

An Evaluative Study of the Kozmetsky Center for Child Protection in Austin, Texas

By
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Abstract

Research Purpose: As more organizations establish child advocacy centers, there needs to be an effective tool to measure their administrative adherence to national goals and objectives. The purpose of this research is threefold. The first purpose is to describe the ideal characteristics of a child advocacy center by examining existing literature and the nine objectives of the National Child Advocacy Center (CAC) Model. The second purpose is to use these components as a guide to evaluate the administrative operations of the Kozmetsky Center for Child Protection. Finally, this project utilizes the research results to provide recommendations for improving administrative operations at the Center for Child Protection.

Methodology: An examination of the National CAC Model objectives and relevant literature reveals five primary categories of the CAC assessment model. The categories include multidisciplinary teams, case management, forensic interviews, health services, and child-friendly facilities. The components are used to assess the administrative practices and adherence to the National CAC standards. The case study research utilized document analysis, structured interviews, and direct observation.

Results: The results of the case study show that the Kozmetsky Center for Child Protection meets all the rated criteria in the forensic interview category. It exceeds the criteria in the child-friendly facility and health services categories. However, the multidisciplinary team and case management categories demonstrated room for improvement.

About the Author

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Chapter One: Introduction

Purpose¹

Child abuse is a problem facing national, state, and local government officials. In 2006, an estimated 905,000 U.S. children were victims of maltreatment. That extraordinary number translates to a victimization rate of 12.1 per 1,000 children (UDHHS 2009). During 2008, 201 Texas children died as a result of parental abuse. (TDFPS 2009). Child abuse can be physical, sexual, or a result of neglect. The Federal *Child Abuse Prevention and Treatment Act* (CAPTA) defines child abuse and neglect as: “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm” (UDHHS 2009).

Public administration plays an important role in child abuse investigations because the majority of organizations providing assistance to victims are nonprofit or governmental. Nonprofit organizations are responsible for implementing effective ways to provide relief to victims and help fight child abuse in the community. The Child Advocacy Center model is a mold that has been adopted by numerous nonprofit programs and organizations to create an effective outlet in dealing with this abuse (Jackson 2004, 412). The development of effective child advocacy organizations can assist overloaded governmental agencies and even provide a more effective source of intervention (Carnes et al. 1999, 242).

¹For examples of other ARPs dealing with child advocacy see Guzman, 2007 and Zarate, 2007.

Traditional Child Advocacy Methods

The methods public and nonprofit agencies use to provide relief for victims of child abuse have changed over time (Stalker et al. 2007, 40). Most of these changes involve different interview techniques based on new findings in the field of behavioral psychology (Stalker et al. 2007, 41). In spite of some improvement, critics of traditional approaches point to inefficiencies in the old methods, such as repeated interviewing and poor interagency coordination (Cross et al. 2007, 1032; Tedesco and Schnell 1987, 267).

Because the investigative techniques used can be uncomfortable and intrusive, the experience may be emotionally damaging and distressful for children. The actual investigation can itself be a type of child abuse (Yeaman 1986; Henry 1997, 1).

Victimized children may experience system-induced trauma that endangers them emotionally and may hamper successful prosecution of the offender. System-induced trauma is perpetuated through excessive interrogation by multiple interviewers - virtual strangers during a short period of time (Jackson 2004, 412; Yeaman 1986, 230). The abused children can experience secondary victimization as a result of systems-induced trauma because the investigative process can compound an underlying sense of victimization. Children's feelings of insecurity can be augmented by social support networks that fail to support and protect them (Carmen and Flanagan 2004, 7).

Child Advocacy Center (CAC) Model

Early in the 1980s, child psychologists, law enforcement officials, child protective services (CPS) workers, medical providers, and community activists believed that social service and criminal justice systems were not effectively working together to build a

system that children could trust.² In 1985, these individuals teamed with former Alabama Congressman and District Attorney Robert E. “Bud” Cramer to create an organization called the Child Advocacy Center (CAC). The CAC in Alabama later became known as the National Children’s Advocacy Center (NCAC) (Carman and Flanagan 2004, 5; Wolf 2000, 4).

The CAC model was developed in accordance with Congressman Cramer’s vision. The initial purpose of the model was to “improve the community collaborative response to child sexual abuse and the criminal justice processing of child sexual abuse cases in such a way that would not further harm the children involved” (Jackson 2004, 412). The CAC model provides a standard for improving traditional methods of intervention in child abuse cases by coordinating a unified effort among the systems that support victims and their families (Carman and Flanagan 2004, 5). Initially, the model focused on child sexual abuse because those cases were typically not supported by sufficient medical evidence, making the child’s personal testimony in court imperative (Jackson 2004, 412). By the early 1990s, however, the CAC’s model treatment plan expanded to incorporate all types of child abuse cases (NCAC 2004).

Often programs operating within other organizations (e.g., district attorney’s offices, hospitals) adopt the NCAC model’s approach to child abuse cases. The majority of organizations that adopt the NCAC model are independent nonprofit centers. The number of programs and organizations that have adopted the CAC model has grown from twenty-two in 1992 to over 650 in 2007. These organizations form a national network of

² See additional references Jackson, 2004, 411; Sheppard and Zangrillo, 1996, 21; National Children’s Advocacy Center, 2004.

Children's Advocacy Centers that have served over 148,000 children (NCAC 2004, Wolf 2000, 4).

Kozmetsky Center for Child Protection



Figure 1.1: Kozmetsky Center For Child Protection's Facility

The Kozmetsky Center for Child Protection (KCCP), located in Austin, Texas, is a nonprofit child advocacy center instituted in 1989 under the leadership of the Travis County District Attorney's office in a collaborative effort with community volunteers. It is the "first stop" for children, ages twelve and under, who reside in Travis County and enter the justice system because they are either suspected victims of sexual or physical abuse, or because they have witnessed a violent crime.

Once officials suspect child abuse, either law enforcement investigates as a criminal matter or CPS investigates as a civil matter. All referrals come through Austin's Child Protective Services or local law enforcement. Police departments referring victims to the CCP include: Austin, Bee Cave, Cedar Park, Jonestown, Lago Vista, Lakeway,

Leander, Manor, Mustang Ridge, Pflugerville, Rollingwood, Sunset Valley, Westlake, and the Travis County Sheriff's Office (CPCOM).³

Once these agencies formally launch a criminal or civil investigation, the KCCP coordinates with CPS and law enforcement officials to fully investigate the case and offer services to victims and their non-offending family members. Services aimed at preventing additional victimization are provided at no charge to the victim or the victim's family (Wolf 2000, 60). The services offered to child abuse victims at the Center's facility include: forensic interviews, education about child abuse, medical exams, psychological counseling, and court school for children in the justice systems. The KCCP remains actively involved with the case throughout the court process if Travis County's District Attorney's Office decides to prosecute the case (Center for Child Protection 2004).

There is no waiting list for children in need of services nor is any child turned away. The Center for Child Protection has a general mission: to reduce the level of trauma experienced by children during the investigation and prosecution procedures of child abuse cases. In an effort to reverse alarming statistics in Travis County, the KCCP adopted the NCAC model's primary program objectives (Center for Child Protection, 2004).

Research Purpose

As more organizations establish child advocacy centers, there is an increasing need for an effective tool to assess administrative adherence to national goals and objectives. The purpose of this research is threefold. The first purpose is to describe the

³ Child Protective Center Operations Manual (CPCOM), see the "Child Protective Services" brochure located in the Appendix.

ideal characteristics of a child advocacy center by examining existing literature and incorporating the nine objectives of the National Child Advocacy Center (NCAC) Model. The second purpose is to use the practical ideal components as a guide to evaluate the effectiveness of administrative operations of the Kozmetsky Center for Child Protection. Finally, this project utilizes the research results to provide recommendations for improving administrative operations at the Center for Child Protection.

Chapter Overview

Chapter one provides a brief background of child abuse and its relevance in the public administration field, as well as a history and overview of child advocacy centers. Chapter two offers an explanation of and substantiates each component of the CAC assessment model. The third chapter describes the three types of research methodology utilized for this case study. Chapter four reveals the results of the methodology. Lastly, chapter five presents the study's conclusions and future recommendations for the Kozmetsky Center for Child Protection's administrative operations.

Chapter Two: Components of CAC Model Assessment Tool⁴

Chapter Purpose

The purpose of this chapter is to identify and describe the core components of the Child Advocacy Center (CAC) Model assessment tool. This tool is based upon the National CAC model's nine program objectives and existing scholarly literature. Child advocacy programs and organizations wishing to adopt the CAC model must adopt the nine program objectives in order to become a member of the national network of Children's Advocacy Centers (NCAC 2004). These nine core objectives include: the establishment of a child-friendly facility; the establishment of multidisciplinary teams; administer acceptable investigative forensic interviews; provide thorough interviewer training; ability to provide of health services; effective decision-making and policy development; the ability to track case data; and increasing community awareness (Wolf 2000).

CAC Core Components

The CACs nine program objectives tend to overlap. This research categorizes eight of the nine core objectives: child-friendly facility, multidisciplinary teams, forensic interviews, interviewer training, provision of health services, decision-making and policy development, and case tracking into five categories. The five categories are used to assess whether the CAC member is adhering and practicing the national CAC model objectives.⁵

The five primary categories of the CAC model identified from the literature and CAC handbook are:

⁴ For additional examples of practical ideal type models see O'Neil 2008; Gradney 2008; West 2007.

⁵ For additional supporting literature see Cross et al. 2007 1032; Wolf 2000; NCA 2008; Jackson 2004; National Children's Advocacy 2004.

1. Multidisciplinary Team
2. Case Management
3. Forensic Interviews
4. Health Services
5. Child-Friendly Facilities

The characteristics of the model are sequential (West 2007). The first section discusses Multidisciplinary Teams.

Multidisciplinary Teams

The CAC model requires member CAC organizations to develop a functioning and effective multidisciplinary team (MDT) (NCA 2008, 1). A MDT is a group of professionals who represent various disciplines and work collaboratively to promote a thorough understanding of case issues and assure the most effective system response possible (Wolf 2000, 27). MDTs were established to provide a holistic treatment to the victim. The team addresses the child's legal, social, therapeutic, and medical needs (Bell 2001, 77). The purpose of an interagency response is to coordinate intervention that eliminates potential trauma to children and their families (NCA 2008, 2). This intervention is accomplished by creating a less invasive interview process, which is achieved by providing fewer forensic interviews and interviewers, better inter-agency coordination, and more timely referrals for needed services (Wolf 2000, 28; Carman et al. 2004, 21).

Interagency Coordination

Interagency coordination can provide a team approach that facilitates efficient information sharing (Wolf 2000, 27). Poor inter-agency collaboration became an

obstacle for positive case outcomes (Jackson 2004, 412). The concept of multidisciplinary and coordinated responses to child abuse has evolved in the United States since the early 1970s (Stalker et al. 2007, 39). In 1967 there was an increase in child maltreatment reports, most likely a result of recently enacted legislation by all states requiring doctors, teachers, and other professionals to report suspected incidents of child abuse (Sheppard and Zangrillo 1996, 21). These laws required that, once notified, CPS and law enforcement bodies notify one another of reported cases to encourage cooperation in investigations. Most states required CPS to investigate reports of family abuse, whereas, law enforcement was required to investigate potential criminal violations outside of the child's family (Sheppard and Zangrillo 1996, 22).

The first experimentation with a coordinated multidisciplinary response to child abuse occurred in 1971 by Dr. Henry Giarretto and his colleagues, who began a Child Sexual Abuse Treatment Program in California. The program's goal was to provide psychiatric services to families in which incest was alleged. Giarretto realized that in order to successfully treat incest, he must mitigate the negative impact of the criminal justice system to the treatment process. As a result, he and his colleagues developed a high level of cooperation between themselves and police, CPS, probation officers, district attorneys, and judges (Stalker et al. 2007, 39). Giarretto claimed the program was successful in treating cases involving incestuous child sexual abuse because the program included "a coordinated effort for creative management cases involving child sexual abuse that is backed by the authority of the criminal justice system but enables intervention of a nonpunitive fashion" (Giarretto et al. 1978, 232). The successes of this study lead to similar programs in other jurisdictions (Stalker et al. 2007, 39).

A multidisciplinary coordination approach to managing child abuse cases became more common partly because of the work of C. Henry Kempe and his colleagues. In the 1950s, Kempe created the first hospital-based child protection team consisting of a social worker, pediatrician, and a nurse. By 1978, Kempe's hospital team had expanded to include CPS representatives, psychologists, psychiatrists, lawyers, and educators. Following this model, CPS began to supervise community-based teams with a similar composition. The teams managed cases of physical abuse and provided support to families (Stalker et al. 2007, 40). Kempe levied that the teams were necessary because the cases were so complex and emotionally draining that the diagnosis and treatment planning needed to be shared by a number of professionals (Kempe 1978).

By the 1990s, laws in states such as Tennessee mandated team investigations. In other states, team coordination was a result of individuals voluntarily working together on each case (Stalker et al. 2007, 42). In 1997, Kolbo and Strong (1997) conducted research to determine the number of states implementing team approaches in child abuse investigations. They found that thirty-three of the fifty states had a multidisciplinary approach to child abuse. Further, legislation enacted in thirty of those states mandated multidisciplinary teams (Kolbo & Strong 1997). Their research, based on a national survey of state and organizational level administrators working with child abuse investigations, concluded that the MDT approach introduced a wider range of viewpoints and permitted greater joint decision-making. Respondents utilizing a multidisciplinary approach reported more accuracy in assessments, better assessment plans, and higher success rates of positive case resolution (Kolbo & Strong 1997).

A study conducted in 2000 by Faller and Henry described the processes and outcomes of a Midwestern community's approach to case management of child sexual abuse (Faller and Henry 2000, 1215). By using data, collected from 323 criminal court files for sex crimes against children, Faller and Henry (2000, 1217) identified specific benefits of utilizing a MDT approach in child sexual abuse cases. Evidence showed that CPS and law enforcement successfully collaborated. CPS and law enforcement were able to acquire information about open cases more expeditiously than agencies not using a collaborative approach (Faller and Henry 2000, 1218). The results support the importance of collaboration between CPS and law enforcement. Faller and Henry (2000, 1213) concluded that community professionals can successfully work together on the behalf of abused children.

Currently, the use of multidisciplinary teams is common in the field of child protection. By 2002, all fifty states had legislation requiring at minimum the cross-referral of the cases among professional agencies (U.S. Department of Health and Human Services 2002). The federal government has also passed legislation to grant incentives to states utilizing multidisciplinary teams in their child abuse investigations. The Child Abuse Prevention and Treatment Act of 1974 mandates that states receiving federal funding through the act must institute multidisciplinary teams. In 1986, the federal government passed the Children's Justice Act, which offers funding to states in return for creating task forces comprised of child advocates, CPS, health, judicial, law enforcement, legal, mental health, and parent participants to review and evaluate the handling of child abuse cases (Sheppard and Zangrillo 1996, 23). The ideal CAC model requires each MDT to represent seven disciplines: law enforcement, child protective services,

prosecution, mental health, medical, victim advocacy, and the child advocacy center (Wolf 2000, 27).

Investigation Involvement

Multidisciplinary models vary from integrated teams that actively work together on investigations to minimal cross-referral practices with modest collaboration (Jones et al., 2005, 255). According to the CAC model objectives, a desirable MDT should provide an ongoing, involved participation by representatives from law enforcement, child protective services, prosecution, mental health, medicine, victim advocacy, and the CAC (NCA 2008, 1; Wolf 2000, 27). There are exceptions to the team's composition. Member organizations located in small, rural areas may employ one person to fill multiple roles. For example, a CPS worker may function as an interviewer and a case worker. On the other hand, MDTs may include professional members to supplement the team such as court-assigned guardians, civil attorneys, federal investigators, and domestic violence providers (Wolf 2000, 28). Although members of each agency collaborate, MDTs respect the rights and obligations of each of the different agencies to follow their own mandates (NCA, 2008, 2).

Written Agreement

The CAC model mandates essential criteria regarding MDTs. The 2008 guidelines require that organizations wishing to adopt the CAC model have a written interagency agreement formalizing cooperation and commitment. It must be signed by the participating team member's supervisor. These documents must also address the MDT's policy on how information sharing will take place, as well as ensure the timely exchange of relevant information (NCA 2008, 3). Secondly, all members of the MDT,

including participating CAC staff, are routinely involved in the investigations and/or MDT interventions. The intervention stage begins when the child is initially referred to the CAC and ends after the legal process is completed (NCA 2008, 3). Lastly, organizations should have both formal and informal mechanisms that allow MDT members to provide feedback regarding operational and administrative matters. Written proof of these mechanisms should be a part of the organization's policy manual (NCA 2008, 4).

Feedback Mechanisms

Creating an atmosphere of trust will enable an atmosphere of openness. Therefore, the CAC model requires that member organizations provide a formal or informal forum to allow team members to provide regular feedback about operational and administrative matters (Wolf 2000, 31).

An experimental study by Cross et al. (2007, 1031) was conducted in 2007 to determine the effectiveness of CAC organizations response in child abuse investigations. Data was collected about investigation methods in 1,069 child sexual abuse cases with forensic interviews (Cross et al. 2007 1038). The cases were collected from four CAC organizations and four non-CAC organizations located in the same state (Cross et al. 2007, 1036). The study found that the CACs offered a more thorough, child-oriented, and coordinated response to the child abuse reports. This response was enhanced by an increase in MDT member communication and better management of cases (Cross et al. 2007, 1050).

Case Management

Intervention in child abuse cases is primarily accomplished through administrator actions. Case management depends upon the processes and procedures administrators enact during an investigation (Wolf 2000). Case management practices directly influence children's lives and facilitate both positive and negative case outcomes. Administrative management of cases immediately impacts children's safety by identifying the degree of danger to which a child is exposed in their present living situation. Poor case management may negatively affect the mental health of the victim and the victim's families, produce unreliable and inaccurate reports from the victim, and reduce the chances of successfully prosecuting offenders (Smith et al. 2006, 354; Jones et al. 2005, 256).

Reports of child maltreatment increased from 150,000 children per year in the early 1960s to 2.9 million children per year in the mid 1990s (Sheppard and Zangrillo 1996, 21). The higher case loads resulted in increased criticism about the traditional methods administrators used to manage their cases (Smith et al. 2006, 354). Agencies such as courts, prosecutors' offices, CPS agencies, and police departments received complaints alleging that other participants in the same investigations did not coordinate their investigations and decision-making. This created a substandard result in maintaining information and coordinating assistance for the child (Cross et al. 2007, 1032). A study by Zellman and Fair (2002), found a lack of organized case management caused CPS to conduct multiple forensic interviews on each child by multiple interviewers with little interagency communication.

The CAC model responds to the perceived limitations of traditional case management models (Smith et al. 2006, 354). It specifies how CAC member organizations should manage cases. In traditional organizations, professionals often fail to distribute case information to one another or to the child's family. This lack of communication often prevents professionals from forming an appropriate plan of action and following through on a child's case (Cross et al. 2004, 1033). The CAC model requires optimal case management from the time the child is referred to the child advocacy center until the child's case has been resolved in the legal system. CAC models adopt this process to prevent a child from "falling through the cracks" (NCAC 2004). MDTs manage cases by utilizing two different processes: case reviews and case tracking (NCA 2008, Wolf 2000).

Case Review

A case review is the formal process during which MDT members meet together to discuss and share information about the investigation, case status, and services needed by the child and the child's family. Case reviews monitor case progress, encourage accountability, and help assure the child's needs are being met in a timely fashion (Wolf 2000, 81). This often includes monthly discussions between select MDT members and the child's guardian (Cross et al. 2007, 1033). The case reviews allow for an evaluation of the child's forensic interviews and medical examinations. During the case review, the team members discuss, plan, and monitor the progress of the investigation and discuss the child's protection. Also, case reviews should assist legal professionals working the case by providing input for prosecution and sentencing decisions (Wolf 2000, 81).

The CAC model requires that the intended tasks occurring during the case review and the case review procedures are included in the organization's manual or the team's written protocol. This serves to maximize efficiency and enhance the quality of the process (Wolf 2000, 82). The CAC model also requires member organizations to review cases at least once a month (NCA 2008, 26). The organization or MDT must present written documentation defining the frequency of case reviews, the designated attendees, the case selection criteria, the designated facilitator at the review, the mechanism for notifying which cases are to be discussed, procedures for distributing the meeting information to absent members, and the location of the meeting (NCA 2008, 27, Wolf, 2000, 82). The case review is designed as a comprehensive overview of the child's case; therefore, the designated attendees of the case review should include team members from law enforcement, CPS, prosecution, medical and mental health services, victim advocacy, and CAC (NCA 2008, 28).

Case Tracking

As part of case management, all organizations that adopt the CAC model must develop and implement a system to monitor the case progress and outcome. Tracking is a systematic method that specifies the collection of specific data on each case. Tracking systems are usually computerized, but CAC member organizations with limited resources may use manual tracking methods. Tracking provide demographic information, case information, and investigation outcomes. This information can be summarized as using statistics and may be used for grants, case management decisions, and other reporting purposes (Wolf 2000, 89, Jackson 2004, 418).

The CAC model requires member organizations to provide written documentation describing the process used for case tracking (NCA 2008, 30). All organizations must identify a specific individual in charge of implementing the tracking process (Wolf 2000, 90). Organizations are required to retrieve specific information on all CAC clients such as demographic information about the child, family, and offender; the type of abuse; relationship of alleged offender to the child; MDT involvement and outcome; charges filed and case disposition in criminal court; child protection outcomes; and status and/or outcomes of medical and mental health referrals (NCA 2008, 30). Member organizations must establish policies regarding how and when the case tracking information will be made available to all members of the case MDT (NCA 2008, 31). Poor communication can prevent team members from communicating important details to other professionals working on the case, thus preventing disclosure of relevant findings (Cross et al, 2004, 103).

Organized case reviews and sound case tracking are required components of a CAC model investigation; however, forensic interviews are the cornerstone of the process (Wolf, 2000, 49).

Forensic Interviews

A forensic interview occurs when a professional interviews a child in order to establish whether the child has been maltreated. Child disclosure is the most significant means by which authorities discover child abuse; therefore, disclosure during a forensic interview is often a critical piece of evidence for authorities (Lippert et al. 2008, 1, Cronch et al. 2005, 196). Traditional methods utilized in forensic interviews are criticized for encouraging inaccurate disclosures during the interview process (Cross et

al. 2007, 1032). Social workers, prosecutors, and child health officials argue that interviewers lack the knowledge and expertise to elicit accurate responses from a child victim (Cronch et al. 2005, 196).

The forensic interview is conducted for six reasons. First, to determine the likelihood the child has been abused; second, to identify the perpetrators; third, to obtain forensically sound facts necessary for professionals and law enforcement to ascertain what actually occurred; fourth, to allow the victim to disclose details of the abuse and professionals to assess its extent and nature; fifth, is to gather information about the child in order to determine suitable treatment; and finally, to establish a treatment plan if one is needed (Cronch et al. 2006, 196; Wolf 2000, 49). The forensic interview in a CAC should include a statement from the child obtained in a developmentally, un-biased, fact-finding manner that supports accurate and fair decision-making by the MDT (Wolf 2000, 49). The interview should center on the child and be coordinated to eliminate duplicative interviewing. If the child is unwilling or unable to provide information concerning any aspect of the abuse, officials should employ other interventions to assess the alleged abuse and the child's safety (NCA, 2008, 8).

One of the primary goals of the CAC model is to improve child forensic interviewing following the allegations of child abuse (Cross et al. 2007, 1032). The model requires certain policy and procedural formats in the areas of forensic interview processes, interview recording methods, qualified forensic interviewers, and interviewer training (Wolf 2000).

Forensic Interview Process

An ideal interview process has the following characteristics: a reliable, sound procedure devised prior to conducting the first interview; a limited number of interviews; and a limited number of professional that have contact with the child (Cronch et al. 2005, 200; Jones et al. 2005, 256). The CAC assessment model has created a distinct interview procedure, the first phase of which is an information-gathering interview between an MDT member and a non-offending caregiver. This assists the investigation by providing facts and a clinically sound assessment that serves as a foundation for treatment planning.

In the second CAC-approved phase, an MDT member meets with the victim to establish a rapport, assess the child's developmental stage, and elicit information that will clarify allegations. This is the most difficult phase because the MDT member must gain the child's trust. The forensic interview allows the interviewer to establish a rapport with the child and allows the child to lead the conversation as much as possible (Carnes et al. 2001, 231). The trained professional interjects questions related to the abuse allegations in ways that the interviewer deems appropriate (Cross et al. 2007, 232). The interview lasts no longer than two hours (NCAC 2004). The interviewer must incorporate multiple techniques in order to decrease the likelihood of false positives or negatives.

Lastly, the MDT member closes the interview process and makes pertinent recommendations (Wolf 2000, 50). Every organization adopting the CAC model must create written guidelines or agreements in the organization's manual describing the interview process. The NCA establish protocol involving communication between the team and the interviewer and the recording or documentation of the interview. These guidelines ensure interview consistency and quality (Wolf 2000, 51).

The CAC model requires that all forensic interviews be legally sound, non-duplicative, non-leading, and neutral (Wolf 2000, 52). One way to accomplish this is by limiting the amount of case information provided to the interviewer prior to the forensic interview (NCA 2008, 8). Studies show that a child's account of events is more accurate when the account is generated freely without coercive suggestions by the interviewer. Limiting interviewer information about the case decreases the likelihood of interviewer coercion (Cronch et al. 2005). The CAC model allows organizations to establish one of three policies. The first allows the interviewer to attend pre-interview briefings, providing the interviewer full knowledge of the case facts prior to meeting with the child (Carnes et al. 1999, 244). The second method limits the amount of information the interviewer is given before the interview, but informs the interviewer of more facts throughout the interview. Lastly, the organization may have the interviewer conduct an "allegation-blind" interview, sharing only information about the child's developmental level with the interviewer prior to the meeting. Although the organization may adopt any of the three methods and still comply with the CAC ideal standard, it is necessary that the organization determine a clear policy regarding interviewer preparation in the organization's policy manual (Wolf 2000, 51). According to the 2008 National CAC standards, forensic interviews of children must take place at CAC facilities as opposed to other settings. "The CAC is the setting where the MDT is best equipped to meet the child's needs during the interview" (NCA 2008, 10).

Reduction of Multiple Forensic Interviews

Traditional methods of forensic interviewing are often criticized by mental health and social work professionals for creating unnecessary stress for children and for being

ineffective in assessing the truth during interviews.⁶ This criticism occurs partly because traditional agencies tend to conduct multiple forensic interviews with children during investigations (Wyatt 1999, 19). Wyatt (1999, 20) concludes that the average child may be interviewed up to ten times prior to going to court.

Multiple interviews may have incongruous effects and produce false or misleading disclosures (Smith et al. 2006, 355). Repeated interviews with children may eventually elicit from the child inaccurate reports of the event under investigation and even cause the child to recant (Cronch et al. 2003, 203). Ceci and Bruck's study (1993, 403) address interviewer reluctance to recognize their own suggestibility in a child's recount of events. They examined the social and motivational factors that disproportionately influence children by evaluating existing case studies and literature (Ceci & Bruck 1993, 405). For the purposes of their study, suggestibility is defined as the "degree to which children's encoding, storage, retrieval, and reporting of events can be influenced by a range of social and psychological factors (Ceci & Bruck 1993, 404). The results indicated that children can be led to make false or inaccurate reports about crucial and personally experienced events (Ceci & Bruck 1993, 432). Repeated questioning or interviewing is one factor associated with inaccurate accounts of the child's experiences. Ceci and Bruck (1993, 419) found that children had a proclivity to change their answers when asked the same question twice, presumably because the child interprets the second question as, "I must not have given the correct response the first time; therefore to comply and be a good conversational partner, I must try and find the

⁶ Cross et al. 2007, 1032; Ceci & Bruck 1993; Ghetti et al. 2002, 235; Tedesco & Schnell 1987, 267; Whitcomb 2003, 152.

right answer.” The more a young victim is asked to relate the events of his or her abuse, the greater the likelihood of the statement becoming inaccurate (Jones et al. 2005, 256).

Studies show that multiple forensic interviews during the investigation correlate to inflicting system-induced harm upon the child victim (Henry 1997, 500; Berliner & Conte 1995, 382). The child may experience stress as a result of recounting embarrassing events to strangers, from being reminded of traumatic details, or by having to accuse an important person in their lives of wrongdoing (Ghetti et al. 2002, 238; Cross et al. 2007, 1034). Psychiatrists Tedesco and Schnell (1987) conducted a study examining the psychological impact on child abuse victims as a result of specific types of systematic interventions. They sent questionnaires to 120 local child abuse councils, mental health facilities, individual therapists, and other professionals in a position to provide direct care to victims of child care. Each recipient was asked to distribute the questionnaire to child victims who had testified in criminal court (Tedesco & Schnell 1987, 268). Forty-eight recipients responded to the survey. On average, the children were interviewed seven times with an average interview length of one hour (Tedesco & Schnell 1987, 269). The study found that there was a high correlation between repeated interviewing and perceived harm. Children consistently identified multiple interviews as causing the most distress during their interactions while in the system (Tedesco & Schnell 1987, 271).

A study of a similar nature was conducted by Henry (1997) to determine whether three primary system interventions—interviews, testifying, and removal from the home—are likely to reproduce in the child victims feelings of powerlessness, stigmatization, and betrayal. The ninety children interviewed for the study had been involved with the juvenile or criminal court system due to sexual abuse by a household member (Henry,

1997, 501). Henry utilized the “Intervention Stressor Inventory” to measure probable levels of trauma based upon the participants’ answers. He found that the number of interviews was related to elevated trauma scores (Henry 1997, 502-505). The study identified one immediate step professionals can take to minimize potential system-induced trauma: reduce the number of investigatory interviews. To this end, it is critical that community based protocols that coordinate interventions and prevent duplicate interviews (Henry 1997, 507).

The CAC assessment model means to decrease the number of times a victim must recollect his or her story and limit the system-induced stress a child experiences during the investigation by conducting a limited the number of forensic interviews (Jackson 2004, 415; Jones et al. 2005, 256). To prevent multiple interviews, the CAC model mandates that MDT members with investigative responsibilities be present for the initial interview to ensure that the information they need from the child can be gathered at that time. In order to fulfill this requirement, facilities must provide an interview setting that grants the non-interviewing team members observable access to the interview as well as the ability to communicate with the interviewer during the interview (NCA 2008, 37). CAC model facilities often incorporate one-way mirrors enabling team-members to observe and listen to live interviews.⁷ Other facilities have closed circuit TV or video-teleconferencing equipment which projects the interview into a room where members may watch (Jackson 2004, 416; Wolf 2000, 52).

⁷ See Wolf (2000, 52); Carman & Flanagan (2004, 9); Smith et al. (2006, 355); Walsh et al. (2003, 30).

Forensic Interview Recording Method

The CAC model requires that some type of recording method be utilized during the forensic interview.⁸ The types of recording methods used in CAC facilities include written reports, audio taped interviews, videotaped interviews, or a combination of these methods (Jackson 2004, 416). The CAC model grants member organizations the discretion to determine which recording method to implement (NCA 2008, 9).

Although the CAC model does not require member organizations to videotape the forensic interview, policies that require the interviews to be videotaped are no longer considered novel or innovative (McGough 2002, 179). In lieu of concerns about the lack of reliability of children's statements, prosecutors and child advocates have asserted that constitutional due process mandates investigative interviews with children be videotaped or otherwise electronically recorded. Although the United States Supreme Court has declined to recognize videotaping a constitutional right to due process of law, the Court has noted that videotaping "may well enhance the reliability of out-of-court statements of children regarding sexual abuse" (Vandervort 2006, 1). Therefore, the decision whether to enact legislation or merely promote videotaping of investigative interviews is left to the discretion of local law enforcement (Vandervort, 2006, 2).

Videotaping forensic interviews provides an objective record of the child's report, thereby reducing the need for additional interviews (Ghetti et al. 2002, 242). Not only do videotaping forensic interviews capture the child's report, it eliminates the need for additional interviews during the investigation, and encourages successful prosecution of child abuse offenders (Ghetti et al. 2002, 242). Prosecutors in some jurisdictions may

⁸ See Jackson (2004, 416); Wolf (2000, 51); NCA (2008, 9).

introduce a tape as evidence. Videotaped testimony can reinforce case evidence because it is recorded soon after the actual incident of abuse, before lucidity and detail recollection begin to deteriorate in the mind of the young victim. This timing is important in light of the fact that most child abuse cases take roughly one year to go through the court system (Walsh et al. 2008, 3).

A videotaped forensic interview by a professional interviewer in an informal, relaxed setting allows for a more concise accounting of details than could the delayed testimony of a young child, subjected to questioning and cross-examination by attorneys in an emotionally charged, intimidating courtroom. The videotaped interview negates the need for a repetitive recounting of disturbing details, clouded by the passage of time, and alleviates confusion that could generate disbelief of the child's story (McGough 2002, 183). Videotaping concomitantly provides increased transparency in the interview process, allowing jurors to witness the child's natural reactions and responses and more accurately judge credibility (McGough 2002, 184).

Eaton, et al. (2001) conducted a research experiment involving undergraduate students to determine whether courtroom testimony in comparison to a child's videotaped recount of events, affected the child's credibility. The study indicated that a child's live courtroom testimony and videotaped testimony were perceived as equally credible. Because requiring a child to testify in court can be psychologically devastating, the researchers purport that videotaping offers an equivalent alternative (Eaton et al. 2001).

The CAC model grants member organizations discretion to determine whether or not to videotape forensic interviews (NCA 2008, 9). The CAC model, however, does

require the CACs have written documentation of their interview procedures, including recording and/or documenting of the interview (NCA 2008, 9).

Research indicates that organizations and programs adopting the CAC model are twice as likely to be referred for prosecution as those using traditional methods because of the decreased number of forensic interviews, as well as the availability of videotaped interviews (Smith et al. 2006, 359).

Walsh, et al. (2008, 3) found that total child abuse case processing generally took more than two years. The prolonged period of time often serves as an additional source of emotional trauma for the victim (Walsh et al. 2008, 3). As a result, CAC models emphasize a prompt investigation and effective prosecution (NCAC 2004). In order to expedite and strengthen the prosecutorial process, the CAC model offers an efficient, thorough, and dependable investigation (NCAC 2004).

Forensic Interviewer

The third element in the forensic interview category is the forensic interviewer. Forensic interviewers must possess the necessary skill and sensitivity to conduct effective and humane forensic interviews with child abuse victims (Jones et al. 2005, 257). A single interviewer is ideal for conducting the forensic interview if there is more than one interview. Multiple interviewers often ask redundant questions, which require children to repeat their answers (Cross et al. 2007, 1034). The CAC model provides for a single interviewer, preferably a child forensic interview specialist, to conduct the team interview. This policy “eliminates the need for separate interviews or interviewers” (Cross et al. 2007, 1034).

The CAC model allows for variance when determining which MDT member conducts the forensic interview. The interviewer may be conducted by a CAC professionally trained forensic interviewer, law enforcement officer, CPS worker, medical provider, federal law enforcement officer, or other available MDT member as long as the individual interviewer has completed formal forensic interviewing training (NCA 2008, 9; Jackson 2004, 415). The national CAC model requires that, if the organization employs a professional interviewer, that he or she should possess a BA or BS degree in a field related to social science, education, criminal justice, nursing, or psychology. An advanced degree such as an MA, MS, or MSW is preferred (Wolf 2000, 49). Also, the interviewer must complete a competency-based child abuse forensic interview training that includes child development or documentation of forty hours of nationally or state recognized forensic interview training that includes child development (NCA 2008, 9).

MDT members should establish which team member is the most appropriate interviewer prior to the forensic interview. The member organization's written policies should include a statement designating what criteria teams will utilize to determine who will conduct the interview (NCA 2008, 10). Criteria used to choose the interviewer should consist of the interviewer's ability to establish rapport with the child, prior contact with the child, objectivity, knowledge of forensic interviewing techniques, and experience in interviewing children of a specific age or developmental level (Wolf 2000, 50).

Forensic Interviewer Training

The final element in the forensic interview category is forensic interviewer training. The key to effective investigations means collecting accurate information. Poor interviewing skills can alienate and distress children, lead to untrue assessments about the child's allegations, and grant defense attorneys the opportunity to attack the child's interview as suggestive or misleading (Jones et al 2005, 257). In order to prevent this from occurring, ongoing training in forensic interviewing is essential to a quality system, and should to be available to every investigator. Training should include: didactic information regarding memory and suggestibility, interviewing techniques, and opportunities for practice and feedback (Cross et al. 2007, 1033).

The National Child Advocacy Center believes that interview training requires cross-disciplinary and cross-cultural training and support (NCAC 2004). The CAC national model requires all CAC member organizations provide opportunities for professionals conducting forensic interviews to receive specialized training (Wolf 2000, 55). Ideally, trainees are allowed to study and observe child interviews through a one-sided mirror or closed circuit television, and are encouraged to study videotaped and audio taped interviews (Cross et al. 2007, 1033). Training may include conference attendance, literature about forensic interviewing, role play, peer review, and ongoing supervision (Wolf 2000, 55). Regardless of the organization's method, the procedures used to educate forensic interviewers must be established in the organization's policy manual (NCA 2008, 11).

Forensic interviewing is an essential component of the CAC model and is a priority in the investigation, however, the health services component is enacted immediately when the child abuse is initially reported (Wolf, 2000, 62).

Health Services

Frequently, children require medical and psychological treatment services during an investigation because of the physical and emotional trauma that children incur during the abuse and the investigative process. Because professional services can be expensive, especially for families without medical insurance, children and their families in traditional advocacy systems often forfeit the benefits that quality medical and mental health care can provide (Lippert et al. 2008, 860). Swenson, et al. found that medical services offered by traditional child advocacy agencies are rarely accessed by victims of abuse, even when those victims are placed in state custody (Swenson et al. 2003, 138).

The CAC model requires that all participating CAC organizations ensure specialized medical evaluation, treatment, and services are available to CAC clients, regardless of the family's ability to pay (Wolf 2000, 62). According to the 2008 guidelines, not only are medical and mental health exams critical to the child's physical wellbeing, but children may also disclose relevant case information to medical personnel that they did not share with MDT members during the initial investigation (NCA 2008, 16). The CAC model requires that health services be rendered through medical exams and mental health treatment (Wolf 2000; NCA 2008).

Medical Treatment

There are many purposes for a medical evaluation in child abuse cases. They include: ensuring the safety and well-being of the child; diagnosing, documenting, and

addressing medical conditions resulting from abuse; differentiating medical findings that are indicative of abuse from those that are explained by other medical conditions; assessing the child for any developmental, emotional, or behavior problems needing further evaluation and treatment and making referrals as necessary; and reassuring and educating the child and their family (NCA 2008, 18). The CAC model does not specify that the medical specialist follow a particular procedure during the medical exam; however, each MDT's written protocol must state the purpose of the medical exam (Wolf 2000, 63).

The CAC model requires that medical evaluations, performed by qualified health providers, are available to every child referred to the center. The CAC model requires that the medical exams be performed by pediatricians, family practice doctors, nurse practitioners, physician assistants, or nurses with pediatric experience and child abuse expertise (Wolf 2000, 61). The majority of CAC medical examiners are pediatricians and general practitioners. Due to financial constraints, some centers primarily employ nurses and nurse practitioners. Jackson (2004, 411) conducted a study to assess the variation between select core components in seventy-one CAC member organizations. She found that CAC member organizations have an average of 2.33 medical examiners on staff (Jackson 2004, 417). The organization must provide proof that their medical provider meets one of the following criteria: Child Abuse Pediatrics Sub-board eligibility, Child Abuse Fellowship training or child abuse Certificate of Added Qualification, documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations, or documentation of sixteen hours of formal medical training in child abuse evaluation (NCA, 2008, 17). The ability to maintain full

time medical staff may vary due to the organization's location and financial constraints (Wolf 2000, 61).

Each center must describe in their organizational manual how and where they intend to provide medical evaluations to the children (Wolf, 2000, 63). The CAC model prefers for medical treatments to be provided on-site, but services may sometimes be referred to hospitals and clinics. The examinations should not be held in a hospital emergency room if avoidable, because the emergency room setting can inflict additional trauma on the child (Wolf 2000, 64).

CAC model standards require organizations provide written documentation of their policies, including the circumstances under which a medical evaluation is provided (NCA 2008, 17). Temporary or permanent injuries incurred from physical or sexual abuse may require immediate medical attention. In some cases, internal injuries as a result of abuse are not detectable without a medical examination (Swenson et al, 2003, 138). The CAC model states that medical exams should be offered to all children suspected of sexual abuse, regardless of the ability to detect injury. Each organization must develop written protocols that explain how children in need of medical care are identified (NCA 2008; Wolf 2000, 63).

The medical exam should occur immediately following the forensic interview, making the practitioner to be aware of disclosures made by the child during the forensic interview that may assist the practitioner with his or her medical evaluation. If the initial screening process indicates that a child has suffered sexual or physical abuse within the past 72 hours, then the child can be considered in urgent need of emergency medical care (NCA 2008, 18). The CAC model requires organizations to define and include in their

written protocol what constitutes a medical emergency and how the situation is addressed (Wolf 2000, 64).

Similar to the CAC model forensic interview policy created to avoid duplicate interviews, the CAC model requires CAC organizations to limit the number of medical evaluations performed on the child. In order to assure the quality and consistency of medical evaluations, healthcare providers are required to document the examination findings with diagnostic-quality documentation using still and/or video documentation (NCA 2008, 19). This procedure not only ensures quality but reduces the need for duplicate exams because physicians performing additional consultations or second opinions can review the recorded material (Wolf 2000, 65).

Mental Health Services

Studies show that children subjected to physical and sexual abuse are at risk of experiencing social and psychological trauma that requires mental health treatment (Swenson et al. 2003, 138). Tedesco and Schnell have researched emotional trauma that children experience when disclosing abuse. Statistics support the fact that psychological therapy has minimized, and in some cases, alleviated long-term effects of abuse and disclosure, as well as reduced or eliminated altogether the risk of future victimization (Tedesco and Schnell 1987, 268).

The national CAC model is designed to provide trauma-focused, mental health services to children and their non-offending family members, regardless of their ability to pay (NCA 2008, 22; NCAC 2004). Psychological therapeutic intervention helps prevent child victims from suffering long term adverse social, emotional, and developmental outcomes. Because their participation impacts a child's recovery, therapy is offered to

family members (NCA 2008, 23). In the CAC model, psychological therapists do not perform investigative functions but should be available for consultation about crisis intervention, developmental issues, and mental health issues (Wolf 2000, 69). Because mental health treatment is a clinical process designed to mitigate long term adverse impact on the child, the organization or MDT should provide written documentation concerning how the forensic process will remain separate from the mental health treatment. The specific role and contribution that the mental health professional will play in accordance with the MDT should be stipulated in either the MDT's written documentation or the organization's policy manual. These policies must also articulate the amount of information therapists may share with MDT members, while maintaining the patients' right to confidentiality (NCA 2008, 22).

The CAC model strongly suggests that eligible mental health providers possess at minimum a master's degree in a related mental health field (NCA 2008, 22). Jackson (2004) found that over 67% of the therapists employed by the CAC member organizations hold either a Master of Arts or a Master of Science degree from a recognized institution (Jackson 2003, 417). Not all eligible candidates must hold a graduate degree, they may be student interns in an accredited graduate program, a licensed or certified mental health professional, be supervised by a licensed mental health professional, or have completed forty contact hours of training focused mental health trauma within the first six months of association with the organization (NCA 2008, 23). Regardless of their professional background, the CAC model requires that the child advocacy center give mental health providers the opportunity to participate in ongoing

professional training and at least eight hours of annual training in the field of child abuse (NCA 2008, 24).

The national CAC model strongly recommends that a child's therapy be rendered on-site (Wolf 2000, 70). However, this recommendation may not be feasible due to the range of mental health issues, the geographic location of the organization, or funding deficits that require that mental health services be referred to professionals practicing in the community (Wolf 2000, 69). Jackson's (2003) study found that the average number of on-site therapists employed at participating CAC member organizations was 2.87 (Jackson 2003, 417).

The CAC model requires that the facility conduct the forensic interviews and case reviews (Wolf 2000, 49). Due to potential financial limitations, the model only strongly encourages the medical exam and mental health treatments be conducted onsite as well (Wolf 2000, 61-69). The facility that houses the CAC organization can be described as a "one-stop shop" for children (Newman et al. 2005, 170). Therefore, the CAC model specifies characteristics that encourage a child-friendly facility (Wolf 2000, 36).

Child-Friendly Facility

The CAC standard requires that all organizations adopting the CAC model provide a facility with a child-friendly setting that is both physically and psychologically safe for children and their families. The CAC model concept requires that the child-focused facility be a comfortable, neutral environment that ensures the child's comfort (Wolf 2000, 17). The CAC model incorporates the U.S. Department of Justice's general guidelines for improving a child's forensic interview experience include specific recommendations to create a comfortable and developmentally appropriate interview

environment (U.S. Department of Justice 1999). Additionally, the CAC model builds upon the general guidelines and formulates its own distinct guidelines for member organizations (Jackson 2004; Wolf 2000, 17).

Newman (2005) found that CPS and law enforcement investigators used CAC organizations in their child abuse investigations partly because of their child-friendly environment. Respondents indicated the facilities provide an alternative to conducting forensic interviews at police stations or hospitals, which have an intimidating, institutional type atmosphere. Respondents described CAC facilities as nurturing, homey, warm, and safe (Newman et al. 2005, 170).

Design Specifications

The CAC model guidelines state there is no correct way to build a CAC facility because most CAC facilities differ in size and structure. Nevertheless, each facility must possess certain characteristics (NCA 2008, 36). Every qualifying organization must provide waiting rooms for children and their families, child play areas, investigative interview rooms, separate interview or meeting rooms for non-offending parents, separate treatment and medical offices for on-site medical exams, conference rooms, office space for CAC personnel, and office space for MDT members. Waiting rooms provided for the children must feature a welcoming environment, since that is the first contact a child will have with the facility. This type of environment helps soothe the child's initial anxiety about the facility, which should also be easily accessible for employees and children and their family members (Wolf 2000, 18; Jackson 2004, 414).

Neutral Environment

According to the American Professional Society on Abused Children, child interviews should be located in a “neutral environment whenever possible...private, informal, and free from unnecessary distractions” (APSAC, 2002). If children perceive the interview environment as stress-free and non-intimidating, they may be more apt to provide accurate information.⁹ When conducting a study on child forensic interviews in CAC organizations, Cross (2007) found that, unlike CAC organizations, traditional agencies conducted forensic interviews in schools, children’s homes, and police stations (Cross 2007, 1049). Conducting a child’s forensic interview at a police station may frighten children because the perpetrator may be interviewed there simultaneously, or the location may cause the child to believe that he or she has done something wrong (Cross et al. 2007, 1034). The CAC model requires facilities to be a “neutral environment,” a child-friendly facility where interviews and services for victims and their families can be conducted (NCAC 2004).

Ideally, the CAC is located within its own facility, a structure separate from police stations, CPS buildings, and courthouses (Walsh et al. 2003, 3). The CAC model mandates that the facility design provide complete separation of victims from their alleged offenders. A child should not experience any anxiety about potentially crossing paths with an alleged offender. Each organization should develop a plan to ensure that children will not have contact with perpetrators while on the CAC’s premises (Wolf 2000, 18). In their evaluation of the Heartland Child Advocacy Center in Georgia, Carman and Flanagan (2004) found organizations that adopt the CAC model are more

⁹See Lippert et al. (2008, 3); Saywitz & Nathanson (1993, 614); Goodman et al. (1991, 414).

likely to provide “comfortable, child-friendly, home-like environments designed to offer children warmth, support, and protection” (Carman et al. 2004, 6).

Conceptual Framework Table

Table 2.1 outlines the five model categories of the CAC: multidisciplinary teams; case management; forensic interviews; health services; and child-friendly facility.

These categories are used to assess the Kosmetsky Center of Child Protection.

Table 2.1: Conceptual Framework Linking Ideal Objectives to the Literature

Ideal Type Categories	Literature
Multidisciplinary Teams (MDT)	Bell (2001); Carman & Flanagan (2004); NCA (2008); Wolf (2000)
Interagency Coordination	Faller and Henry (2000); Giarretto (1978); Jackson (2004); Kempe (1978); Kolko and Strong (1997); Sheppard and Zangrillo (1996); Stalker (2007); US Department of Health and Human Services (2002); Wolf (2000)
Ideal Type Categories (MDT's Continued)	Literature
Investigation Involvement	Jones, Cross, Walsh, and Simone (2005); NCA (2008); Wolf (2000)
Written Agreement	Cross, Jones, Walsh, Simone, Kolko (2007) NCA (2008) Wolf (2000)
Feedback Mechanisms	Cross, Jones, Walsh, Simone, Kolko (2007); Wolf (2000)
Case Management	Cross, Jones, Walsh, Simone, Kolko (2007); Jones, Cross, Walsh, and Simone (2005); National Child Advocacy Center (2004); Sheppard and Zangrillo (1996); Smith, White, Fricker-Elhai (2006); Wolf (2000); Zellman and Fair (2002)
Case Reviews	Carman & Flanagan (2004); Cross, Jones, Walsh, Simone, Kolko (2007); Jackson (2004); NCA (2008); Wolf (2000)
Case Tracking	Cross, Jones, Walsh, Simone, Kolko (2007); Jackson (2004); NCA (2008); Wolf (2000)
Forensic Interview Interview Process/ Limited Repetition of Forensic Interviews	Berliner and Conte (1995) Carman & Flanagan (2004); Carnes, Gardell, Wilson & Orgassa (2001) Ceci and Bruck (1993); Cronch, Viljoen, and Hansen, 2005 Cross, Jones, Walsh, Simone, Kolko (2007) Ghetti, Weede, Goodman (2002); Henry (1997) Jackson (2004); Lippert, Cross, Jones & Walsh (2008); National Children’s Advocacy Center, (2005); NCA (2008); Smith, Witte, and Fricker-Elhai (2006) Tedesco and Schnell (1987); Walsh, Jones & Cross (2003);

	Whitcomb (2003); Wolf (2000); Wyatt (1999)
Forensic Interview Recording Method	Eaton, Ball & O'Callaghan (2001); Ghetti, Weede, and Goodman (2002) Jackson, (2004); McGough (2002); NCA (2008) Smith, Witte, and Fricker-Elhai (2006); Vandervort (2006) Walsh, Lippert, Cross, Maurice & Davison (2008); Wolf (2000)
Forensic Interviewers	Cross, Jones, Walsh, Simone, Kolko (2007) Jackson, 2004; Jones, Cross, Walsh, and Simone (2005) NCA (2008); Wolf (2000)
Forensic Interviewer Trainer	Cross, Jones, Walsh, Simone, Kolko (2007) Jones, Cross, Walsh, and Simone (2005) National Children's Advocacy Center (2005)a,b; NCA (2008); Wolf (2000)
Health Services	Lippert, Cross, Jones, and Walsh (2008) Swenson, Brown & Sheidow (2003); NCA (2008); Wolf (2000)
Medical Examination	Jackson (2004); NCA (2008) Swenson, Brown & Sheidow (2003) Wolf (2000)
Mental Health Evaluation	Carman & Flanagan (2004) Jackson (2004) National Children's Advocacy Center (2005) a,b NCA (2008) Newman, Sue, Dennefelsar, Pendleton (2005) Swenson, Brown & Sheidow (2003) Tedesco and Schnell (1987) Wolf (2000)
Ideal Type Categories	Literature
Child-Friendly Facility	Jackson (2004) NCA (2008) U.S. Department of Justice, Office of Crimes for Victims (1999) Wolf (2000)
Design Specifications	Jackson (2004) NCA (2008) Wolf (2000)
Neutral Environment	APSAC (2002) Carman & Flanagan (2004) Cross, Jones, Walsh, Simone, Kolko (2007) Goodman, Bottoms, Schwartz-Kenny & Rudy (1991) Lippert, Cross, Jones & Walsh (2008) National Children's Advocacy Center (2005) a,b NCA (2008) Saywitz & Nathanson (1993) Smith, Witte, and Fricker-Elhai (2006) Walsh, Jones & Cross (2003) Wolf (2000)

Chapter Summary¹⁰

This chapter reviewed existing literature on the processes utilized in child abuse investigations and prosecutions and linked those findings to the nine program objectives of the Child Advocacy Center model. The literature indicates a clear relationship

¹⁰ For more Texas State Applied Research Projects dealing with children see Ledesma (2007); Boukhris (2007); Blank (2006).

between objective implementation and a decline in the degree of trauma a child faces during investigative and court proceedings (Jackson 2004; Carmen and Flanagan 2004) . It is therefore critical to remember that advocacy center research findings, in the interest of the victims, ought to continually be subject to scrutiny and audit (Wolf 2000; Joa and Edelson 2004). The next chapter provides a description of research methodology used in this case study.

Chapter Three: Methodology

Chapter Purpose

The purpose of this chapter is to describe the methodology used to assess the Kozmetsky Center for Child Protection in Austin, Texas. The five components of the practical ideal model, each representing a CAC model objective, organize data collection in the assessment of the Center for Child Protection. The research assesses each component using different research methodologies.

Case Study¹¹

This paper uses a case study as its research design. Case study is a common research strategy in political science, psychology, social work, business, and community planning (Yin, 2003, 1). Case study is necessary to perform a comprehensive assessment of the Center for Child Protection, because it enables investigators to incorporate multiple research methods into one study, also known as triangulation (Yin 2003, 99).

Triangulation is beneficial because each research method contains strengths and weaknesses. If using only one methodology, there is a danger that the research findings will be biased. A research design should consist of more than one method (Babbie 2001, 113).

¹¹ Survey analysis was methodology intended to be used in this case study but was not included because late in the study, participating administration had reservations and withdrew their support. The survey questionnaire was created on Survey Monkey and is located in the Appendix in hopes that future researchers will find it useful. The responses were intended to measure four categories in the model: multidisciplinary teams, case management, forensic interviews, and health care.

Survey analysis was the most accurate way to relay the perceptions of approximately 100 MDT members including: CPS officials, law enforcement officers, prosecutors, health care providers, child advocates, and KCCCP employees. The survey consisted of 14 close-ended questions developed from the conceptual framework. The survey consisted of five answer choices: “4) Always Describes My Experience,” “3) Often Describes My Experience,” “2) Sometimes Describes My Experience,” “1) Rarely Describes My Experience,” and “0) Never Describes My Experience.”

The sole purpose of this study is to assess the Kozmetsky Center for Child Protection. The “case” in this research is the Center for Child Protection. The case study uses document analysis, survey analysis, structured interviews, and direct observation.

Operationalization Table

The operationalization table is presented in Table 3.1. The purpose of this table is to connect the conceptual framework, the research methodology, the evidence, and the sources. The table outlines the operational relationship between each model component and the corresponding methodology used to explore it. When viewed in its entirety, the research method enables a comprehensive assessment of the Kozmetsky Center for Child Protection.

Table 3.1 Operationalization of the Conceptual Framework

Ideal Type Categories	Research Method/ Source	Evidence
Multidisciplinary Teams		
Interagency Coordination	Document Analysis/ CPCOM ¹²	Policy requiring each team to be represented by the following: Law Enforcement, CPS, Prosecution, Medical, Mental Health, Victim Advocacy, and CCP.
	Structured Interview	Are MDTs always required to provide representation from the following disciplines: Law Enforcement, CPS, Prosecution, Medical, Mental Health, Victim Advocacy, and the KCCP?
Written Agreement	Document Analysis/ CPTOM ¹³	<ul style="list-style-type: none"> •Policy mandating an interagency agreement formalizing cooperation and commitment. •Policy mandating that the interagency agreement be signed by the supervisors at each participating agency.
Investigation Involvement	Document Analysis/ CPCOM	Policy indication that all team members are routinely involved in the MDT investigation and/or MDT interventions.
	Structured Interview	<ul style="list-style-type: none"> •Are MDT members required to remain involved with the case throughout the investigation? •Does the same person or persons assigned by each agency to the MDT remain on the team throughout the investigation?
Feedback Mechanisms	Document Analysis/ CPCOM	Policy describing mechanisms in place for employee feedback.

¹² Child Protection Center Operations Manual, see Bibliography for reference.

¹³ Child Protection Team Operations Manual, see Bibliography for reference.

Ideal Type Categories	Research Method/ Source	Evidence
Case Management		
Case Reviews	Document Analysis/ CPCOM & CPTOM	<p>Written policy and criteria describing case reviews include:</p> <ul style="list-style-type: none"> •Designated attendees •Case selection criteria •Designated facilitator •How facilitator is to coordinate case review •Mechanism for distribution of agenda and/or notification of cases to be discussed •Mechanism for collaborative MDT member case sharing •Location of meeting
	Structured Interview	<ul style="list-style-type: none"> • How is the facilitator determined for each MDT? • Are case reviews held at minimum once a month? (Case review meetings do not include informal discussions and pre and post-interview debriefings).
Case Tracking	Document Analysis/ CPCOM	<ul style="list-style-type: none"> •Policies describing the case tracking process •Policy requiring an individual be identified to oversee case tracking •Mechanisms enabling tracking data to be shared with participating agencies and other involved parties
	Document Analysis/ CPCOM	<p>Policy identifying the types of data retrieved on clients include:</p> <ul style="list-style-type: none"> •Demographic data about the child and family •Demographic data about the alleged offender •Relationship of alleged offender to the child •MDT involvement and outcomes •Charges filed and case disposition in criminal court •Child protection outcomes •Status/outcome of medical and mental health referrals.
	Structured Interview	<ul style="list-style-type: none"> •What type of case tracking method does the KCCP implement? •Are the tracking results available to all MDT members?
Forensic Interview		
Forensic Interview Process and Reduction of Multiple Interviews	Document Analysis/ CPCOM	<p>Guidelines describing the forensic interview process including pre-and post-interview information sharing, decision-making, and procedures including:</p> <ul style="list-style-type: none"> •Policy requiring forensic interview to take place at KCCP's facility •Precautions taken to ensure to forensic interviews legally sound, non-duplicative, non-leading and neutral •Collection of appropriate information from family/caretakers to avoid duplication •Criteria for selecting the appropriate interviewer •Selection of personnel attend/observing the interview •Preparation/information sharing with the forensic interviewer •Communication between the MDT and interviewer •Interview process/methodology
Forensic Interview Recording Method	Document Analysis/ CPCOM	Guidelines describing the recording methods and/or documentation of the interview
	Direct Observation/ KCCP Facility	Recording devices present in all interview rooms

Ideal Type Categories	Research Method/ Source	Evidence
Forensic Interviewers	Document Analysis/ CPCOM	Policy mandating that forensic interviewers must be: <ul style="list-style-type: none"> •Conducted by a MDT/CCP member AND <ul style="list-style-type: none"> •Have completed competency-based child abuse forensic interview training that includes child development OR <ul style="list-style-type: none"> •Have documentation of 40 hours of nationally or state recognized interview training that includes child development
Interview Training	Structured Interview	<ul style="list-style-type: none"> •Is ongoing training provided for forensic interviewers? •How often is forensic interviewer training provided?
	Document Analysis/ CPCOM	Demonstration that the following <i>Continuous Quality Improvement Activities</i> occur: <ul style="list-style-type: none"> •Ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 3 hours per every 2 years of CEU/CME credits •Interviewer participation in a formalized peer review process
Health Services		
Medical Treatment	Document Analysis/ CPCOM	Policy describing: <ul style="list-style-type: none"> •Circumstances under which a medical evaluation is recommended •Protocols followed to identify children in need of medical care due to abuse or unmet medical attention •Purpose of the medical evaluation •Referral process of medical evaluation if necessary •Procedures in place in case of medical emergencies •Precautions taken to prevent multiple medical evaluations •Procedures utilized to document provided medical care •Coordination of medical evaluation with the MDT to prevent duplicative interviews of the child and family/caretakers about child's medical history •Existing procedures for medical interventions in cases of suspected physical abuse and maltreatment, •Availability of medical treatment to all children regardless of their ability to pay •Protocol outlining where primary care services are provided if not at the KCCP
		Policy ensuring that medical evaluations are provided by health care providers with pediatric experience and child abuse expertise demonstrated by one of the following: <ul style="list-style-type: none"> •Child-Abuse Pediatrics Sub-board eligibility •Child abuse fellowship training or abuse Certificate of Added Qualification •Documentation of Satisfactory completion of competency-based training in the performance of child-abuse evaluations, OR •Documentation of 16 hours of formal medical training in child sexual abuse evaluation
	Direct Observation/ KCCP Facility	The CCP facility contains medical exam rooms for conducting onsite medical exams.
	Structured Interview	•At what stage in the investigation are medical exam findings shared with the MDT members?

Ideal Type Categories	Research Method/ Source	Evidence
Mental Health Services	Document Analysis/ CPCOM	Policy requiring mental health services be provided by professional with pediatric experience and at least one of the following <i>Training Standards</i> : <ul style="list-style-type: none"> •Completion of Masters in a related mental health field •Student intern in an accredited graduate program •Licensed/certified or supervised by a licensed mental health professional •A training plan for 40 contact hours of specialized, trauma-focused mental health training, clinical consultation, clinical supervision, peer supervision and/or •Mentoring within the first 6 months of association
		Policy describing: <ul style="list-style-type: none"> •Procedures facilitating the coordination of information about the mental health evaluations and treatments for all children •Availability of specialized trauma-focused mental health services made available on-site or documentation of linkage agreements with other appropriate agencies or providers •Roles of mental health professional on MDTs and their attendance at case review •Provisions in place to protect clients’ right to confidentiality but enabling sharing of relevant information with MDT members •Separation of forensic and mental health treatments within facility •Procedures to ensure mental health services be provided to children and non-offending family members regardless of their ability to pay
	Direct Observation	The CCP Facility contains therapy rooms for on-site mental health services.
Child-Friendly Facility		
Design Specifications	Direct Observation	Facility must: <ul style="list-style-type: none"> •Encompass designated, well-defined, task appropriate spaces •Be physically accessible (Must meet ADA or state guidelines) •Be maintained in a manner that is physically safe and “child proof” (e.g., toys and materials sanitized) •Provide staff, volunteer, or MDT member supervision of children and families •Maintain separate and private areas for clients awaiting services, case consultation, case discussion, meetings, and interviews •Provide soundproof meeting rooms •Allow for the live observation of interviews by MDT members •Be accessible to clients and MDT members
	Document Analysis	Policy mandates : <ul style="list-style-type: none"> •The facility provides for live observations on interviews by MDT members •Child-proof precautions
	Structured Interview	The facility is maintained in a manner that is “child proof.”
Neutral environment	Direct Observation/ KCCP Facility	The facility is located in its own building
	Document Analysis/ CPCOM	Policies describing procedures ensuring separation of victims from alleged offenders

Document Analysis

Document analysis is one of three research methods performed in this research.

“The most important use of documents is to corroborate and augment evidence from

other sources” (Yin 2003, 87). Document analysis provides specific details to corroborate information from other sources and allows inferences to be made from other documents. Documents are a stable format that can be reviewed repeatedly, and offer coverage that spans a long period of time (Yin 2003, 86). A potential weakness of utilizing document analysis is that some documents may have limited access, especially documents containing information about minors.

Document analysis in the Center for Child Protection was not affected by irretrievability issues; however, the documents available related only to the organization’s stated policies and procedures. Information in these documents pertains only to the administrative intentions of the Center, but is not an accurate gauge of the extent policies and procedures are practiced. Documentation pertaining to whether the organization followed written policies and procedures is kept by management personnel at the Center (CPTOM, CPCOM), and these documents were restricted because of child confidentiality issues.

This research uses document analysis is used to assess each of the five ideal type categories. In the first category, multidisciplinary teams (MDT), document analysis is confirms the existence of MDTs, the procedures regarding interagency agreements, and the policies mandating team member involvement in child abuse investigation. The second category, case management, uses document analysis to describe the policies and methods the KCCP uses when conducting case reviews and case tracking. Document analysis is used in the third category, forensic interviews, to describe the interview process, how the MDT intends to limit the number of forensic interviews, the methods used to record the forensic interviews, the qualifications of the forensic interviewers, and

professional training available to the interviewers. Document analysis is used in the fourth category, health services, to assess the protocols used in providing medical exams to the child victim and mental health treatment to the child and non-offending family members. Lastly, document analysis is used in the child-friendly facility category to describe the precautions the KCCP takes to ensure that child victims do not come into contact with offenders.

Sampling: Document Analysis

A member of the managerial staff at the KCCP made documents available that describe the policies and operations that are to be implemented by staff. The operational manuals were not restricted in anyway and provided a stronger study. Table 3.2 provides a list of the analyzed documents.

Table 3.2 List of Documents

Documents:
HR Employee Manual
Child Protection Center Operations Manual (CPCOM)
Child Protection Team Operations Manual (CPTOM)
Hypothetical Interagency Agreement
Investigative Process Chart
Building Layout
CCP Program Services Brochure

Assessment Criteria: Document Analysis

The evidence collected was collected and measured using a four-point scale. The highest rating, “Meets Criteria,” was given if all the criteria were met. If the majority of the criteria were present, then the component earned “Mostly Meets Criteria.” If a

minority of the criteria was met, then the component received a rating of “Meets in Part.” Lastly, if none of the criteria existed, then the component received “Does Not Meet Criteria” (West 2007, 53).

Structured Interviews

Structured interviews are an effective research methodology in conducting a comprehensive assessment of the Kozmetsky Center for Child Protection. According to Yin (2003, 89), “one of the most important sources of the case study information is the interview.” Structured interviews are valuable because they allow the researcher to corroborate certain established facts or discover new information. The interview process requires that questions reflect the case study protocol and are phrased in an unbiased manner that serves the inquiry’s purpose (Yin, 2003, 90). The prepared questions for structured interviews may be open-ended and presented in a fluid conversational format, but are more likely to follow a structured format (Yin, 2003, 89). Weaknesses associated with structured interviews include potential response bias due to poorly constructed questions and reflexivity, as when an interviewee tells the interviewer what they want to hear (Yin, 2003, 86). In order to reduce the probability of potential weaknesses, interview questions in this research contained a certain set of open-ended questions based on the conceptual framework. Each interviewee was asked the same questions and no follow up questions were raised.

The eleven structured interview questions address all five ideal type categories – multidisciplinary teams, forensic interviews, case management, health services, and child-friendly facilities¹⁴. Questions one through three assesses the first category, multi-disciplinary teams and examines the professional makeup of MDTs and the extent of the

¹⁴ See the Appendix for a list of structured interview questions.

team members' involvement throughout the investigation. Questions 4-7 were included to evaluate the criteria in the Case Management category. Specifically, questions 4-5 examine case review frequency and participation, whereas questions 6 and 7 examine the Center's case tracking system. Questions 8 and 9 evaluate the forensic interview category by inquiring about training opportunities offered to forensic interviewers. Question 10 question was used to assess the Health Services category, and asks about MDT member accessibility to medical exam information. Finally, one structured interview question was derived to assess the fifth category, Child-Friendly Facility. Question eleven asks whether the KCCP's location provides convenient access for employees and clients.

Sampling: Structured Interview

The structured interview sample included two management level staff members at the Kozmetsky Center for Child Protection who have served or are serving on a multidisciplinary team. Participants were referred for the interview because of their inclusive knowledge about the KCCP's administrative policies and procedures. The interviews were conducted over the phone and lasted between twenty and thirty minutes each. Interviews were conducted privately so participants could answer the questions freely. The interviewee's names were not revealed in order to protect their anonymity.

Assessment Criteria

The structured interview responses were not rated because of the limited number of interview participants. Instead, the responses were used to provide further insight about criteria rated through document analysis or criteria not provided in the KCCP's documents.

Direct Observation

Direct Observation was used to assess the Kozmetsky Center for Child Protection. Direct observation occurred when the researcher visited the case study site (Yin 2003, 92). First hand observation enables discovery in a way other methods cannot (O'Neal 2008, 51). "Observational evidence is often useful in providing additional information about the topic being studied" (Yin, 2003, 93). The observation of the site can be so relevant to the study that the researcher may take photographs to convey important case characteristic to outside observers (Yin, 2003, 93).

There are potential weaknesses in using direct observation as a research method. First of all, observers may experience a bias towards the subject or phenomenon that they observing and that bias may be relayed in the research. Secondly, direct observation can be time consuming and expensive for the observer. In this study, direct observation served as a necessary, strong research methodology for the ideal-type categories. However, direct observation was limited in case management because confidentiality issues made it inaccessible to a KCCP outsider. Also, only two of the four child interview rooms were available for direct observations because the other two were occupied. Thirty-one photographs were taken of the facility.

In this study, direct observation was used to measure characteristics listed in the child-friendly facility category. Direct observation of the facility allowed the researcher to see the facility's interview room layout, child-proof safety precautions, physical accessibility by disabled persons, and if the KCCP was located in a reasonably accessible location for victims and their families and MDT staff. Direct observation was one

method used to measure the CCP's neutral environment by determining if the facility was located in its own building.

Sample: Direct Observation

The KCCP building and aspects of the facility were directly observed. The structures observed included four waiting areas for children and family members, five medical exam rooms, four therapy rooms, two child interview rooms, a children's computer lab, an outdoor play area, two volunteer training rooms, a multidisciplinary team meeting room, law enforcement offices, a prosecutor's office, and a large conference area.

Assessment Criteria: Direct Observation

Each criteria measured by direct observation required an affirmative or negative response. The evidence collected was collected and measured using a four-point scale. The highest rating, "Meets Criteria," was given if all the criteria were met. If the majority of the criteria were present, then the component earned "Mostly Meets Criteria." If a minority of the criteria was met, then the component received a rating of "Meets in Part." Lastly, if none of the criteria existed, then the component received "Does Not Meet Criteria" (West 2007, 53).

Human Subjects Protection¹⁵

This applied research project was submitted to the Texas State Institutional Review Board and received a formal exemption from full or expedited review. The exemption request number is EXP2009P8525. This research caused no risk or discomfort to the subjects. The survey contained a consent form stating that all

¹⁵ See the Appendix for a formal Human Subjects Protection Exemption approval granted by the Institutional Review Board at Texas State University.

participation was voluntary and respondents were to receive no benefit for their participation. The participants remained anonymous and did not provide any identifying information.

Chapter Overview

This chapter outlined the research methodology used in the case study, which included, document analysis, structured interviews, and direct observation. The next chapter presents the results of the case study that assessed the Kozmetsky Center for Child Protection.

Chapter Four: Results

Chapter Purpose

The purpose of this research is to assess the Kozmetsky Center of Child Protection using the five components of the practical ideal type model developed from the literature and the National Child Advocacy Center (NCAC) Model. This chapter summarizes the results of the data collected from the case study of the Kozmetsky Center of Child Protection. The five components of the CAC assessment model include:

- Multidisciplinary Teams
- Case Management
- Forensic Interviews
- Health Services
- Child-Friendly Facility

The health services, forensic interviews and child-friendly facility categories achieved the highest ratings of “Meets Criteria” and “Exceeds Criteria.” The MDTs and case management categories received ratings of “Mostly Meets Criteria.”

Multidisciplinary Teams (MDT)

The first component of the CAC assessment model is the creation or existence of multidisciplinary teams. The literature and the original CAC model’s objectives state that CAC member organizations must establish MDTs comprised of seven disciplines, indicate interagency cooperation between the agencies involved, require all MDT members demonstrate investigation involvement, and provide feedback mechanisms for team members. Document analysis and structured interviews were the two types of research methodologies used to assess the multidisciplinary teams.

MDT Interagency Cooperation – Document Analysis

The first assessment criterion of the MDT category is that CAC organizations must maintain interagency cooperation from the following disciplines: law enforcement, CPS, prosecution, mental health, medical, victim advocacy, and the Children’s Advocacy Center. Agencies should provide for this requirement in written documents. The KCCP Operations Manual included this stipulation, therefore earning the highest rating, “Meets Criteria.”

The Child Protection Center Operations Manual (CPCOM) designates that government agencies coordinate with the KCCP. Coordinating members include staff members from the Travis County District Attorney’s Office, the Travis County Sheriff’s Office, Texas CPS, Dell Children’s Medical Center of Central Texas, and the Austin Police Department. Other law enforcement agencies in Travis County that participate with MDTs include: the police departments of Austin Independent School District, Pflugerville, Jonestown, Lakeway, Cedar Park, Leander, Sunset Valley, Mustang Ridge, Lago Vista, Manor, Bee Cave, West Lake Hills, and Rollingwood. (CPCOM, Standard 2, Criterion)

MDT Interagency Coordination – Structured Interview

The first structured interview question was created to measure the diversity of interagency coordination. The question asks participants whether MDTs require representation from all seven professional disciplines: law enforcement, CPS, prosecution, medical, mental health, victim advocacy, and the KCCP. The interview participants maintained that each of the seven disciplines is represented on every team; however, many teams consist of individual members serving dual professional capacities.

When professionals are assigned to each case it is known as “staffing.” Supervisors from all disciplines are notified about staffing regardless of their agency’s participation in individual cases. There may be overlap in some instances (e.g., Center for Child Protection staff may represent the Center as well as the mental health component, depending on the case.) Personnel limitations or the lack of professional qualifications of assigned team members may cause this overlap.

Written Agreement – Document Analysis

The CAC model clearly stipulates that all agency administrators must sign an Interagency Agreement annually. This agreement may take the form of written documentation, guidelines, and/or protocols that team members will follow. Additionally, the agreement must be signed by agency supervisors. Based upon the reviewed documents, the KCCP met all of the criteria and earned the highest rating of “Meets Criteria.”

The document used for case study research was the “Hypothetical Interagency Agreement.” This document contains the components of a standard interagency agreement. Fictitious agency names were created in the agreement to ensure confidentiality purposes. The agreement consists of five sections: the purpose of the interagency collaboration, the duties of the participating police department, the services offered by the CAC organization, CPS’s investigative responsibilities, and an agreement requiring that the all contractually bound agencies relay personnel complaints to the other agencies. (Hypothetical Interagency Agreement, Appendix) This agreement must be signed annually by all participating agencies (CCPOM, Standard 2, Criterion A).

Investigation Involvement – Document Analysis

The second assessment criterion in the MDT category stipulates that all MDT members must be routinely involved in the case investigation. The KCCP written guideline require that team members participate in each case investigation and collaborate “as appropriate.” Individual teams are required to create their own guidelines regarding their collaborative activities (CPTOM Standard 2, Criterion B). This question earned a rating of “Mostly Meets Criteria” because even though it may be impossible to function at 100% team participation, the KCCP’s written policy should include more precise language concerning team member participation goals.

Investigation Involvement – Structured Analysis

Structured interview questions two and three were further analyzed MDT member involvement during an investigation. Question two asked whether MDT members are required to remain involved throughout the investigation. Interview participants stated that there is no standard for member participation and that participation is based upon the severity and needs of the specific case. In some instances, team members from CPS may stay involved in a case because of issues pertaining to the child’s safety at home. Members from law enforcement and the prosecutor’s office may cease investigative participation if the case no longer warrants participation.

Question three asked participants whether the same person, assigned by each agency serving on the MDT, remains involved throughout the investigation. The KCCP allows agencies to replace their MDT representatives. The interviewees stated that sometimes CPS will designate a different representative to the MDT because the child’s case has been transferred to another department, staffed with different employees.

Feedback Mechanisms – Document Analysis

The last assessment of the MDT category covers whether the KCCP provides routine informal or formal feedback opportunities for all team members. The KCCP established the Child Protection Executive Committee as the formal mechanism by which all team members may make suggestions or report problems (CPCOM Standard 2, Criterion B). This observation earned a rating of “Meets Criteria.” Table 4.1 depicts what criteria were measured for the MDT component, where the criteria were located in documents, and the assigned rating.

Table 4.1: MDT Results Table – Document Analysis

Assessment Criteria	Document Location	Rating
MDT Coordination		
Policy mandating that team participation consist of representative from seven disciplines: Law Enforcement, CPS, Prosecution, Medical, Mental Health, Victim Advocacy and KCCP.	Operations Manual Standard 2, Criterion A	Meets Criteria
Policy indication that all team members are routinely involved in the MDT investigation and/or MDT interventions.	CPT – Operations Manual Standard 2, Criterion B	Mostly Meets Criteria
Written Agreement		
Policy mandating an interagency agreement formalizing cooperation and commitment.	•CCP – Operations Manual Standard 2, Criterion A •Hypothetical Interagency Agreement	Meets Criteria
Policy mandating that the interagency agreement must be signed by the supervisors at each participating agency.	CCP – Operations Manual Standard 2, Criterion A	Meets Criteria
Feedback Mechanisms		
Policy regarding the mechanisms that the CCP has developed for employees to offer feedback.	CCP – Operations Manual Standard 2, Criterion D	Meets Criteria

Case Management

The second component of an ideal CAC model system is case management. Maintaining effective case management procedures is an important administrative function during a child abuse investigation. The case management component combines

the NCAC model requirements of conducting case reviews and implementing case tracking (NCA 2008, 27).

Case Reviews – Document Analysis

The first criterion of the case management category is case reviews. The MDT has an extensive multidisciplinary case review process that begins with the inception of a case and continues, as needed, throughout the civil or criminal case (CPCOM, Standard 9, Criterion A, B). The CPCOM (Standard 9, Criterion C) states the program administrator is responsible for the identification, scheduling, notification, and facilitation of the MDT cases. The KCCP has a documented policy describing how the program administrator is to notify MDT members about attending case reviews (CPCOM Standard 9, Criterion D).

Document analysis revealed that there are two avenues through which MDT member share information: through informal and formal staffing. The information exchanged between MDT members varies at each level of the investigation. The case information members are authorized to share during an informal and formal staffing is included in the Interagency Agreement (CCPOM Standard 2, Criterion C).

The KCCP has written policy identifying how case review information is conveyed to absent team members. If staff is unable to attend or to send a designee, someone present in the meeting takes responsibility for notifying the absent party of any and all information relevant to their role in the case. Staffing notes, designated as attorney/client work product, must also be made available for review by the team members (CPCOM Standard 9, Criterion E). There was no evidence of written policy requiring all cases to be granted a minimum of one monthly case review; therefore, the

documentation provided in the Child Protection Team Operations Manual and Child Protection Center Operations Manuals “Mostly Meets Criteria” listed under case reviews.

Case Reviews – Structured Interview

Structured interview questions four and five provided insight into how case reviews are conducted, as opposed to how they are designated to function according to operations manuals. Interview question four asked how the MDT determines who will be the facilitator. Participants revealed that the KCCP hires a program facilitator to serve on all MDTs. This person is responsible for all case review coordination. Question five inquired whether case reviews are held at least once a month. The interviewees responded that case review frequency depended on the type of case. If, upon referral, the child has experienced physical abuse, the case is deemed a medical case. Medical case reviews occur weekly. If a case is referred by law enforcement and is advancing through the legal system, case reviews take place twice a month.

Case Tracking – Document Analysis

Case Tracking is the second criteria in the case management category. The Ideal CAC model requires the KCCP to provide a description of the process used for case tracking and identify an individual in charge of overseeing the process. The CAC assessment model also compels the KCCP establish policies describing how the tracking data will be released to partner agencies.

According to the CPCOM (Standard 10, Criterion D), team members provide a portion of the data that is collected and stored in the database. The director of program services is responsible for the system development and oversees the responsibility of data entry and collection performed by the program coordinator.

The Kozmetsky Center for Child Protection’s tracking system is designed to combine relevant information about a case that will allow professionals to determine where the child has been in the system, what services were offered by the facility, and what services were provided. The system is not designed to retain statements, reports or other case details, but to maintain a central system that stores case numbers, the professionals involved in the investigation, and services provided by the team (CCPOM Standard 10, Criterion A). The system should be capable of reporting demographic information needed for the NCA for making these outcomes statistical reports and be able to document case outcomes, making these outcomes available to the KCCP (CCPOM, Standard 10, Criterion B). Team members have access to the data stored in the database through the director of program services and the program coordinator (CCPOM Standard 10, Criterion E).

The CAC assessment model requires the tracking system to be functional and current. KCCP’s case tracking system earned a rating of “Mostly Meets Criteria” because the documentation did not clearly indicate whether the outcomes of all medical and mental health services provided by external resources are tracked by the database.

Case Tracking – Structured Interview Analysis

Structured interview questions six and seven measure the KCCP’s case tracking methods. Question six assessed the type of tracking system implemented. The current database is created in Microsoft Access; however, the database is currently under development by the technical support department at University of Texas. The participants indicated that the database stores the case’s demographic information, case numbers, professionals involved, and services provided by the MDT. Question seven

asks whether all MDT members are able to access the case tracking results. The participants stated that team members do have access through the director of programs services and program coordinator, however the database development team and Center staff are working together to increase MDT access in a way that is secure yet user-friendly.

Table 4.2 illustrates what criteria were measured for the case management component, where the criteria were located in the provided documents, and the criteria's assigned rating.

Table 4.2: Case Management Results Table – Document Analysis

Category Criteria	Assessment Criteria	Document Location	Rating
Case Review	Written Policy describing criteria for case reviews and case review policies, which must include: <ul style="list-style-type: none"> •Designated Attendees •Case selection criteria •Designated facilitator •Mechanism for distribution of agenda and/or notification of cases to be discussed •Location of meeting 	CPC Operations Manual Standard 9, Criterion A, B, C, D, E	Mostly Meets Criteria
	Policy indicating that case reviews must occur at least once a month	N/A	Does Not Meet Criteria
	Policy indicating the existence of and process by which a designated individual coordinates and facilitates the case review process	CPC Operations Manual Standard 9, Criterion C and D	Meets Criteria
	Documentation describing how case review information is to be shared amongst absent MDT members	CPC Operations Manual Standard 9, Criterion E	Meets Criteria
Case Tracking	A description of the process used for case tracking	CPC Operations Manual Standard 10, Criterion A	Meets Criteria
	Policy regarding the CCP ability to retrieve case specific information on all clients. The minimal requirements are met: <ul style="list-style-type: none"> •Demographic info about the child and family •Demographic info about the alleged offender •Relationship of alleged offender to the child •MDT involvement and outcomes •Charges filed and case disposition in criminal court •Child protection outcomes •Status/outcome of medical and mental health referrals 	CPC Operations Manual Standard 10, Criterion B	Mostly Meets Criteria

Category Criteria	Assessment Criteria	Document Location	Rating
	Policies regarding how tracking data may be released to participating agencies or parties other than the MDT that adheres to confidentiality requirements.	CPC Operations Manual Standard 10, Criterion D and E	Meets Criteria
	Policies identifying the individual in charge of implementing case tracking.	CPC Operations Manual Standard 10, Criterion C	Meets Criteria

Forensic Interviews

The third component in the CAC assessment model is forensic interviews. The forensic interview is the cornerstone of the child abuse investigation (Wolf, 2000, 49). The forensic interview component uses four criteria to gauge the strength of forensic interviews: the forensic interview process, which includes limiting multiple interviews; forensic interview recording methods, forensic interviewers, and forensic interviewer training. The criteria are based on the NCAC Model requirements (NCA, 2008, 27).

Forensic Interview Process/Limiting Repetitive Interviews – Document Analysis

The first criterion of the forensic interview category is the forensic interview process, which requires avoiding multiple forensic interviews. This CAC Assessment Model does not require a certain forensic interview process; however the CCP must provide written guidelines describing the general forensic interview process.

“Interviewer selection” - The CAC model requires teams to select an interviewer at the beginning of the investigation. The KCCP allows teams to randomly select an interviewer, unless the child has special needs such as a language barrier. All information obtained in the recorded forensic interview is evidence and must be maintained by the law enforcement officer or caseworkers. Team’s case planning, specific to the interview, is conducted both before and after the interview based on the case circumstances (CPCOP, Standard 5, Criterion F).

“Team member attendance during the forensic interview” - The KCCP requires law enforcement, CPS, forensic interview staff and the district attorney’s office participate in all interviews for cases in which they play a role. The interview observers may communicate with the interviewer during the interview’s intermission. All member agencies support this policy (CPCOM Standard 5, Criterion D).

“Sharing interview information” - The MDT follows established guidelines, including the interagency agreement, to address process issues regarding forensic interviews and the information sharing process (CPTOM, Standard 5, Criterion A).

“Guidelines ensuring that interviews are legally sound/ preventing duplication” - The Kozmetsky Center for Child Protection’s forensic interviewers and the prosecutors in the district attorney’s office work together to stay current on new techniques and laws that affect the forensic interview process. Peer review, or video review, is a part of this process. Video review by prosecutors and forensic interviewers is held once a month at the KCCP’s facility. A second peer review, open to prosecutors, is routinely attended by all forensic interviewers. Participants review and critique interviews and techniques for legal suitability. The KCCP’s written guidelines state that children who have made a clear, credible outcry at the time of report are scheduled immediately for an interview, without a cursory interview, whenever possible. This prevents a child from repeating the story multiple times. Written policy also states that team members must share information asked of family members, to avoid repetitive questioning (CPCOM Standard 5, Criterion B).

“Location of Interview” – All recorded interviews of children less than thirteen years of age are conducted at the Center for Child Protection. Due to a lack of resources,

training, and victim support, all outlying jurisdictions in Travis County bring children of all ages to the KCCP's facility to conduct forensic interviews. The exception is if the only available adult able to bring the child to the interview is the alleged offender. In this case, the forensic interview is conducted at a different location by a KCCP staff member (CPTOM, Standard 5, Criterion E).

The evidence provided by document analysis received a rating of "Meets Criteria."

Forensic Interview Recording Method – Document Analysis

The second criterion listed in the forensic interview category is the forensic interview recording method. The CAC assessment model adopts the National CAC Model's requirement of providing documentation of the forensic interview to reduce repetitive interviews, accurately relay the child's account of events, and provide a training tool for future interviewers (Wolf 2000, 60).

The child protection team operations manual (Standard 5, Criterion C) requires that each interview room be equipped with a digital recording device that provided video to team members via computer monitor at designated stations in the facility. The KCCP earned the highest rating of "Meets Criteria" based on the documentation.

Forensic Interview Recording Method – Direct Observation

This study used direct observation and determined the interview rooms contained recording devices. Because there are many different types of recording devices, direct observation allowed for a visual description of the digital recording devices. Two interview rooms were observed and both contained devices capable of digitally recording both images and sounds. These machines were located the back wall in the upper rear

corner of the interview rooms. The two images below (Figure 4.1 and 4.2) picture the digital recording devices. The recording device earned a rating of “Meets Criteria.”



Figure 4.1: Interview Room Digital Recording Device



Figure 4.2: Interview Room Digital Recording Device

Forensic Interviewers – Document Analysis

The third criterion of the forensic interview category is forensic interviewers. The CAC assessment model requires the interviewer be a MDT member, have forty hours of forensic interview training, or have completed a training including child development. The study used document analysis to gauge the KCCP's policies regarding professional training of the forensic interviewers. The child protection center operating manual (Standard 5, Criteria G) requires that the MDT members conducting the forensic interview be members of the Child Advocacy Center of Texas Professional Society of Forensic Interviewers. The levels of membership vary based on the interviewer's tenure, number of interviews completed, and training completed. Because the CACTX Professional Society of Forensic Interviewers requires members to complete a forensic interview training that emphasizes child development, the KCCP earns a rating of "Meets Criteria."

Forensic Interviewer Training – Document Analysis

The fourth and last criterion used to evaluate the forensic interview category is forensic interviewer training. A successful forensic interview depends upon the abilities of the interviewer; therefore, the Center must provide interviewers with ongoing training opportunities and a formalized peer review process. Forensic Interview Training earned a rating of "Meets Criteria."

The Center for Child Protection provides onsite training to specify how forensic interviews are conducted. Interviewing skills and rules about interviewing are taught in house (CPCOM Standard 5, Criteria G).

The Kozmetsky Center for Child Protection’s forensic interviewers and prosecutors collaborate in order to stay abreast of new techniques and laws that affect the forensic interview process. A formal monthly peer review is critical to this process. A second peer review is routinely attended by all forensic interviewers (CPCOP Standard 5, Criterion B). Also, the CACTX society offers support to interviewers through training and peer review (CPCOP Standard 5, Criteria G).

Forensic Interviewer Training – Structured Interview Analysis

Structured interview questions eight and nine were designed to provide an additional measurement of forensic training opportunities the KCCP makes available to MDT interviewers. Interview question eight asked whether forensic interviewers are provided training opportunities. Interview participants stated that onsite and offsite training opportunities are made available to forensic interviewers. Question nine asked how often training opportunities are provided. Participants responded that forensic interviewers are required to attend at least three off-site interview training seminars a year.

Table 4.3 outlines the criteria measured by document analysis for the forensic interview category, the location of the documents, and the criteria rating.

Table 4.3: Forensic Interview Results Table – Document Analysis

Category Criteria	Assessment Criteria	Document Location	Rating
Forensic Interview Process/Ltd Multiple Interviews	<p>The CCP must have written guidelines describing the general forensic interview process including pre-and post-interview information sharing and decision-making, and interview procedures. These must include:</p> <ul style="list-style-type: none"> •Criteria for choosing an appropriately trained interviewer for the specific case •Which personnel are to attend/observe the interview •Preparation/information sharing with the forensic interviewer •Use of interpreters •Communication between the MDT and interviewer •Interview process/methodology 	CPC Operations Manual Standard 5, Criterion A, B, C, D, E, F	Meets Criteria
	Guidelines developed to ensure that forensic interviews are conducted in a legally sound, non-duplicative, non-leading and neutral manner	CPC Operations Manual Standard 5, Criterion B	Meets Criteria
	Process MDT members follow in gathering information from the family/caretakers of the child to avoid duplication	CPC Operations Manual Standard 5, Criterion B	Meets Criteria
	Policy mandating forensic interviews be conducted at the facility and instructions for any interviews not conducted on the premises	CPC Operations Manual Standard 5, Criterion E	Meets Criteria
Forensic Interview Recoding Method	KCCP must have written guidelines describing the recording and/or documentation of the interview	CPC Operations Manual Standard 5, Criterion F	Meets Criteria
Forensic Interviewers	Policy mandating that forensic interviews must be conducted by a MDT/CCP member, have completed competency-based child abuse forensic interview training that includes child development, or have documentation of 40 hours of nationally or state recognized interview training that includes child development	CPC Operations Manual Standard 5, Criterion F	Meets Criteria
Forensic Interviewer Training	<p>Interviewer must demonstrate that the following <i>Continuous Quality Improvement</i> Activities take place:</p> <ul style="list-style-type: none"> •Ongoing education in child maltreatment field and/or forensic interviewing consisting of a minimum of 3 hours every 2 years •Participation in a formalized peer review process for forensic interviewers 	CPC Operations Manual Standard 5, Criterion F	Meets Criteria

Table 4.4 summarizes the direct observation results used to measure the forensic interview recording method.

Table 4.4: Forensic Interview Recording Method Results – Direct Observation

Criteria Observed	Criteria Rating
Digital recording devices located in forensic interview rooms.	Meets Criteria

Health Services

The fourth component of the CAC assessment model is the provision for health services for child victims and their non-offending family members.

Medical Treatment – Document Analysis

The research used document analysis to assess the KCCP’s policies and procedures designated to provide adequate medical care to the child victims in need. The CAC model requires that all CAC member organizations provide medical treatment to all qualifying victims regardless of their ability to pay. Children are not charged for the medical exams when conducted at the KCCP as part of the investigation of their cases. Either insurance or the requesting agency pays the physician and the hospital. The KCCP does not receive any form of payment for the exam. (CPTOM, Standard 6, Criterion B)

The CPTOM requires the health practitioner to determine the medical exam’s purpose prior to the exam being conducted. In addition, the written policy also describes the protocols used to determine when and how a medical exam will be given. When the child or authority’s make an allegation, medical staff performs a forensic exam to look for evidence, injury or a sexually transmitted disease. A MDT member may also request an exam to rule out any of the above.

A local pediatrician, who has extensive experience in performing exams on children, and providing testimony specific to child abuse cases, conducts non-emergent forensic medical exams. The exams take place at either the KCCP facility or through the direction of the Dell Children's Hospital satellite program. Emergent exams, conducted within 96 hours of assault, are performed by SANE nurses, who are supervised by the pediatrician. Except under extraordinary circumstances, medical exams performed by a physician or nurse will not be repeated at the KCCP's facility but at Dell Children's Hospital (CPTOM Standard 6, Criterion A).

The physician may take photographs and reports in order to obtain a second opinion. The evidence must be collected and preserved in accordance to hospital and legal standards and is not monitored by the staff at the KCCP. The medical professional provides a forensic medical assessment to the team members involved in the investigation with a forensic assessment of a child's case; however, this individual may provide a verbal update of the results, if needed, immediately following the exam (CPTOM Standard 6, Criterion F). The pediatrician and medical staff provide information whenever a case requires their expertise (CPTOM, Standard 6, Criterion D).

The policies and procedures provided in the CPTOM "Meets Criteria" for the medical services component.

Medical Services – Structured Interview Analysis

The research used structured interview analysis to determine how quickly MDT members access medical exam information. Interview question ten inquired at what stage the child's medical exam findings are shared with the case's MDT members. Interviewees stated that MDT members are granted access to medical exam written

reports at various stages during the investigation. If the team members feel the medical findings are crucial to the case, verbal reports are provided immediately after the exam.

Medical Services – Direct Observations

The research used direct observation to determine if the KCCP’s facility includes exam rooms adequate for conducting medical evaluations. Medical evaluations are provided every Wednesday at the facility in one of four exam rooms. The observed medical exam rooms “Meet Criteria.” Figure 4.3 illustrates one of the KCCP’s medical exam rooms.



Figure 4.3: Medical Examination Room

Mental Health Services – Document Analysis

The research utilized document analysis to determine if the KCCP offered mental health services. The criteria in the documents pertained to the professional qualifications of mental health providers; trauma-focused services available to children and their non-

offending family members on the premises, regardless of one's ability to pay, and written policies describing the role the mental health provider serves on the MDT.

According to the CPCOM and program services brochure, (Standard 7, Criterion A and B) the Kozmetsky Center for Child Protection provides a variety of mental health services to children and their families currently in the criminal and civil justice systems. Clients incur no charge for services provided at the KCCP's facility; however, if clients have insurance or are currently in treatment, appropriate referrals are made for the family. Therapeutic services are provided by licensed staff holding licensed clinical social worker credentials and/or licensed master social worker (CPCOM Standard 7, Criterion A and B; Program Services Brochure).

Individual and family therapy occurs at the facility in rooms specifically designed for the type of therapy provided. The Center is also cautiously experimenting with nontraditional therapeutic services including pet therapy. (CPCOM, Standard 7, Criterion E) Forensic services are separate from clinical services. The forensic interview positions and the staff therapist positions are separate entities and do not intermingle job duties. (CPCOM Standard 7, Criterion G)

A clinician, generally the clinical director or staff therapist, conducts the therapy and attends the MDT meetings in order to represent the mental health discipline. The Interagency Agreement provides for MDT member information sharing. Clients are notified about the limits of confidentiality, as it pertains to their treatment, prior to receiving services at the Center (CPCOM, Standard 7, Criterion D). The provided documentation "Meets Criteria" for the mental health services component.

Health Services – Direct Observation

Direct observation research was conducted to determine if the facility integrated designated spaces for on-site therapy. The facility boasts five individual therapy rooms, some geared towards younger children, as well as group therapy rooms with capacities for approximately twenty people. Figures 4.4 and 4.5 provide examples of the facility's therapy rooms. This component was given a rating of "Exceeds Criteria" because not only does the KCCP meet the required criteria, Figure 4.5 demonstrates group therapy room, which are not required by the CAC assessment model. Therapy is open to non-offending family members in an effort to provide education about the investigative process, as well as emotional support.



Figure 4.4: Individual Therapy Room



Figure 4.5: Group Therapy Room

Table 4.5 illustrates what criteria measure the health services component, where the criteria were located in the provided documents, and the criteria's assigned rating.

Table 4.5: Health Services Results Table – Document Analysis

Category Criteria	Assessment Criteria	Document Location	Rating
Medical Treatment	<p>Written documentation of policies for:</p> <ul style="list-style-type: none"> •The circumstances under which a medical evaluation is recommended •The protocols in place to identify those children in need of medical care for suspected or possible injury or illness resulting from abuse or unmet medical attention •The purpose of the medical evaluation •Description of the medical evaluation is made available? (Define the referral process) • Description of medical emergencies are addressed • Description of multiple medical evaluations are limited • Description of medical care documentation • Description of medical evaluation coordination with MDT in order to prevent duplication of interview of the child and family/caretakers about the child's medical history • Description of procedures in place for medical intervention in cases of suspected physical abuse and maltreatment 	CPC Operations Manual Standard 6, Criterion A, B, C, D, E, F	Meets Criteria
	Policy stating that specialized medical evaluation and treatment services are available to all CCP clients regardless of their ability to pay	CPC Operations Manual Standard 6, Criterion B	Meets Criteria
	Medical evaluations are provided by health care providers with pediatric experience and child abuse expertise	CPC Operations Manual Standard 5, Criterion A	Meets Criteria
	<p>The medical providers meet at least one of the following:</p> <ul style="list-style-type: none"> •Child-Abuse Pediatrics Sub-board eligibility •Child abuse fellowship training or abuse certificate of added qualification, •Documentation of Satisfactory completion of competency-based training in the performance of child-abuse evaluations (OR) •Documentation of 16 hours of formal medical training in child sexual abuse evaluation 	CPC Operations Manual Standard 5, Criterion A	Meets Criteria
	Policy mandating that specialized medical care is routinely made available onsite OR CCP must have a protocol outlining how the primary care and other needed healthcare services are provided if not on the CCP premises	CPC Operations Manual Standard 5, Criterion E	Meets Criteria

Category Criteria	Assessment Criteria	Document Location	Rating
Mental Health Services	Policy specifying mental health services be provided by professional with pediatric experience and child abuse expertise. Must meet one of the following <i>Training Standards</i> : <ul style="list-style-type: none"> •Completion of Masters degree in a related mental health field •Student intern in an accredited graduate program, •Licensed/certified or supervised by a licensed mental health professional •A training plan for 40 contact hours of specialized, trauma-focused mental health training, clinical consultation, clinical supervision, peer supervision, and/or mentoring within the first 6 months of association (or demonstrated relevant experience previously) 	<ul style="list-style-type: none"> •CPC Operations Manual Standard 7, Criterion A •Program Services Brochure (Attached) 	Meets Criteria
	Specialized trauma-focused mental health services made available on-site or documentation of agreements with other appropriate agencies or providers	CPC Operations Manual Standard 7, Criterion A	Meets Criteria
	Mental health services are available regardless of the client's ability to pay	<ul style="list-style-type: none"> •CPC Operations Manual Standard 7, Criterion A •Program Services Brochure (Attached) 	Meets Criteria
	Written documentation showing that MDT members have access to the appropriate mental health evaluation and treatment for all CAC clients	CPC Operations Manual Standard 7, Criterion A	Meets Criteria
	Written Policy includes: <ul style="list-style-type: none"> •The mental health professional's role on the MDT and provisions for his/her attendance at case review. •The provisions regarding sharing the relevant information with the MDT members while protecting the clients' right to confidentiality •How the forensic process is separate from the mental health treatment 	CPC Operations Manual Standard 7, Criterion D, G	Meets Criteria
	Mental health services provided to non-offending family members and/or caregivers on site or documentation of written agreements with other appropriate agencies or providers	CPC Operations Manual Standard 7, Criterion A, E, F	Meets Criteria

Table 4.6 summarizes the direct observations results of The Center for Child

Protection's health services facilities.

Table 4.6: Health Services Results Table – Direct Observation

Criteria Observed	Criteria Rating
Medical Exam Rooms	Meets Criteria
Therapy Rooms – Individual Therapy Group Therapy	Meets Criteria Exceeds Criteria

Child-Friendly Facility

The final category of the CAC model is child-friendly facility. Victims come into direct contact with the Kozmetsky Center for Child Protection's facility (CCP 2004). The facility should be designed to create a comfortable, child-friendly atmosphere to help children feel psychologically and physically safe (Wolf 2000, 17). This atmosphere is accomplished by requiring CAC member organizations to meet certain design specifications and creating a neutral environment.

Design Specifications - Document Analysis

The CPCOM served as the most informative document in the analysis of design specifications. Not only did the operation manual maintain that the KCCP must meet ADA guidelines to accommodate visitors with disabilities, it provided standard safety precautions that the KCCP takes to maintain a child-safe environment. The KCCP's manual requires that all areas of the facility be child-proofed, which includes cleaners and toxic chemicals to be locked in janitor's closets, electrical sockets must be covered, window blind cords are to be secured, and sharp objects must be put away after use. Additionally, donations of stuffed animals and other materials must be inspected for button eyes and attachments that may present a choking hazard to children (CPCOM Standard 1, Criterion C).

The forensic interview rooms must adhere to design instructions that enable non-interviewing team members to view the interview and communicate with the interviewer. Document Analysis provided a visual assessment of the forensic interview rooms. Team members have two observation options during an investigation. First, each room provides a one-way mirror facing the observation room, which contains observing team

members. Additionally, each room's digital recording may be viewed simultaneously by computer at one of the designated viewing stations. If necessary, noise barriers, such as sound machines, are utilized to provide privacy during the interview (CPCOM Standard 1, Criterion B).

Design Specifications – Structured Interview Analysis

Structured analysis was utilized in addition to document analysis to determine whether the KCCP facility is easily accessible. The interviewees were asked in Question eleven whether they thought KCCP's facility is conveniently located for employees and clients. The response was that the location was easily accessible from downtown Austin. One problem sometimes encountered is that clients and their families rely on public transportation. Since the Center is not currently on the Capital Metro bus line, the closest stops are located less than a mile away from the facility. The KCCP's Board of Directors and participating MDT agencies are working to expedite stops closer to the site. Additionally, clients' transportation needs are individually assessed and a taxi services are utilized if necessary.

Design Specifications – Direct Observation Analysis

Direct analysis was used to observe the facility's location, layout, interview rooms, meeting rooms, and child appropriate accommodations. The CAC assessment model requires that the facility's location be easily accessible to clients and employees. The Kozmetsky Center for Child Protection is located in East Austin less than three miles from the Travis County district attorney's office, the Austin police department, and the Travis County sheriff's department. The site is seven miles away from one of the CPS

offices serving Travis County. (See Figure 4.6 provides a map illustrating the facility's location in Austin, TX).

Another model requirement is that the facility must possess child-oriented characteristics to create a welcoming environment. Part of the exterior building structure resembles a castle (See Figure 4.7) and there is an outdoor playground for children (see Figure 4.8).

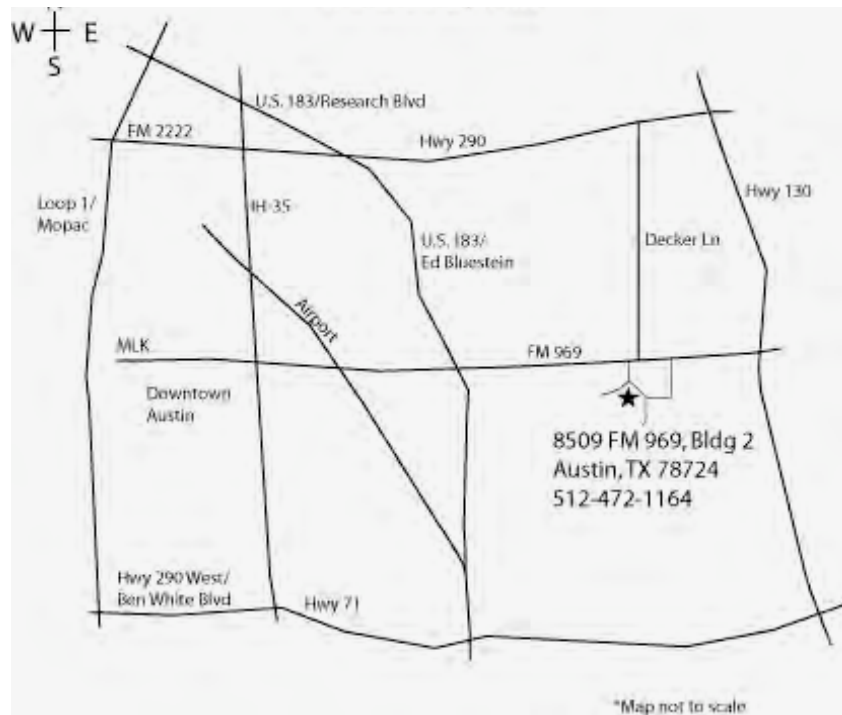


Figure 4.6: Kozmetsky Center for Child Protection Map



Figure 4.7: Facility’s Exterior



Figure 4.8: Child Playground

The interior of the facility boasts bright primary colors and waiting rooms geared toward younger children, with a host of toys and books (see Figure 4.9 and 4.10). In the medical wing, ceilings are imprinted with designs to distract the children’s attention (see Figure 4.12). There are separate waiting areas for older children, including a crafts area (see Figure 4.11) and a computer room (see Figure 4.13). Family waiting rooms are available for a more private waiting experience (see Figure 4.14).

The Center maintains four forensic interview rooms. Team members have two observation options during an investigation. First, each room is equipped with a one-way mirror that faces into an observation room used by case team members. Additionally, each room’s digital recording can be viewed via computer monitor at designated stations in the Center (see Figures 4.15-4.18). The KCCP received ratings of either “Meets Criteria” or “Exceeds Criteria” in the design specification component. The designated areas provided for children such as the playground, computer lab, crafts room, ceiling décor, and detailed exterior went beyond the CAC model requirements.



Figure 4.9: Children's Waiting Room



Figure 4.10: Children's Waiting Room



Figure 4.11: Children's Craft Room



Figure 4.12: Ceiling Imprints throughout the Medical Ward



Figure 4.13: Computer Room for Older Children



Figure 4.14: Private Family Waiting Room



Figure 4.15: Forensic Interview Room



Figure 4.16: One-Way Mirror Located in Interview Rooms



Figure 4.17: Interview Viewing Room for Team Observations



Figure 4.18: Interview Viewing Station with Live Digital Feed

Neutral Environment – Document Analysis

Document analysis was used to determine what written policies and procedures ensure the separation of victims from alleged offenders. The Kozmetsky Center for Child Protection’s policy states that alleged offenders may not be scheduled to attend interview or therapy appointments at the KCCP facility. However, if during the course of an investigation, an alleged offender is discovered on the premises, the MDT and KCCP staff work together to escort the alleged offender off the premises (CPCOM Standard1, Criterion A). The procedure in place earned a rating of “Meets Criteria.”

Neutral Environment – Direct Observation

Direct observation was used to determine whether the Center for Child Protection adhered to the requirement of being located in its own building. Figure 4.19 illustrates the KCCP’s newly constructed 30,000 square foot facility. This building is solely occupied by the KCCP and achieves a rating of “Meets Criteria.”



Figure 4.19: The Kozmetsky Center for Child Protection’s Facility

Table 4.7 illustrates the criteria that measured the child-friendly facility category, where the criteria were located in the provided documents, and the criteria’s assigned rating.

Table 4.7: Child-Friendly Results Table – Document Analysis

Category Criteria	Assessment Criteria	Document Location	Rating
Design Specification	The facility allows for live observations on interviews by MDT members.	CPCOM, Standard 6, Criterion A, B, C, D, E, F	Meets Criteria
	The facility is maintained in a manner that is “child proof.”	CPCOM, Standard 6, Criterion B	Meets Criteria
Neutral Environment	Written policies and procedures that ensure separation of victims and alleged offenders.	CPCOM, Standard 5, Criterion A	Meets Criteria

Table 4.8 summarizes the direct observations results indicating the KCCP’s design specifications and the neutrality of the environment.

Table 4.8: Child-Friendly Facility Results – Direct Observation

Component	Criteria Observed	Criteria Rating
Design Specification	Child Appropriate Facility	Exceeds Criteria
	Interview Rooms Provide for Live Observation	Meets Criteria
	Provides Sound Proof Interview Rooms	Meets Criteria
	Separate and Private Waiting Room Areas	Meets Criteria
	Accessible Location for Children/Employees	Meets Criteria
Neutral Environment	Facility is located in its own structure	Meets Criteria

Chapter Summary

This chapter provided the results of the case study of the Kozmetsky Center for Child Protection. The research methodology included document analysis, structured interview analysis, and direct observation. The final chapter provides a conclusion and offers recommendations for improvement for the Kozmetsky Center for Child Protection.

Chapter Five: Conclusion and Recommendations

Chapter Purpose

The purpose of this applied research project is threefold. The first purpose is to describe the ideal components of the CAC assessment model by examining existing literature and the National Child Advocacy Center's objectives. The second purpose is to use the five components in the CAC model as a guide to evaluate the administrative operations of the Kozmetsky Center for Child Protection. Finally, this project uses the research results to provide recommendations for improving administrative operations at the Kozmetsky Center for Child Protection.

Chapter one discussed the alarming rates of child abuse, described traditional child advocacy approaches in combating child abuse, introduced the National Child Advocacy Center model, and provided an overview of the Austin-based Kozmetsky Center for Child Protection. The second chapter compiled and presented components of the CAC assessment model. Chapter three presented the research methodology utilized to evaluate the administrative operations at the Kozmetsky Center for Child Protection based upon the CAC assessment model. Chapter four presented the findings of the case study research, which included data from document analysis, structured interview analysis, and direct observation.

The purpose of the fifth chapter was threefold. The first objective was to offer recommendations for improving the Kozmetsky Center for Child Protection's administrative operations. The second purpose was to offer recommendations for future research involving child advocacy centers. The third purpose was to present a conclusion of the research conducted during this applied research project.

Recommendations

The CAC Assessment Model developed in chapter three consisted of five components. Table 5.1 displays the components of the model, the elements of each component, a ratings summary of each element, and corresponding recommendations for improving the administrative practices of the Center for Child Protection.

Multidisciplinary Teams (MDT)

A child advocacy organization cannot achieve CAC membership without providing evidence of MDT collaboration. The Center for Child Protection “Meets Criteria” by providing adequate documentation of MDT collaboration, interagency cooperation, and feedback mechanisms. Investigation involvement is the only MDT component receiving a less than perfect rating. Investigation involvement earned a “Mostly Meets Criteria” rating because KCCP’s existing policies do not require all MDT members to participate throughout the entirety of the investigation. According to the interviewee participants, the KCCP is located within a large jurisdiction, Travis County. Because of the large caseload and the transference of cases to other divisions within the same agency, full member participation is not always possible. Wolf (2000, 27) discusses some organizations reasons for not assigning all seven members to a MDT, such as personnel shortages or funding limitations.

The Center for Child Protection may consider providing a more precisely written policy stating investigation participation goals. This may allow for less confusion about what involvement is expected of a team member during the investigation, as well as increase team member participation.

Case Management

Effective administrative case management can have both a positive and negative impact on case outcome. The CAC Assessment Model combined two National CAC objectives to create this category: case tracking and case reviews. Both case review components received the ranking “Mostly Meets Criteria.” The criteria observed to measure case reviews received high ratings except for frequency of case review meetings. The rating “Did Not Meet Criteria” was assigned because the KCCP does not provide written policy requiring all cases to conduct monthly case review meetings. Structured interview analysis revealed that cases are assigned different need levels. A case requiring medical attention or a case in the criminal system would require more frequent reviews. However, a case that needs only CPS’s attention would not receive a monthly case review. The case reviews category received an overall rating of “Mostly Meets Criteria.” The KCCP should consider revising their policy to require at least one case review a month per case. This designated meeting time, even if brief, would allow for team collaboration that could provide a future benefit to the child.

The second element of case management is case tracking. The KCCP’s documents and interview participants provided adequate evidence of a sound case tracking system, especially by revealing their plans for a new database being built by the computer staff at University of Texas. Nonetheless, this category received one rating of “Mostly Meets Criteria.” The provided documents did not clearly state whether the system tracks the outcomes of mental health services that have been referred to community resources. It may be beneficial to be more specific in describing the extent of case tracking performed for services referred outside of the facility. One purpose of CAC

organizations is to become more involved in the victim's treatment during the investigation. This is accomplished by awareness of all treatment outcomes.

Forensic Interview

The Center for Child Protection is to be applauded for their outstanding effort in the forensic interview category, as evidenced by document analysis and direct observation. There were four elements in this category: the forensic interview process, the forensic interview recording method, forensic interviewer, and forensic interviewer training. All rated criteria received the highest ratings of "Meets Criteria." The Kozmetsky Center for Child Protection should continue their current forensic interview practices.

Health Services

The CAC assessment model requires that CAC organizations provide health services to victims and their non-offending family members. The health services category consists of two components: medical treatment and mental health services. The Kozmetsky Center for Child Protection received the highest rating of "Meets Criteria" for medical treatment and "Exceeds Criteria" for mental health services. The operation manuals provided a specific, thorough documentation of required policies and procedures pertaining to health services. The KCCP possesses a state of the art facility that contains individual, family, and group therapy rooms. Group therapy rooms are not required by the CAC model; however, it is a beneficial resource for victims and their families. The Kozmetsky Center for Child Protection should continue their current health services practices.

Child-Friendly Facilities

The CAC assessment model requires that CAC facilities that follow certain design specifications to provide a neutral environment. The facility is critical as it serves as the “first stop” for a child in the investigative process. The child-friendly category received ratings of both “Meets Criteria” and “Exceeds Criteria.” The facility provided welcoming characteristic throughout the 30,000 square foot facility. The decor boasted bright, primary colors. There were waiting areas for children of all ages as well as for adults. The health services wing was separate from the forensic wing. The facility met exceeded design qualifications pertaining to the child-friendly exterior, ceiling décor, and activity rooms including the computer lab and crafts room. All other design specifications and aspects used to measure environment neutrality “Meet Criteria.”

Table 5.1: Summary of Findings and Recommendations Table

Component	Rating	Recommendation
Multidisciplinary Teams	Mostly Meets Criteria	
Interagency Cooperation	Meets Criteria	Continue existing coordination practices
Investigation Involvement	Mostly Meets Criteria	Provide clear protocol for team members expected involvement
Feedback Mechanisms	Meets Criteria	Continue existing formal and informal feedback practices
Case Management	Mostly Meets Criteria	
Case Reviews	Mostly Meets Criteria	Provide more description about required frequency of case reviews. Provide documentation that case reviews are held at minimum once a month
Case Tracking	Mostly Meets Criteria	Provide more description concerning how the results of the health services referrals are tracked.
Forensic Interviews	Meets Criteria	
Forensic Interview Process	Meets Criteria	Continue existing interview process procedures
Forensic Interview Recording Method	Meets Criteria	Continue with existing recording method
Figure 4.1 (Recording Device)	Meets Criteria	
Figure 4.2 (Recording Device)	Meets Criteria	
Forensic Interviewer	Meets Criteria	Continue with existing training program opportunities
Forensic Interviewer Training	Meets Criteria	Continue with existing training program opportunities

Component	Rating	Recommendation
Health Services	Exceeds Criteria	
Medical Treatment Figure 4.3 (Medical Exam Room)	Meets Criteria Meets Criteria	Continue with existing policies and procedures
Mental Health Services Figure 4.4 (Individual Therapy) Figure 4.5 (Group Therapy)	Meets Criteria Meets Criteria Exceeds Criteria	Continue with existing policies and procedures
Child-Friendly Facility	Exceeds Criteria	
Design Specifications Figure 4.6 (Exterior) Figure 4.7 (Playground) Figure 4.8 (Child Waiting Room) Figure 4.9 (Child Waiting Room) Figure 4.10 (Craft Room) Figure 4.11 (Ceiling Decor) Figure 4.12 (Child Computer Lab) Figure 4.13 (Family Waiting Room) Figure 4. 14 (Interview Room) Figure 4.15 (One-Way Mirror) Figure 4.16 (Live Viewing Room) Figure 4.17 (Digital Viewing Room)	Meets Criteria Exceeds Criteria Exceeds Criteria Meets Criteria Meets Criteria Exceeds Criteria Exceeds Criteria Exceeds Criteria Meets Criteria Meets Criteria Meets Criteria Meets Criteria Meets Criteria	Continue with exemplary existing policies and procedures
Neutral Environment Figure 4.18 (KCCP Facility)	Meets Criteria Meets Criteria	Continue with existing policies and procedures

Future Research Recommendations and Conclusion

Towards the end of this study, the KCCP ceased survey participation was withdrawn due to concerns about the research and confidentiality issues. Child advocacy organizations like the Center for Child Protection take careful measures to protect the confidentiality of their clients. Although document analysis, direct observation, and structured interviewing provided a detailed description of existing policy, a survey of MDT members would have enabled a more comprehensive research approach in determining how well the policies are implemented. Child abuse is a tragic and it would behoove the Kozmetsky Center for Child Protection to provide more insight about their administrative policies so their innovative operations might be shared for the benefit of child abuse victims. Nonprofit agencies provide more to a community than just the

services they offer, they can serve as an educational tool for individuals or organizations interested in providing public service.

Research in the child advocacy field is sorely lacking. This study focused on the policies and procedures of the organization because there was no concrete method to measure the impact child advocacy organizations have upon children. Research in this area is difficult because it must accommodate confidentiality required for children and be careful not to inflict additional stress. Willing participants are often few, therefore, studies' results suffer poor accuracy. Research should be conducted in an effort to create a thorough, noninvasive research technique that accurately assesses the effectiveness of child advocacy organizations.

Based upon document analysis, structured interviews, and direct observation, the Kozmetsky Center for Child Protection appears to be a very well developed and child advocacy center. The organization has successfully created a multidisciplinary coordinated effort to increase the effectiveness of case management and provide organization to child abuse investigations. Similar organizations are needed in other communities to combat child abuse.

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Multidisciplinary Team Member Survey

1. Consent Form

Hello! My name is Kate Campbell, and I am a graduate student pursuing a Masters in Public Administration at Texas State University in San Marcos, Texas. This is research being conducted as part of an academic assignment. The purpose of this survey is to gauge the administrative practices at the Center for Child Protection. You have been asked to participate in this study by completing a survey because you have served as a member on a multidisciplinary team (MDT).

The survey consists of thirteen (13) straight-forward questions asking you to describe your MDT experience on a scale of 1-5. One (1) describes the question as never being your experience as a member of a MDT and five (5) meaning this has always been your experience. The survey should require 10-15 minutes of the participant's time.

Participation in this survey is voluntary and you may withdraw from the study at any time. You may choose not to answer any of the questions for any reason. The data collected in the surveys will remain anonymous. Thank you for your time and assistance.

*** 1. I fully understand the consent form and its contents.**

Yes

Multidisciplinary Team Member Survey

2. Survey Questions

1. Our team always includes a member from each of the following 7 disciplines:

Law Enforcement

CPS

Prosecution

Medical

Mental Health

Victim Advocacy

Representatives of the Center for Child Protection

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

2. All team members remain involved with the case throughout the investigation.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

3. The same person or people from the agencies come to our meetings each time.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

4. MDT meetings are effectively coordinated and arranged before the actual meeting takes place.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

5. I am always aware of the team facilitator at our MDT meetings.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

6. The facilitator runs our MDT meetings efficiently and effectively (for example, the facilitator keeps team members focused on the case at hand).

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

7. I receive a list of cases to be discussed at upcoming MDT meetings prior to the actual meeting.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

Multidisciplinary Team Member Survey

8. Recommendations from the case reviews are communicated to the appropriate parties for implementation.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

9. Our case review meetings are held at least once a month. (Case review meetings do not include informal discussions, pre-interview debriefings, or post-interview debriefings).

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

10. MDT members participate fully in the meetings and contribute to discussion about the case.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

11. I feel comfortable asking questions during our case review meetings.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answers:

12. MDT members with investigative responsibilities are routinely present for the forensic interviews.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

13. As a forensic interviewer, I am offered opportunities for ongoing training and peer reviews.

(training opportunities may include:

- Attendance at workshops or conferences,
- Reading current research and literature on forensic interviewing,
- Review of recorded interviews,
- Observations of interviews,
- Peer reviews, and
- Ongoing supervision)

***This question is intended for team members who have served as the forensic interviewer.**

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

Multidisciplinary Team Member Survey

14. Findings of the medical evaluation are shared with MDT members in a routine and timely matter.

1. Never Describes my Experience 2. Rarely Describes my Experience 3. Sometimes Describes my Experience 4. Often Describes my Experience 5. Always Describes my Experience

Answer:

Structured Interview Questions

1. Do all multidisciplinary teams consist of representation from the following seven disciplines: law enforcement, CPS, prosecution, mental health, medical, victim advocacy, and the Kozmetsky Center for Child Protection?
2. Are MDT members required to participate in the investigation until the case has been closed?
3. Does the same person from each agency (who is initially appointed to the team) remain involved throughout the investigation?
4. How is the team facilitator determined?
5. Are case reviews held once a month for each case?
6. What type of case tracking system does the Kozmetsky Center of Child Protection utilize?
7. Are the case's tracking results made available to all MDT members?
8. Is ongoing training provided for all forensic interviewers?
9. How often are forensic interview training opportunities provided for MDT interviewers?
10. During what stage in the investigation are the medical exam findings shared with MDT members?
11. Is the Kozmetsky Center for Child Protection's facility conveniently located for employees, children and their families?

WHERE TO CALL FOR HELP

Police/Fire/Ambulance Emergency	911
Texas 211 Resource Center	211
MHMR Hotline to Help	472-HELP 472-4357
Family Forward	459-5490
CAPE Team (child psychiatric emergencies)	448-0185
Child/Elder Abuse Hotline	(800) 252-4500
TCSO/APD Child Abuse Unit	834-3890
APD Mental Health Deputy	974-5397
TCSO Mental Health Deputy	473-9734
Domestic Violence Hotline	928-9070
Sexual Assault Hotline	440-7273
Texas Poison Control Center	(800)POISON 1 (800)764-7661
Women, Infant & Children	(800) WIC4You (800) 942-4968
Texas Safe Riders	(800)252-8255

The Center for Child Protection offers intervention to children and their protective caregivers who have made a confirmed outcry of abuse within the criminal and civil justice systems. The Center is a member of the Travis County Child Protection Team (CPT) which is made up of the following agencies: Travis County District Attorney's Office, Child Protective Services, Austin Police Department, Travis County Sheriff's Office, A.J.S.D., Police Department, Children's Hospital of Austin, and all other law enforcement jurisdictions within Travis County.

PROGRAM STAFF

The Center's program staff are trained professionals. Licensed staff hold Licensed Clinical Social Worker (LCSW) credentials and/or Licensed Master Social Worker (LMSW). Interns from area universities participate in provision of services under the supervision of both university staff and the Center's licensed staff. The Center maintains a staff of trained volunteers who assist in the provision of Center program services under the supervision of Center staff.

**THE CENTER FOR
CHILD PROTECTION
PROVIDES ALL SERVICES AT
NO CHARGE.**

REV 052306

Program Services



center for child protection
HELPS. HOPE. HEALS.

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8509 FM 969 Bldg 2
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SERVICES OFFERED AT THE CENTER FOR CHILD PROTECTION CENTER INCLUDE:

THERAPY SERVICES FOR PROTECTIVE CAREGIVERS

Individual and family therapy services are available for the protective caregiver in Child Protective Services (CPS) confirmed cases of abuse and neglect. Therapy services are seen as particularly critical in cases where the protective caregiver is ambivalent in their support of their child. Providing therapeutic support and intervention can assist the protective caregiver in working through recent crisis and ambivalence towards more productive problem solving and consistent emotional support of their children. Services are available to clients in English and Spanish.

THERAPY SERVICES FOR CHILDREN & ADOLESCENTS

Individual and family therapy services are available for children and adolescents who have experienced trauma through confirmed cases of abuse or have been witness to a violent crime. Traumatic experiences can have debilitating effects on the victim without appropriate therapeutic intervention and support. The client is assisted in addressing the traumatic experience in efforts to understand how the event has impacted their emotions, thoughts and behaviors, as well as their relationships with others. The client is assisted in examining ways to manage their emotions and behaviors in a constructive manner and to decrease self-defeating behaviors. Services are available to clients in English and Spanish.

REUNIFICATION SERVICES

As children prepare to go back into their parent's home, there often are many emotions and questions each family member experiences in anticipation of reunification. Short-term individual and family therapy services are available to CPS clients to address reunification issues. Sessions prior to reunification are provided, as well as provided in a limited number of sessions after reunification has taken place. The family will be provided with referrals to out-patient therapists for ongoing family therapy services.

TERMINATION SERVICES

When the decision has been made to relinquish parental rights, it is particularly important to allow for disclosure as much as possible for the child and parent, as well as siblings, if they are involved. CPS staff may refer their clients for this service which occurs in one session. In situations where a client is experiencing significant emotional distress, additional individual therapy services for the client can be provided.

EMERGENCY CLINICAL EVALUATIONS

The Center Clinical Staff are available to provide clinical assessment of clients that may be at risk for suicidal or homicidal behaviors. The evaluation is done by assessing current risk factors and stressors, emotional functioning, and current behaviors and ideations. Depending on emergency intervention and transport of the client, the Clinical Staff member will provide the client with information on accessing appropriate psychiatric follow-up services.

FAMILY ASSESSMENT

Sometimes when working with complex family systems, it is difficult to get a handle on the dynamics that are key to understanding difficulties a family is experiencing. The Center for Child Protection's Clinical Staff are available to take referrals from the Child Protection Team (CPT) staff to do a Family Assessment which encompasses a mental status exam, psychosocial history, assessment of current level of functioning, problem identification and clinical insight into what problems/barriers are contributing to the family's difficulties in functioning and what can be done to address these issues in an effective manner.

CASE MANAGEMENT

Intensive in-home case management and counseling support services are available to families that have complex needs including medically involved children, children in need of developmental assessment, and/or children in other high risk situations. Referrals are taken from the CPT members and other community professionals. To access this resource, contact the Center's Clinical Director or any member of the program staff. Intensive in-home

case management and counseling support services are available to clients in English and Spanish.

PROTECTIVE PARENTING AND SUPPORT GROUP

Parents who become involved with Child Protective Services (CPS) as a result of abuse/neglect, risk, or protective issues are often overwhelmed not only with the system, but also the current or previous family of origin dynamics that are often barriers to healthy individual and family functioning. This group is designed to address issues related to trauma and protectiveness through both education and psychotherapy. This group meets in the evenings or during the day. Call for a current schedule. Families must call to pre-register. Child care is provided.

COURT SCHOOL

Court School is a relaxed introduction to being a witness in a trial. Information is provided for young children, teens and caregivers who may be testifying in court. It is an opportunity to learn about the court system, how to take care of yourself during the trial, and the different roles of the courtroom participants. Individual cases are not discussed. Court School is held in an actual courtroom and is led by Center staff and volunteers in cooperation with attorneys and staff from the Travis County District Attorney's Office. Children learn about and practice appropriate courtroom behavior and participate in a mock trial.

PARENT EDUCATION GROUP

The parent education group is designed to assist parents in developing the skills and tools necessary to feel more successful as a parent. Topics addressed include child development, goals of misbehavior in children, communication skills, use of natural and logical consequences, and determining what skills will be most useful in specific parent-child conflicts or situations. The Parent Education Group meets in the evenings or during the day. Call for a current schedule. Families must call to pre-register. Child care is provided. Services are available to clients in English and Spanish.

All services for clients are free of charge.



Kate Campbell <annakatherine22@gmail.com>

FW: Exemption Request EXP2009P8525 - Approval

Campbell, Anna K <ac1537@txstate.edu>

Thu, Mar 26, 2009 at 4:12 PM

To: "annakatherine22@gmail.com" <annakatherine22@gmail.com>

From: ospirb@txstate.edu [ospirb@txstate.edu]
Sent: Thursday, March 26, 2009 3:25 PM
To: Campbell, Anna K
Subject: Exemption Request EXP2009P8525 - Approval

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Based on the information in IRB Exemption Request EXP2009P8525 which you submitted on 03/23/09 11:27:50, your project is exempt from full or expedited review by the Texas State Institutional Review Board.

If you have questions, please submit an IRB Inquiry form:

http://www.txstate.edu/research/irb/irb_inquiry.html

Comments:
No comments.

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Hypothetical Interagency Agreement
Between Waco Police Department and House of Ann and Waco Child Protection
Services

I. Purpose

These agencies enter into this agreement for the following purposes:

- To promote a strong Coordinated Community Response to Domestic Violence, and address the shared dual concerns of domestic violence as well as child maltreatment;
- To create a multi-agency Domestic Violence Response Team that will respond immediately to domestic assault incidents, and investigate possible child abuse & neglect;
- To standardize the community response to domestic violence.

II. Duties of WPD

- a. Respond to all domestic assault calls in a timely fashion;
- b. Provide copies of Incident Reports to House of Ann within 24 hours of domestic violence-related incidents;
- c. Host the new Domestic Violence Response Team at the police department, and assign one patrol officer to the team to conduct on-site and follow-up investigations;
- d. Hire a fulltime advocate to serve as Victim Liaison for the DVRT;
- e. Provide an in-house work space for the advocate and access to WPIS so long as it furthers the purpose of the DVRT, and information is not shared with outside agencies or persons;
- f. Provide an in-house work space for one CPS caseworker and access to WPIS so long as it furthers the purpose of the DVRT, and information is not shared with outside agencies of persons;
- g. Attend weekly interagency meetings with staff from House of Ann, the city attorney's office, probation, Lutheran Social Services (batterer treatment services) and probation; and child protection services.

III. House of Ann will

- a. Provide shelter and advocacy services to all victims of domestic violence within its ability;

- b. Staff a 24-hour crisis line available 7 days a week;
- c. Assist victims of domestic violence in seeking Orders for Protection;
- d. Provide counseling services to children;
- e. Attend weekly interagency meetings with staff from the police department, the city attorney's office, probation, Lutheran Social Services (batterer treatment services) and probation; and child protection services.
- f. Place one advocate fulltime at the police department to serve as Victim Liaison for the Domestic Violence Response Team; who will accompany the DVRT patrol officer and caseworker on all on-site and follow-up investigations;
- g. Not share any confidential information from victims of domestic violence with other agencies or individuals unless authorized by the individual victim; and
- h. Not release or share protected information from the police department or child protection services with other agencies or individuals, including victims.

IV. Waco Child Protection Services will

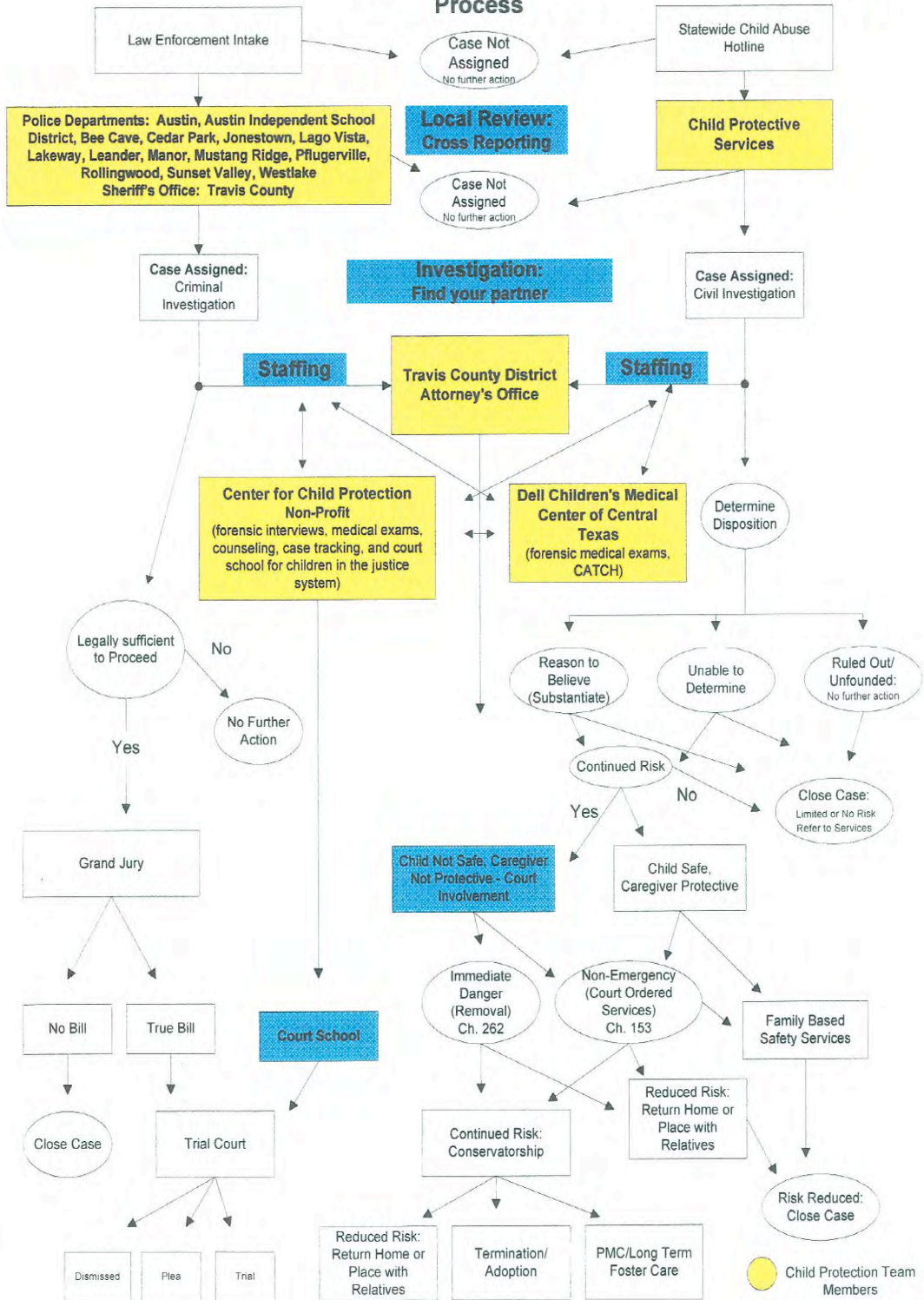
- a. Follow-up on all reports of child neglect and maltreatment;
- b. Follow-up on all reports of children's involvement incidents of domestic assault or violence;
- c. Assign a caseworker to the DVRT and locate that caseworker at the police department;
- d. Share information and resources with fellow DVRT team members so long as it furthers the purpose of the team, and information is not shared with outside agencies or persons; and
- e. Attend weekly interagency meetings with staff from the police department, the city attorney's office, probation, Lutheran Social Services (batterer treatment services) and probation; and House of Ann.

V. Law Enforcement/Advocacy Program Domestic Abuse Complaint Procedure

Whenever the House of Ann, Waco Police Department or Waco Child Protection Services identifies or receives a complaint regarding the response of one or more of the employees of the other's agency, the previously assigned Points of Contact at each agency agree to contact each other for the purpose of investigating and rectifying the complaint .

Child Protection Team Process

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- Child Protection Team Members
- Primary Points of Staffing for Multidisciplinary Case