Midwest Regional
CHILDREN'S ADVOCACY CENTERS




2013 Key Survey Findings

National Multi-Site Survey of Children's Advocacy Centers

The Midwest Regional Children's Advocacy Center is funded through a grant from the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Acknowledgements

We would like to extend a special thank you to the National Children's Alliance and the Regional Children's Advocacy Centers for their support in the design of the survey and for providing contact information for the Children's Advocacy Centers recruited to participate in the survey.

Most importantly, an expression of gratitude for the Children's Advocacy Centers that completed the survey and for your contribution to the field's understanding of current trends and developments related to the work of child abuse professionals across the nation.

The following National, Regional and Local partners assisted in the creation and dissemination of this multi-site survey.

National Children's Alliance (NCA)
Northeast Regional Children's Advocacy Center
Southern Regional Children's Advocacy Center
Western Regional Children's Advocacy Center
International Association of Forensic Nurses
Children's Advocacy Centers of Illinois
Minnesota Children's Alliance
Michigan Chapter of the National Children's Alliance
Missouri Kids First
West Virginia Chapter of Children's Advocacy Centers
Wisconsin Chapter of Children's Advocacy Centers

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Executive Summary

This summary provides an overview of the key findings from the 2013 Multisite Survey of Child Advocacy Centers conducted by the Midwest Regional CAC. The purpose of this survey was to gain a deeper understanding of the essential services provided to child victims seen at CACs across the nation, including but not limited to forensic interviews, medical evaluations and victim advocacy.

In collaboration with local, regional and national partners, the Midwest Regional CAC chose to assess the areas of inquiry listed below.

Primary Areas of Inquiry

- **Who is providing essential services to children seen at CACs?** This includes demographic information about the institutions completing the survey as well as the education and professional background of its employees and multidisciplinary team members. This survey also explores whether or not CACs provide services to Commercial Sexual Exploitation of Children (CSEC) victims, and if so, what those services might look like.

- **To What extent are CACs providing quality medical evaluations to their clients?** Data gathered to assess this question included training and experience of medical professionals working with CACs as well as the proportion of children referred for medical evaluations and those who actually received a medical evaluation.

- **To what extent are CACs providing quality victim services to their clients?** While advocacy for children and families is at the core of the CAC model little is known about the professional and educational background of victim advocates working with children and families in this setting. This survey collected data to begin exploring the avenues by which professionals enter into victim advocacy work at CACs.

This survey has been conducted since 2009 and provides valuable insight into the trends around forensic interviewing, medical practices and other emerging issues being addressed by CACs. In addition to data about CAC services, it collects anonymous salary information for various CAC professionals that is summarized in a separate report available to you on the Midwest Regional CAC website - www.mrcac.org.

In this report you will find tables and figures of the data collected as well as interpretation of trends from 2009 when the first survey of this kind was conducted.

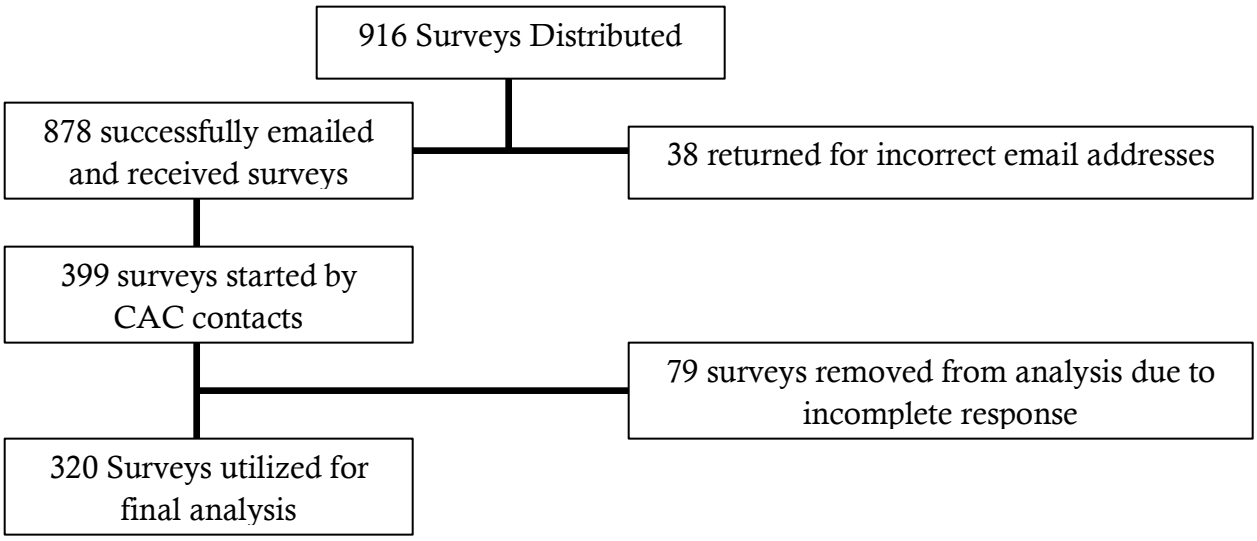
Summary of Key Findings

Forensic Interviewing	
Professionals Conducting Forensic Interviews	72% of respondents indicated they utilize specialized interviewers employed by the CAC.
Forensic Interview Training	Approximately 57% of respondents indicated their forensic interviewers were trained in more than one forensic interviewing modality in 2013.
Forensic Interview Peer Review	CACs participating in forensic interview peer review (96%) increased by 14% from 2009 to 2011.
Medical Services	
Professionals Conducting Medical Evaluations	Physicians and certified Pediatric Sexual Assault Nurse Examiners provide the majority of acute medical evaluations for CACs across the nation. Aggregated data on SANE-P and SANE-A nurses, indicates 71% of respondents use a SANE provider, approximately 5% higher than the aggregate data from 2011.
Children Receiving Medical Evaluations	The average percent of children actually receiving medical evaluations is about 35% (SD 25.49), similar to the average reported in 2011 (36%).
Medical Peer Review	Participation in technology facilitated peer review has increased two-fold since 2011 from 14% of respondents to 27% of respondents.
Victim Services	
Professionals providing victim advocacy	The majority of CAC respondents (66%) have at least one full-time victim advocate employed at the CAC.
Training of Victim Advocates	The majority of CACs require a Bachelor's or Masters Degree with work experience. The most common are Bachelor's in Social Work, Criminal Justice and/or Psychology.
CSEC Response	
CACs providing services to CSEC victims	About 74% of respondents indicated they serve CSEC victims, however, only about 13% of the CACs serving this population have policies and procedures in place to address their specific needs.
Services provided to CSEC victims	Almost all CACs who indicated working with the CSEC population provide forensic interviews at their CAC and will be involved in the MDT Coordination of the case and victim advocacy for the child and family
Funding for CSEC	As CSEC is a newly emerging population for CACs, an overwhelming amount (91%) does not receive any funding designated for serving these victims.

Methodology

In November 2013, the Midwest Regional CAC distributed a comprehensive online survey to collect information regarding trends in forensic interviewing, medical practices and other important emerging issues currently being addressed by Children's Advocacy Centers (CACs) across the nation.

The National Children's Alliance (NCA) and Regional Children's Advocacy Centers provided contact information for 916 CACs in the United States. One contact at each of these CACs was emailed a unique link to the Qualtrics survey, an online survey tool recognized and utilized by academic institutions. Of the 916 emails generated to CACs, 38 were returned for incorrect addresses. Of the 878 who received emails, 83 provided incomplete data and a total of 320 successfully completed the survey and provided sufficient data for analysis in this report. The **response rate of 36%** is relatively higher than the national average for online survey completion for similar purposes.



Limitations

A limitation of the data is the large number of surveys that were removed due to incomplete responses, which in turn lowered the response rate. However, we do know that the survey sample is representative of the population when compared to other data sources and previous surveys. Collecting data solely online may also limit the number of individuals participating in the survey due to technical difficulties and or comfort with technology.

Survey Respondents

CAC Organizational Profile

The data provided in this report was collected from a representative sample of Children's Advocacy Centers in the United States. The majority of the respondent CACs, 80%, are accredited by National Children's Alliance, while 17% hold associate status, and the remaining 3% are developing and/or non-members of NCA.

Table 1. Survey Respondent Demographics

Variable	Count	Percentage
Geographic location **		
Frontier	5	2%
Tribal	13	4%
Rural	155	49%
Suburban/Rural	133	42%
Suburban	55	17%
Urban	79	25%
Other	5	2%
Regional Representation		
Midwest	94	30%
Northeast	43	14%
South	115	36%
West	62	19%
CAC Structure		
Nonprofit 501c3	180	56%
Hospital Based	26	8%
Government Based	51	16%
Umbrella 501c3	53	17%
Other	9	3%
Population Size		
15,000 or less	24	8%
16,000 to 25,000	16	5%
26,000 to 35, 000	12	4%
36,000 to 49,000	23	7%
50,000 to 99,000	46	15%
100,000 to 499,000	141	45%
500,000 to 999,000	27	9%
More than 1 Million	27	9%

**Participants were instructed to select all definitions that apply to their CAC service area.

Survey results supported the thought that many CACs often serve multiple counties. In fact, the average number of counties served by respondents was 3.18 (SD 5.25). About half of the respondents serve more than one county, and the most number of counties served by one CAC is 50 counties. It is important to note that population size and area of counties varies

considerably across the nation, greatly impacting the services provided by CACs serving that community.

Client Profile

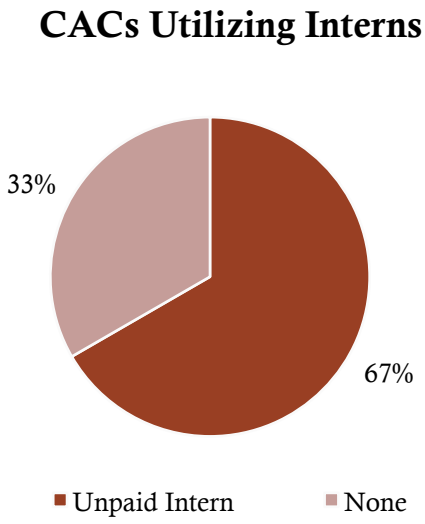
In addition to the number of counties served by a CAC, the survey asked respondents to indicate how many children are interviewed at their CAC annually. The average number of children interviewed was 356, with a range from 17 children to 3,000 children.

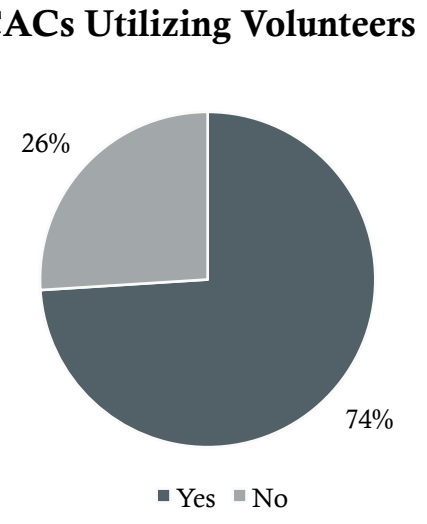
When asked to provide the minimum and maximum age served as defined in the CAC protocol, the average minimum age was reported as 1.5 years (SD 1.37), and the average maximum age was reported as 17.33 years (SD 8.73). About 62% of CACs reported they serve children 2 years of age or older as defined by their protocol, and about 49% indicated the they serve children up to the age of 18 as defined by their protocol.

CAC Capacity Profile

The average annual budget of CACs who completed the survey is $481,719.20 with a range from $9,000 to $6,304,922.00.

Figure 1. Intern and Volunteer Utilization





While the majority of CACs utilize interns and volunteers, very few have begun to use Americorps VISTAs as a potential augmentation to their staff capacity. Only 4% of respondents indicated they used Americorp VISTAs. Those who have utilized Americorp VISTAs have had a great success in adding additional skilled capacity to their organization.

Forensic Interview Key Findings

Forensic Interviewer Training and Experience

When asked who routinely conducts the majority of interviews at their CAC, 72% of respondents indicated they utilize specialized interviewers employed by the CAC. This is very comparable to survey results from 2011 that indicated 77% employed specialized forensic interviewers. Many of the CACs reported the use of other professionals on the multidisciplinary team including law enforcement; child protective services and contracted forensic interviewers in addition to those employed by the CAC.

About 60% of survey respondents identified that forensic interviewers employed by the CAC have additional responsibilities, the most common being the CAC Director and/or program coordinator.

Table 2. Forensic Interview Training by Year

Forensic Interview Training	2009		2011		2013	
	n	%	n	%	n	%
Corner House Forensic Interview Protocol[1]	-	-	-	-	102	32%
RATAC[1]	-	-	-	-	99	31%
Finding Words/Child First (NCPTC)[1]	-	-	-	-	124	39%
APSAC	59	25%	88	23%	43	14%
NCAC/Huntsville	125	53%	211	54%	133	42%
NICHD	16	7%	39	10%	33	10%
State Based Training	91	39%	159	41%	112	35%
Other	-	-	63	16%	27	8%

[1]Previous surveys combined these trainings in to one category and the results were as follows, 2009-69%, 2011-56%.

*** The following trainings were not included in the table due to a low response rate; First Witness, RADAR, Childhood Trust

When asked to select what type of training their forensic interviewers' have obtained, participants were able to select any and all trainings that had been attended and completed by their interviewers. Over half of respondents indicated that their interviewers are trained in more than one forensic interviewing modality.

Approximately 57% of respondents indicated their forensic interviewers were trained in more than one forensic interviewing modality in 2013.

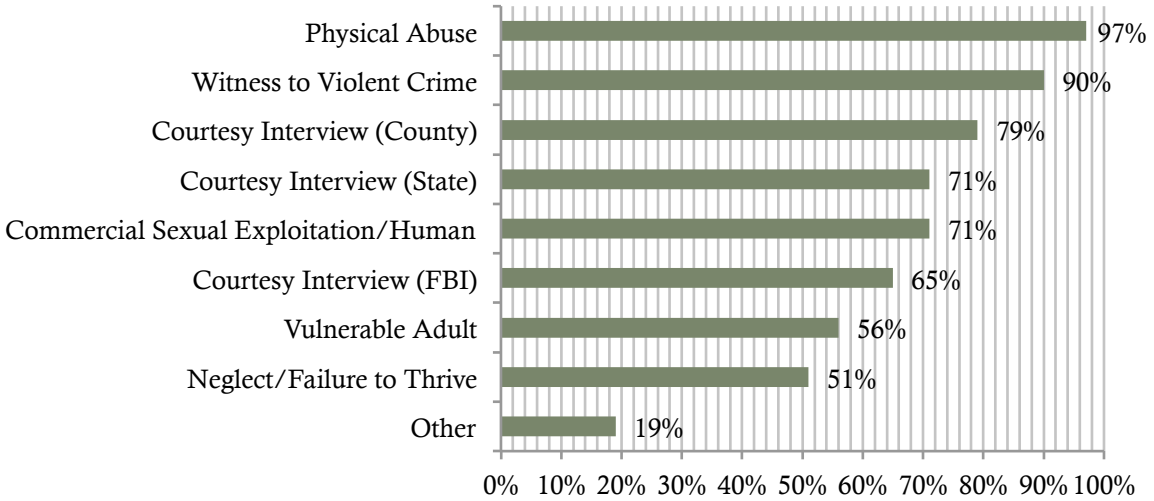
Table 3. Number of Forensic Interviewers Trained in Multiple Modalities

	Count	Percent
Trained in 1 Modality	123	38%
Trained in 2 Modalities	81	25%
Trained in 3 Modalities	56	17%
Trained in 4 or more Modalities	48	14%

Often, states will identify a specific protocol or modality to be utilized by CACs. Approximately 55% of survey respondents indicated that their state has identified a particular protocol to be utilized, the two most common being RATAC and Finding Words/Child First.

While one of the primary goals of CACs is to provide forensic interviews for victims of child sexual abuse, they often are a resource in the community for other types of investigations such as commercial sexual exploitation and vulnerable adults.

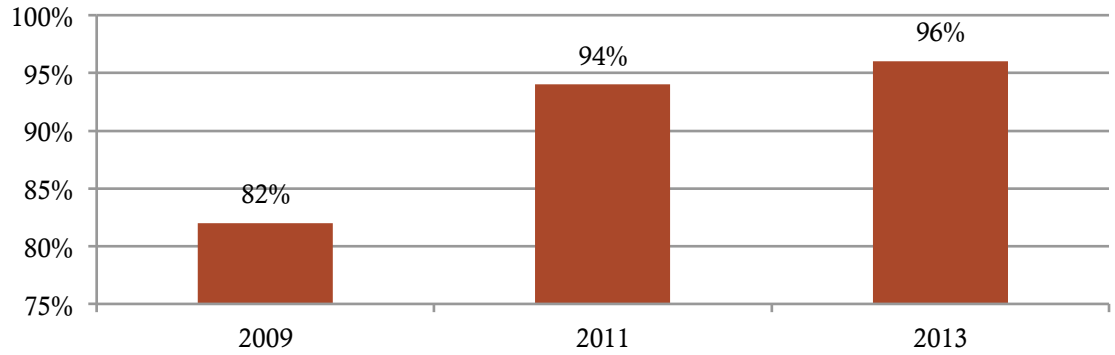
Figure 2. Percent of CACs Providing Interviews by Case Criteria



Forensic Interviewer Peer Review and Quality Improvement

Participation in peer review is recognized as best practice in the field of forensic interviewing and is taught as a valuable tool in many if not all forensic interviewing training curriculum. Over the last two years, we have continued to see an upward trend of those participating in forensic interview peer review.

Figure 3. Participation in Forensic Interview Peer Review by Year



Frequency of participation in peer review varies across the nation, with monthly and quarterly participation as the most common. The NCA Standards for Accreditation recognize the importance of peer review, however they do not address frequency. Most CACs participate in peer review quarterly (40%) and/or monthly (31%). When asked how they conduct forensic interview peer review, about half (52%) of respondents indicated they peer review regionally with other CACs in the area and about 42% peer review within the CAC staff.

19% of respondents indicated that their forensic interviewer has been asked by defense counsel to review a forensic interview done at another CAC other than their own. This is a 7% increase from the 2011 survey results.

Access to continuing education and ongoing quality improvement is also indicated in the NCA Standards for Accreditation for all forensic interviewers working with a CAC. Professionals in the field have a variety of ways to access pertinent research and trends in the field including online training, statewide conferences, Midwest Regional CAC Journal Clubs, and the Child Abuse Library Online (CALiO). When asked specifically about participation in training related to Commercial Sexual Exploitation of Children (CSEC), 72% indicated their CAC staff has participated in such training and about 21% have offered training on the subject matter.

Table 4. Forensic Interviewer Participation in Continuing Education

	Count	Percent
Conferences	243	77%
State and local peer review	244	77%
Statewide trainings	225	71%
Midwest Regional CAC eLearning Courses	179	57%
NCAC Webinars	157	50%
Midwest Regional CAC Peer Review	50	19%
Midwest Regional CAC Journal Club	54	17%

***Note: Participants were asked to check all that apply

Table 4 above indicates that while many CACs are continuing to send staff and team members to conferences and statewide trainings for professional development they continue to turn toward online alternatives to provide professional development opportunities.

Medical Evaluation Key Findings

Medical Evaluation Refferals and Provision

Accredited CACs are required to have written protocols and policies regarding referrals for medical evaluations, many of which rely on the disclosure of the child before making the decision to refer or not. On average, about 47% of children seen at CACs are referred for a medical evaluation; however about 41% of the CAC respondents indicated that every child seen at the CAC is referred for medical evaluations. The average percent of children actually receiving medical evaluations is about 35% (SD 25.49), similar to the average reported in 2011 (36%).

Figure 4. Average Medical Evaluations Received by CAC Structure (% of Children)

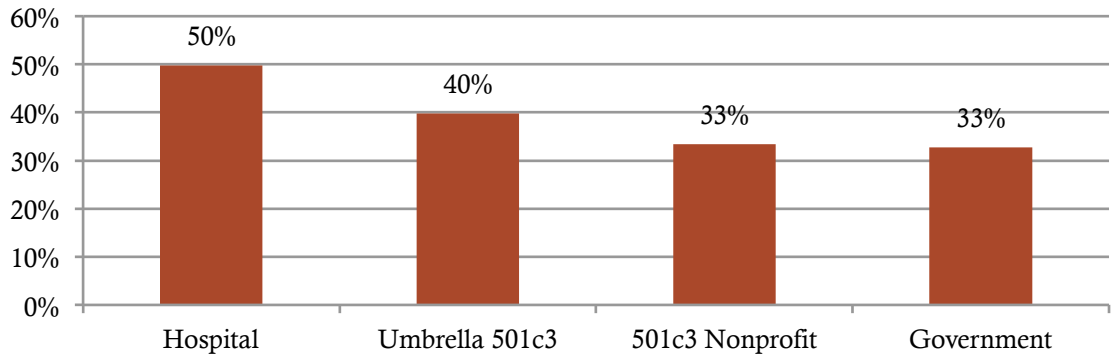


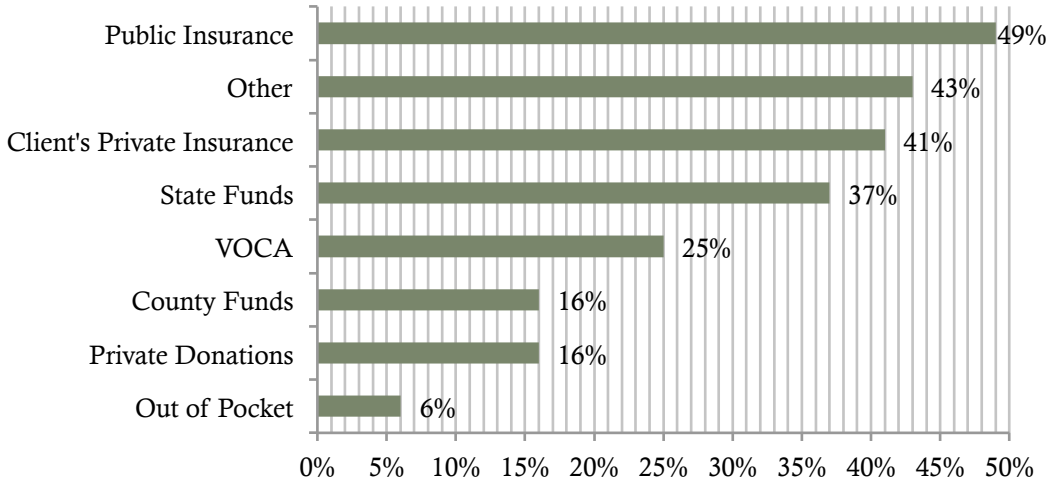
Table 5. Medical Evaluations Received by CAC Structure

	Average (%)	Standard Deviation	Range
Hospital	49.79%	29.24	21 - 100%
Umbrella 501c3	39.80%	26.44	5 - 95%
501c3 Nonprofit	33.39%	24.04	2 - 100%
Government	32.81%	32.81	5 - 95%

We can see that the range of medical evaluations received by CAC structure also provides important information. Hospital based CACs rarely provide medical evaluations less than 21% of children, whereas the other structures sometimes provide exams to 5% or fewer children. When asked whether or not their CAC provides medical evaluations for physical abuse and/or neglect in addition to sexual abuse, 15% of respondents indicated they provide exams for physical abuse and 85% indicated they provide exams for both physical abuse and neglect.

Payment for medical evaluations varies by CAC and community. Figure 5 below provides a quick snapshot of the sources of funding for medical evaluations for CAC clients. Other sources of funding include Crime Victim Compensation and Law Enforcement reimbursement.

Figure 5. Medical Evaluation Funding Sources



Medical Provider Training and Experience

Medical providers evaluating children seen at CACs are required by the NCA Standards of Accreditation to have 15 hours of training in child sexual abuse evaluations in addition to

their medical licensure. About 34% of respondents indicated that the medical provider and/or their employer funded the foundational education and training in child sexual abuse, and about 22% of CACs provided the funding for the foundational training themselves.

Table 6. Medical Staff Providing Acute Medical Evaluations

Discipline	2009		2011		2013	
	n	%	n	%	n	%
Physician (MD)	162	81%	224	62%	174	55%
Nurse Practitioner	59	29%	102	28%	80	25%
Nurse - SANE-P Certified[1]	-	-	-	-	116	37%
Nurse - SANE-A Certified[1]	-	-	-	-	93	30%
Nurse - SANE-P Trained not Certified[1]	-	-	-	-	19	6%
Forensic Nurse Examiner (FNE)[2]	-	-	-	-	31	10%
Other	-	-	27	7%	24	8%

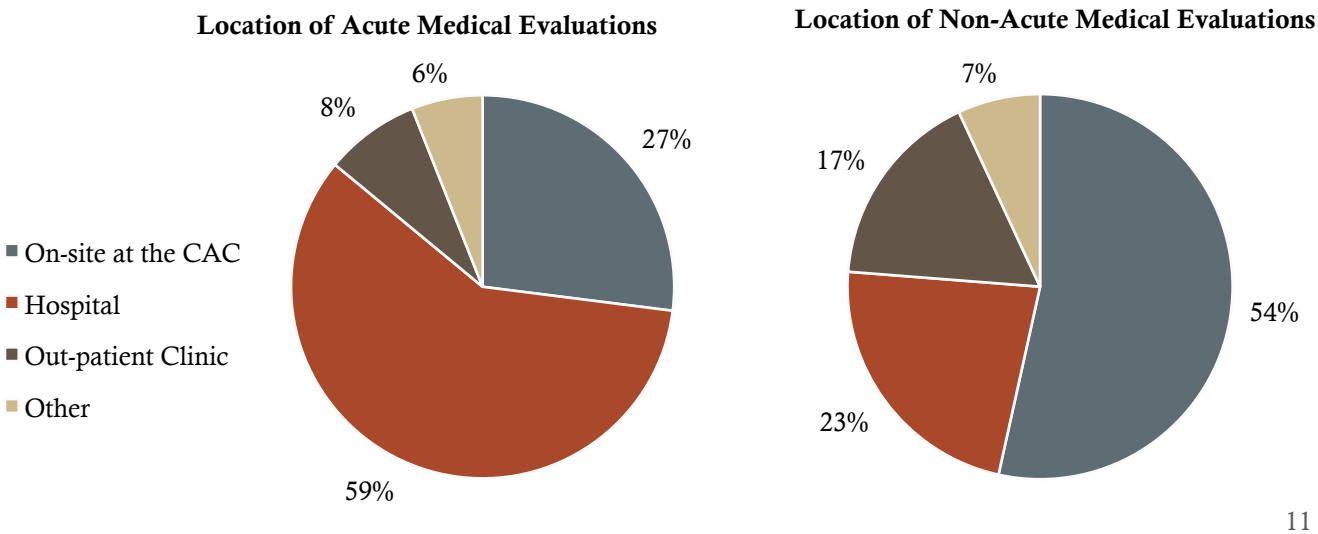
*** The following disciplines were not included in the table due to a low response rate; Physician's Assistant, Nurse (RN), Nurse, SANE-A Trained not certified

[1]Previous surveys combined the noted disciplines as SANE Nurse. This is now disaggregated to explore differences. 2009 survey findings for SANE nurses indicated 42% and 2011 survey findings indicated 65%

We continue to see Physicians and certified Pediatric Sexual Assault Nurse Examiners providing the majority of acute medical evaluations for CACs across the nation. If we aggregated the data on SANE-P and SANE-A nurses, approximately 71% of respondents indicated they use a provider with such SANE training and/or certification, which is approximately 5% higher than the aggregate data from 2011.

This survey also explored where the majority of acute medical evaluations were occurring as acute was defined as being seen by a medical provider in less than 72 hours.

Figure 6. Location of Acute and Non-Acute Medical Evaluations



Due to the nature of acute medical evaluations, the majority (59%) is conducted at a nearby hospital. The data does show, however, that about 54% of respondents are providing non-acute medical evaluations on-site at their Children's Advocacy Center.

Survey findings indicate that **54%** of Children's Advocacy Centers provide medical services on-site for non-acute evaluations.

Given that over half of the CACs in the US are located in rural areas, we were also interested in exploring approximately how long it takes a child to travel from the CAC to the medical provider for both acute and non-cute medical evaluations. The data collected did not indicate a significant difference in travel time for type of exam and most often clients are traveling less than 15 minutes (40% of respondents for acute evaluations and 29% of respondents for non-acute evaluations). About 17% of respondents indicated families must travel an hour or more for acute medical evaluations and 12% for non-acute medical evaluations.

Table 7. Medical Staff Providing Non-Acute Medical Evaluations

Discipline	2009		2011		2013	
	n	%	n	%	n	%
Physician (MD)	162	81%	224	62%	185	59%
Nurse Practitioner	59	29%	102	28%	84	27%
Nurse - SANE-P Certified[1]	-	-	-	-	91	29%
Nurse - SANE-A Certified[1]	-	-	-	-	68	22%
Forensic Nurse Examiner (FNE)[2]	-	-	-	-	27	9%

*** The following disciplines were not included in the table due to a low response rate; Physician's Assistant, Nurse (RN), Nurse, SANE-P Trained not certified, SANE-A Trained not certified

[1]Previous surveys combined the noted disciplines under one label - SANE Nurse, which has since been disaggregated to explore the differences between the certifications and trainings. The 2009 survey findings for SANE nurses indicated 42% and the 2011 survey findings indicated 65%

The survey results indicate that CACs are utilizing physicians more frequently for non-acute medical evaluations than Sexual Assault Nurse Examiners (SANEs). This may reflect that while acute cases are most often seen in the hospital, likely by a SANE nurse in the Emergency Room, non-acute cases are seen often on site at the CAC by a contracted or employed physician.

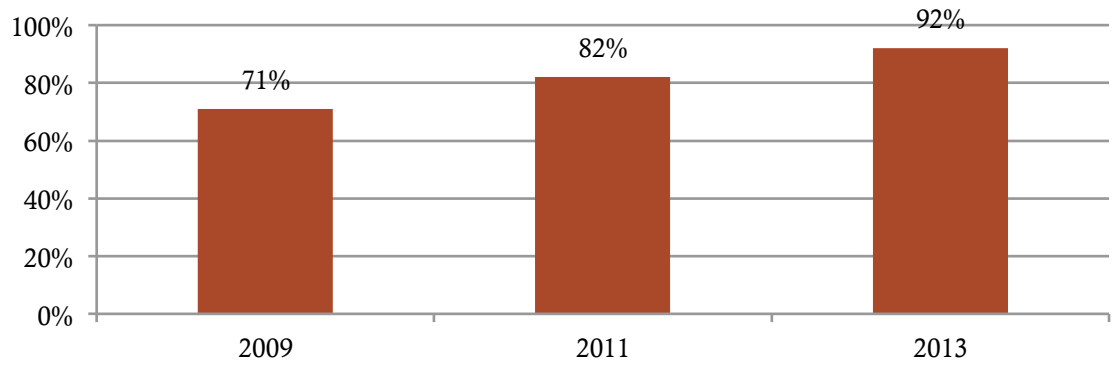
Medical Peer Review and Quality Improvement

Regular consultation or peer review with advanced medical consultants is recognized as best practice to ensure diagnostic accuracy by the National Children's Alliance and other professional organizations. Peer review and consultation most often begins with the supervising medical provider. When asked who provides the supervision for non-physician medical providers at their CAC, 31% of respondents indicated a Child Abuse Board Certified Pediatrician, 19% a staff physician, 11% a primary care physician in the community and 10% an emergency room physician.

11% of survey respondents indicated that their non-physician medical provider does NOT receive any supervision.

Participation in medical peer review has continued to increase, with about 92% of respondents indicating their medical providers participate in peer review and quality improvement activities. The majority of medical providers conduct peer review on a quarterly or monthly basis (45% of respondents).

Figure 7. Participation in Medical Peer Review by Year



CAC Medical providers participate in peer review and quality improvement in a variety of ways. The most popular types of peer review are statewide peer review (38%), and regional with other medical providers in the area (37%). About 27% of respondents indicated their medical providers participate in peer review online through the Midwest Regional CAC Peer Review via Webex and myCasereview (formerly Telehealth Institute for Child Maltreatment).

Participation in technology facilitated peer review has increased two-fold since 2011 from 14% of respondents to 27% of respondents.

Having access to an advanced medical consultant as defined by NCA is an important resource for peer review and quality improvement. Many of the CACs (22%), indicated that their CAC's medical provider is an advanced medical consultant and all others do have access to an expert for consultation or second opinion. Most often, expert review is taking place over the phone or via email (47%), and only about 18% of respondents indicated they have a written formal agreement with an expert.

Victim Services Key Findings

Victim Advocate Training and Experience

Victim Advocates provide crucial assistance to children and families as they move through the investigation process and seek resources to begin the healing process. The majority of CAC respondents (66%) have at least one full-time victim advocate employed at the CAC and about 15% have a part-time advocate employed. The range of victim advocates employed by respondent CAC's is from none to nine victim advocates.

Table 8. Professionals Providing Victim Advocacy to Children and Families

	Count	Percent
Victim Advocate(s) employed by CAC	215	68%
Prosecutor's Office Victim Advocate(s)	130	41%
Other CAC Staff Member	78	25%
Community Sexual Assault Advocate(s)	44	14%
Community Victim Advocate(s) through Linkage Agreement	44	14%
Other	27	9%

Funding for the Victim Advocate position varies significantly among CACs with the most common sources from VOCA (31%) and grants (18%), or a combination of the two. Only about 62% of CACs have funding set aside in their budget to acquire additional training for their advocates.

The professional and educational background of Victim Advocates working with Children's Advocacy Centers is incredibly diverse. The survey asked respondents to describe the professional background and education of their Victim Advocate. While some CAC's

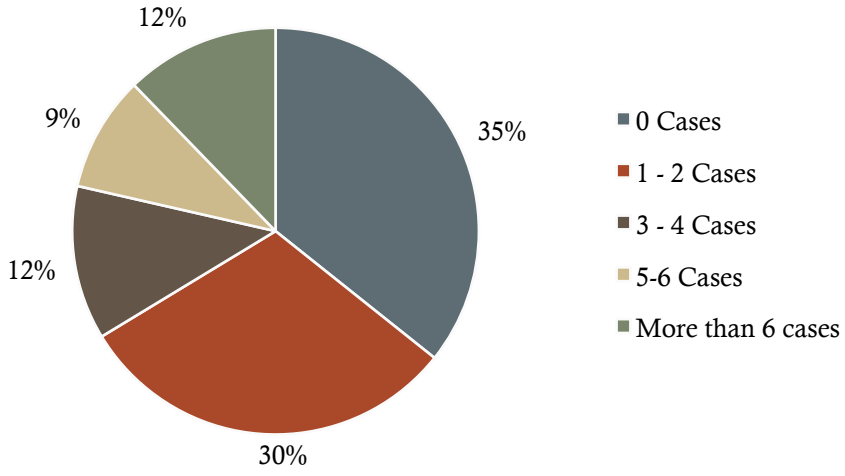
require a minimum of an Associates Degree in child welfare or human services, the majority of CACs require a Bachelor's or Masters Degree with work experience. The most common degrees for Victim Advocates as indicated by the survey population were Bachelor's in Social Work, Criminal Justice and/or Psychology. Masters in Social Work and/or Counseling were also very common among respondents.

Commercial Sexual Exploitation of Children (CSEC) Key Findings

CACs Serving CSEC Victims

In many states across the nation, CACs and the Multidisciplinary Team (MDT) model have been recognized as an effective approach for identifying, investigating and treating Commercial Sexual Exploitation of Children (CSEC) victims. Of those CACs who responded to the survey, 74% provide services to CSEC and human trafficking victims. While some CACs began providing services in the late 1980's and early 1990's, over 70% started providing services after 2010, indicating that this population is relatively new territory for CACs.

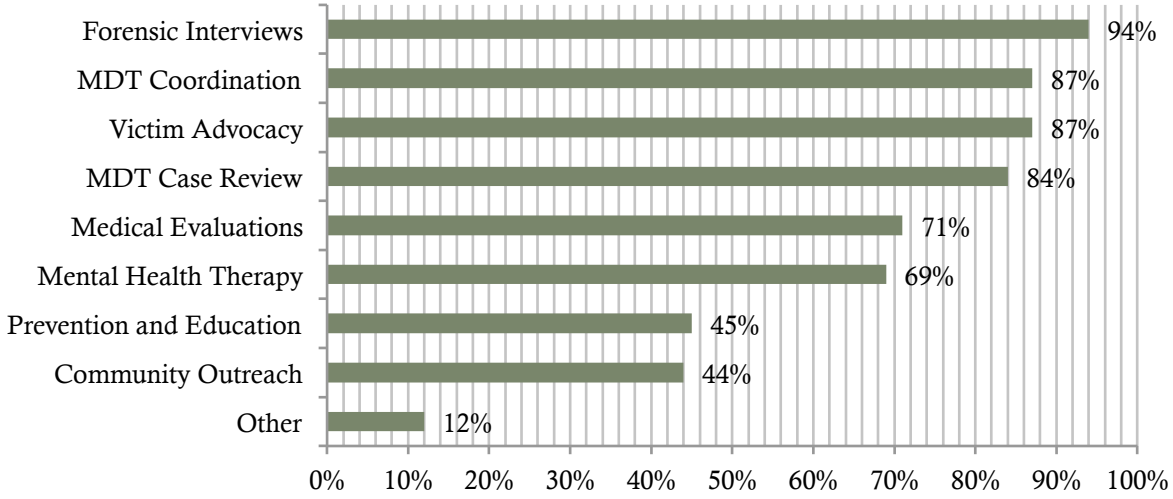
Figure 8. Cases Identifying CSEC as Primary Criterion for Referral to CAC Annually



The range of number of children being referred to the respondent CACs for the primary allegation of CSEC is from zero to 300 children with the average around five children annually. The CAC who indicated 300 children served is Kristi's House in Miami, FL and is nationally recognized for their work with CSEC and trafficked victims.

While three-fourths of respondents indicated they serve CSEC victims, only about 13% of the CACs serving this population have policies and procedures in place to address their specific needs. This may be reflective of the information provided regarding whether or not that child was referred to the CAC as result of CSEC as the primary criterion for the case to be opened. Other contributing factors leading to a lack of policies and protocols could be the small number of victims served, inability to easily change and/or update team policies and protocols or education and training around the unique needs of these victims.

Figure 9. CAC Services Provided to CSEC Victims



Almost all CACs who indicated working with the CSEC population provide forensic interviews at their CAC and will likely be involved in the MDT Coordination of the case and victim advocacy for the child and family.

As CSEC is a newly emerging population for CACs, an overwhelming amount (91%) do not receive any funding designated for serving these victims. Those few CACs (10%) who do receive funding have found sources available through the Federal and State Government. Moreover, the majority of CACs (90%) have not been involved in the creation of legislation at either a federal, state or local level.

It is evident that CACs are increasingly recognized as important players in the response to CSEC and MDT professionals could greatly benefit from additional training and technical assistance on responding to these kinds of cases.

Conclusion

In summary, this survey demonstrates national progress towards meeting the NCA Standards for Accreditation and providing best practices to children in our communities. We continue to see the importance of high quality foundational training, continuing education and peer review increase among all child abuse professionals. Survey findings also indicated that participation in technology facilitated peer review for both forensic interviewers and medical providers has increased two-fold since 2011.

Most important, we see the CACs role in working with CSEC victims has become more pronounced over the last decade. With about 74% of our Nation's CACs providing services to CSEC victims, it is clear that national, regional and state institutions have identified the coordinated multidisciplinary response as a model for working with this population. The survey findings demonstrated that while many CACs are providing services to this population only about 13% have written policies and protocols to support their unique needs during the investigation and treatment. Additional training and technical assistance in this area would be greatly beneficial for CAC professionals and the important work they are doing with this newly emerging population.

Once again, thank you to all of those CACs that participated in completing this survey and contributing to a better understanding of current CAC trends and emerging issues. We sincerely hope the availability of this information is helpful to CACs and MDTs across the nation as it will certainly inform the work of the Midwest Regional CAC in the future.

For more information or inquiries please contact the **Midwest Regional Child Advocacy Center** at:

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