltreatment, as well as appropriate licensure and credentialing, including physicians (CAP-MDs and MDs), physician assistants (PAs) and nurse practitioners (NPs). Sexual Assault Nurse Examiners (SANEs) without advanced practice certification, however, may only participate in evidence collection and documentation for an acute medical examination for suspected maltreatment.

B. Medical professionals must demonstrate continuing education in the field of child maltreatment consisting of a minimum of 10 contact hours every two years to be consist with NC CMEP requirements.

STATEMENT OF INTENT

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who provide medical services to receive specialized training and support. As with all other CAC/MDT disciplines, it is vitally important that medical providers remain current on developments in the field relevant to their delivery of service to children and families.

Medical providers must be familiar and up to date with published research studies on findings in maltreated and non-maltreated children, sexual transmission of infections in children, and current medical guidelines and recommendations from national and state professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect, the American Professional Society on the Abuse of Children, the Centers for Disease Control and Prevention, the North Carolina Child Medical Evaluation Program (NC CMEP), and the North Carolina Pediatric Society Committee on Child Abuse and Neglect.

C. Medical professionals providing child sexual abuse evaluations to CAC children/patients must demonstrate that all laboratory and physical findings deemed "diagnostic" of sexual abuse have undergone expert CQI review by an "advanced medical consultant", to include review of medical photographs or videos, laboratory reports, and other clinical materials, as appropriate.

- **Expert CQI review with a child abuse pediatrician is preferred and can occur in multiple ways, including via a direct linkage agreement with a specific provider,**

through myCaseReview sponsored by the Midwest Regional CAC, or through other identified state-based medical expert review systems that have access to an "advanced medical consultant" including CACNC clinical consultants.

- **Physicians or advanced practice nurses can also provide expert CQI review if they have the following qualifications:**
    - **Meet the minimum training standards outlined for a CAC medical provider, including licensure in good standing, NC CMEP roster status, and covered by medical malpractice insurance**
    - **Have performed at least 100 child sexual abuse exams with an expert medical preceptor.**

The CAC and medical providers must adhere to a protocol that supports, and monitors, clinician participation in expert case review for <u>all</u> sexual abuse cases in which there are positive physical and/or laboratory findings. Minimally, the CAC must maintain a dated log that includes clinician name, advanced medical expert name, de-identified case information, clinical findings and impressions, diagnosis, and CQI reviewer findings. For all other CAC medical evaluations (including sexual abuse without diagnostic findings and/or other forms of maltreatment), it is best practice that the CAC and medical providers must adhere to a protocol that supports, and monitors, clinician participation in a CQI process that minimally includes peer-to-peer and/or clinician-to-expert case review for a pre-established subset of children/patients (it is recommended that a minimum of 10% of these cases are randomly selected and reviewed).

STATEMENT OF INTENT

The accuracy and integrity of forensic medical evaluation findings is critically important in child sexual abuse cases. While only a small percentage of medical evaluations result in a positive or diagnostic finding for sexual abuse (about 3-5% of non-acute cases per the medical literature), it is critical to the health, the safety of the child, and the integrity of the investigations that the findings are accurate. Research indicates that routine participation in CQI activities, including peer review and consultation with an advanced medical consultant, is critical to receiving diagnostic accuracy. Because a false positive (overcalling), can lead to a miscarriage of justice, it is essential that physical findings deemed diagnostic for child sexual abuse are reviewed by an advanced medical consultant.

The medical provider must be able to provide documentation of participation in expert review with an advanced medical consultant on all physical findings deemed diagnostic for child sexual abuse for the purpose of CQI and CAC case-tracking.

D. Specialized medical evaluations for children/patients, who meet case acceptance criteria, are available on-site or offsite through linkage agreements with NC CMEP rostered providers employed by other appropriate institutions or agencies.

STATEMENT OF INTENT

Specialized child medical evaluations are a critical component of the CAC multidisciplinary team and must be provided by licensed CAC employees, contract providers, or through a linkage agreement with a medical provider or agency. All medical providers and physician supervisors as outlined in component A must be rostered through NC CMEP.

E. Specialized medical evaluations are offered, available, and accessible to all CAC children who meet CAC case acceptance criteria at no cost to the family *(defined by NCA as "regardless of ability to pay").*

STATEMENT OF INTENT

Specialized medical evaluations are offered, available, and accessible to all CAC children who meet CAC case acceptance criteria at **no cost** to the family (defined by NCA as "regardless of ability to pay"). A child's insurance status and/or a family's financial resources should never be a factor in determining who is referred for and/or is able to access a specialized child medical evaluation when there are concerns for maltreatment.

For children referred to the CAC by the local Department of Social Services (DSS), Medicaid is the first payor when billing for a specialized child medical evaluation. If the child is not Medicaid-eligible, the CAC may bill NC CMEP.

For children referred to the CAC by law enforcement without DSS involvement, the CAC may bill the child's health care insurance or invoice the North Carolina Crime Victim's Fund for a specialized child medical evaluation. However, the evaluation must be provided at **no cost** to the family. The CAC must assume responsibility for the co-payment or any other associated costs.

ALL CHILDREN REFERRED TO A CAC AND WHO MEET CAC CASE ACCEPTANCE CRITERIA, ARE ENTITLED TO, AND SHOULD BE OFFERED, A HIGH QUALITY, SPECIALIZED MEDICAL EVALUATION. CAC PROTOCOL, LINKAGE AGREEMENTS AND CONTRACTS MUST INCLUDE HOW EVALUATIONS ARE OFFERED AT NO COST TO THE FAMILY, MINIMALLY, IN ALL CASES MEETING THE CASE ACCEPTANCE CRITERIA. ADDITIONALLY, THE PROTOCOL, LINKAGE AGREEMENT AND CONTRACTS MUST INCLUDE CLINICAL CRITERIA WHEREBY CHILDREN ARE REFERRED BY THE MDT FOR A MEDICAL EVALUATION AT NO COST TO THE FAMILY.

F. CAC/MDT written protocols include the circumstances under which a specialized child medical evaluation for maltreatment is recommended, accessed, and provided.

STATEMENT OF INTENT

The protocol and guidelines must include all components of the specialized medical evaluation. The purpose of an evaluation for suspected maltreatment extends far beyond providing an evidentiary examination for the purpose of the investigation. The primary goal is to help ensure the health, safety, and well-being of the child.

In cases of suspected child maltreatment, a specialized child medical evaluation, in addition to a forensic interview, is considered best practice because:

- Disclosure is a process, rather than an event. When there are concerns for maltreatment, a child may not disclose all aspects of the maltreatment experience during their initial disclosure and/or during the forensic interview.
- Children often experience more than one form of maltreatment.
- Children who experience maltreatment frequently experience other forms of trauma and/or psychosocial risk and thus could benefit from a specialized child medical evaluation.
- Children referred to a CAC often have undiagnosed and/or inadequately addressed medical, developmental, oral/dental, reproductive, behavioral, emotional, educational, and psychosocial needs. Many do not have a medical home and/or have had routine access to primary care.

A specialized child maltreatment evaluation may include the following:

- Clinical input during the clinical intake process to help identify and address any emergent or urgent need.
- Review of relevant information/history from referring agencies and MDT partners
- Review of clinical and/or non-clinical records
- Observation of the forensic interview and/or review of forensic interview findings
- Caregiver medical interview
- Child medical interview outside of the presence of caregivers or other professionals, with the exception of language interpreters
- Physical examination with a caregiver or chaperone always present
- Laboratory and radiological evaluation, when clinically indicated.
- Forensic evidence collection, when indicated (including coordination with referring agencies for collection of potential forensic evidence outside of the medical protocol)
- Formulation of clinical conclusions and medical diagnosis(es)
- Development of safety and well-being recommendations and a treatment plan for the child, to potentially include recommendations for the caregiver or siblings.
- Clinical documentation of clinical findings and conclusions, medical diagnosis(es), recommendations, and the treatment plan
- Timely communication of clinical findings and conclusions, medical diagnosis(es), recommendations, and the treatment plan

Each CAC protocol must address the following:

- Clinical criteria used to determine which children are, and are not, referred by the MDT for a specialized medical evaluation [referral for medical evaluations should <u>not</u> be limited to children for whom forensic findings are anticipated and/or children who have disclosed penetration during sexual abuse]

- Process whereby a non-offending caregiver may request a medical evaluation if not referred by the MDT.
- Case-level clinical intake process to include involvement of a designated medical provider when indicated.
- Family access to the medical evaluation, including location and transportation.
- Timing of the medical evaluation, relative to:
    - Urgency of medical need
    - Timing of the forensic interview
    - Child, family, CAC, and/or MDT needs
- Timely notification and scheduling with families and relevant MDT partners
- General content of the medical evaluation, including components directly above
- Collaborative strategies to minimize or eliminate duplicative questions asked during the child forensic interview and the child medical interview.
- Clinical documentation requirements, minimally adhering to NC CMEP standards.
- Communication regarding clinical findings and conclusions, medical diagnoses, safety and well recommendations, and the treatment plan with children/patients, families, CAC staff, MDT partners, courts, and other professionals, as appropriate

The MDT's written protocols or agreement must include qualified medical input to define the referral process and how, when and where examinations are made available. Examinations can be differentiated between those needed emergently (without delay), urgently (scheduled as soon as possible with qualified provider), or non-urgently (scheduled at the convenience of family and MDT partners, but ideally within 1-2 weeks). Some patients may also benefit from a follow-up examination. CACs are responsible for ensuring that exams are performed by experienced, qualified medical providers at the appropriate location and time, and that examinations are photo-documented to minimize unnecessary repeat examinations. This requires a linkage agreement with emergency departments and other medical providers to develop a process for referral, consent to exchange information, and feedback. The North Carolina Pediatric Society Committee on Child Abuse and Neglect has developed guidelines for the emergency department evaluation of child sexual and physical abuse. The recommendations are that all children seen in the emergency department setting for maltreatment concerns should be referred to a CMEP rostered provider for a comprehensive medical evaluation and completion of any outstanding diagnostic testing.

CACs are increasingly performing medical evaluations for suspected physical abuse, psychological maltreatment, neglect, and other forms of psychosocial risk, as referred by the MDT, or requested by the non-offending caregiver, and/or established within the case acceptance criteria. The ability of the CAC to perform medical evaluations for physical abuse

and other forms of maltreatment is dependent on the training and experience of the medical provider, child/patient age, nature of the injuries or medical findings, safety concerns, and provider access to additional medical experts, assessment, testing and/or imaging, treatment, and intervention resources. Medical providers must adhere to clinical standards and NC CMEP guidelines when evaluating children/patients less than three years of age.

G. Documentation of medical findings is maintained by written record and photo-documentation, when applicable. Medical records storage must be HIPAA compliant. The medical records storage must be secured, sufficiently backed up, and accessible to authorized personnel in accordance with all applicable federal and state laws and the executed Administrative Order for your CAC.

STATEMENT OF INTENT

Clinical findings and relevant reports, images, photographs, and audio-visual recordings; clinical conclusions and medical diagnoses; safety and well-being recommendations; and the treatment plan must be carefully, thoroughly, and legibly documented within the child/patient's medical record. Final reports must be generated in a timely manner, minimally meeting NC CMEP and North Carolina Medicaid standards. [See https://www.med.unc.edu/pediatrics/cmep].

Medical records should be maintained in compliance with federal laws and guidelines governing the protection of patient privacy. Additionally, the medical record, including all notes and supporting materials, must be 'backed-up' whereby a second copy is maintained in a separate physical location in the event that the original record is misplaced/lost, corrupted, destroyed, and/or otherwise unavailable or non-retrievable. Copies should be maintained electronically through either a password protected external hard drive/flash drive) or in a digital environment).

The CAC protocol must include a mechanism for the medical evaluation and release of records whereby written consent is obtained from a non-offending caregiver and local DSS when applicable. A dated log of record releases should be maintained by the CAC, with additional documentation in the child/patient's medical record, in accordance with federal privacy rules.

In North Carolina, the specialized child medical evaluation documentation should meet the guidelines outlined in the NC CMEP medical report template. Child Medical Evaluations (CMEs) performed at the request of DSS should only be released to DSS or upon court order from a judge. DSS maintains the authority to release medical information per agency/state policy. Even in situations where the medical record can legally be provided without separate written consent or court order, a log of record releases should be maintained with the medical record in accordance with federal privacy rules.

Diagnostic-quality photographic documentation of the ano-genital exam findings should be obtained in all cases of suspected sexual abuse using still and/or video documentation. This is particularly important if the examination findings are thought to be abnormal. Photographic

documentation allows for CQI review, consultation or a second opinion and may also obviate the need for a repeat examination of the child.

H. MDT members and CAC staff are trained regarding the purpose and nature of the specialized child medical evaluation for suspected maltreatment. Designated MDT members and/or CAC staff educate children and caregivers regarding the evaluation, in advance of the medical evaluation whenever feasible.

STATEMENT OF INTENT

The specialized child medical evaluation for suspected maltreatment often raises significant anxiety in children/patients and their caregivers, often due to misconceptions about the physical examination (how it is conducted and how findings are interpreted), concerns about physical pain or discomfort, and concerns about psychological distress or re-traumatization. An appropriately trained medical provider performing an evaluation typically addresses this anxiety. However, in many CAC settings, the child/patient and caregiver are introduced in advance to the medical evaluation by nonmedical personnel. Therefore, it is essential that nonmedical MDT members and CAC staff receive training and ongoing supervision to ensure that they can educate children and families about the nature and purpose of a specialized child medical evaluation, and respond appropriately to common questions, concerns, and misconceptions.

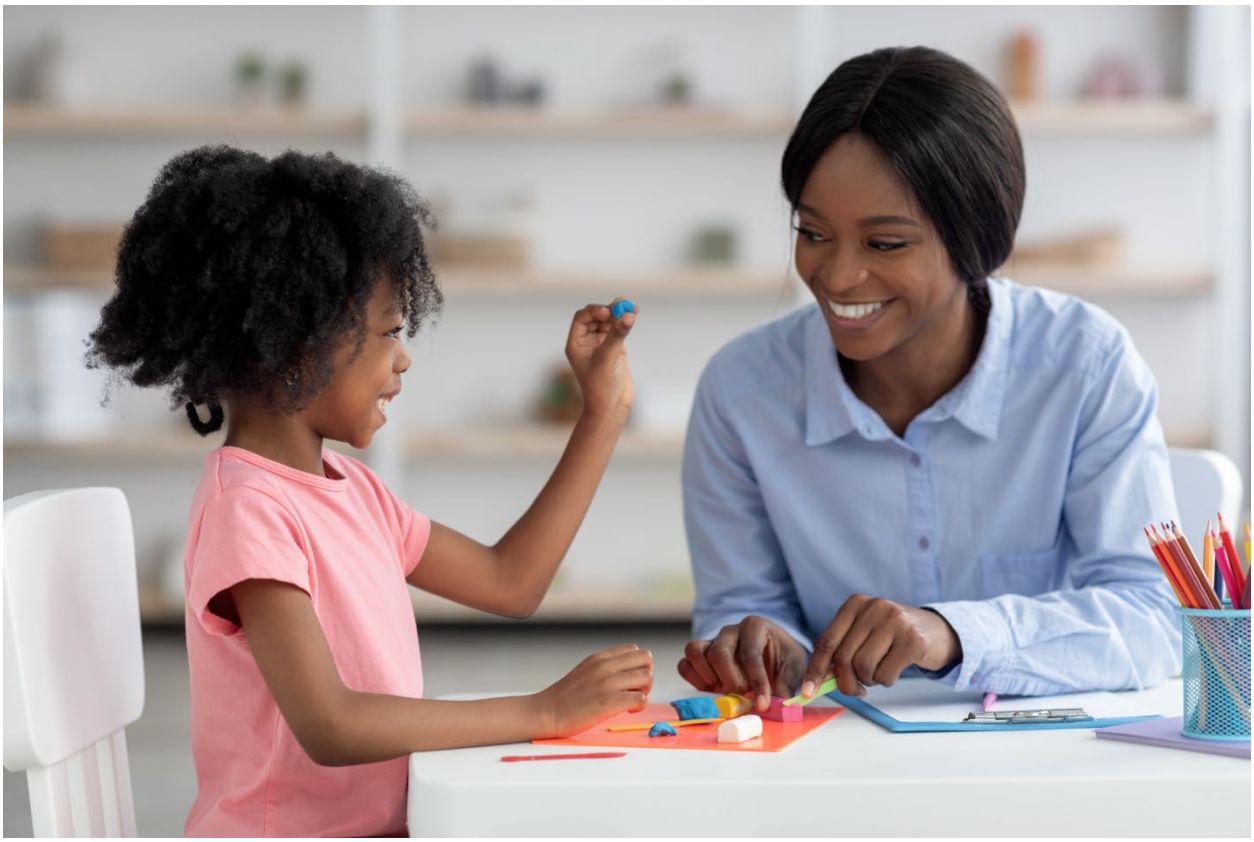
I. Findings of the specialized child medical evaluation are shared with the MDT in a routine, timely, and meaningful manner.

STATEMENT OF INTENT

Because the specialized child medical evaluation is an important part of the response to suspected maltreatment, findings of the medical evaluation should be shared with, and explained to the MDT in a routine and timely manner to facilitate discussion of concerns and ensure case decisions can be made effectively. The legal duty to report findings of suspected maltreatment to the mandated agencies is an exception outlined by the HIPAA privacy requirements, allowing for ongoing relevant communication between and among members of the MDT.

The protocol must include specific guidelines for the MDT and medical providers regarding what and how information can be shared with the MDT, to include during case review in accordance with state laws and professional ethical practice standards.

MENTAL HEALTH: Standard 6



Evidence-based, trauma-focused mental health services, designed to meet the clinical needs of the child and caregivers, are consistently available as part of the multidisciplinary team response.

RATIONALE

A CAC's mission is to promote and foster safety, well-being, and healing for children and families. The CAC's response begins at first contact with the child and family. Without effective therapeutic intervention, many children who have experienced trauma may suffer ongoing or long-term adverse social, emotional, developmental and health outcomes. Evidence-based treatments and other practices with strong empirical support reduce the impact of trauma and the risk of future maltreatment and other negative consequences. For these reasons, an MDT response must include screening for trauma exposure and/or symptoms by identified members of the MDT as part of the MDT response, who then use that information to link mental health services for assessment and trauma-focused mental health treatment for children and caregivers.

Evidence shows parental and family support is often the key to the child's recovery and ongoing protection, and mental health services are often an important factor in a caregiver's capacity to support their children. Therefore, family members may benefit from counseling and support those aids in addressing the emotional impact of child maltreatment allegations and related emotional triggers, and in reducing or eliminating the risk of future maltreatment. Mental health treatment for caregivers is a critical component of CAC services, given that many may have trauma histories themselves or are current victims of intimate partner violence. Such services include information, support and coping strategies for themselves and their children about child maltreatment, dealing with issues of self-blame and grief, family dynamics, parenting education and the impact of child maltreatment and other trauma experiences. Siblings, other children in the family such as cousins, and, in some cases, extended family members may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic setting. The nature of the impact on children and families underscores the importance of collaboration with community providers to improve outcomes for their health and well-being. The CAC case review process provides a vehicle for these collaborative discussions.

For the purposes of the standards, "mental health services" are defined as:

- Services that include trauma-informed, mental health screening, assessment, evidence-based treatment, and certain supports and interventions
- Outpatient psychotherapy that incorporates an evidence-based mental health treatment model approved by NCA. Current NCA-approved treatment models include AF-CBT, CFTSI, CPP, EMDR, PCIT, and TF-CBT
- Services provided by licensed health professionals, provisionally licensed mental health professionals under the supervision of a licensed clinician, and/or student interns from an accredited graduate program who is providing co-therapy with a licensed mental health professional.
- Services provided by clinicians who successfully complete intensive training in an evidence-based, child mental health treatment model ("EBT") including, AF-CBT, CPP, CFTSI, EMDR, PCIT, and TF-CBT. Minimal training includes 40 hours of instruction and

clinical consultation; training programs that include fewer than 40 contact hours may be supplemented with contact hours in evidence-based assessment.

- Clinicians who are engaged in continuing education, minimally 8 contact hours every two years, in the field of child maltreatment, trauma, and clinical application of evidence-informed treatment.

CRITERIA - Essential Components

A. Mental health services are provided by licensed professionals (or provisionally licensed, when supervised by a licensed clinician) trained to deliver trauma- focused, evidence-supported mental health assessment and treatment. All mental health providers for CAC children and families, whether providing services onsite or by linkage agreement with outside individuals, agencies, or institutions, must meet the following training, licensure, and medical malpractice requirements:

1) The CAC must further demonstrate that its mental health provider(s) meet at least ONE of the following criteria:

- **Licensed or provisionally licensed (with appropriate supervision) to provide clinical services in a relevant mental health field.**
- **Student intern in an accredited mental health related graduate program, when providing co-therapy with a licensed/certified mental health professional**

2) The CAC must ensure all providers are trained, and certified if applicable, to provide mental health assessment and/or treatment per CAC protocol requirements (or per standards, as highlighted below)

The CAC must demonstrate that all mental health provider(s) who receive CAC referrals have successfully completed intensive training in an evidence-based, child mental health treatment model (EBT), including AF-CBT, CFTSI, CPP, EMDR, PCIT, and TF-CBT. Training must include a minimum of 40 contact hours (didactic instruction and consultation); training programs that include fewer than 40 hours may be supplemented with contact hours in evidence-based assessment. Trained clinicians must be able to provide treatment to children who have experienced trauma through sexual abuse and other forms of maltreatment. (See "Putting Standards into Practice"). Children's Advocacy Centers of North Carolina (CACNC) recognizes that a clinician may receive training that meets this standard through various platforms, including the North Carolina Child Treatment Program (NC CTP) and the Medical University of South Carolina.

3. Clinicians providing mental health treatment to CAC children and families must maintain professional liability coverage.

B. Clinicians providing mental health treatment to CAC children and families must demonstrate completion of continuing education, minimally 8 contact hours every two years, in the field of child maltreatment, trauma, clinical practice, and/or cultural application of evidence-informed treatment.

STATEMENT OF INTENT

Because new research constantly emerges regarding the efficacy of mental health treatment modalities it is vital for clinicians to remain up to date on new research, evidence-supported treatment methods, and developments in the field that would help ensure the delivery of high-quality, relevant, and accessible services to children and families.

C. Evidence-supported, trauma-focused mental health services for the child are consistently available and include:

1. **Screening for traumatic events and related trauma symptoms, including risk for self-harm and suicide, to determine the need for treatment and treatment urgency.**
2. **Evidence-based, trauma-informed assessment to guide treatment.**
3. **Individualized treatment plan based on assessments that are periodically re- assessed.**
4. **Individualized, evidence-supported treatment appropriate for the child.**
5. **Child and caregiver engagement in treatment**
6. **Monitoring of trauma symptom reduction**
7. **Referral to other community services as needed.**

STATEMENT OF INTENT

The above description of services should guide discussions about expectations with all professionals who may provide mental health services, whether on-site or by referral via a linkage agreement. This will ensure that appropriate, relevant, and accessible services are available for the child and are outlined in a linkage agreement.

D. Mental health services are offered, available, and accessible to all CAC children who meet CAC case acceptance criteria at no cost to the family *(defined by NCA as "regardless of the ability to pay").*

STATEMENT OF INTENT

ALL CHILDREN REFERRED TO A CAC ARE ENTITLED TO, AND SHOULD BE OFFERED EVIDENCE-SUPPORTED, TRAUMA-FOCUSED MENTAL HEALTH SERVICES. CAC PROTOCOL, LINKAGE AGREEMENTS AND CONTRACTS MUST INCLUDE HOW EVALUATIONS ARE OFFERED AT NO COST TO THE FAMILY, MINIMALLY, IN ALL CASES MEETING THE CASE ACCEPTANCE CRITERIA. ADDITIONALLY, THE PROTOCOL, LINKAGE AGREEMENT AND CONTRACTS MUST INCLUDE CLINICAL CRITERIA WHEREBY CHILDREN ARE REFERRED BY THE MDT FOR MENTAL HEALTH SERVICES AT NO COST TO THE FAMILY.

IF A CAC CHOOSES TO BILL INSURANCE, THE CAC MUST WAIVE OR OTHERWISE COVER CO-

PAYMENTS. THE CAC MUST ALSO IDENTIFY AN ALTERNATIVE FUNDING SOURCE FOR THOSE CHILDREN WHO HAVE NOT MET THEIR DEDUCTIBLE. OVERALL, A FAMILY SHOULD NOT INCUR ANY EXPENSE FOR RECOMMENDED EVIDENCE-BASED, TRAUMA-INFORMED OUTPATIENT TREATMENT.

E. The CAC/MDT's written protocols include access to appropriate trauma-informed mental health assessment and treatment for all CAC children.

STATEMENT OF INTENT

All children referred to a CAC are entitled to, and should be offered evidence-supported, trauma-focused mental health services, including clinical assessment (both pre- and post-treatment) and treatment, when clinically indicated. Because mental health is a core component of a CAC's multidisciplinary team response, the CAC/MDT's written protocols must detail how such care may be provided and accessed by all CAC children.

F. The CAC/MDT's written protocols define the role and responsibility of the mental health professional(s) on the MDT, to include:

1. **Attending and actively participating in MDT case review and case management**
2. **Sharing relevant information with the MDT while protecting the children and families' rights to confidentiality and the mental health professional's legal and ethical requirements**
3. **Serving as a clinical consultant to the MDT regarding child trauma, general mental health needs, and evidence-based treatment**
4. **Monitoring and sharing with the MDT in the child and caregiver's engagement in, and completion of, treatment.**

STATEMENT OF INTENT

Evidence shows the importance of collaboration among community professionals serving children and families to improve clinical outcomes. A trained, licensed mental health professional participating in the MDT case review process assures that the child and caregiver's treatment needs can be assessed, monitored, and considered as the MDT makes case decisions. In some CACs, the child and caregiver's treatment provider(s) serve in this role; in others, it may be a mental health consultant.

G. The CAC/MDT's written protocols or policy include provisions about the sharing of mental health information, children and family's confidentiality, and mental health records that are protected in accordance with state and federal laws.

STATEMENT OF INTENT

Mental health services are designed to assess and mitigate the long-term adverse impacts of trauma and/or other mental health conditions, whereas investigative processes seek to gather evidentiary information and determine what the child may have experienced. Every effort

should be made to maintain clear boundaries between mental health treatment and investigative processes.

Each CAC must be aware that mental health treatment records containing identifiable, protected health information (PHI) are protected by HIPAA. Records pertaining directly to a child maltreatment investigation can be exempt from HIPAA and do not always require caregiver consent for release. The CAC should maintain a log of record releases of mental health treatment information per HIPAA regulations.

The protocol must include specific guidelines for the MDT and mental health providers regarding what and how information can be shared during case review, in accordance with state laws and professional ethical practice standards.

H. The CAC must provide services and/or referrals for the non-offending caregivers to address:

1. **Safety and well-being of the child**
2. **Involvement in their child's treatment when clinically appropriate**
3. **Emotional impact of maltreatment allegations for children and non-offending caregivers**
4. **Risk of future maltreatment**
5. **Issues or distress that allegations may trigger, including caregivers' own history of trauma and/or current experience of maltreatment, violence and/or other trauma.**
6. **Caregiver mental health assessment and treatment needs**

These services may be provided directly by the CAC and/or with linkage agreements with other trained, licensed providers.

STATEMENT OF INTENT

Evidence clearly demonstrates that non-offending caregiver and sibling support aids in the recovery of children directly experiencing or exposed to maltreatment and violence. Healthy caregiver and child relationships allow for healthy overall family functioning and well-being. CACs have long provided supportive services for caregivers and siblings through support groups, mental health services, and ongoing follow-up, either on-site or by linkage agreement.

It is important to consider the range of mental health issues that could impact the child's recovery or safety with particular attention to the caregiver's mental health, substance abuse, domestic violence, and other trauma history. Caregivers, siblings, and other family members may benefit from assessment, support, and mental health treatment to address the emotional impact of maltreatment allegations, reduce, or eliminate the risk of future maltreatment, and address issues that the allegations may trigger. Assessments and supports may be provided by clinicians, victim advocates or others, either on staff at the CAC or via linkage agreement.

I. Clinicians providing mental health services to CAC children must participate in ongoing clinical supervision and/or consultation by a trained, licensed provider.

STATEMENT OF INTENT

Clinical supervisors, clinical consultants and/or a senior clinician on staff must be licensed and trained in at least one of the six evidence-based treatment models approved by NCA. Supervision and consultation should be documented in a linkage agreement, log, or letter from the supervisor, consultant, or senior clinician. Clinical supervision or consultation is necessary to ensure appropriate quality services for CAC children and families. Individual and/or group supervision options for meeting this standard include:

Clinical supervision and/or consultation, may be offered individually or in a group, by a licensed senior clinician trained in an approved EBT. Clinical supervisors/consultants/senior clinicians may include:

- CAC staff
- Community mental health providers
- Nationally endorsed EBT trainers
- Other CAC staff within the state
- CACNC staff or contractors

CASE REVIEW: Standard 7

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 must occur at least once a month. Its focus is on planning and monitoring current cases. It is a formal process that serves as a complement to ongoing case discussions among the MDT members. Every CAC must implement a written process to set the criteria for review. The method and timing of case review may vary to fit the unique needs of a CAC community. For example, some CACs review every open case, while others review only complex or problematic cases or cases involved in prosecution. Representatives from each required discipline on the MDT (see standard 7c), including case specific representatives, must participate and provide input at case review. Confidentiality should be addressed in the CAC's written protocols or guidelines, in keeping with state and/or federal laws and professional ethics that govern information sharing among MDT members, including during case review.

Case review is the formal process that enables the MDT to monitor and assess its independent and collective effectiveness to ensure the safety and well-being of children and families. The process encourages mutual accountability and helps to assure that children's and families' needs are met sensitively, effectively and in a timely manner. Case review serves multiple purposes:

- Informed, collective case decisions are made.
- Recommendations are coordinated.
- Collaborative efforts are fostered.
- Formal and informal communications are promoted.
- Mutual support is provided.
- Experience and expertise of MDT members is shared and discussed.
- Protocols and procedures are reviewed.

CRITERIA - Essential Components

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

The CAC/MDT's protocol must include:

1. **Purpose of meetings**
2. **Frequency of meetings**
3. **Location of the meeting**
   - **In-person, which is best practice.**
   - **Hybrid: in-person with mechanism for virtual option**
   - **Virtual: mechanism for meeting, which must be a HIPAA compliant platform**
4. **Designated facilitator and/or coordinator**
5. **Designated attendees**
6. **Mechanism for review of all new cases**
7. **Process for developing case review agenda, including how MDT members add cases.**

8. **Process for HIPAA compliant distribution of the agenda**
9. **Procedures for addressing follow-up recommendations.**
10. **Procedures for re-review or notification to MDT members of outstanding cases**
    Note: *This could be a formal review, or a list provided to MDT with an opportunity for any updates*

STATEMENT OF INTENT

To maximize efficiency and to enhance the quality of a comprehensive case review, the CAC's written protocol clearly defines the process and expectations for all MDT members.

B. An intentional collaborative meeting for the purpose of reviewing and coordinating cases. This should be conducted monthly, at a minimum.

STATEMENT OF INTENT

Case review is a formal process that is conducted in addition to informal discussions and pre- and post-interview meetings. It affords the MDT the opportunity to review active cases, provide updated case information, address obstacles to effective investigations and service delivery, coordinate interventions, and receive training. It is a planned, regularly scheduled meeting of all MDT members and occurs at least once a month. Best practice would be minimally twice per month.

C. MDT agency representatives actively participating in case review must include, at a minimum:

1. **Case specific law enforcement investigator/supervisor**
2. **Case specific department of social services investigator/supervisor**
3. **Prosecutor**
4. **Medical provider**
5. **Mental health clinician**
6. **Case specific victim advocate**
7. **Case specific forensic interviewer**
8. **Children's Advocacy Center applicable staff**

STATEMENT OF INTENT

Full MDT participation at case review allows for the contribution of distinctive professional perspectives and expertise to optimize informed decision-making, case planning and coordinated service delivery. Case review must be attended by the identified agency representatives capable of making, informing and/or advocating for independent and collective decisions and providing the team with knowledge and expertise of their specific professions. All those participating should be familiar with the CAC/MDT process and the purpose and expectations of case review. Forensic interviewers, irrespective of which agency employs them, must be present at case review. Case review must include participants who are actively working on the cases under review, or who are representing case specific agencies with knowledge of

the case, to ensure direct communication between all parties. This does not preclude additional agency representatives' supervisors from participating as well. Additional agencies outlined in the administrative order may participate at the direction of the MDT. Participation in person is optimum; however, participation can be accomplished virtually as necessary to ensure the participation of all required disciplines and to respond to public health emergencies.

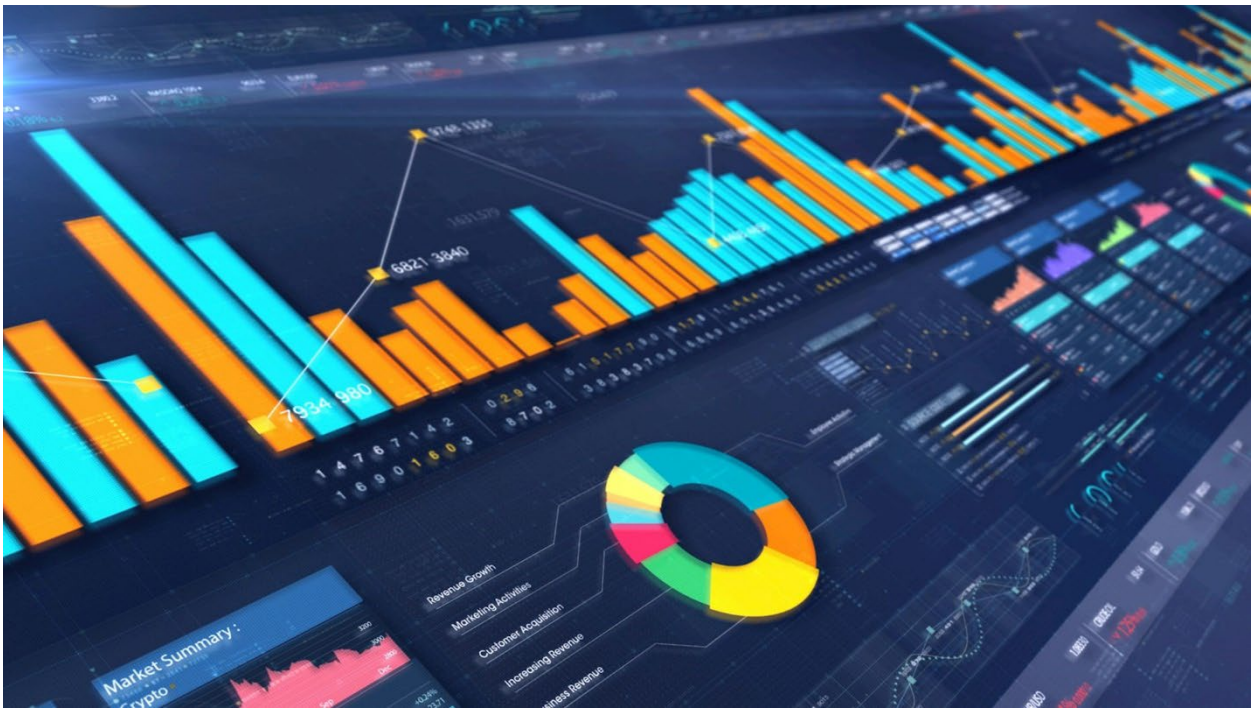
D. Case review is an informed and collaborative decision-making process with input from all MDT agency representatives.

- **Review of forensic interview outcomes**
- **Assessment of the family's reaction and response to the child's disclosure and involvement in**
- **the criminal justice and/or child protection systems**
- **Discussion, planning, and monitoring of the progress of the criminal investigation**
- **Discussion of child protection and other safety issues**
- **Discussion of issues and needs unique to individual children and families, including issues pertaining to access to services.**
- **Discussion of medical evaluation need or review of medical evaluation findings**
- **Discussion of emotional support and treatment needs of children and family members and strategies for meeting those needs.**
- **Discussion of how the CAC and MDT intervention is impacting the child and their family, including positive changes and challenges.**
- **Ensuring that all children and families are afforded the legal rights and comprehensive services to which they are entitled.**
- **Review of criminal and if applicable child protection case update, ongoing involvement with the child and family, and final dispositions**
- **Input for prosecution and charging**
- **Provision for court education and court support and accompaniment**
- **Review of prosecution sentencing decisions/dispositions**
- **Child well-being and outcomes, as available**

STATEMENT OF INTENT

In order to make informed case decisions and optimize service delivery and improve child and family outcomes, essential information and professional expertise are required from all disciplines. Decisions and interventions must be made with the input, discussion, and support of all involved professionals, and efforts must be coordinated, comprehensive and non-duplicative. The process and facilitation must ensure there is equitable participation and discussion among all MDT members to adequately address their respective and shared goals, mandates, interventions and services, questions, concerns, and outcomes.

CASE TRACKING: Standard 8



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 systems are able to collect and document demographic, case information, investigation outcomes, and intervention outcomes as well as generate statistical reports. The data collected is useful for monitoring ongoing case progress and program evaluation in order to inform continuous quality improvement, provide critical support for seeking funding, and respond to grant requirements.

Data collected from CACs is useful for advocacy, research, and legislative purposes to advance the field of child maltreatment. It may also be required for federal funding reporting requirements. Each CAC utilizes the case tracking system that suits its determined needs and is able to be supported by its available resources. Any case tracking system implemented must be compliant with all applicable privacy and confidentiality requirements.

CRITERIA - Essential Components

A. **The CAC/MDT's written protocols include the case-tracking process and information gathered through case closure at the CAC. This includes final disposition by the department of social services, law enforcement and the prosecutor's office, when applicable.**

STATEMENT OF INTENT

Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response. Often, MDT members will have a system to collect their own agency data; however, the MDT response requires the sharing of this information among its members to better inform individual and collective decision-making, ensure accurate updates to children and families, and inform quality improvements in coordinated services delivery. The CAC/MDT's written documents must detail the CAC's purpose, information to include, and a process for case tracking.

B. **The CAC tracks and, at a minimum, can retrieve and report statistical information.**

1. **Statistical information includes the following data:**
2. **Demographic information about the child and family**
3. **Demographic information about the alleged offender**
4. **Type(s) of alleged maltreatment**
5. **Relationship of alleged offender to child**
6. **MDT members involved with children and families and relevant outcomes.**
7. **Final case disposition for the department of social services, law enforcement and the prosecutor**
8. **Status and provision of medical and mental health referrals and/or services**
9. **Status and provision of victim advocacy services**

STATEMENT OF INTENT

CACs are required to demonstrate the ability to collect and retrieve case-specific information for all CAC clients. This includes basic demographic information, services provided, and outcome information contributed by the MDT in a thorough and timely fashion. Codifying case tracking procedures in CAC/MDT's written documents underscores its importance and helps to assure the MDT members are accountable to each other and ultimately, to the children and families they individually and collectively serve.

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

STATEMENT OF INTENT

Case tracking is an important function of the CAC that requires dedicated time and accuracy in its implementation. Designated individuals must be identified to implement and/or oversee the case-tracking process, and the number and type of individual(s) charged with this responsibility is determined by the CAC's staffing and case volume. Some CACs define case tracking as part of the MDT coordinator or case manager's role. Some dedicate a staff position 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. The CAC/MDT's written protocols must outline how MDT agencies can access case-specific information and aggregate data for quality assurance, quality improvement, funding, and research purposes.

STATEMENT OF INTENT

Because case data may be useful to MDT members for a variety of purposes, it is important that all members have access to aggregate and/or specific case information as determined through discussions with all participating agencies. Policies must also include how the release of this data to participating agencies and other complies with confidentiality requirements.

E. The CAC collects child and family feedback, as appropriate, to inform service delivery.

STATEMENT OF INTENT

Continuous quality assurance is the hallmark of a well-functioning CAC. This requires seeking feedback directly from children and families regarding their experiences with all aspects of CAC services so that improvements may be made as needed and on an ongoing basis. Soliciting feedback can be accomplished using various tools including, but not limited to, satisfaction surveys. To optimize the quality of the feedback received, survey instruments need to be valid and reliable. CACs that actively participate in NCAs Outcome Measurement System (OMS) can be assured that they meet and exceed this requirement.

ORGANIZATIONAL CAPACITY: Standard 9

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 and implementation of its operations. This entity oversees ongoing business practices of the CAC, including setting and implementing administrative policies, hiring, and managing personnel, obtaining funding, supervising program and fiscal operations, and long-term planning. CAC organizational structure depends upon the unique needs and resources of its community; it may be an independent nonprofit agency, a component of an umbrella organization such as a hospital or nonprofit human service or victim service agency, or part of a governmental entity, such as prosecution, social services, or law enforcement. Each of these options has strengths, limitations, and implications for collaboration, planning, governance, community partnerships, and resource development. Regardless of where the program is housed or under what legal auspices, all CACs must create a structure such that participating agencies feel equal investment in, and collaborative responsibility for, its operations, protocols, and services.

CRITERIA - Essential Components

A. The CAC is an incorporated, private nonprofit organization, government-based agency, university or health care system, tribal entity, or a component of such an organization, agency, system, or tribal entity.

STATEMENT OF INTENT

The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This is critical to maintain, grow and ensure sustainability of the CAC, its components, and services.

B. The CAC maintains, at a minimum, current general commercial liability, professional liability, directors' and officers' liability, and cyber liability insurance as appropriate for its organization.

STATEMENT OF INTENT

Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Nonprofit CACs, including those that are a component of an umbrella nonprofit or nonprofit hospital, must carry, at a minimum, general commercial liability, professional liability, cyber liability, and directors' and officers' liability insurance. Government-based CACs must carry, at a minimum, general commercial liability, professional liability, and cyber liability insurance or provide documentation of comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed, including renters, property owners, and automobile insurance, depending upon their individual needs. Other policies to consider would be: non-owned and hired, medical liability, workers compensation, unemployment, sexual/physical misconduct, employment practices liability, or to be added to an external contractor's policies as an additional insured on the certificate of insurance.

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

Every CAC must have written policies and procedures that govern its administrative operations. Administrative policies and procedures must include, at a minimum:

1. **Personnel policies, procedures, and documents must include:**
   a. Job descriptions for all positions
   b. Anti-discrimination policy
   c. Conflict of interest policy
   d. Whistleblower policy
   e. Social media use policy
   f. Corrective action and grievance/appellate policy

2. **Financial management policies must include:**
   a. Accounting policies and procedures that demonstrate adequate internal controls and segregation of duties.
   b. Credit card usage policy

3. **Safety and security policies must include:**
   a. Code of conduct (this should guide behavior between CAC staff, between CAC staff and MDT members, and between CAC staff, MDT members and children and families)
   b. Child protection policies, including the obligation to report maltreatment.
   c. Emergency response policies (including medical emergencies, natural disasters, fire, flood, power outage, and acts or threats of violence)
   d. Building security and safety policy and procedures (including client safety when onsite contractors/building managers are in the building, exit diagrams and plans for evacuation, staff alert system, alarm system for the property, coded locks)
   e. Anti-violence in the workplace policy
   f. Weapons on premises policies and procedures
   g. Drug usage policy
   h. Smoke-free environment

4. **Information technology policies must include:**
   a. Document retention and destruction policies
   b. Data security policies
   c. Confidentiality policies – HIPAA requirements

STATEMENT OF INTENT

The CAC has clearly developed organizational policies and procedures that ensure appropriate administrative governance. This is critical to maintain, grow and ensure sustainability of the CAC, its components, and services.

D. The CAC and/or its umbrella organization is required to conduct an annual independent financial audit when its annual actual expenses meet or exceed $750,000. If a CAC and/or its umbrella organization expends $750,000 or more in a single fiscal year of federally grant paid expenses the entity is required to complete a federal single audit in addition to the independent audit.

Organizations whose annual gross expenses fall below $750,000 and meet or exceed $200,000 must conduct a CPA-completed financial review. Those organizations with gross annual expenses below $200,000 must provide their Board-approved financial statements.

This applies to the entity as a whole, not to individual programs that operate under the same agency EIN.

STATEMENT OF INTENT

Confidence in the integrity of the fiscal operations of the CAC is critical to the long-term sustainability of the organization. An annual independent audit is one tool to assess for fiscal soundness and internal controls for financial management. A financial review is sufficient for those CACs with annual actual expenses equal to or less than $750,000 and that meet or exceed $200,000. CACs with annual budgets below $200,000 must provide their Board-approved financial statements.

Reporting Requirements for Audited Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) that meet or exceed $750,000 are required to have an audit of their financial statements. If a management letter is prepared by the independent accountant (CPA), it must be included with the audit report. Additionally, if a CAC and/or its umbrella organization expends $750,000 or more in a single fiscal year of federally grant paid expenses the entity is required to complete a federal single audit in addition to the independent audit.

Reporting Requirements for Reviewed Financial Statements:
All centers with annual actual expenses (as determined by United States generally accepted accounting principles) less than $750,000 that meet or exceed $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 must be included with the review report.

E. The CAC has, and demonstrates compliance with, written screening policies for staff, board members and volunteers. Policies must include national criminal background checks, sex offender registration checks, child abuse registry checks. The CAC must provide training and supervision to staff, Board, and volunteers on this process. In discussion with its Board and MDT, a CAC must determine what is a disqualifying finding in a background check.

Background checks should be completed upon hiring of CAC staff, contracting with direct service providers, or onboarding Board members, and volunteers, and then every two years thereafter. Linkage agreements with direct service providers must include requirements for background checks by the contracted agency/provider with the agency/provider policy and log of completion on file at the CAC. Per North Carolina Administrative Code, CACs are prohibited from accessing child abuse registry checks through the North Carolina Department of Health and Human Services Responsible Individuals List (RIL).

STATEMENT OF INTENT

CAC staff, direct service providers, Board members and volunteers perform a wide variety of functions within CACs, and CACs could attract individuals who are emotionally unprepared or unfit for the nature and expectations of the work.

F. The CAC has a written succession plan to ensure the orderly transition of leadership and direct service staff positions and the continued operations and service provision by the CAC.

STATEMENT OF INTENT

A succession plan assists in guiding and safeguarding the CAC and/or its umbrella organization through unplanned or unexpected change. This kind of risk management, mission and business continuity is equally important in facilitating a smooth transition when CAC staff change is predictable and planned. A succession plan outlines leadership development, staff development and emergency responsibilities for the CAC, and it reflects its commitment and helps ensure a sustained, healthy functioning organization. The plan should be developed specific to the uniqueness of the CAC or its umbrella organization, and reviewed and updated annually, to include at a minimum:

- Temporary staffing strategies
- Long-term and/or permanent leadership replacement procedures
- Cross-training plan
- Financial considerations to include a Board approved operating reserve that is maintained.
- Communication plan
- Leadership and direct service positions/functions essential to the operation of the CAC to include maintenance of updated job descriptions
  Note: For CACs who are under umbrella entities, are medical/governmental/tribal based the plan will look different than for those who are stand-alone agencies. Please draft the policy to reflect how the CAC informs the umbrella of an absence or employee loss and what agency policy will be followed for replacement.

G. **The CAC has addressed its sustainability through the implementation of a current strategic plan approved by the governing entity of the CAC.**

STATEMENT OF INTENT

To assure long-term viability of the organization, the CAC must have a plan that addresses programmatic and operational needs. The governing entity for such a plan may be an oversight committee or a board of directors, as appropriate for the CAC's organizational structure and needs. If the CAC is under an umbrella organization, the umbrella's strategic plan can be used if it includes CAC specific goals, objectives, and timelines. In general, to be considered current, a strategic plan should be no more than five years old.

Plan should include at, a minimum:

- Stakeholder input in plan creation
- Goals, objectives, and timeline
- Mechanism for routine monitoring of plan implementation
- Review and approval by CAC board or relevant governing body

H. The CAC promotes employee well-being by providing training and resources regarding the effects of vicarious trauma, providing techniques for building resiliency, and maintaining organizational and supervisory strategies to address vicarious trauma and its impact on staff.

STATEMENT OF INTENT

To help ensure the health and well-being of all employees and improve employee retention, the CAC must raise awareness about the impact of work-related trauma exposure through training and develop organizational practices that identify and mitigate against negative consequences for staff, the delivery of quality services, and staff turnover. This includes identifying the risk of vicarious trauma for frontline staff and those exposed to the associated trauma of the work more indirectly. Additionally, it includes trauma-informed workplace practices and techniques for individual self-care and resiliency. CACs and umbrella organizations should integrate and maintain organizational and supervisory strategies to address and respond to vicarious trauma among staff members.

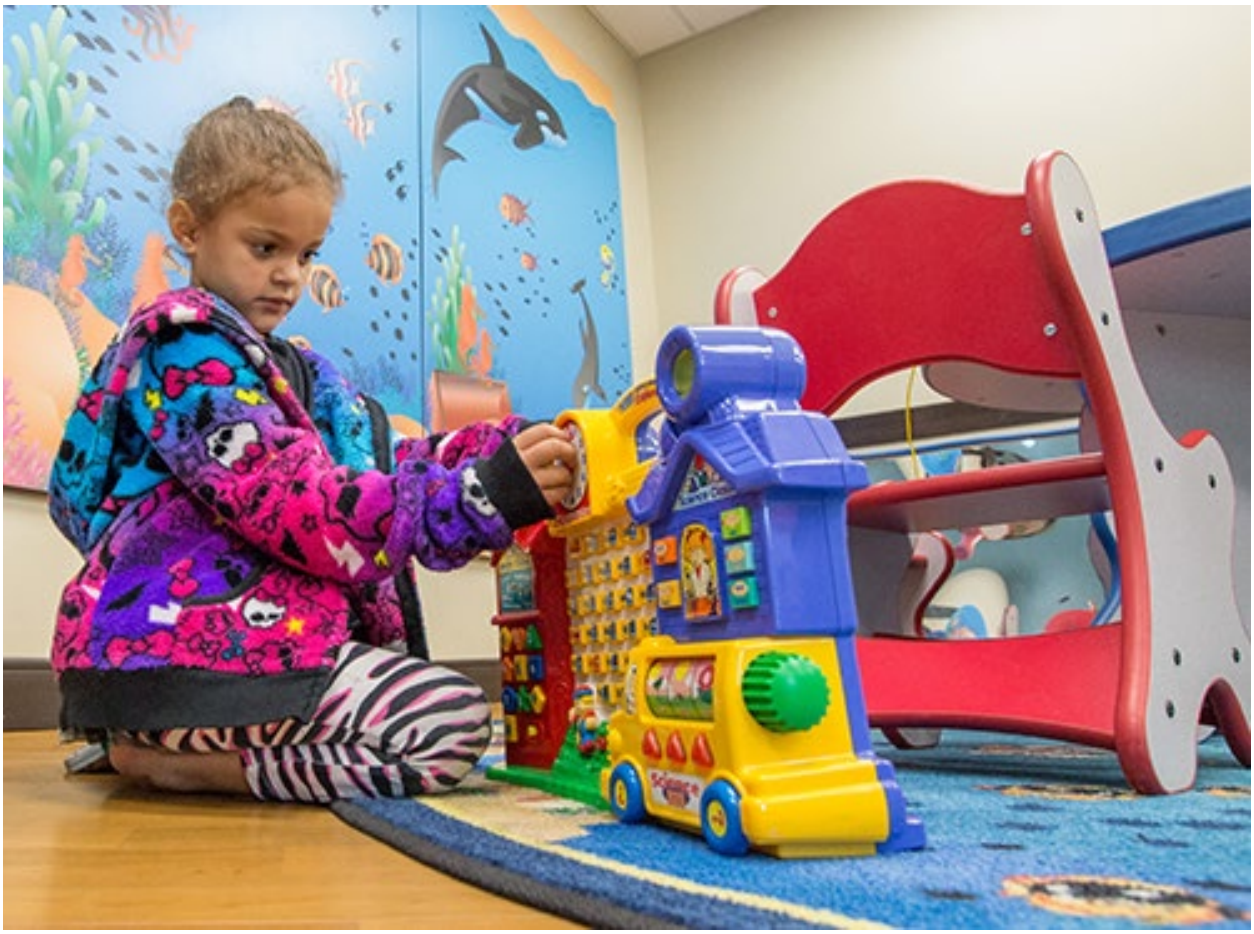
I. The CAC provides and/or facilitates training and resources on vicarious trauma and building resiliency of all MDT members.
Note: It could be helpful if the CAC *provides a list of potential trauma exposures of the MDT, which could include minimally the review of child abuse images from cases, interviews with offenders, interviews with other case involved individuals.*

STATEMENT OF INTENT

CACs have a primary role in building and enhancing the functioning of the MDT. A highly functioning MDT assures vicarious trauma is acknowledged and addressed and has an awareness and understanding of the importance of work-related trauma exposure and its

potential consequences. While MDT agencies have primary responsibility for the health and well-being of their respective staff, the CAC is responsible for providing training, ongoing recognition, and discussion and strategies to collaboratively address vicarious trauma and help build team members' resiliency. Moreover, the health of the MDT directly impacts service delivery to children and families. Therefore, attention to this issue is important for helping to ensure high-quality services and improve outcomes for maltreated children and families.

CHILD-FOCUSED SETTING: Standard 10



The CAC is comfortable, private, physically, and psychologically safe, accessible, and welcoming for children and their family members.

RATIONALE

A CAC requires a separate, child/youth- setting that provides a safe, comfortable, and neutral place where forensic interviews and CAC services can be appropriately provided for children and families. While every center may look different, the criteria below help define specific ways the environment can help children and families feel physically and psychologically safe and comfortable. These include making sure the physical setting meets basic child safety standards, ensuring alleged adult offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating a welcoming environment for those served.

All CACs are unique to their community and there is not a gold standard way to build, design or decorate a CAC. The CAC should have adequate square footage, for its determined on-site operations that conforms to safety and accessibility laws and generally accepted guidelines. The CAC must have space, equipment, or procedures to ensure the privacy of children and families, CAC staff, and MDT members as appropriate. Care should be taken to ensure space for the separation and observation of children and families as indicated. Additionally, MDT members should have access to workspace and equipment on-site to carry out the necessary functions associated with their roles on the MDT, including, but not limited to, meeting with families, participating in forensic interviews and sharing necessary information. Consideration should be given to future growth and the need for additional space as caseloads increase and additional program components are needed.

Special attention should be given to designing and decorating the facility to be comfortable and welcoming for children and families, CAC staff, and MDT members. Attention to detail can help alleviate anxiety, instill comfort, and ensure the CAC is a welcoming place for all children and nonoffending family members.

CRITERIA - Essential Components

A. The CAC is a designated, task-appropriate facility or space that:

1. **Is maintained in a manner that is private, physically, and psychologically safe, and developmentally appropriate for children and families.**
2. **Provides observation and supervision with children and families within sight or hearing distance of CAC staff, MDT members, or volunteers at all times.**
3. **Is convenient, accessible, and welcoming to children, families, and MDT members.**
4. **Is appropriate for the delivery of CAC services.**
5. **Provides age-appropriate toys and resources that are child-proofed, cleaned, and sanitized to be as safe as possible.**

STATEMENT OF INTENT

The CAC is a child-focused setting that ensures both physical and psychological safety for all children and families. Special attention should be paid to the location, design, and accessibility of the CAC for the children, families and MDT members that utilize the center.

B. The CAC has, and abides by, written policies and procedures that ensure separation of victims and children/youth with concerns for problematic sexual behaviors throughout delivery of services at the CAC, including forensic interviews. CACs may provide services to youth with problematic sexual behaviors, but they must have developed and implemented appropriate safety protocols to protect other children receiving services at the CAC.

STATEMENT OF INTENT

The CAC has written policies and procedures that ensure the separation of victims and children/youth with concerns for problematic sexual behaviors during the investigative process and throughout service delivery of the full array of CAC services.

Written policy should dictate that alleged adult sex offenders, and others deemed to be a possible threat to the child and non-offending caregiver, are prohibited from CAC property because they create risk for maltreatment, violence, intimidation, or psychological distress. If the CAC shares space with another agency, the physical space, scheduling, and policies must assure separation of CAC children and families from the other agency's clientele, the community-at-large or potential offenders. Physical features, policies, and scheduling practices ensure physical and psychological safety of CAC children and family members.
Note: For agencies who have co-located space your policy will need to state how you ensure separation of CAC clients and families from other individuals in the building or on the grounds where CAC services are provided.

Many CACs serve a vital role in their communities by providing services for children with problematic sexual behaviors. CACs that offer services to this population should have policies and procedures in place to maintain physical and psychological safety at all times for other child victims and their families visiting the CAC.

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

STATEMENT OF INTENT

Component C refers to new buildings and custom-designed facilities. For CACs operating in older building or facilities reasonable accommodations must be made to ensure the facility is physically accessible to children and family members, CAC staff and MDT members. If the CAC cannot be structurally modified, arrangements for equivalent services should be made through a linkage agreement with an alternate location that meets CAC facility standards. CACs must be in compliance with state and federal guidelines including the Americans with Disabilities Act (ADA).

D. Separate and private area(s) are available for confidential case consultation and discussion, meetings, or interviews, and for children and families awaiting services.

STATEMENT OF INTENT

To ensure a physically and psychologically safe environment for children and families, confidentiality and respect for privacy is of paramount concern in a CAC. Children and families, CAC staff, and MDT members require privacy to discuss cases in a location where visitors or others not directly involved with the case may overhear them. Separate areas should also be available for private family member interviews and for individual family members to privately discuss aspects of their case with CAC staff and MDT members. Care should be taken to ensure that private meeting areas are not only physically separate but also soundproofed, so conversations cannot be overheard. Some centers place soundproofing materials in or on walls when building or refurbishing their centers. Others place stereos or sound machines in rooms to block sound.

E. CACs are required to implement a code of conduct for CAC staff and MDT members ensuring the safety of children and families. CAC staff members must have received and agreed to the code of conduct. MDT members must be informed of the CAC's code of conduct and that it guides work within the CAC.
Code of conduct content must include:

- **Child and family safety and well-being is a primary priority that guides policy and practice decisions.**
- **Collaborative practice that emphasizes the value of a CAC**
- **Interaction not related to CAC service provision between CAC staff, direct service providers, MDT members and children and families is prohibited.**
- **Physical contact between children and families and CAC staff, direct service providers, and MDT members should be avoided unless necessary for the provision of services or for safety and well-being purposes.**
- **CAC staff interaction with children and families should be interruptible and/or observable.**
- **It is the duty of CAC staff and MDT members to immediately report suspected child maltreatment including witness to violence.**
- **A procedure to report violations of the code of conduct.**

STATEMENT OF INTENT

A code of conduct is a set of rules around the behavior for CAC staff and MDT members, and it acts as an explicit expression of personal and professional expectations in their work with one another and with children and families. It also serves as an external statement of the CAC/MDT's commitment to its core values and principles for interdisciplinary, cross-agency work. In addition, a code of conduct helps provide for a healthy work environment for CAC staff and MDT members, and thereby helps ensure the delivery of high-quality, relevant, and accessible child- and family-centered services. In the event of any violations of stated codes of conduct, it also provides an understanding of how to report and/or address them.

F. A child safety assessment must be conducted annually to ensure that the building and CAC space is a safe and child-focused setting for children and their families.

STATEMENT OF INTENT

Core to CACs is their ability to provide a setting that underscores the critical importance of providing and/or restoring a sense of safety, both physically and psychologically, for children and families in crisis. Safety must be assured for children and families to participate in forensic interviews, investigations, evaluations and identified services. Assessments must be conducted at least annually to ensure physical and psychological safety is met as children and families' needs change.

The child safety assessment tool should be reviewed every two years and updated as needed.

G. North Carolina CAC staff and MDT members are mandatory reporters of suspected maltreatment to the Department of Social Services as well as law enforcement. If location of the child or the location of the maltreatment is unknown report to the Department of Social Services and Sheriff's Department located within your county. CACs are required to ensure that mandated reporter training is provided to all staff and volunteers. Updates to state statutes and mandated reporter laws must be provided to CAC staff and volunteers annually, if applicable.

STATEMENT OF INTENT

Given the nature of the work of CACs/MDTs, all those involved in the delivery of services to children and families must be trained and understand the requirements of mandated reporter laws and the procedures for reporting known or suspected instances of child maltreatment. Annual training is important to ensure that changes in the law and/or agency reporting procedures can be understood and observed.