Current Trends in Forensic Interviewing and Medical Evaluations: A Review of the Children's Advocacy Center Model

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Child maltreatment in the United States remains a serious threat affecting millions of children and families each year. According to *Child Maltreatment 2010*, a report published by the U.S. Department of Health and Human Services (HHS), Child Protective Service (CPS) agencies received over 3.3 million referrals, involving the alleged maltreatment of about 5.9 million children across the United States. Over 25% of the cases reported were those of physical or sexual abuse (HHS, 2011).

Children's Advocacy Centers (CACs) were first developed in the 1980s and play an increasingly significant role in the response to child sexual abuse and other forms of child maltreatment in the United States. In 2011, CACs served 269,000 children, a number that has doubled in the past decade. With multidisciplinary collaboration at the heart of the CAC movement's ideology, these centers are able to bring together professionals such as law enforcement agencies (LE), CPS centers, prosecution offices, mental health therapists, and medical associations to provide a holistic response to a child's disclosure of abuse. Recent research indicates that CAC investigations typically result in positive outcomes. This type of investigation is preferred by most nonoffending caregivers (Cross et al., 2008; Faller & Palusci, 2007).

There are currently 750 accredited Children's Advocacy Centers and 200 developing centers and multidisciplinary teams nationwide. These subscribe to various membership levels (affiliate, associate, and accredited) within the National Children's Alliance (NCA), a program appropriated by the Victims of Child Abuse Act in 1992 and charged with administering over $9 million in funds to CACs. Under NCA's leadership, the movement of CACs has grown from 30 to more than 950 centers and identified multidisciplinary teams focused on child abuse intervention. The Alliance oversees a rigorous accreditation process for CACs that is informed by evidence-based models of care and treatment. There are ten standards CACs must achieve to become accredited: (1) multidisciplinary team (MDT), (2) cultural competency and diversity, (3) forensic interviews, (4) victim support and advocacy, (5) medical evaluation, (6) mental health, (7) case review, (8) case tracking, (9) organizational capacity, and (10) child-focused setting (NCA, nd).

The 1992 Victims of Child Abuse Act also created an infrastructure of four Regional Children's Advocacy Centers (RCAC) located in the Northeast, Midwest, West, and South to provide training and technical assistance to MDT professionals and CACs. The RCACs provide a variety of training opportunities to move centers towards NCA accreditation and work with communities interested in developing a multidisciplinary response to child abuse. The National Children's Alliance recognizes that "no single model for an ideal multidisciplinary program exists because each community's approach must reflect its unique characteristics" (Walsh, Jones, & Cross, 2003). Although communities vary in ways to create a CAC, the child maltreatment community recognizes specific standards with regard to forensic interviewing, forensic medical evaluations, multidisciplinary teams, and trauma-focused therapy (Cross et al., 2008).

Methodology

To gather data about trends in the CAC movement, the Midwest Regional Children's Advocacy Center (MRCAC) distributed a survey using Qualtrics, an online survey tool. The survey was created to inform the training and technical assistance efforts of the RCACs and evaluate how well CACs are meeting the required professional qualifications for forensic interviews and medical evaluations outlined by the NCA Accreditation Standards. The survey was e-mailed to the primary contact at 747 CACs. The National Children's Alliance (NCA) provided the primary contact e-mail addresses for their member Children's Advocacy Centers. Each contact was assigned a unique link to the survey tied to its agency's operations. The survey consisted of 106 questions about forensic interview practices and medical services as well as key position salaries and job descriptions. In all, 470 CACs (63%) responded.

Survey Sample

The regional and geographic distribution of survey participants is representative of the CAC population (see Table 1). When compared with Project Access, implemented by NCA, the sample for this survey is very similar. Project Access found that CACs were 45% rural, 10% suburban, and 45% urban. Regionally, they were 27% Midwest, 14% Northeast, 37% South, and 22% West.

The information for Project Access was reported based on zip code analysis using census definitions rather than the self-report format implemented with the survey.

The survey sample is also representative of the various CAC structures reported in Project Access: 56% independent nonprofits, 17% hospital-based, 16% government-based, and 17% as a program of a larger umbrella nonprofit. Overall, more accredited centers completed the survey (78% of respondents) than associate centers (20% of respondents). This is also similar to Project Access's distribution: 64% accredited and 15% associate.

It is important to note that 44% of respondents serve roughly 200–499 children per year and 42% operate with an annual budget of from $100,000 to $250,000. The majority (57%) of participating CACs reported having 1–4 paid employees (23% having only 1–2 paid employees). This is significant because many of these employees hold multiple roles in CACs.

Results

The survey results suggest three findings: (1) Both forensic interviewers and medical examiners are receiving increased training in more than one modality to better service their diverse clientele, (2) there has been a significant increase in peer-review participation from 2009 to 2011, and (3) and the prevalence of children receiving a medical evaluation has steadily increased (see Table 2).

Forensic Interviews

Forensic interviews have been defined as "a professional interview designed to assess or evaluate the truth about a suspicion of child maltreatment" (Cross, Jones, Walsh, Simone, & Kolko, 2007). Furthermore, the NCA Standards for Accreditation require that "Forensic Interviews are conducted in a manner that is legally sound, of a neutral, fact-finding nature, and coordinated to avoid duplicative interviewing" (National Children's Alliance, nd). Recent research has identified several characteristics that lead to more accurate and complete disclosures from the child. These characteristics include rapport building during the interview, use of open-ended questions, and age-appropriate vocabulary and language (Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007; Cross et al., 2007; Wood & Garvin, 2000).

These characteristics are core components of the many different forensic interview trainings and modalities, including CornerHouse and the National Children's Advocacy Center (NCAC). The NCA Standards for Accreditation consider documentation of 40 hours of a "competency-based child abuse forensic interview training that includes child development" essential to conducting a forensic interview at a CAC.

The results of this survey suggest that CACs have moved toward employing specialized forensic interviewers rather than relying on LE and CPS professionals. In 2011, 77% of CACs reported the

Table 1. Survey Sample Demographics

VARIABLE	COUNT	PERCENTAGE
Geographic Location		
Rural	211	51%
Urban	75	18%
Suburban	82	19%
Other	54	12%
Regional Representation		
Midwest	137	29%
Northeast	69	14%
South	187	39%
West	85	18%
CAC Structure		
Nonprofit 501c3	256	62%
Hospital Based	38	9%
Government Based	58	15%
Umbrella 501c3	66	13%
Other	5	1%
Population Size		
Less than 25,000	22	6%
25,000 to 49,000	44	12%
50,000 to 99,000	82	22%
100,000 to 499,000	156	42%
500,000 to 999,000	45	12%
More than 1 Million	26	7%
Number of Children Served Annually		
Fewer than 99	30	8%
100 to 199	90	23%
200 to 499	170	44%
500 to 799	36	9%
800 to 1199	34	9%
1200 to 1999	14	4%
More than 2,000	10	3%
Annual Budget		
$99,000 or less	35	9%
$100,000 to $250,000	159	42%
$251,000 to $499,000	106	28%
$500,000 to $750,000	30	8%
$751,000 to $1,000,000	16	14%
More than $1,000,000	37	10%

Table 2. Key Findings From the Multisite Children's Advocacy Center Survey

Variable	Key Findings
FORENSIC INTERVIEWING	
Professionals Conducting Forensic Interviews	The majority of CACs (77%) reported that they employed a specialized forensic interviewer to conduct forensic interviews at their CAC. Many CACs reported using other professionals, such as from law enforcement or child protection, in addition to a CAC-employed forensic interviewer. CAC-employed forensic interviewers have increased 25.8% since 2009.
Forensic Interview Training	CornerHouse (56%) and the National Children's Advocacy Center (54%) forensic interview trainings continue to be the most popular trainings. The survey also indicated that forensic interviewers are often trained in more than one modality.
Forensic Interview Peer Review	CACs participating in forensic interview peer review (94%) increased by 12% from 2009 to 2011. The majority of CACs conduct peer review on a monthly or quarterly basis.
Number of Interviews per Interviewer per Day	About 50% of CACs reported one to two interviews conducted per interview per day. In contrast, 46% reported three to four interviews conducted per interviewer per day.
Number of Interviews per Interviewer per Week	There was no apparent trend in the number of interviews conducted per interviewer per week, which greatly depends on the location of the CAC and population served. For example, some urban centers reported that interviewers conduct over 10 interviews per week, and some rural centers reported conducting only one to two interviews per week. Additionally, 73% of respondents provide after-hours forensic interview coverage.
Recording of Forensic Interviews	CACs recording forensic interviewers increased from 90% in 2009 to 94% in 2011, for which the majority (81%) use a DVD to record.
MEDICAL SERVICES	
Professionals Conducting Medical Evaluations	SANE nurses are the primary medical providers for CACs (65%) with physicians following close behind at 62%. This is a flip from the 2009 data that reports physicians at 81% and SANE nurses at 42%. (Note that participants were able to select all professionals that conduct medical evaluations at their CAC, therefore the total will be greater than 100%.)
Training of Medical Professionals	The majority (54%) of CAC medical providers have received pediatric SANE training, 47% have attended Medical Training Academy, and 37% are Board-certified pediatricians. Medical providers can be trained in more than one capacity. For those who reported using SANE nurses to conduct medical evaluations, 40% are receiving supervision from a professional who has not received specialized child abuse medical evaluation training.
Availability of Medical Evaluations	Nearly every CAC surveyed (96%) provides the opportunity for a medical evaluation to all CAC clients.
Completed Medical Evaluations	Approximately 36% of children are actually receiving a medical evaluation (SD 26.49). This varies greatly on the size, location, and structure of the CAC. Hospital-based CACs, 63.69% (SD 28.96); 501c3 nonprofit CACs, 34.18% (SD 24.95); government-based CACs, 31.08% (SD 23.65); and umbrella 501c3 CACs, 30.60% (SD 20.73).
Medical Peer Review	Participation in medical peer review has increased from 71% in 2009 to 82% in 2011. Modes for conducting peer review include statewide (28%), regional (28%), technology facilitated (14%), institution wide (9%), and other (19%).
Medical Evaluation Documentation	The majority of participants reported the use of a digital camera (56%) or a colposcope with still camera (66%) by their primary medical provider to document exam findings. Note that multiple methods of documentation may be used.

use of a CAC-employed forensic interviewer, a 25.8% increase from 2009. This increase is likely due to recent federal, state, and local funding cuts that have led to a reduction of Law Enforcement and Child Protective Services workforce. As a result, CACs have been compelled to hire additional staff to fulfill the forensic interview role. The RCACs have also provided scholarships to novice forensic interviewers to gain more skills by attending a nationally recognized training.

The NCA Standards for Accreditation also highlight peer review and quality improvement activities as an important measure to be undertaken by CACs to ensure best practice. Studies have discussed the importance of specialized training in combination with regular peer review and monitoring (Wood, 2000; Lamb et al., 2007; Cross et al., 2007). Survey results indicate that peer review has become integrated into the culture of CACs, with 94% participating in forensic interview peer review. It is well to note that forensic interview peer review is not possible without the use of recording equipment, whether it be audio, video, or both. The survey results for recorded interviews (94% of respondents) correspond with the number of CACs participating in peer review. The results also found that 22% of respondents are mandated to record forensic interviews, demonstrating that other investigative partners value peer review as a quality improvement activity.

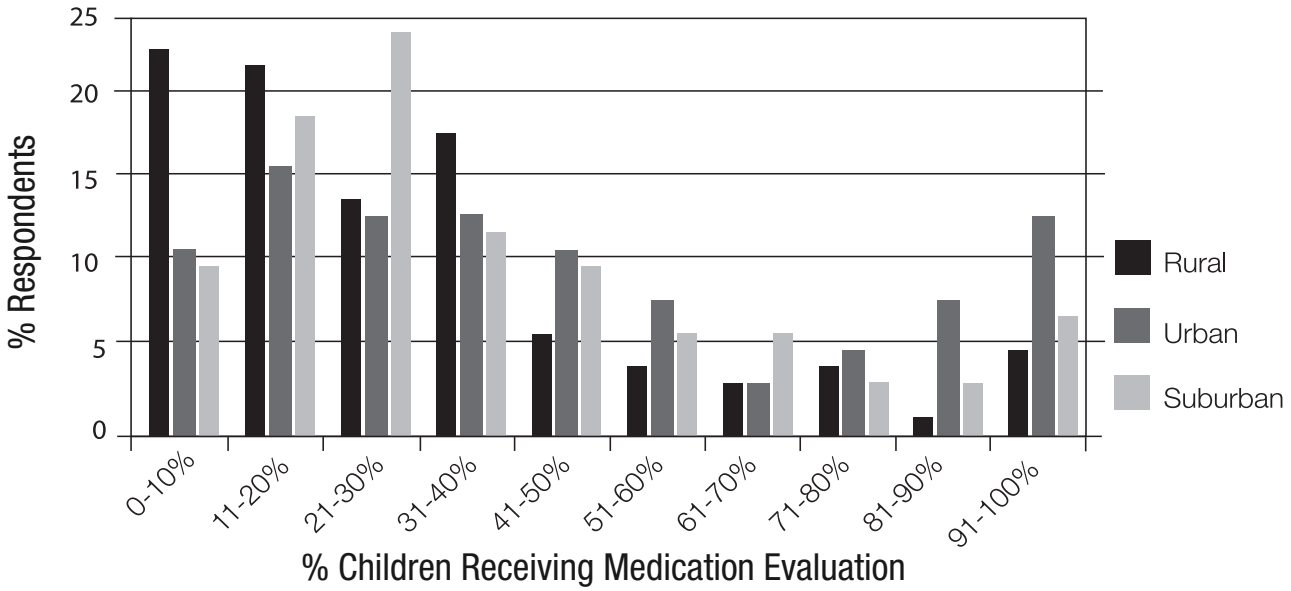
Medical Evaluations

The rise of forensic medical evaluations is acknowledged in the child maltreatment field and has been an avenue for new research and system improvement. Medical examinations have become a valuable part of an investigation as they improve the likelihood of timely medical care to a child victim and can provide information to support legal decisions (Adams et al., 2007). The NCA Standards of Accreditation recognize that a "medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate history is essential in making the medical diagnosis and determining appropriate treatment of child abuse" (p. 18). The NCA Standards of Accreditation also highlight that photo documentation of medical evaluations is the standard of care and allows for peer review and quality improvement practices (National Children's Alliance, nd).

The American Board of Medical Specialties (ABMS) approved the child abuse pediatrics specialty in 2006, and the American Board of Pediatrics (ABP) issued the first certification examinations in November 2009. Nationwide, there are only 264 pediatricians certified by the American Board of Pediatrics in the field of child abuse pediatrics, amounting to an approximate ratio of one Board-certified child abuse pediatrician for every 313,000 children (*Workforce Data 2011–2012,* 2012*)*, or one child abuse pediatrician for every 2,633 founded cases of child abuse (HHS, 2011). Seven states have no Board-certified child abuse pediatricians, and 16 additional states have fewer than three CAPs, indicating that access to experts in the field is limited for a significant proportion of the country.

In 2011, 62% of CACs reported physicians (MDs) as the primary medical providers, a 19% decrease from 2009. CACs using Board-certified child abuse pediatricians have increased from 63 in 2009 to 137 in 2011. Sexual assault nurse examiners (SANEs) have taken the lead as the primary medical providers for CACs, increasing from 42% in 2009 to 65% in 2011. The survey indicated that 28% of respondents utilized certified nurse practitioners (CNP) to complete medical evaluations. While the survey did not ask specifically about pediatric nurse practitioners (PNP), these professionals have played an important role in the CAC movement and serve as a valuable resource for child abuse medical evaluations. It is important to note that for this particular question, respondents were able to check all professions that provide medical evaluations for their CAC; therefore, CACs could be

Figure 1. Children Receiving Medication Evaluation



using a combination of professionals to provide services. For example, physicians must supervise CACs that utilize pediatric SANEs as primary medical providers; thus, the CACs would indicate utilizing both a physician and SANEs. This may explain why the number of physicians has remained flat while SANEs have increased in number.

In addition to the professional shift, we also see that pediatric SANE training (54%) is the most common training for 2011 providers, although Medical Training Academy (47%) is close behind. Participation in medical peer review increased 11% from 2009 to 2011, another direct result of the 2010 Revised Medical Standard for Accreditation. The majority of participants reported that primary medical providers use a digital camera (56%) or a colposcope with still camera (66%) to document exam findings. Additional peer review modalities have surfaced from 2009 to 2011, with statewide and regional peer review leading the way. Technology-facilitated peer review, including NCA n.e.t. Medical Peer Review and Telehealth Institute for Child Maltreatment (THICM), have continued to be successful tools for peer review in both the medical and forensic interview fields. All THICM cases are peer reviewed by a panel of nationally recognized Board-certified child abuse pediatricians (CAP). Recent research suggests that CAPs have "greater knowledge and competence in interpreting medical and laboratory findings in children with Child Sexual Abuse" when compared with pediatric SANEs and advanced practice nurses (APN) in the field (Adams et al., 2012, p. 383).

Nearly every CAC surveyed (96%) provides the opportunity for a medical evaluation to all of its clients. This is a great advancement in the field and is a direct result of the revised Medical Standard in the 2010 NCA Standards for Accreditation (NCA, nd). Approximately 36% of children are actually receiving a medical evaluation (SD 26.49). This average is skewed with outliers from urban centers and hospital-based CACs (see Figure 1).

Figure 1 indicates that hospital-based centers are indeed having an impact on the national average of percentage of children receiving medical evaluations. Hospital-based CACs provide medical exams on average to 63.69% (SD 28.96) of their clients, much greater than nonhospital-based CACs (501c3 independent nonprofits, 34.18% [SD 24.95], government based, 31.08% [SD 23.65], and 501c3 umbrella, 30.60% [SD 20.73]).

Conclusions

Data gathered from this survey demonstrate progress toward meeting best practices in the field of child maltreatment and progress toward meeting the NCA Standards for Accreditation. A significant increase in peer review participation for both forensic interview specialists as well as medical providers demonstrates continuous quality improvement in the field. Peer review provides not only an opportunity for professional growth but also an opportunity to discuss and review best practices in action, a necessary process to ensure that we are providing the best quality care for children seen at CACs.

Although progress has been made in providing medical evaluations to CAC clients, a substantial number of children still are not receiving this service. With increased training and technical assistance in this area, the average number of children receiving medical exams is expected to increase over the next few years.

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