The National Children's Alliance: Empowering Local Communities to Serve Victims of Child Abuse

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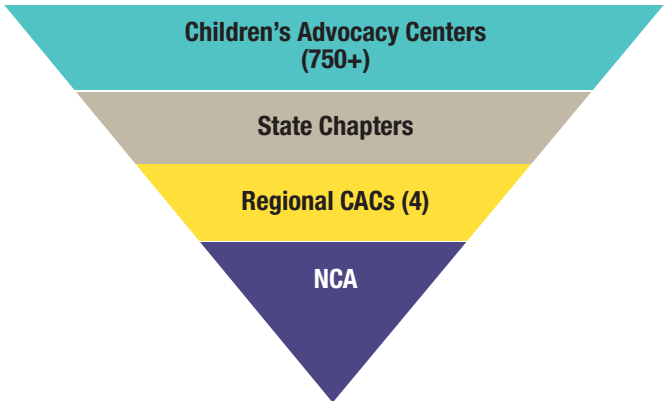
The National Children's Alliance (NCA) is a nonprofit membership organization whose mission is to empower local communities to serve victims of child abuse (NCA, About NCA, 2011). Former Congressman Bud Cramer (Alabama) developed the NCA in 1987. His goal was to bring organization and coordination to the community-level children's advocacy centers (CACs) that were developing across the country. The NCA mission is accomplished by empowering the work of local CACs, such as providing training, grants for development and sustainability, and technical assistance. Membership is through an accreditation process that exists to strengthen best practices both within the CAC and the community being served.

While the NCA's mission is to empower work at the community level through individual CACs, this work would not be possible without the partnerships of the state chapters of CACs and the regional CACs (see Figure 1). There are four centers with regional designation across the country that serve as keystones to the training and technical assistance provided at the local level. These are located in Huntsville, Alabama (Southern), St. Paul, Minnesota (Midwest), Philadelphia, Pennsylvania (Northeast), and Colorado Springs, Colorado (Western). These centers provide such resources as "bootcamps" to prepare for submitting an application for accreditation, online and onsite learning opportunities, telemedicine-based reviews for medical–mental health–forensic interview services, and online library assistance for professionally-based articles (see Table 1).

Figure 1: Organizational Structure of National Children's Alliance



Although no two CACs will look or function exactly alike (Walsh, Jones, & Cross, 2003), research has shown that collaborative investigative efforts employing best-practice techniques (in an environment in which the child is able to feel at ease) lead to better coordinated investigations, more satisfaction from the caregiver of the child in the investigative process, and better referral rates for mental health and medical services (Walsh et al., 2007; Cross et al., 2008). For this reason, the NCA holds the multidisciplinary team (MDT) as central to the effectiveness of child abuse work at the local level. A CAC cannot be effective in its local community without the partnership and participation of the MDT.

A Trauma-Based Approach

Child sexual abuse makes up 65% of the cases seen in CACs across the country; physical abuse, neglect, witnessing violence, and drug endangerment comprise the other cases (NCA Annual Report, 2011). The original standards focused on issues related to child sexual abuse, but the most recent revision included information from the evidence-based literature about the need to use a trauma-based approach to any form or child abuse/neglect. This was done due to CACs being utilized by their local MDTs to assist with interviewing and service delivery for all forms of abuse/neglect and the growing understanding of the long-term issues encountered by child victims. The current standards remain focused on issues related to child sexual abuse but incorporate information in the evidence-based literature about the need to use a trauma-based approach to address the long-term issues associated with *any* form of child abuse or neglect.

The evidence base for the short- and long-term negative consequences of child abuse is robust and growing. One of the largest scale projects on the subject is the Adverse Childhood Experiences (ACE) study. After analysis of adult's self-reports of traumatizing events during childhood, the study group has

Table 1: Listing of Regional CAC Coverage and Services

Regional CAC	States Supported	Partial List of Programs/Services
Northeast (Philadelphia, PA) http://www.nrcac.com/default.asp	CT, MA, ME, NH, NJ, NY, RI, PA, VT	-Medical Training Academy -Forensic Interview Training -National Symposium on Child Abuse -Onsite Training and Technical Assistance -New Director Orientation -Court Prep Training -Accreditation "Bootcamp" -myCaseReview -Topical Webinars -Victim Advocate Training -Child Abuse Library Online -Expert Peer Review
South (Huntsville, AL) http://www.nationalcac.org/	AL, AR, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV, DC	
Midwest (St. Paul, MN) http://www.mrcac.org/	IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, WI	
West (Colorado Springs, CO) http://westernregionalcac.org/index.php	AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY	

published numerous articles showing the cumulative adverse effects that childhood trauma has on adult health and well-being, including premature death, increases in chronic disease conditions, higher rates of attempting suicide, and more engagement in high-risk sexual activity and substance misuse (Felitti et al., 1998; Centers for Disease Control and Prevention, 2013). Physical abuse, sexual abuse, and neglect were each categorized as ACEs in the study. Other researchers have looked specifically at victims of child sexual abuse and also shown long-term negative consequences to both physical and emotional health (Trickett, Noll, & Putnam, 2011).

This trauma-based understanding of the potential for negative consequences for victims of child abuse is central to the CAC approach. Advocating for and facilitating a coordinated approach to an investigation can not only lead to better case outcomes (U.S. Department of Justice, 2008) but may also minimize the trauma experienced by children and their family members through the process (Jones et al., 2007; Bonach, Mabry, & Potts-Henry, 2010). Ensuring that the professionals providing services to the child are properly trained and remain current in their field through continuing education and participation in peer review is another important role of the CAC in minimizing trauma a child may experience as part of the investigation itself.

For example, many victims, family members, and even professionals may believe that the medical evaluation for possible sexual abuse is a painful and negative experience for a child. On the contrary, when someone with knowledge and experience in the field of child abuse performs an examination, most children do not rate the exam negatively (Palusci & Cyrus, 2001; Marks, Lamb, & Tzioumi, 2009; Hornor et al., 2009). It is important for the CAC not only to ensure access to qualified providers in the community but also to help educate MDT members and other local partner agencies. In this way, a misconception of one component of the investigation does not interfere with needed services being offered to a child and the family. Studies are underway that evaluate rates of referrals for trauma-focused cognitive-behavioral therapy to children served by CACs as this is a modality that has proved beneficial to child abuse victims by reducing some of the long-term negative effects (Mannarino et al., 2012; U.S. Department of Health and Human Services, 2012). This specialized service requires initial and ongoing training with expert oversight, which is outlined in the NCA's mental health standard.

Medical Standards

The NCA developed the first set of practice standards in 1996 aimed at building CAC services that use methods with evidence-based foundations. Since that time, the standards have been revised according to emerging information in the evidence-based literature. Currently, ten standards (see Table 2) that describe minimum best-practice components must be met for a CAC to qualify as an accredited center (NCA Standards, 2011). While centers are working toward meeting the standards for accreditation, they can still be part of the NCA for training and other areas of support at the level of associate, affiliate, or satellite member. Accredited and associate members submit a report to the NCA every 6 months. Once accredited, a CAC's membership status must be renewed every 5 years in a process that includes a detailed written report on adherence to accreditation standards and an in-person site visit.

Table 2. National Children's Alliance Standards for Accredited Members

Program Components

1. Multidisciplinary Team
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
10. Child-Focused Setting

Source: NCA, NCA Standards … (2011).

The specific standards for providers of medical, mental health, and forensic interview services all stress two criteria: (1) the need for specialized training within the area of service and (2) the need for professionals providing these services to stay current in the field and participate in continuous quality improvement activities, such as expert peer review (NCA Standards, 2011). The current medical standards (Table 3) were approved in 2011, but another revision is expected within 4 years. The description of services in the standards stress that the evaluation of children should focus on their overall well-being instead of limiting the evaluation to the collection of potential evidence. Information in the current medical standard is based largely on a consensus article published in 2007 by leaders in the field of child sexual abuse (Adams et al., 2007). This article emphasizes that the child's overall health and well-being should be the focus of the medical evaluation (in addition to accurate interpretation of exam findings and collection of forensic material when indicated) because many victims of abuse have co-occurring disabilities, unmet general health needs, or both. Children are sometimes not

Table 3. National Children's Alliance Standards for Accredited Members: Medical Evaluation

Standard = specialized medical evaluation and treatment services that are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

CRITERIA

1. Medical providers (physicians, nurse practitioners, nurses, or physician assistants) must meet at least ONE minimum training standard.
   a. Child abuse pediatrics sub-board eligible or certified.
   b. Completion of a competency-based training in performance of child abuse evaluations.
   c. Documentation of 16 hours of formal medical training in child sexual abuse evaluation.
2. Specialized medical evaluations are made available onsite or through linkage agreements with appropriate providers.
3. Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.
4. The CAC must have written documents to include:
   a. Screening criteria to be used to determine the timing of the medical evaluation.
   b. How the medical evaluation will be made available, including how emergency situations are addressed.
   c. How multiple medical evaluations are limited.
   d. How medical care is documented (medical history, physical and diagnostic-quality photographic documentation).
   e. How the medical evaluation is coordinated with the MDT to avoid duplication of interviewing of the child.
   f. How medical evaluations for physical abuse will occur.
5. CAC and/or MDT provide opportunities for those who conduct medical evaluations to participate in ongoing training and peer review.
   a. Minimum of 3 hours every 2 years of CEU/CME credits in the field of child sexual abuse must be completed.
   b. Photodocumented examinations are reviewed with *advanced medical consultants*. Review of ALL exams with positive findings is strongly encouraged. *(Advanced medical consultant* = physician or advanced practice nurse who has considerable experience in the medical evaluation and photodocumentation of children suspected of being abused, and who is involved in scholarly pursuits, such as conducting research studies, publishing on the topic, and speaking at regional or national conferences the topic of child abuse.)
6. MDT members and CAC staff are trained about the nature and purpose of a medical evaluation so they can competently respond to common questions, concerns, and misconceptions.
7. Findings of the medical evaluation are shared with the MDT in a routine and timely manner.

Source: NCA, NCA Standards … (2011).

referred for a medical evaluation if there is a perception that it would not yield forensic evidence for the investigation. Therefore, the CACs again need to help educate the MDT and their community that the benefits of an exam go far beyond the collection of evidence, and that the absence of physical findings of trauma in the anogenital area in no way discounts a valid disclosure of sexual abuse (Heger et al., 2002).

Within the medical standard, regardless of the education of the provider (registered nurse, advanced practice nurse, physician assistant, or physician), a minimum amount of initial and continuing education specific to child abuse is designated. This was established because research has shown that, regardless of the degree of the provider, experience within the field of child sexual abuse is a major determining factor when it comes to accuracy in interpreting examination findings (Adams et al., 2012; Campbell et al., 2010; Makoroff et al., 2002). The other factor that has been linked to accuracy in interpreting examination findings is participation in expert peer review (Adams et al., 2012). This is especially true for providers who do not perform exams on a regular basis (fewer than five exams per month). To participate in expert review of examination findings, a provider must be able to obtain diagnostic quality photodocumentation of the anogenital findings. Although this does require access to specialized equipment that is cost-prohibitive to some centers, it is possible to assemble the needed components for diagnostic-quality images for just a few thousand dollars compared with spending over tens of thousands of dollars on a medical-grade colposcope and recording system.

Support for Medical Providers

Access to someone qualified to provide expert peer review of examination findings may be difficult for some centers as well, especially if they are not located in close proximity to an academic medical resource. In response to this need, the Midwest Regional CAC established an online, de-identified expert case review system, called myCaseReview (formerly known as Telehealth Institute for Child Maltreatment). More information about this program can be found on the Web site for the Midwest Regional CAC's Medical Academy through the link provided in Table 1.

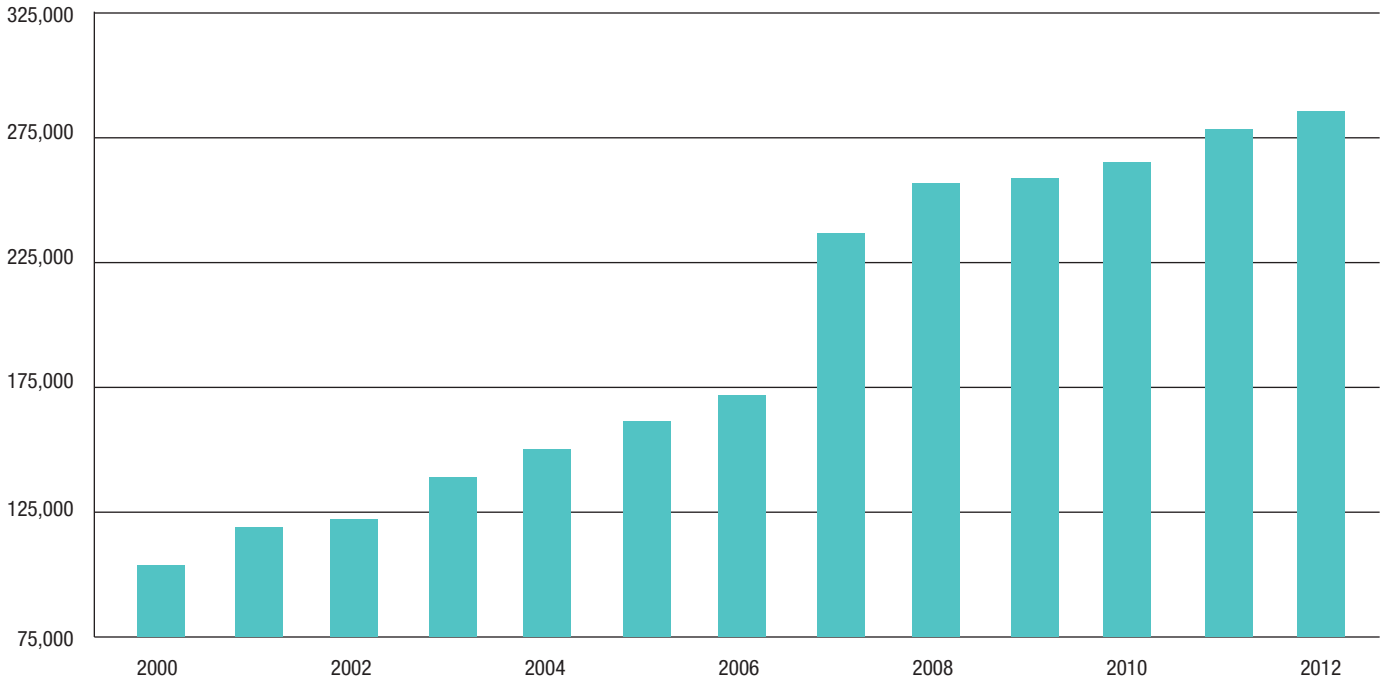
A recent review of CAC services appeared to indicate that progress is being made toward meeting best-practice standards in the field. Specifically, the survey showed that forensic interviewers and medical providers were receiving increased training, peer-review participating was increasing, and the percentage of children receiving a medical evaluation was increasing (Stephens, Martinez, & Braun, 2012).

The process of applying to the NCA for initial or re-accreditation by a CAC is rigorous. While accreditation in and of itself signifies adherence to quality standards and brings an inherent level of validation, there are other benefits to membership beyond funding support. The NCA manages a members-only e-mail listserve for networking and customizable public awareness campaigns. In addition, it has testified at Senate and House hearings about the importance of both the intervention and prevention of child abuse, thereby raising national awareness of the importance of CACs.

Improving Outcomes at CACs

As a nonprofit entity that receives federal funding and individual donations, the NCA is committed to good stewardship with its resources. The annual report, including fiscal information, is available in open forum online (NCA Annual Report, 2011). Over 90% of the revenue received from sources such as the federally based Victims of Child Abuse Act is disbursed to the local CACs and state chapters for growth and development (NCA Annual Report, 2011). The NCA and its member organizations also participated with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the U.S. Department of Justice for an evaluation of the CAC's response to child abuse. OJJDP (Cross et al., 2008) funded a comparative review by an external research group between four communities with CACs and four communities of similar composition that did not have CACs

Figure 2: Number of Children Served in CACs in the United States by Year



Source: National Children's Alliance (2013). Used by permission.

In this evaluation, communities with CACs had greater involvement of law enforcement in sexual abuse evaluations, more evidence of coordinated investigations, and higher rates of referrals for medical and mental health services. Children served by a CAC had a medical evaluation in 48% of the cases, which was significantly higher than those served in comparison communities (21%). Caregiver satisfaction was higher in cases served by CACs. In addition, the CACs in this particular study were identified as providing other services to their communities, including training and consultation. The MDT partners in the communities with CACs regarded the CAC staff as leaders and experts in the field of child abuse for their area.

Despite the NCA's struggles to maintain long-term effectiveness and viability as a nonprofit entity, the number of CACs available to MDTs and children across the country has more than doubled since the year 2000. Two thirds of counties in the United States now have access to a CAC. Accordingly, the number of children served by the CAC model has increased by 175% since 2000 (see Figure 2)(NCA, 2013). The news from child welfare data sources that rates of child sexual abuse continue to decline is encouraging (Finkelhor & Jones, 2012). However, there are still thousands of children affected by this issue each year, indicating the need to keep intervention and prevention efforts moving forward.

As the service areas of CACs continue to grow, the NCA will continue to evaluate ways to assist its membership with training, advocacy, and support. This has already included partnering with agencies dealing with victimization by child pornography. Other issues, such as addressing the needs of children who have been trafficked for sex and other crimes, may benefit from inclusion in CAC services when they clearly fall within the mission of the NCA.

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