



**A PROTOCOL
DEVELOPMENT GUIDE
FOR CHILDREN'S ADVOCACY
CENTERS &
MULTI-DISCIPLINARY
TEAMS**

A collaborative multidisciplinary response in child abuse cases has been found to be effective in reducing trauma to children, promoting successful legal intervention, and ensuring the availability of appropriate follow-up services for children and their families. A highly functioning Multi-Disciplinary Team (MDT) is at the core of every Children's Advocacy Center that serves as the neutral, child-focused site within which coordinated investigation, intervention and case management can be accomplished.

Protocols or operational guidelines are the mechanisms that prescribe the collaborative response among core members of the MDT, including law enforcement, child protection, prosecution, medical, mental health, victim advocacy and Children's Advocacy Center professionals.

The purpose of written guidelines is to:

- Clarify the roles of each discipline;
- Coordinate the activities of each agency;
- Reduce duplication of effort; and
- Focus activities on the needs of the child to reduce trauma and promote healing.

Operational guidelines should be developed collaboratively to promote respect for the rights, mandates, and obligations of each agency that is a core member of the MDT, and should be detailed enough to guide an investigation that includes multiple agencies and disciplines so that coordination and cooperation is maximized.

NOTE: Disciplines/titles of multidisciplinary team members may vary around the country. The discipline titles used in this document represent the key broad categories needed for a multidisciplinary team and are not meant to be exclusionary. Also, in complex urban environments, there may be multiple layers of "team" to address the unique issues of case volume and numbers of personnel.

How to Utilize This Tool

In developing or revising guidelines for handling child abuse cases in your community, your team may wish to address the following issues using key questions included for each of the stages. The stages outlined in this document are:

Stage I: Definition of Team Purpose, Composition and Function

Stage II: Case Initiation

Stage III: Case Decision Making

Stage IV: Case Resolution

Stage V: Creating a CAC

Stage I: Definition of Team Purpose, Composition and Function

Objective: At the completion of this stage the multidisciplinary agencies involved will have identified a shared vision and goals, created definitions and criteria for cases involving the multidisciplinary response, and established guidelines for communication and information sharing.

Guiding Questions:

1. What is the working definition of “team”? Is the team a group of specified individuals from core agencies assigned to respond together to allegations of abuse (e.g. investigation team)? Is the team a group of representatives of agencies working together cooperatively to manage interventions in child abuse cases (e.g. review team or advisory team)? Are there multiple teams fulfilling different functions at different times throughout an intervention?
2. What is the purpose/philosophy of the team? What do you see as the ultimate outcome as a result of the team’s collaborative efforts?
3. What are the goals of the multidisciplinary intervention as it relates to the investigation, assessment, treatment and outcomes for the child and family?
4. Who are the members of the team? Does it minimally include representation from the following and how is membership determined? Define the roles and responsibilities of each of the partners.
 - Law Enforcement (LE)
 - Child Protective Services (CPS)
 - Prosecution
 - Mental Health
 - Medical
 - Victim Advocacy
 - Children’s Advocacy Center (CAC)
5. Who are the other liaisons that are needed to serve other communities within your jurisdiction?
6. What kinds of relationships or processes are, or need to be, in place with these liaisons to foster their involvement?
7. What geographic area does the team cover? Specifically, who needs to be involved for each jurisdiction?
8. What definitions of child maltreatment are used for the types of cases covered under the guidelines? What other definitions of terms are used or needed in the guidelines?
9. What types of cases are handled utilizing the team approach? How will the team prioritize their focus on these cases?
 - Ages of children served
 - Allegations Investigated:
 - Sexual Abuse
 - Physical Abuse
 - Neglect/Abandonment
 - Witness to Injury or Violent Crime
 - Kidnapping/Commercial Sexual Exploitation
 - Other
10. Who ultimately signs the guidelines from each discipline committing the partner agencies to the MDT/CAC process? (How will agency leadership be involved in the guidelines development process to ensure they fully support the final product?)

11. How frequently are the guidelines and team function evaluated? What formal mechanism is established for multidisciplinary team members to provide feedback and suggestions? Who takes the lead in ensuring that the guidelines are reviewed at least every three years and updated whenever there is a change in leadership or policy/practice?
12. How do the guidelines ensure that all members of the multidisciplinary team, including appropriate CAC staff as defined by the needs of the case, are routinely involved in investigations and/or team intervention? One mechanism to identify where and when members of the team enter the process is to develop case flow diagrams to map how a case typically progresses through the current response system.
13. How do the MDT guidelines ensure that joint investigations and timely information exchange are accomplished in agreed upon cases, as defined in operating guidelines, while protecting confidential information in a manner consistent with legal, ethical, and professional standards of practice?
14. How do the guidelines address LE and CPS first response procedures so that joint forensic interviews occur at the CAC, where one has been established, in at least 75% of the cases meeting the MDT criteria for joint investigation? If a CAC has not been established, what provisions are in place for interviews to be conducted in a neutral environment that is psychologically and physically safe and developmentally appropriate?
15. How do the MDT guidelines ensure and demonstrate that members participate in relevant training in child abuse investigation, prosecution and case management on an annual basis?

Stage II: Case Initiation

Objective: At the completion of this stage the multidisciplinary agencies involved will have identified the process for receiving child abuse reports, sharing information prior to the forensic interview of the child (pre-interview meeting), conducting the investigative interview, and follow up items after the completion of the interview (post-interview meeting).

Guiding Questions:

1. What are the roles and responsibilities of law enforcement?
2. What are the roles and responsibilities of child protective services?
3. When and how does cross-referral occur between law enforcement and child protective services to initiate a joint investigation?
4. What agreed upon format or procedures are used for cross-referral? What information needs to be shared? Within what time frames? What are the procedures for routine sharing of information among team members? How do the written guidelines support these procedures?
5. How are cases screened and prioritized? How quickly are cases responded to by the investigative team? What is the first response protocol (in the field)? Who conducts the preliminary risk assessment? How are these procedures documented in the MDT guidelines?
6. What information is collected and shared among investigative team members prior to the forensic interview?
7. Where do the team interviews occur? Are they routinely conducted at the CAC? Are specific locations prohibited unless there are specific circumstances? When and how is a decision made to schedule a forensic interview at the CAC?

8. How do the MDT guidelines ensure that team interviews include participation by all team members with investigative responsibilities in each case?
9. How does the team select an appropriate, trained interviewer? Who conducts the interview with the child?
 - Joint interview (CPS and LE)?
 - Most appropriate team member?
 - Consistent lead agency (CPS or LE)?
 - Child forensic interview specialist?
10. How does the team ensure that the forensic interviews are legally sound, non-duplicative, non-leading, and neutral? What evidence-supported, nationally recognized forensic interviewer training program is utilized to prepare professionals to conduct forensic interviews? What process is implemented for regular peer review for all professionals who conduct FIs for the MDT? How is this documented and evaluated? How is continuing education obtained and documented?
11. Is the CAC/MDT set up in a way that allows other team members to observe the interview? How are team members notified of the interview?
12. How do observers communicate questions or concerns to the interviewer? During breaks in the interview process? Through communications systems (“bug in ear,” phone, teleprompting, texting, etc.)?
13. How are non-offending caretakers and siblings interviewed? Who conducts which interviews? How is the sequence of interviews determined? How is the information gathered in the interviews processed for preliminary case planning?
14. Are the interviews audio and/or videotaped? How is information about the interview shared with absent team members to avoid duplicative interviewing?
15. How does the MDT/CAC promote investigative interviews that are culturally competent? How are the needs of children from distinct cultural groups planned for and met prior to the forensic interview? How are MDT members, CAC staff, volunteers, and board members recruited with a view toward reflecting the demographics of the community to be served?
16. What provisions are made for non-English-speaking children and family members throughout the investigation process, medical exam, and follow-up services provided at the CAC? What provisions are made to understand non-English terms and their cultural context if used by bilingual children?
17. What specialized services are made available for children with disabilities?
18. Do the guidelines commit the MDT/CAC to conducting a community needs assessment on a regular basis, to ensure that services and outreach to underserved populations is of high quality, relevant and accessible to children and families in need of service?
19. What confidentiality policies and procedures for the multidisciplinary team are in place to insure client privacy while allowing for the sharing of relevant information consistent with legal, ethical, and professional standards of practice?

Stage III: Case Decision-Making

Objective: At the completion of this stage the multidisciplinary agencies involved will have identified the processes for interviewing the alleged offender, gathering additional corroborative evidence, referrals for medical evaluations, case review and case staffing, and decisions regarding civil court action and/or criminal prosecution.

Guiding Questions:

1. Where are alleged offenders interviewed? By whom?
2. What procedures are delineated in the MDT guidelines for gathering additional evidence?
3. Who removes children from their home if necessary? Who participates in that decision and how is that information shared with other team members?
4. How are the following medically-related issues addressed in the guidelines?
 - Who determines if a medical examination is needed by the child victim? Under what circumstances is a medical evaluation recommended? What is the purpose of the medical exam? Are medical evaluations offered to all child victims?
 - How are MDT members trained and by whom regarding the purpose of the medical exam? How and by whom are children/families educated regarding the medical evaluation?
 - Who conducts the medical exam? Do health care providers have pediatric and child abuse expertise?
 - Where are the medical exams conducted?
 - What information will be provided to the medical examiner prior to the exam and by whom? How is duplicative information gathering prevented?
 - How is the medical evaluation made available (scheduling, linkage with providers, triage, transportation, etc.)?
 - How are emergency situations addressed (what are the criteria and procedures for an emergency medical exam)?
 - How are multiple examinations avoided?
 - What are the procedures delineated in the guidelines for forensic documentation and collection/preservation of evidence?
 - How is the medical evaluation coordinated with the MDT in order to avoid duplication of interviewing and history-taking?
 - What are the procedures for medical intervention in cases of suspected physical abuse and maltreatment (if applicable)?
 - What provisions are made for sharing relevant information with the team while protecting the client's right to confidentiality?
 - How are findings of the medical evaluation shared with investigators and prosecutors on the MDT in a routine and timely manner?
 - How does the team ensure access to appropriate medical evaluation and treatment for all CAC clients regardless of ability to pay?
5. Which team members are designated in the MDT guidelines to participate in regular formal case staffings? Are the following team representatives included?
 - Law Enforcement
 - Child Protective Services
 - Prosecution
 - Mental Health
 - Medical
 - Victim Advocacy
 - Children's Advocacy Center

6. How do the MDT guidelines ensure that case review meetings occur on a regularly scheduled basis? When and where do team case reviews occur?
7. What are the written criteria for formal case review and case review procedures?
8. Who coordinates case reviews or staffings? How are team members informed of cases to be reviewed prior to case review?
9. How are case reviews conducted? Are they utilized as an opportunity for the MDT to increase understanding of the complexity of child abuse cases?
10. What are the roles of the health care provider, mental health professional, and advocate on the MDT (including case tracking and review?)
11. What provisions are made for participation in MDT case review meetings by a health care provider, a mental health professional, and an advocate?
12. How does the team engage in case decision-making? What procedures are utilized for conflict resolution?
13. How are recommendations from case review communicated to appropriate parties for implementation?
14. How is the case review process evaluated and updated to meet the needs of team members and their agencies?

Stage IV: Case Resolution

Objective: At the completion of this stage, the multidisciplinary agencies involved will have identified the processes for referring the child victim for mental health therapy, support through victim/family advocacy, preparation for court, and case tracking.

Guiding Questions:

1. How is access to evidence-based, trauma-focused mental health evaluation and treatment routinely made available to all CAC clients regardless of ability to pay? Who explains this to the family and child?
2. What alternative mental health services are available (i.e. traditional healing and/or support systems in culturally diverse communities)?
3. Are mental health services provided on-site or through linkage agreements with other appropriate agencies or providers?
4. What provisions are made in the MDT guidelines for sharing relevant mental health information with the team while protecting the client's right to confidentiality? How do the guidelines define the role of the mental health professional on the MDT and at case management deliberations?
5. How is the forensic interview or assessment kept separate from mental health treatment?
6. How are the following victim services routinely made available throughout the investigation and prosecution?
 - Crisis intervention and support (for the victim and non-offending parents)
 - Client education regarding investigation, prosecution and treatment
 - Information regarding the rights of a crime victim and local services
 - Pre-sentencing victim impact statements

7. Who are the individuals/agencies designated to provide victim advocacy services as part of the MDT response? If multiple agencies are involved over the course of an investigation, how do the MDT guidelines provide for coordination of services and information exchange among service providers? How are victim advocates trained and provided with opportunities for continuing education?
8. Are designated, trained individuals available to provide victim support/advocacy on-site and/or through linkages with other service agencies? Do services include:
 - Court support or preparation for the child victim
 - Court accompaniment
 - Crime victims compensation
 - Assistance with access to services such as protective orders, housing, public assistance, domestic violence intervention, and transportation
 - Crisis intervention, risk assessment and safety planning
 - Provision of updates to the family on case status
 - Active outreach and follow-up support services
 - Participation in case review MDT meetings
9. Does the team define the specific roles of volunteers and/or staff who will assist the victim and non-offending family members (i.e. Court Appointed Special Advocates (CASA), Guardians Ad Litem (GALs), Victim Witness Coordinators or Community-based Victim Advocates)?
10. What procedures are in place to provide periodic follow-up contact with the child and/or non-offending caregiver(s) including on-going information about civil and criminal legal proceedings?
11. What provisions ensure that cases are routinely tracked while the case is pending in the child protective and criminal justice systems? What are the case tracking criteria and procedures defined in the MDT guidelines?
12. What mechanisms does the CAC have in place to track and retrieve the following information?
 - Client demographics (including age, ethnicity, disability and gender)
 - MDT involvement and case outcomes for CPS, LE and Prosecution
 - Status/follow-up on medical and mental health services
 - NCA statistical information
 - Other information as appropriate
13. Who is identified to implement the case tracking process?
14. How do team members have access to tracking information?
15. What records are kept at the CAC?
16. What are the procedures to maintain the confidentiality of files, records and reports?
17. How is client and/or caretaker feedback about the investigation and treatment obtained?
18. What ancillary services are provided at the CAC? If offender intervention is provided, how are victim and offender services kept completely separate?
19. How are high profile (such as multiple victim and/or multiple offender) cases handled by the multidisciplinary team?
20. How are new members incorporated onto the team and what provisions are made for regular team training and interdisciplinary cross-training?

Stage V: Creating a CAC

Organizational Capacity

An MDT approach to child abuse cases has been determined through research and practice to provide a mechanism for agencies and disciplines with different mandates, responsibilities, and outcomes to work together toward a more effective and less traumatic intervention in cases of child maltreatment. The MDT response has been further enhanced with the establishment and replication of the Child Advocacy Center (CAC) model across the United States and internationally. The CAC model adds organizational capacity to the MDT response by creating a legal entity responsible for the governance of operations and maintenance of a child-focused facility that is neutral to the investigation and a locus for coordinated service delivery and quality assurance.

A CAC can be an incorporated, private non-profit organization or government-based agency or a component of such an organization or agency. Tasks that may facilitate the process to establish a CAC include:

- A. **Convene a working committee or task force of key individuals.** This includes key representatives of the core disciplines/agencies that respond to child abuse, including mandated responders and service providers. Membership should include prosecution, law enforcement, child protection, medical and mental health, and victim services. In many communities, sexual assault and domestic violence service providers are included as primary providers of victim and family services. Committee representatives should include decision-makers as well as frontline workers and supervisors so that the work of the committee can be implemented. *Who needs to be involved in your community?*
- B. **Select a leader who will convene the group and guide the process.** Leadership is critical to the success of the collaboration. It is helpful to identify a leader who has community prestige and power, excellent group facilitation skills, and a measure of neutrality. The role of task force leader is to encourage all viewpoints, weigh pros and cons, and effectively address agency concerns, while navigating interagency conflict as consensus is negotiated among the partner agencies. The leader should be able to focus the group on system improvements and strengths rather than system failures or deficits. Who are the possible leaders for this process in your community?
- C. **Conduct an assessment of the extent of the child abuse problem in the community and the current response system.** This includes collecting data on the number of cases handled by the core partners (e.g. CPS investigations, law enforcement investigations, cases prosecuted) and existing resources available in the community for medical, mental health and victim services for abused children and their families. It can be helpful to examine a sample selection of child abuse cases and track their route through the existing system to determine strengths, gaps and possible duplication of effort that could be streamlined for the partner agencies, and perhaps more importantly, for the involved children and families. What is the extent of the problem and how might a coordinated MDT improve the community response to child abuse?
- D. **Develop statements of mission and purpose for the CAC.** What is the scope and purpose of the CAC? Who are we? What do we do? For whom and for what purpose?
- E. **Determine the CAC service population.** What geographic area will be covered? Will only sexual abuse victims be served or will victims of physical abuse, severe neglect, sexual exploitation or other forms of child victimization be included?

- F. **Develop an interagency agreement for joint investigation and obtain agency commitment.** What is the common approach that participating agencies have agreed on?
- G. **Determine a CAC management structure.** Who will be the lead agency and how will the MDT be structured?
- H. **Multidisciplinary team protocol development.** How will the participating agencies on the MDT work together/ Who will comprise the MDT? Will some cases be handled by different teams? How will joint investigation occur? How will cases be reviewed and tracked by the team?
- I. **Research potential sources of support.** Who can help and in which ways? Who are the key stakeholders?
- J. **Plan and carry out resource development.** What resources are needed, how will they be obtained, and by whom?
- K. **Plan and implement community outreach and awareness campaign.** How will the community be informed about the CAC and the issue of child abuse?
- L. **Develop governance board or advisory structure.** Who will make policy decisions or provide guidance to the CAC? How will the MDT advisory board be structured? How will members be recruited, oriented, and retained? How will MDT members have input into the process?
- M. **Provide training for MDT members and the community.** How will training be provided, by whom, for whom, and how often? What partnerships can be made in the community to share training? How will information gained in training be brought back to the larger MDT?
- N. **Will the CAC/MDT have a role in providing prevention education in the community?** Will the focus be primary, secondary, or tertiary?
- O. **Develop program evaluation and accountability plans.** How will the CAC/MDT process and structure be evaluated on a regular basis to demonstrate accountability and identify areas where the system is working and areas where there are challenges?
- P. **Cultivate leadership on ongoing basis.** How will leadership be developed to ensure the long-term viability of the CAC/MDT?
- Q. **Staffing and agency roles.** What staff roles and qualifications are needed at the beginning of the CAC and as it grows? Will team members from participating agencies be co-located at the CAC? Will interviews be conducted by a forensic interview specialist employed by the CAC or will agency investigators conduct the interviews?
- R. **Determine the organizational structure and create appropriate legal agreements as needed,** such as articles of incorporation, bylaws, and a board of directors if not currently under an existing organization, MDT advisory board members, interagency agreements, operational protocols, and linkage agreements.
- S. **Develop administrative policies and procedures** pertinent to staff, board members, volunteers, and clients.
- T. **Determine fiscal policies** including budget, insurance coverages, audit requirements, HR policies, and staff and volunteer screening.
- U. **Develop a written succession plan and a strategic plan for the organization.**
- V. **Develop and support training and information on vicarious trauma and resiliency** for staff and partner agency members.

Cultural Competency

1. Develop a cultural competency plan that includes an assessment of the community, goals, objectives, timelines, and a method of evaluation. The plan should look at diversity in a broader way than just ethnicity or language. What is the process for implementing that plan?
2. What provisions are in place for non-English speaking, deaf, or hard of hearing children and their non-offending family members throughout the investigation and after? What resources exist within the CAC, partner agency, and larger community to provide appropriate interpreter services?
3. How does the CAC reflect the larger community? How does the CAC provide an experience that is welcoming and respectful of all members of the community? How does the MDT ensure that all aspects of the process are culturally and developmentally appropriate for the child and their non-offending family members?
4. What type of outreach is needed and planned to engage different parts of the community? Who will be involved? What other community groups can be approached as partners?
5. What steps are taken to ensure that the MDT, staff, volunteers, and board of the CAC reflect the larger community?

Child-focused Setting

1. How will the MDT create a comfortable, private, physically and psychologically safe place for a diverse population of children and their family members? How will the MDT ensure the CAC is geographically and physical accessible to clients and MDT members?
2. What space is required to provide observation and supervision of children? What space is necessary to allow for live observation of forensic interviews by members of the MDT with investigative responsibilities? Is space available for pre and post team meetings? Is space available for confidential and private meetings between the MDT and non-offending caregivers?
3. What provisions are made to separate victims and alleged offenders? What procedures are in written guidelines to remove offenders from the facility? What provisions are made to separate sexually reactive children from other children present in the CAC?
4. How is the safety of children ensured, including confidentiality, privacy, precautions for childproofing the center, and keeping toys clean and hazard-free?
5. How is physical and programmatic space maintained/prioritized for additional on-site services such as medical evaluations and mental health treatment?

Note: This tool was developed by staff of the four Regional Children's Advocacy Centers with funding from the US Department of Justice, Office of Juvenile Justice and Delinquency Prevention. It should only be utilized within the context of technical assistance on the development of MDT and CAC programs. Content is based on procedures and services that comply with National Children's Alliance standards for accreditation of Children's Advocacy Centers.

Addendum

National Children's Alliance (NCA) sets standards for accreditation of Children's Advocacy Center Programs. This addendum will outline minimum standards for training and continuing education for professionals that are part of an MDT affiliated with the CAC and/or employees of the CAC. These criteria are essential to the successful application and review for accreditation and re-accreditation by NCA. Please see the complete version of National Children's Alliance Standards for Accredited Membership, which can be found at www.nca-online.org. Technical assistance can be obtained in meeting these standards by contacting the Regional Children's Advocacy Center that serves your state.

Forensic Interviewers

CACs vary with regard to who conducts forensic interviews on behalf of the MDT. The role can be filled by an employee of the CAC, law enforcement officers, CPS workers, federal law enforcement officers, and other MDT members as determined by the MDT. Regardless of who fulfills the role, certain criteria must be met to minimally meet accreditation standards:

- Forensic Interviewers have specialized training in conducting forensic interviews including:
 - Completion of 32 hours instruction and practice utilizing an evidence-supported interview protocol
 - Pre- and post-testing reflecting understanding of the principles of legally sound interviewing
 - Training content that includes child development, question design, implementation of the protocol, dynamics of abuse, disclosure process, cultural competency, suggestibility
 - Practice component with standardized review process
 - Required reading of current articles specific to the practice of forensic interviewing
 - Curriculum that is included on NCA's list of nationally or state recognized FI training
- Forensic Interviewers must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 98 hours of CEU/CME credits every 2 years.
- Forensic interviewers must participate in a structured peer review process at a minimum of 2 times per year for quality assurance purposes:
 - Ongoing opportunities to network with peers
 - Review and performance feedback of actual interviews in a professional and confidential setting

Victim Advocates

Victim advocacy is integral and fundamental to the MDT response. This role can be filled by a designated victim advocate and/or by another member of the MDT with requisite training and experience. Advocates from multiple agencies may work with families/children at different stages of the process but are coordinated to provide consistent support for the child/family throughout the process.

- A minimum of 24 hours specialized training in Victim Advocacy including the following areas of instruction:
 - Dynamics of abuse
 - Trauma-informed services
 - Crisis assessment and intervention
 - Risk assessment and safety planning
 - Professional ethics and boundaries
 - Understanding the coordinated MDT response
 - Assistance in assessing/obtaining victims' rights as outlined by law
 - Court education, support and accompaniment
 - Assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, interpreters, among others as determined for individual clients
- Victim advocacy service providers must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of 8 contact hours every 2 years.
- Victim advocates provide the following constellation of services:
 - Crisis assessment, intervention, risk assessment and safety planning
 - Assessment of individual needs and cultural considerations
 - Presence at the CAC during the forensic interview
 - Provision of education and access to crime victim compensation
 - Assistance in procuring concrete services
 - Provision of referrals for medical and mental health treatment as needed
 - Access to transportation for case related meetings/events
 - Engagement in the family's response to the investigation
 - Participation in case review to communicate needs to the MDT
 - Provision of case updates to the family
 - Provision of court education and support
 - Coordinated case management among victim advocacy service providers

Mental Health Providers

Evidence based trauma-focused mental health services have been determined to reduce the impact of trauma and provide a higher probability of effectiveness of treatment for children who have experienced child abuse. To ensure that children have access to appropriate mental health treatment, accreditation standards delineate the education and training requirements providers should possess that are employed by or who are a referral source for the CAC by linkage agreement.

The following training requirements are required for mental health providers:

- Mental health providers must demonstrate completion of 40 contact hour CEUs in accordance with the provider's license requirements
- CEUs must be from specific evidence-based treatment for trauma training
- Providers must demonstrate clinical supervision hours provided by a licensed clinical supervisor
- Providers must meet one of three academic training standards:

1. Masters' Degree/Licensed/certified or supervised by a licensed mental health provider
 2. Masters' degree/license-eligible in a related mental health field
 3. Student intern in an accredited graduate program, supervised by a licensed/certified mental health professional, both of whom must also meet the 40 hour training requirement
- Providers must demonstrate completion of continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 years.
 - Evidence-supported trauma-focused mental health services must include:
 - Trauma-specific assessment including traumatic events and abuse-related trauma symptoms
 - Use of standardized assessment measures initially and periodically
 - Individualized treatment plan based on assessments and periodic re-assessments
 - Individualized evidence supported treatment appropriate for children and family members
 - Child and caregiver engagement in treatment
 - Referral to other community services as needed

Medical Providers

Medical evaluations must be conducted by health care providers with specific training in child sexual abuse and pediatrics. This includes physicians, advance practice nurses, physician assistants and sexual assault nurse examiners who meet the following training and eligibility standards for a medical provider. The CAC's written protocols should outline how medical evaluations are accessed by clients and shared with the MDT.

At least one of the following training standards must be demonstrated:

- Child Abuse Pediatrics Sub-board eligibility or certification.
- Physicians without certification, Advanced Practice Nurses, and Physician Assistants with a minimum of 16 hours formal didactic training in the medical evaluation of child sexual abuse.
- SANE's without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency based clinical preceptorship.
- Medical providers must demonstrate continuing education consisting of a minimum of 8 hours every two years in the field of child abuse.
- Providers must demonstrate at minimum that 50% of all abnormal or diagnostic findings have undergone expert peer review by an "advanced medical consultant" (qualifications delineated in NCA Accreditation Standards – see Appendix 2 attached to the Standards).
- Documentation of medical findings by written record and photographic documentation are required to be maintained in compliance with federal rules governing protection of patient privacy.

Source: NCA Accreditation Standards as revised 2017.