15 Lessons Learned from Child Advocacy Centers[1]

Multidisciplinary teams (MDTs) are defined as groups of individuals from diverse organizations and agencies who come together to review cases and address systemic problems. Elder abuse MDTs have existed since the early 1980s (Teaster, Nerenberg, & Stansbury, 2003). However, they have gained greater attention with the establishment of Elder Justice Forensic Centers first developed in California under the financial auspices of the Archstone Foundation in 2003 (Schneider, Mosqueda, Falk, & Huba, 2010). Although elder abuse MDTs have existed for decades, there remains room for improvement (Teaster et al. 2003).

Child abuse MDTs have existed over the same time period, but have gained greater prominence, proliferation, and notoriety. For example, all 50 states statutorily encourage or require some form of collaboration in the realm of child abuse (Child Welfare Information Gateway, 2013a; Jones & Cross, 2003; U.S. DHHS, 1999).[2] One model of a child abuse MDT designed initially to address child sexual abuse is the Child Advocacy Center (CAC). There are over 850 CACs nationwide (Kline, 2014). Although the research base upon which to advocate for the proliferation of CACs remains sparse (Connell, 2009; Lalayants & Epstein, 2005; Newman, Dannenfelser, & Pendleton, 2005), the experiential base upon which to draw is vast. In addition, research on various components of the CAC model has been extensively investigated over the past 30 years culminating in a body of research unimaginable when this field began. For example, there are now evidence-based child forensic interviewing techniques (Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007; Saywitz & Camparo, 2013), medical forensic examinations (Finkel, 2013), and therapeutic interventions (Cohen, Murray & Mannarino, 2013; Runyon, Kenny, Berry, Deblinger, & Brown, 2006).

The field of child abuse has witnessed a sea change in the way society responds to the needs of child victims over the past 30 years (Conners-Burrow et al., 2012; Jones et al., 2010), with the prominence of the MDT approach being paramount among those changes. Research has identified a number of beneficial outcomes associated with the use of a CAC, such as increased collaboration, caregiver satisfaction, child satisfaction with a medical exam, and higher acceptance of cases for prosecution (Cross et al., 2007; Faller & Palusci. 2007; Joa & Godlberg Edelson, 2004; Jones, Cross, Walsh, & Simone, 2007; Miller & Rubin, 2009; Smith, Witte, & Fricker-Elhai, 2006; Walsh, Lippert, Cross, Maurice, & Davison, 2008; Wolfteich & Loggins, 2007). The benefits associated with systems change have accrued to those working within the confines of the various systems as well (Newman, Dannenfelser, & Pendleton, 2005).

Given the distinction between elder abuse and child abuse, and the inequity in resources between the two fields, the adoption of elder abuse MDTs is warranted. This article presents lessons learned from CACs that could enhance the

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[2] For a statutory review of MDTs, see National District Attorney's Association (2008). Multidisciplinary/multi-agency child protection teams statutes, available at http://www.ndaa.org/pdf/ncpca_statute_multidisciplinary_nov_08.pdf. Federal legislation also encourages states to adopt MDTs, for example, "…creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations;…" (Child Abuse Prevention and Treatment Act, 42 U.S.C. 5106a(a)(2)(A)).

development and practice of elder abuse MDTs.[3] There is no inference that the child abuse model is appropriate for explaining elder abuse. Rather, this article focuses on process. Furthermore, this article is not designed to persuade readers that the MDT approach is preferable to remaining in their professional silos. That is a given. Rather, this article is designed to assist those wishing to develop or improve an elder abuse MDT. Information that would be persuasive rather than illuminating is not presented here.

Macrolevel Lessons

Lesson #1: Cultivate a Powerful Political Advocate

People sometimes wonder how CACs became the recipients of federal funding. In the 1980s, many professionals and child advocates voiced their concerns that traditional investigative practices were further traumatizing child victims of sexual abuse (Whitcomb, 1992). In the early 1980s when then District Attorney Bud Cramer (Huntsville, AL), who had been working these cases, looked around for a better way of handling child sexual abuse prosecutions, he found no model upon which to draw (Chandler, 2006). Mr. Cramer proceeded to identify the specific problems with the response to child sexual abuse and then developed solutions to those problems, which eventually formed the components of the first Child Advocacy Center (CAC), established in 1985 in Huntsville, AL. In 1990, Mr. Cramer was elected to the US House of Representatives where he facilitated passage of the *Victims of Child Abuse Act of 1992*[4] (P. Law 102-586) designed to ensure that the National Children's Alliance (NCA), the parent organization for CACs, Regional offices, and local CACs, would receive federal funds to provide support, resources, training, and technical assistance. However, it is advisable to cultivate multiple political advocates on both sides of the isle to ensure continued support upon an advocate's departure.

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[3] Two caveats must be presented. First, as CACs were initially developed to respond to child sexual abuse (Jackson, 2004), much of the CAC literature focuses on child sexual abuse (CSA), just one form of child maltreatment (since that time, many CACs have broadened their eligibility criteria). Alternatively, elder abuse MDTs review all types of elder abuse, but may be dominated slightly by financial exploitation (Navarro, Wilber, & Yonashiro, & Homeier, 2010). Second, CACs were developed explicitly for the benefit of victims. While CACs recognize the needs of offenders, they make no attempt to intervene in their lives. Elder abuse MDTs are encouraged to respond to both victims and offenders.

[4] The Victims of Child Abuse (VOCA) Act of 1990 was introduced by Representative Mike DeWine of Ohio, a former prosecutor who was interested in how to improve the handling of child abuse cases in criminal courts. Congress enacted the Victims of Child Abuse Act of 1990 (Public Law 101-647) on November 29, 1990, designed to create a comprehensive, multidisciplinary response to child abuse across the nation. However, Congress made no appropriation. Bud Cramer's first piece of legislation was the National Children's Advocacy Program Act of 1992 designed to enhance the Victims of Child Abuse Act of 1990 (see Cramer's 1992 testimony at https://www.ncjrs.gov/app/abstractdb/AbstractDBDetails.aspx?id=137920). Congress passed the Victims of Crime Act of 1992 (Public Law 102-586) on November 4, 1992 (Delany-Shabazz, 1995) with appropriation. Representative Cramer led the passage of the amended Victims of Child Abuse Act of 1992 and since that time federal funding has been provided for the development and implementation of Children's Advocacy Centers through the National Children's Alliance, established the four Regional Children's Advocacy Centers, and funded technical assistance and training through the National District Attorney's Association and the National Child Advocacy Center.

Lesson #2: Establish a Parent Organization

In 1987, to ensure that communities starting a CAC adhered to certain core values espoused by the model, then-District Attorney Cramer founded NCA (Chandler, 2006), the organization that would become the parent organization for all CACs.[5] During the 1990s, the model's architects struggled with how to standardize the model. It was not until 2000 that the NCA formally adopted 10 core components of the CAC model (Jackson, 2004). The standards were updated in 2011.[6] The NCA administers an accreditation program to ensure that member programs that use the CAC title function within the NCA standards which define the manner in which services are to be delivered. Importantly, however, it is simultaneously presumed that CACs will differ in meaningful ways as they are developed within the contours of their own community (Jackson, 2004; Walsh, Jones, & Cross, 2003). Thus, CACs must continually strike a balance between adherence to national standards and flexibility in the implementation of those standards.[7] A parent organization has many benefits. It can place parameters around areas of practice,[8] create materials to facilitate the replication of the model,[9] it can provide assistance with legislative action,[10] coordinate efforts (funding, training) among the CACs cull statistics across CACs useful for fund raising, and develop and disseminate a powerful message from the collective.[11] This is an aspirational goal for elder abuse MDTs, but an eye towards developing national standards to ensure the implementation of and adherence to best practices, and a host of other benefits, through a parent organization should nonetheless constitute a critical goal.

Microlevel Lessons

Lesson #3: Fund a Facilitator

Tension exists between promoting the idea that any community can start an MDT without funds in hand and the importance of having a paid facilitator. In reality, both must exist. However, CACs have adopted the position that having a designated person with authority (referred to here as the CAC coordinator, recognizing that CACs use different terms for this designated person) plays a crucial role in a number of ways. Perhaps the most important role of the CAC coordinator is to facilitate the development of the team. An MDT, comprised of a diverse set of professionals, is the foundation of a CAC (Cross, Fine, Jones, & Walsh, 2012). It is this diversity that is the strength of an MDT, but simultaneously the challenge. MDTs are encouraged to work with people's different strengths, work styles, attitudes, and education levels, and to determine how that strength can benefit the MDT. In order for there to be true collaboration the parties must come together to create something different – something

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[5] It should be noted that there are many child abuse MDTs that are not CACs. To use the title CAC, the program must be reviewed by an NCA team and designated as Developing, Associate, or Accredited CAC by the NCA.

[6] The standards currently are being updated again, but current standards are available at http://www.nationalchildrensalliance.org/index.php?s=76

[7] More evaluation and research is needed to distinguish between variation in models that is appropriate because of differences in community needs and variation that instead represent differences in the quality of services (Cross et al., 2008).

[8] The standards are available in a pdf at http://www.nationalchildrensalliance.org/index.php?s=76

[9] The standards are available in a pdf at http://www.nationalchildrensalliance.org/index.php?s=76

[10] http://www.nationalchildrensalliance.org/LegislativeResources

[11] http://www.nationalchildrensalliance.org/NCADigitalMediaKit

greater than the sum of their individual parts (Blowers et al., 2012). Hallet and Stevenson (1980) emphasize that MDT members typically do not start out as a team, but over time these disparate members become a "team." It is a complex task to manage this expertise diversity and unify individual professionals into a cohesive whole (Sheppard & Zangrillo, 1996). A skilled individual must facilitate group development and instill within the MDT a collective team identification, defined as "the emotional significance that team members of a given group attach to their membership in that group" (Van der Vegt & Bunderson, 2005, p. 533). The skilled facilitator must also manage the power dynamics inherent in most teams (Bell, 2001). A paid facilitator (rather than someone from a discipline on the MDT) is preferable for this role as they are perceived as neutral which may serve to diffuse the power differentials among team members. MDTs require committed members who know their position, know their responsibility, and know and trust their teammates (Feng et al., 2010), all of which is aided by a skilled facilitator. In sum, the CAC coordinator must have a strong understanding of group dynamics, how to resolve conflict, how to encourage equal participation from all MDT members, and understanding the key role they play in piecing information together, identifying gaps, and coordinating expert knowledge (Bell, 2001; Brandon et al., 2005). In addition to molding these diverse individuals into a cohesive team, the CAC facilitator may be responsible for coordinating and facilitating case review meetings, handling intake, follow up, and accountability. These are all functions that transform disparate actions into a collective whole.

Lesson #4: Be Prepared for Ongoing Training

All members of an MDT recognize the need for training in their own area of specialization, but other forms of training involving the MDT are equally important. Attending MDT trainings together not only promotes professional development (e.g., enhances investigatory skills), but also promotes morale and builds cohesion and trust among the team members (Newman, Dannenfelser, & Pendleton, 2005). Another important form of training is cross training. Differences among member organizations can include (1) philosophical approaches and organizational missions, (2) operating procedures and organizational capacities to serve children and families, (3) policies related to confidentiality, (4) methods of meeting with and relating to families, and (5) approaches to case planning, types of interventions, tracking of progress, and case closure (OCAN, 2010). These differences need to be made explicit, discussed, and then configured in such a way as to promote a common vision that can accommodate these differences. Finally, training needs to be a line item in the budget as both individual and group training must be on-going. As a practical matter, MDTs are unfortunately frequently plagued with turnover necessitating training dollars.

Lesson #5: Identify the MDT's Core Function

Typically, MDTs are developed to address one or more problems identified in a community. The problem may be a need for systems change, enhancing investigations, or enhancing service delivery for victims. One of the first activities of the MDT is to explicitly identify their core function, which may be written into their mission statement. The reason this activity is so important is that team members may make disparate assumptions about the MDT's core function, which may result in conflict (Jackson, 2012). Consensus among the MDT members on a core function will facilitate team cohesion. Furthermore, in times of disagreement, the facilitator can use the core function as a way of re-directing the team and making choices among alternatives that best suit the core function of the MDT.

Lesson #6: Institutionalize the MDT and Procedures

Some MDTs may have existed informally for years. However, institutionalizing the team and documenting its functions and procedures on paper ensures continuity of existing coordination and collaboration beyond the tenure

of specific individuals (OJJDP, 1998). Memorandums of Understanding (MOUs) are formal agreements between two or more parties that outline the roles, responsibilities, and expectations of each party. MOUs generally are developed to ensure that the participants understand the scope and boundaries of their roles and relationships to one another. For example, the therapist's role on the MDT cannot seep into the role of an investigator. The NCA now requires documentation of how the forensic process is separated from mental health treatment. In addition, MOUs should outline the process for any conflict resolution so procedures are predictable and standardized should differences of opinion occur among members of the group (OCAN, 2010).

Just as formalizing the MDT is necessary, so too is it necessary to formalize the practice of MDTs by the adoption of protocols (Jent et al., 2009). Protocols provide structure and guidance to the MDT's activities. Protocols can be developed for any aspect of the case that concerns the MDT, for example, referral and intake, investigation, decision making, services, and prosecution. Protocols both promote predictability and enhance accountability. Care should be taken in developing and adopting protocols, however, as there are potential legal ramifications when protocols are not followed.

Lesson #7: Identify a Point-of-Contact Person for Families

In spite of all the advances the field of child abuse has made, Jones et al. (2010) report that communication between MDT members and families continues to suffer, with 32 percent of nonoffending caregivers in their study being dissatisfied because of the lack of clear and regular communication regarding the status of the case. Although it seems like such a small detail, communication is critical to client satisfaction. The NCA stresses the importance of families having a designated person families can contact at any time to learn information about their case. This is particularly important when a case is being staffed by an MDT comprised of a diverse range of professionals. Jones et al. (2010) further recommend the implementation of regularly timed verbal or written updates to families about the status of their case by the point-of-contact person.

Lesson #8: Confidentiality is Not Insurmountable

Thirty years ago, confidentiality issues were thought to be insurmountable. Professionals could not figure out how to tackle this issue, but they have figured it out. There are a variety of ways in confidentiality can be dealt with:

- Written protocols can delineate circumstances under which the MDT members can share information
- Each member can sign a confidentiality form at the beginning of each case review meeting
- Clients can be asked to sign a confidentiality form so that case information may be shared among MDT members (Virginia Department of Criminal Justice Services, 2005, p. A-1).
- Statutory changes that permit information sharing among MDT members can be enacted (Child Welfare Information Gateway, 2013b; Virginia Department of Criminal Justice Services, 2005[12])

Confidentiality is a serious issue that is not to be taken lightly. However, concerns about confidentiality need not stand in the way of forming an MDT.

[12] For example, "Any information exchanged for the purpose of such consultation shall not be considered a violation of §§63.2–102, 63.2–104 or §63.2–105." (VA Code §63.2–1503(K)).

Lesson #9: More than one Mission is Acceptable

MDTs do not have to choose among missions. In the 1980s, it was the belief that children were being traumatized by the system that prompted the need for systems change within the criminal justice system. Simultaneously, it was recognized that to disrupt the intergenerational transmission of abuse, children needed to receive therapeutic services and therefore mental health services were incorporated into the CAC model. Thus, the CAC model has adopted a two-pronged mission of addressing the needs of victims while enhancing the criminal justice response (Jackson, 2004). Since its development, it has become recognized that children's recovery is predicated on the non-offending caregiver's mental health as well, and therefore services for non-offending caregivers has been adopted by many CACs. The paramount emphasis on secondary prevention via victims and those surrounding the victim underscores the holistic response to child abuse adopted by the CAC model.

Lesson #10: Screen for Other Types of Abuse

Although a child might be reported for a particular type of abuse, it is now recognized that many children experience multiple forms of abuse. David Finkelhor first developed the concept of polyvictimization in the field of child abuse (Finkelhor, Turner, Hamby, & Ormrod, 2011). Admittedly, CACs have been slow to incorporate this body of research into their practice. However, some CACs have instituted practices whereby they screen non-offending caregivers for trauma exposure, sometimes in the form of a domestic violence screening (Pulido & Gupta, 2002; Thackeray, Scribano, & Rhoda, 2010). Screening for domestic violence was implemented not only because it impacts the non-offending caretaker's ability to protect the child, but also because at least some children will have been victims of exposure to domestic violence, a form of child abuse that will need to be addressed.

Lesson #11: Hold Face-to-Face Case Review Meetings

Case review, where team members come together to discuss cases, has been an integral part of CACs (Jackson, 2004). The face-to-face interactions with other team members provides an opportunity for relationship development, collaboration, and problem solving (Kistin et al., 2010; Newman et al., 2005) while moving the case through the dual track process of victim recovery and the criminal justice system. Studies find that an MDT of moderate size (e.g., 8 to 12) performs best (Van der Vegt & Bunderson, 2005). Kenty (n.d.) provides guidance on facilitating case review. Accountability is important for the MDT members. Therefore, team member assignments should be made explicit during the meeting. The facilitator should also write and distribute cursory meeting minutes as soon as possible, including the documentation of tasks identified at the case review meeting and accepted by team members, and then hold team members accountable at the following meeting (Lee, Li, & So, 2005).

Lesson #12: Participate in and Support Research

When child abuse first came to the public's attention in the 1960s, there was an absence of research on child abuse, how to intervene, and how to investigate and prosecute these cases. Since that time, the field of child abuse has benefited tremendously from research. The field began by identifying child physical abuse markers to enable physicians to distinguish between physical abuse and accidental injuries (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). Distinguishing between normal or accidental injuries and indicators of sexual abuse proved difficult, although over the past 30 years much has been learned that assists physicians in making these judgments (Finkel, 2013). The challenges associated with prosecuting child sexual abuse spawned research on how to extract accurate information from children and there are now several evidence-based interviewing protocols (Saywitz & Camparo, 2013; see Chronach, Viljoen & Hanson, 2005, for a review of forensic interviewing). In response to the need to therapeutically intervene in these cases, researchers began to development

therapeutic interventions, resulting in a number of evidence-based therapies for use with child victims (Wilson, 2012).[13] The NCA endorses the use of evidence-based trauma-focused therapies for use with child victims of sexual abuse, particularly trauma-focused cognitive behavioral therapy, although fidelity remains an issue (Allen & Johnson, 2012).[14] Sometimes research feels remote to practitioners, and it did take over 30 years to accumulate this knowledge, but this research directly and positively impacts the lives of child victims every day.

Lesson #13: Keep Cultural Competency in the Forefront

The NCA believes so strongly that cultural competency permeates all other areas of practice that it is listed second among the ten standards. Cultural competency refers to sensitivity to gender, sexual orientation, race, ethnicity, religion, disability status, family dynamics, literacy, age, and socioeconomic status. A community partnership can work to be culturally competent by:

- Being sensitive to cultural values and ways in which decisions are made
- Being sensitive to ways in which MDT members interact with individuals from diverse backgrounds
- Providing materials that are translated into other languages or hiring interpreters
- Being respectful of others' beliefs
- Providing and/or participating in cultural competency training
- Inviting individuals from groups served by the CAC to join as Board members
- Being open to feedback from representatives of ethnic, religious, racial, and other groups

Lesson #14: Professionalize the Field

The child abuse field has witnessed the gradual professionalization of individuals working in the realm of child abuse. For example, when the field of child abuse began no one had heard of a child abuse specialty for physicians. There were a smattering of physicians throughout the country that dedicated themselves to child sexual abuse (e.g., Heger, Ticson, Velasquez, & Bernier, 2002), but it was a labor of love rather than a professional certification. Today there is a pediatrics subspecialty referred to as child abuse pediatrics.[15] There are also specially trained mental health professionals specializing in the treatment of child victims. Law enforcement and prosecutors also specialize in child abuse, sometimes in the form of child abuse units. This professionalization of the field has no doubt had a tremendous impact on the victims of child abuse.

Lesson #15: Be Realistic and Be Forewarned

Be realistic: An MDT approach can be a hard sell. Some feel the time spent and the number of professionals involved is a price too high to pay (Lee, Li, & So, 2005). Collaboration can result in frustration and conflict. Do not expect to change the world with the creation of an MDT, although it can make the working lives of those on the

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[13] NCTSN & NCA (2008). CAC Directors' Guide to Mental Health Services for Abused Children see http://www.nationalcac.org/images/pdfs/SRCAC/dir.%20guide%20to%20mh.pdf

[14] Not every child needs additional services. Everyone responds differently to trauma. A supportive family may be more important than therapy in some cases. Given the diverse needs of victims, a continuum of accessible treatments and services is imperative (Tavkar & Hansen, 2011).

[15] American Board of Pediatrics, see https://www.abms.org/who_we_help/physicians/specialties.aspx

team more enjoyable and their work more effective. An MDT is a tool, not a remedy that will solve all problems (Anetzberger, 2011).

And be forewarned: Improvement never ends. Even after 30 years of implementing reforms, there is still room for improvement. Jones et al. (2010) write that reforms have historically focused on victims, but it is time to consider the needs of those around the victims. Jones, Cross, Walsh, and Simone (2007) found that nonoffending caregivers are more satisfied with services when they feel supported by investigators, which may enable them to better support their children. This suggests the need to pay attention to these intangibles (Featherstone & Fraser, 2012).

Conclusions

This paper identified fifteen lessons learned from CACs. Some lessons were more philosophical than practical, but each was identified to enhance the development and practice of elder abuse MDTs. While it would be nice if every community could have an Elder Justice Forensic Center, in reality they cannot. However, every community can have an elder abuse MDT. Additional resources presented in Appendix A are available to assist communities in developing their own elder abuse MDT.

Appendix A – Additional Resources

Center for Excellence in Elder Abuse and Neglect. Creating an Elder Justice Forensic Center. Irvine, CA: Center of Excellence in Elder Abuse and Neglect, Archstone Foundation, and UniHealth Foundation. DVD and manual available for purchase at http://terranova.org/ProductDetail.aspx?pid=EAFD

Office of Justice Programs (2000). Our Aging Population: Promoting Empowerment, Preventing Victimization, and Implementing Coordinated Interventions (NCJ 186256). Washington, DC: Office of Justice Programs. http://ojp.gov/docs/ncj_186256.pdf

Michael S. McCampbell (2010). The Collaboration Toolkit for Community Organizations: Effective Strategies to Partner with Law Enforcement. Office of Community Oriented Policing Services, US Department of Justice. https://cops.usdoj.gov/RIC/Publications/cops-p192-pub.pdf

Susan Keilitz, Brenda K. Uekert, & Theresa Jones (2012). Prosecution Guide to Effective Collaboration on Elder Abuse. Williamsburg, VA: National Center for State Courts. http://www.eldersandcourts.org/Elder-Abuse/~/media/Microsites/Files/cec/Prosecution%20Collaboration.ashx

NCALL provides a list of resources for a coordinated community response to elder abuse http://ncall.us/sites/ncall.us/files/resources/CCR%20Resources_0.pdf

Lori A. Stiegel (2005). Elder Abuse Fatality Review teams: A Replication Manual. Washington, DC: American Bar Association Commission on Law and Aging. http://apps.americanbar.org/aging/publications/docs/fatalitymanual.pdf

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