CHILD ADVOCACY CENTRES IN AUSTRALIA - A WAY FORWARD

Improving multi-agency services for children who have been harmed

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Churchill Fellow 2006
40th Anniversary Churchill Fellowship (WA)

The Winston Churchill Memorial Trust
Rewarding Australians Striving for Excellence

Natalie Hall

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Signed *Natalie Hall* Date 5th May 2007

INTRODUCTION

My travel from January 15th 2007 to March 15th 2007 as a Churchill Fellow (2006) was a fantastic experience and is for me a career highlight as well as being a personally rewarding and challenging time. The fellowship enabled me to travel to the USA, Canada, UK, Sweden, Poland and Hong Kong in order to study multi-agency services provided to children and families where the child requires a forensic interview, medical examination, legal services, counselling and family support services. This report provides a summary of the Child Advocacy Centre model of service delivery originating in the US and other key training, legislative and service developments in the countries I visited.

Without the financial support of the Churchill Trust, this would not have been possible. I am indebted to the work of the Trust and the thousands of Australians who contribute financially to supporting the development opportunities that the Trust provides.

I would like to acknowledge the people I met during my travels, each one welcoming and enthusiastic; it was a pleasure to discuss with international colleagues a shared commitment in working with children. I learnt so much from each of them; their work is inspirational and has fuelled my passion for improving services for children here in Australia.

I am grateful to my referees who had confidence in me and to the Senior Officers of both the Department for Child Protection and the WA Police who supported my absence from the work place. I also thank the staff of the Child Interview Unit who continued the good work of this service whilst I was away and who are also committed to improving our service to children who have been harmed.

Thankyou to my husband Andrew, an excellent travelling companion, who provided emotional support and was a great sounding board for the ideas I developed as we worked and travelled and for providing additional insights and encouragements as only he can.

Very special thanks to my parents Jennifer and Ross Wightman who cared for our children during our absence, you are truly wonderful. Without such supportive and loving parents, parents in law, extended family and friends we could not have travelled together and could not have relaxed knowing our children were happy and well cared for by you all. Thankyou.

Finally and most importantly to Jacob, Mitchell, Thomas, Jenton and Darcie, five precious people who were willing to put up with absent parents so that "we could go and learn about helping other children", Thankyou. I dedicate my life, my work and this report to each of you. You are all wonderful people and I am very proud to be your Mum.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION

I was awarded the 40th Anniversary Fellowship in WA for a project of concern to children and young people. Specifically to research multi-agency services for children who have been harmed, an examination and comparison of services provided to children and families where the child requires a forensic interview, medical examination, legal services, counselling and family support services. This involved the assessment of specific strategies for cohesive service provision and success in whole of government/agency responses and direct contact with Multidisciplinary Teams and Child Advocacy Centres world wide to assess strategies for developing child focused services and to identify key factors in motivating agencies, energizing resources and collaborative responses.

HIGHLIGHTS

It is difficult to select highlights from an amazing eight week world study tour however:

- I learnt a great deal from exceptional leaders I met along the way, Dr Astrid Heger, Victor Veith, Bill Copeland, Cindy Blackstock, Maria Keller-Hamela and Patty Miller each of whom have worked tirelessly in the child protection area for many years, and who spoke of their own personal strategies for building strong teams, growing and sustaining services and achieving change.
- Attending the 21st International Conference on Child and Family Maltreatment in San Diego California U.S.A. was a rare opportunity. Unfortunately international travel for government employees who are child protection practitioners is almost non-existent so it was particularly exciting to plan my travels around this conference
- Visiting the Child Advocacy Centres - taking in the details of layout, board membership, service design, unique enhancements, strengths and areas of ongoing development. Learning from the positives as well as the challenges each centre was experiencing
- Establishing links and relationships with so many wonderful people around the world and what a delight it is to still be in contact with them by email.

RECOMMENDATIONS

As a manager within one government agency I have been encouraged by the current State Government's commitment to develop whole of government responses to a variety of community issues, including child protection, however I have also observed the difficulties and delay in achieving tangible change at the service level as departments struggle to adjust policy, cultures and ways of working. Each of us working in this area are acutely aware that no single service or agency can address the issue of child protection or meet all the needs of a child and family coming to the attention of the system. The Child Advocacy Centre (CAC) model of service delivery is a tangible way for children and communities to see how agencies change the way they do things and come together to make services to families less complicated and more comprehensive. It is a model that was developed at the grass roots and it works. CACs have been established within local communities by leaders committed to making a difference and working smarter. Standards have followed, along with technical support, training, legislative changes and policies which have consolidated the CAC model and multidisciplinary teams as the preferred way to enhance service provision to children.

There is no need to re-invent the wheel. The 20 year history of the CAC model offers a lot of information to Australians, as do the evaluations of these programs, which have found them to be efficient, cost effective and above all a preferred model of service provision for children. Therefore I recommend:

1. The Child Advocacy Centre model of integrated service provision across agencies be established in Australia. Local communities are to be encouraged to take ownership and leadership of the design and service provision of each centre in order to meet the needs of

local children of all backgrounds and circumstances. Purpose built buildings or co-location of all stakeholders is not essential (although optimal) however absolute multi-agency commitment and collaboration are vital. Let us plan CACs that provide a multidisciplinary response, comprehensive assessment of a child's situation and quality services.

2. Child Advocacy Centres become the visible service within communities for vulnerable children. Funding for service delivery should be sufficient to undertake a wide range of measures to prevent and respond to all forms of violence and abuse against children, including educational and media campaigns, the provision of child-friendly legal, medical and psychosocial services and data collection capable of monitoring the prevalence of violence against children.
3. Children and young people are to be involved in the design and implementation of CACs and other strategies to address the violence against them.
4. Indigenous communities are to be involved in planning and developing CAC services, based on community readiness and with consistent support from government particularly in rural and remote areas.
5. Mobile facilities be considered as an excellent alternative for service provision in rural areas. Collaboration across agencies such as Health, Education, Protection and Police could increase the viability of such facilities. A well equipped van could provide a variety of services by qualified professionals: forensic medical and interviewing, health examinations, assessments, clinic services, vaccinations, dental or education services. A mobile facility in rural areas may achieve many purposes and become a welcome visitor to communities throughout the country.
6. Development of a National forum to develop and nurture Child Advocacy Centres across Australia providing technical assistance and support, application of standards, best practice and continual improvement in service provision to children and young people.
7. Share the success of the Child Advocacy Centre model with other sectors and service providers such as Domestic Violence programs and the Office of the Public Advocate. In some communities combined services may be beneficial or preferred.
8. Provision of quality training to professionals in the area of child abuse and maltreatment across all sectors and services, from interviewing expertise, investigations and prosecution to therapeutic interventions, including improved links to universities who are training future doctors, nurses, teachers, social workers, lawyers, psychologists and others who work with children.
9. Expand legislation and resource appropriately the visually recorded interviewing of children witnessing Domestic Violence, Homicide and other Violent Crimes.
10. Implement an Extended Forensic Evaluation model for those children who have trouble disclosing in one interview.
11. Develop Specialist Prosecution teams with prosecutors trained and experienced in child abuse cases, specialised Courts and Judicial Officers. This will improve the level of experience and commitment to communicating with children and prosecuting crimes against them.
12. Legislative reform to remove the need for children to attend court by involving Defence Lawyer representatives or Judicial officers in the recorded interviewing of children. The recorded interview becomes the child's complete evidence.
13. With other leaders across government and non government services and the community, develop a vision for ending child abuse and maltreatment in Australia.

IMPLEMENTATION and DISSEMINATION

As a social worker committed to advocating for children and improving system responses to them when they are harmed or at risk, I have a small but direct sphere of influence in promoting change within the Child Interview Unit and connected services. Immediately along with colleagues from the WA Police, Department for Child Protection and Office of the Director of Public Prosecutions we have committed to making changes to service delivery to improve the service provided before a forensic interview and after an interview in order to gather better information, improve

assessments and provide more comprehensive support to children and families. We have also agreed on the need to improve the interviews themselves to further assist in the prosecution of offenders.

Many of my recommendations will require the tangible support of others and the development of working groups across agencies and with communities to implement. This report attempts to stimulate the interest and commitment of others to take on this work within Western Australia and across the nation. I am also committed to sharing the information about the CAC model and its success in the US, Canada, Iceland, Sweden and Poland across this state, Australia and Asia. I will do so by speaking publicly at conferences and providing this report to all interested parties. I will also be providing this report to the colleagues I visited on my travels who were keen to know about developments around the world and how they can be learning from each other.

CornerHouse. Minneapolis, Minnesota

Patty Miller. First Witness. Duluth Minnesota

BACKGROUND TO PROJECT

In March 1998, the Department for Child Protection (DCP) and the Western Australia Police agreed to work together to develop a joint approach to the investigation of child abuse, in recognition of the need to ensure that children who have been abused do not experience additional unintentional stress during the assessment and investigation of an allegation. Joint training commenced and joint interviews of children were conducted with hand written notes or statements being taken. In June 2004 the Child Interview Unit was established to ensure the agencies would be able to provide a quality service through the training of highly skilled professional and full-time child interviewers. Interviews have been visually recorded since November 2004 and legislative changes allow for the use of the visual recording as part of the child's evidence in chief in criminal proceedings and also within Family or Children's Court proceedings.

The purpose of the Child Interview Unit is to interview children who have experienced physical and sexual abuse as well as children who are witnesses to the physical or sexual abuse of other children. The paramount concern of Specialist Child Interviewers is the safety and wellbeing of the child. Interviews are conducted in an anti-discriminatory, culturally aware, developmentally sensitive, objective and legally defensible manner. The interview techniques used are child-centred, with the purpose of determining truth, and where offences are disclosed, the interviewers strive to maximise the attainment of admissible evidence. The new WA Four Phase Forensic Model of interviewing was developed in consultation with key stakeholders and incorporates research based evidence in interviewing children. It is an excellent model and has been recommended to the Australian Law Reform Commission as the preferred model for interviewing children in Australia by Dr S. Caroline Taylor.

Since 2004 I have been involved in the implementation of the Child Interview Unit in Perth and training of forensic interviewers for the Department and WA Police state wide. The Unit is in its infancy phase of development with the first interviews being utilised in criminal proceedings within the last twelve months. Feedback from the Director of Public Prosecutions, Judiciary and the Unit's own Quality Assurance program is currently informing a review of the interview model, specifically the length of interviews and their application within the court setting. There have been difficulties in maintaining the skill level and expertise of interviewers within both the metropolitan unit and state wide. In addition an independent Evaluation was completed in January 2007, the report and its recommendations are now being considered by the Senior Officers of DCP and Police.

The Churchill Fellowship Award was a timely opportunity for me to travel overseas and explore well developed multi agency services for children. I visited service models from a variety of geographic, socioeconomic and culturally diverse areas. The services varied in resourcing, stakeholder participation, management structures and operational procedures. In examining services from different perspectives including service provision, staff development, management, and whole of government responses, I am able to make reflections based on the history of joint approach to child abuse in Western Australia, the strengths and weaknesses of the current Child Interview Unit and regional service provision as well my learning from international practice in this area and the wisdom of others I met during the fellowship.

PROGRAMME SUMMARY (full details in Appendix)

14/01/07 - 11/02/07	Las Vegas, NEVADA; Los Angeles and San Diego, CALIFORNIA; Phoenix and Flagstaff ARIZONA; Minneapolis, Bemidji, Duluth and Winona MINNESOTA; Chicago ILLINOIS U.S.A.
12/02/07 - 15/02/07	Toronto, ONTARIO CANADA
16/02/07 - 22/02/07	New York, NEW YORK U.S.A.
23/02/07 - 03/03/07	London UNITED KINGDOM
04/03/07 - 07/03/07	Stockholm and Linkoping SWEDEN
08/03/07 - 11/03/07	Warsaw, POLAND
13/03/07 - 15/03/07	HONG KONG

KEY FINDINGS

WHAT W.A. IS CURRENTLY DOING WELL

The current co-located service model in Perth between the Department for Child Protection and WA Police is focused on the forensic interviewing of children, as part of a collaborative response between these two agencies, in order to reduce multiple interviews for differing agency purposes. The joint response between the two agencies relies on Detectives and Case Managers from each agency initiating joint response discussions, planning and decision making, which may include a joint interview at the Child Interview Unit. The quality of the current joint response across the two agencies is variable with often only basic information sharing occurring prior to an interview and limited planning or discussion occurring. There is certainly much room for improvement in service provision to vulnerable children and their families in Perth in order to provide a seamless holistic response across multiple agencies and systems (health, mental health, police, protection, prosecution, court) that is timely, supportive and compassionate whilst also providing rigorous assessment, treatment, prosecution and support services.

It became clear during my visits that some aspects of WA service provision to children are excellent:

- The WA Four Phase Forensic Model of Interviewing is well researched and of an excellent standard.
- The WA Specialist Child Interview Training Course is a comprehensive course for forensic interviewers. A key strength of this course is the amount of skills rehearsal.
- WA has firm legislation allowing the use of the Visually Recorded Interviews in Criminal, Family and Children's Court proceedings
- Victim Support Services provided by the Department of the Attorney General in WA for those children where a prosecution is pursued are of an equivalent standard provided in other parts of the world.

Whilst both the model of interviewing and training course are of an excellent standard there are implementation issues that require attention including transferring knowledge into practice, maintenance of skills and quality assurance.

CHILD ADVOCACY CENTRES

During my travels I visited sixteen Child Advocacy Centres (CACs), fourteen in the United States of America (U.S.), one in Sweden and one in Poland each providing services to children who have been harmed. When researching the CAC model before my trip I had not realised the depth of influence this model has had on service development not only across the U.S. but internationally. CACs have also been established in Canada and Iceland. My visits to London and Hong Kong also considered joint agency models, and whilst joint interviewing of children and joint training was well established in these countries any co-location was principally around the provision of interviews for children, similar to that currently provided in Perth, rather than the more fully developed multi-disciplinary team response of the CAC model.

CACs were developed in the US in the 1980s "in response to criticism of system induced trauma"[1] on children who had been harmed. The first centres were established in 1984 in Los Angeles and 1985 in Huntsville Alabama. In 2006 there were 640 CACs across the US, 400 accredited CACs and 200 associate or developing centres.[2]

In 1987 Congressman Bud Cramer (then District Attorney of Madison County Alabama) founded the National Children's Alliance (NCA) (formerly known as National Network of CACs) in response to the growing number of child abuse intervention programs and the demand for guidance, training and standards. NCA is a not-for profit membership organisation whose mission is to assist communities seeking to improve their response to child abuse by establishing and maintaining CACs.[3] In 1990

Federal law ensured that the NCA would receive some federal funds to provide support, resources, training and technical assistance to centres. Four Regional Children's Advocacy Centres (RCACs) have been implemented and "assist communities to

- Assess a community's capacity to provide services
- Develop a comprehensive, multidisciplinary response to child abuse particularly the CAC model
- Develop and negotiate interagency agreements and protocols
- Maintain open communication and case coordination
- Enhance professional skills among the interdisciplinary partners
- Coordinate and provide training to disciplines represented on the team
- Identify and develop funding and marketing strategies
- Strengthen the organisational capacity of CACs
- Plan for expansion
- Increase community understanding of child abuse."[4]

Some of the training provided by the NCA through RCACs includes Medical Training, Introduction to CAC Management, New Directors Orientation, Advanced CAC Leadership, Team Facilitators, Multidisciplinary Team Development and Accreditation Boot Camps. The information, guidance and standards set by the National Children's Alliance assists any community contemplating the development of a CAC to discuss thoroughly service design, resourcing and quality assurance issues. It is widely acknowledge by the NCA that CACs need to be developed to suit the communities they are to serve, therefore local organisations and agencies need to make their own decisions about key stakeholders, management structures, funding sources, interview process, support services, service location and operating hours.

There are ten standards a CAC must meet for accreditation with the National Children's Alliance:

1. **Child-Appropriate/Child-Friendly Facility**: a comfortable, private setting that is both physically and psychologically safe for clients
2. **Multidisciplinary Team (MDT):** including representation from Child Protective Services, Law Enforcement, Prosecution, Mental Health, Medical, Victim Advocacy and the Children's Advocacy Centre
3. **Organisational Capacity:** a legal entity responsible for program and fiscal operations, basic administrative practices.
4. **Cultural competency and diversity:** policies, practices and procedures that are culturally competent (i.e. the capacity to function in more than one culture, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community)
5. **Forensic interviews:** neutral, fact finding, and coordinated to avoid duplication
6. **Medical evaluations,** specialised medical evaluation and treatment as part of the CAC team response
7. **Therapeutic Intervention:** Specialized mental health services as part of team response at investigation and throughout subsequent legal proceedings
8. **Victim Support/Advocacy:** as part of team response throughout the investigation and subsequent legal proceedings
9. **Case Review:** team discussion and information sharing regarding the investigation, case status and services needed by the child and family, to occur routinely
10. **Case Tracking:** system for monitoring case progress and tracking outcomes, suitable for all team components.[5]

In an ideal world, no child would be abused. The reality is that many children are. "CACs bring together, in one location, child abuse professionals who can support the needs of the child victims and their families."[6] "CACs provide a comprehensive, culturally competent, multidisciplinary team response to allegations of child abuse in a dedicated, child-friendly setting."[7]

Child Advocacy Centres combine the wisdom and professional knowledge of team members for a more complete understanding of case issues and a more supportive response for the child victim and family. "This is only accomplished with mutual respect and open communication between the professionals providing the service. CACs provide:

- consistent and fast follow-up to abuse reports,
- medical and mental health referrals that more effectively help the child and the child's family,
- dramatic reduction in the number of interviews a victim must undergo,
- increased successful prosecutions and most importantly
- consistent and compassionate support for the child and family." [8]

CACs are funded from a variety of sources including State Government, Local Government, National Children's Alliance Grants, private donations, endowments or foundations, fundraising and Federal Grants under the Children's Justice Act and Victims of Crime funding. With the strong growth of CACs many states have developed state-wide organisations or Chapters building local networks and responding to laws that are unique to their state. In addition to networking and mentoring opportunities Chapters are often working to educate state leadership about protecting children and the needs of CACs. Chapters may provide access to state-wide training and other resources. [9]

The history and strength of the National Children's Alliance and CACs across the US was clearly evident throughout my study tour. I visited centres both accredited and non-accredited, some had been providing services for over 20 years, others were newer centres and one had been open for only 12 months. Not all services where necessarily located under one roof in a CAC but where there were off site linkages, these were strong and clear with agreed case management protocols and referral mechanisms in place. The level of expertise, training, technical support and assistance provided by the NCA and Regional Children's Advocacy Centres to CACs is outstanding. CACs across the country are provided with opportunities to learn from each other within counties and across states, to attend conferences and to access training for interviewers, investigators, medical staff, therapists and managers. The professionals involved in multidisciplinary work have a greater appreciation and understanding of the mission of other disciplines and excellent access to cross-disciplinary training, both of which lead to more informed decision making.

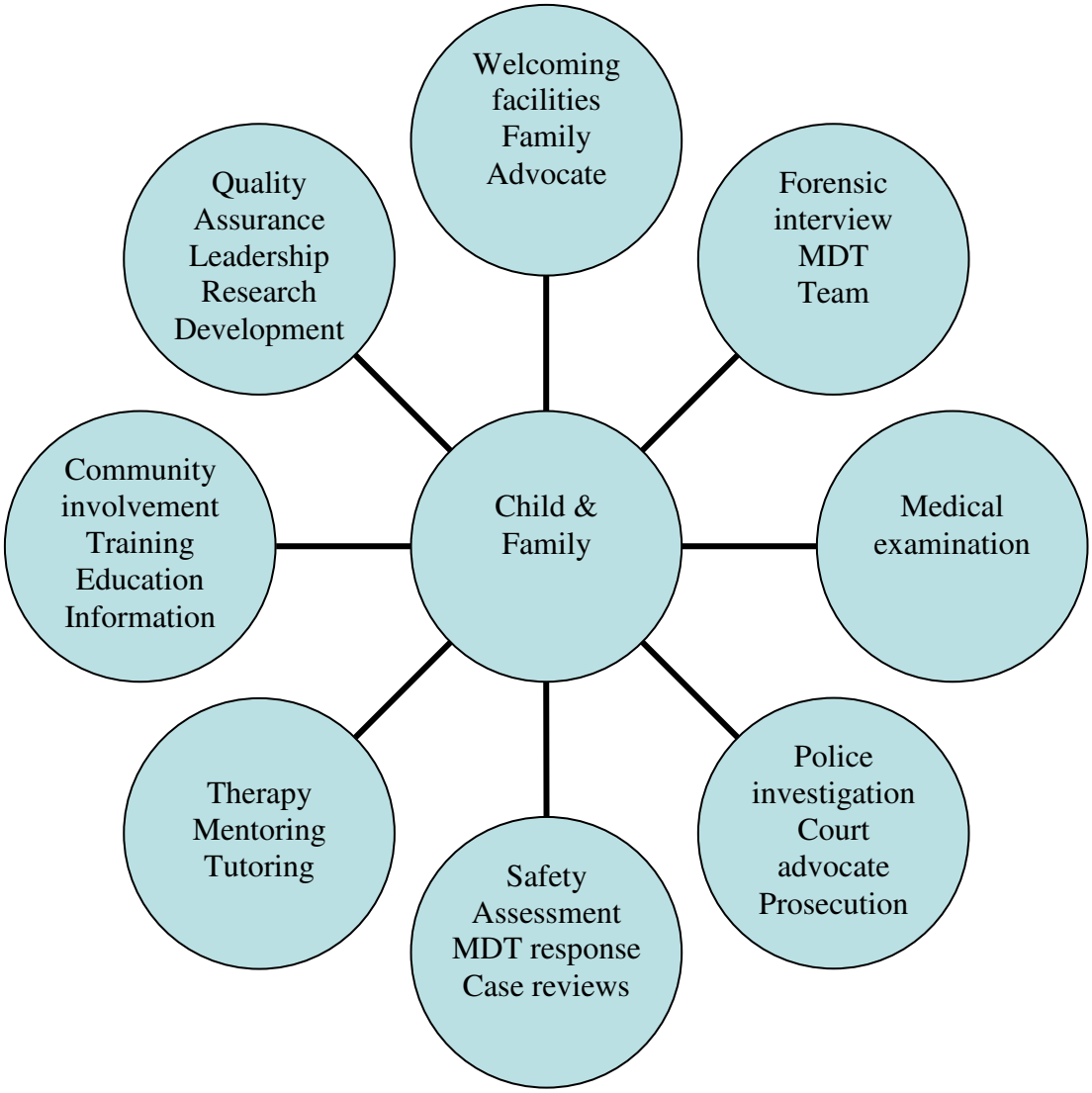
It was my observation each CAC is firstly established in the local community and then continues to mature along a continuum from developing program to accredited program and finally towards being a centre of excellence:

- Developing programs were working towards implementing each of the ten standards, provided a child friendly location, forensic interviews and multidisciplinary child protection responses including medical examinations and therapeutic services. They also had roles in advocating within systems and involvement in community and public events.
- Accredited programs met each of the standards including case review and case tracking processes, some had 24/7 availability or had developed child abuse expertise in a particular area (e.g. multi-disciplinary team training, healthy team development or extended evaluations), others offered ongoing training to staff, other professionals and the community. Advocacy included proactive building of relationship with government and community to expand outreach and advocacy measures.
- Centres of Excellence were providing local, regional and national leadership in the area of child protection or child advocacy. Some centres incorporated all vulnerable children into their work such as children in family violence situations or those who had experienced other forms of trauma. Team members were involved in research and education efforts and advocacy included prevention programs, legislative reform and improvement of systems for child protection.

Accredited CACs are required to undergo an accredited membership re-evaluation by the NCA every five years. This process ensures that accredited members maintain the high level of operation.

WHAT DOES THE SERVICE AT CAC LOOK and FEEL LIKE FROM A CHILD and FAMILY PERSPECTIVE?

- Referral and intake processes are well coordinated. Families are contacted prior to their visits, information is gathered from family and from all Multi-Disciplinary Team (MDT) members, information is provided to the family about appointments, the assessment process and services
- Facilities are welcoming and child friendly, with plenty of space, including rooms for private discussion pre and post interviews, examinations and therapy
- Child and Family are greeted by a Family Advocate who remains their contact point until services are no longer required or are transferred to another person (eg Victim Support Service, Child Protection Service). Written information about the service/process is provided to the family
- A Play Leader greets the child and accompanies him/her to a designated play area (separate to the waiting room) whilst the child plays and relaxes, observation provides some information about the child's capabilities and targeted activities aimed at success help to build the child's self esteem, relax the child and assist him/her to feel at ease in talking about him/herself.
- Mental Health intervention (if required) is provided early on in the visit, (eg where child or adult distress or presentation is concerning) a mental health professional is rostered to provide immediate assessment or crisis intervention
- MDT meeting is held to review case information and plan interview (including observations from Family Advocate , Therapist, Play Leader)
- Interviewer meets child, introduces him/herself, shows the child the interview room and conducts interview, MDT members observing.
- Child returns to play room or alternate play area
- MDT meeting to discuss interview information and plan response
- Child and Parent informed of plan
- Family Advocate informed of outcome and plan
- Medical examination can be undertaken on the same day, same location. Complete physical examination is undertaken (known as Well Child Examinations in the U.S.) including assessment of growth and development, height, weight, hearing, vision, and where appropriate photo documentation, x-rays, genital examination, forensic evidence collection and pathology
- Mental Health services for child/parent arranged at the CAC or referral made to a local service
- Family Advocate initiates follow up with family – 2 days, 2 Weeks, 2 months, minimum to ensure linkage to services
- Case Reviews – any MDT member can nominate a case for review for planning purposes, case tracking or Quality Assurance and training
- Peer Review: includes medical review of cases and review of interviews
- Case Tracking: allows for cases to be tracked right through to court conclusion and/or until support services are no longer required.



OTHER SERVICES PROVIDED BY CACs THAT ENHANCE CARE OF THE CHILD

- Transport where the family has difficulty accessing the CAC
- 24/7 responsiveness
- Assessment interviews - where there is no clear disclosure of harm by the child but information is required from the child about their situation
- Extended Forensic Evaluations - where it is agreed one forensic interview may not be in the best interests of a child. An extended interview process has been developed and is acceptable to all MDT members including Prosecutors
- Tutoring for children after therapy sessions
- Tutoring for parents whilst child in therapy
- Mentoring provided to children requiring additional support
- University students recruited to be mentors and tutors for children in care/need (USA)
- Medical examinations for all children coming into the care of the Child Protective Service agency within 24 hours.
- Tele medicine utilised by the CAC to provide support to remote clinics as well as training and peer review
- Mobile facility: includes recording equipment for interviews and a medical suite.
- Therapy for children who have experienced any kind of trauma – burns, violent crime, dog attacks, witnesses to homicide, domestic violence.
- Centralised data collection

EVALUATION OF THE CAC MODEL

An evaluation by a team from the University of New Hampshire, funded by the Office of Juvenile Justice and Delinquency Prevention (U.S.A.) was designed to evaluate the impact of CACs on children, families, systems and communities in 2006. One thousand child sexual abuse cases were reviewed, an equal proportion from four CACs and from four communities without CACs. The research findings "highlighted many benefits of CACs and established some of the first research-based support for the CAC model of child abuse investigation:

- CACs showed significantly more evidence of coordinated investigations
- More children involved with a CAC received a forensic medical examination
- Sixty percent of CAC cases included a referral for mental health services versus only 22% of comparison community cases
- Parents and caregivers in the CAC sample were more satisfied with the investigation than in the comparison sample
- All of the CACs in the study were regarded as community leaders and experts in the area of child abuse, by the community."[10]

The evaluation also makes other comments about the CAC model and interagency work in general which are useful in reflecting on current service delivery and development in Australia:

- CACs have moved from a focus on reducing number of interviews for children (this is now rare in any model) and are now effective at increasing multi-agency involvement in child abuse cases
- Interagency coordination at CACs was greater but does require constant work to maintain, specific agreements between agencies assist this (eg Case Review processes)
- Only CACs with strong involvement from law enforcement and district attorneys showed an impact on criminal justice outcomes
- Most caregivers and children in CAC communities were very satisfied. There was still room for improvement in some area (more commitment from investigators and more frequent communication about the case)
- Some dissatisfaction from children about the interview experience (15%-20%) indicates that improving children's comfort should be a high priority for all investigators;
- As CACs differ dramatically one from another in program design, client and case characteristics, referral pattern, agency involvement and outcomes it is recommended CACs use data on procedural and outcome variations to initiate discussions about performance standards and benchmarks of practice.[11]

In addition, a separate study conducted in 2005 by the National Children's Advocacy Center in partnership with the National Children's Alliance, has shown that on a case by case basis, traditional investigations were 36% more expensive than investigations conducted in a community with a CAC. "The average cost of a CAC investigation was U.S.$2902 compared to U.S.$3949 for a non-CAC investigation, generating a cost savings of more that U.S.$1 000 per case."[12]

CONCLUSION: CHILD ADVOCACY CENTRES A WAY FORWARD

The World Health Organisation and the International Society for the Prevention of Child Abuse and Neglect adopted and recommended in their 2006 report a systematic, multisectoral approach to child protection (sometimes referred to as "the public health model"[13]) in which action is taken to

- "prevent the problem from occurring;
- detect the problem and respond when it does occur;
- minimise its long term negative impacts.

In the case of child maltreatment, this means

- implementing measures to prevent violence against children;
- detecting cases and intervening early;
- providing ongoing care to victims and families where maltreatment occurs;
- preventing the reoccurrence of violence."[14]

Child Advocacy Centres are a multisectoral approach to intervening early and providing care to victims and families. CACs should be designed by communities to ensure they develop appropriate services which are responsive, comprehensive and accountable. A CAC can provide the health, social, educational, legal and financial interventions and assistance that combined can lead to improved outcomes for the children and families using the services. CACs become visible services in the community, children and parents are aware of them through community programs, campaigns and websites and CACs provide leadership in developing the skills of others who work with children. People feel confident in accessing the services at a CAC and cases are followed up to make sure no one falls through the gaps. Developing CACs in Australia is an exciting possibility - involving children, families and communities in doing so will ensure success.

The major compelling success of the CAC model over current service design and provision in Western Australia is that the CAC model is holistic in its response to a child that has been harmed. In the CAC model a comprehensive service is provided which includes more than the interviewing of children with an information gathering/prosecution focus.

OTHER AREAS RESEARCHED DURING THE PROJECT TOUR

Whilst visiting CACs and services I also gathered information and insight into innovative and comprehensive developments in other areas aimed at improving the skills, knowledge and abilities of practitioners working with child abuse issues.

1. CENTRES OF EXCELLENCE

Violence Intervention Program Los Angeles, California U.S.A.:
"Intervening to protect and treat all victims of violence"

Dr. Astrid Heger is an internationally recognised expert on the medical diagnosis of child abuse and neglect and sexual assault in all ages. The need for improved technology resulted in her pioneering the use of photo-documentation of injuries associated with child abuse and sexual assault. In 2006 she was awarded the American Academy of Paediatrics 2006 Award for Outstanding Service to Maltreated Children. Under the guidance of Dr Heger, the Violence Intervention Program has grown from the original CAC service to children to services to over 5000 adults and children a year.

In 1984, the Centre for the Vulnerable Child (CVC) was founded at the Los Angeles County and University of Southern California Medical Centre for the purpose of better serving children and families. The CVC established a prototype Child Advocacy Centre with a multidisciplinary team for the evaluation, treatment and investigation of child abuse and neglect. Today the CVC remains the largest child abuse centre in California. In 1995, services were expanded to include additional comprehensive medical and mental health services for victims of sexual assault, domestic violence and elder or dependent adult abuse. This new program was named the Violence Intervention Program (VIP) and provides medical, forensic, mental health, social and legal services for all victims of violence, regardless of gender or age. Although children continue to be the focus, this expansion to include all victims of interpersonal and family violence moved the CVC into a new phase by creating the first Family Advocacy Centre. The VIP treats the effects of all types of abuse while also emphasizing community-based prevention to end the cycle of family violence. To fulfil its mission of "intervening to protect and treat all victims of violence" the program continues to rely on private funds to support direct services such as housing, transportation, English as a Second Language classes, mentoring and tutoring. The VIP offers a complete medical assessment for every child within 24 hours of him/her entering the care of Child Protective Services and has expanded its services aimed at children in the foster care system and ensuring their safe return to their own neighbourhoods and schools.[15] The following programmes are provided by VIP:

- Everychild Foundation Center for the Vulnerable Child
- VIP Community Mental Health Center Inc
    - Mentoring and Tutoring

- Suspected Child Abuse and Neglect Sexual Assault Center
    - Forensic Medical Clinic
- Community Based Assessment and Treatment Center
    - Primary Care for Children in Foster Care
- Adult Protection Team
    - Elder Abuse Forensic Center
- Sexual Assault Center
- 24 Hour Domestic Violence Response Team
- Los Angeles County Elder Abuse Forensic Center

Rady's Children Hospital and Chadwick Centres for Children and Families - San Diego California U.S.A. "Protecting Children... Building Strong Families"

One of the largest centres of its kind, the CAC is based within the Children's Hospital site and is committed to family-centred care and a multidisciplinary approach to child abuse and family violence. Family Support Services are used to help families experiencing overwhelming stress to enhance functioning and prevent and reduce adverse child outcomes, services include

- Intensive in home support
- Health and developmental assessment
- Case management
- Parent education and family groups
- Linkage to health, mental health and community resources
- Trauma Assessment and Counselling Services

The Chadwick Center has also provided professional education services for 25 years at the core and advanced level to professionals and para-professionals, including hosting the San Diego International Conference on Child and Family Maltreatment (annually since 1986), a Clinical Training Program, Summer Seminars and Customised Training.

The Chadwick Center is involved in the National Call to Action: A Movement to End Child Abuse and Neglect. A collaboration of organisations throughout the US have developed a 20 year National Action Plan to reduce child abuse and neglect by preventing maltreatment and protecting children by improving effective service interventions. The Center also established in 2002 a Child Maltreatment Research centre which conducts research on the prevention, diagnosis and treatment of child maltreatment.[16]

The Nobody's Children Foundation, Poland.
"Towards a better system to help abused children"

The Nobody's Children Foundation is a nonprofit non-governmental organisation in Poland that was established in 1991 when Medecins du Monde (Doctors of the World) interested a group of local professionals – physicians, educators and psychologists – in confronting the problem of child abuse. The Foundation formulated its main goal as developing an efficient aid system for abused children, a system that would integrate activities of state institutions, local authorities and non-governmental organisations working for the benefit of children. The Foundation has two main aims:

- "to enhance social sensitivity to the problem of child abuse, with a special emphasis on professionals working with children, who potentially form the first link of the intervention chain and
- to improve the competence of professionals working with children in diagnosis and intervention in cases of child abuse."[17]

Services include specialist service delivery at the Child and Family Centre (Child Advocacy Centre model) in Warsaw and the Pociecha Help Centre for Children and Families therapy centre. Other programs include supporting nine Polish cities in developing local programs of assistance to abused

children; the Abused Child Film Library of educational films; leadership in a consultation program for Central and Eastern Europe (CEE), inspiring and supporting CEE-based teams in designing or implementing assistance projects for abused children and their families; organising international conferences; national media campaigns "Childhood without Violence" "Bad Touch" and "Child in the Web" and significantly the "Child under the Umbrella of Law" program, aimed at improving the situation of children who participate in legal procedures which resulted in innovative legislative reform in cases involving children.

In 2004 the Foundation was awarded the inaugural Multidisciplinary Team Award by the International Society for Prevention of Child Abuse and Neglect (ISPCAN).

2. LEADERSHIP and VISION

Cindy Blackstock, Executive Director
Caring for First Nations Children Society (FNCFCS) Canada
"Building Helping Communities"

During my visit to Toronto I had the pleasure of meeting with Cindy Blackstock, a member of the Gitksan Nation who has worked in the field of child and family services for over 18 years. She was a social worker with the provincial government and worked for a First Nations child and family service agency before assuming her current role in 1998. The FNFCS is a national organisation which seeks to promote and support the work of First Nations child and family service agencies and regional organisations in Canada by providing research, professional development and networking services. A key project of the FNCFCS is the First Nations Research Site which disseminates research information to First Nations service agencies and is currently coordinating three national research projects designed to benefit First Nations communities.

Cindy spoke of the Reconciliation: Looking Back; Reaching Forward event held in Niagara Falls, Canada in October 2005 which drew together child welfare leaders and resulted in forming a concept of reconciliation in child welfare. The concept is comprised of four phases and engages both Indigenous and non-Indigenous people in a process of Truth Telling (listening and sharing about the past), Acknowledging (affirming and learning from the past), Restoring (addressing the problems of the past and embracing new possibilities) and Relating (Indigenous people are in the best positions to make decisions and move forward on a new path). Participants identified key values to guide these four phases of reconciliation those including Self-determination; Culture and language; Holistic approach; Structural interventions and Non discrimination.[18] Child welfare reconciliation with First Nations people stems from the belief that child welfare systems can, and must, do better for Indigenous children, youth, and families. First Nations people have reclaimed the responsibility for ensuring the safety and well being of First Nations children, young people and families and the Touchstones of Hope outline a positive way forward, a framework and invitation to all working in the child welfare sector to join First Nations people in making a difference whether that be in research, evaluation, service provision or in partnerships between agencies, governments, and academic institutions.

Save the Children, Sweden
"Our vision is a world in which all children's rights are fulfilled"

Save the Children Sweden is a politically and religiously unaffiliated non-government organisation. Every two years, 85 000 members elect a board who decide on the aims and direction of the organisation. In meeting with Asa Landberg, Psychologist with Save the Children in Stockholm I learnt not only of the direct care services provided to children and families but how these link to the Save the Children's key recommendations in response to the UN Secretary General's Study on Violence against Children 2006. Save the Children calls upon all governments to urgently commit to end all forms of violence against children and to build national child protection systems that include the elimination of violence as a priority goal.

Six key recommendations

1. States should as a matter of urgency, explicitly prohibit all forms of violence against children, including sexual abuse and exploitation; corporal punishment and all others forms of degrading punishment, in all settings, including the home.
2. States should develop a national child protection system and allocate sufficient funds to undertake a wide range of measures to prevent (and respond to) all forms of violence against children, including educational and media campaigns, the provision of child-friendly legal, medical and psychosocial services, and disaggregated data collection capable of monitoring the prevalence of violence against children.
3. States should: establish mechanisms for listening to girls and boys with the aim of involving children directly in the design and implementation of policies (and programmes) that address the violence against them. Children's own actions to address violence should also be supported.
4. States should: do their utmost to minimize the number of children coming into conflict with the law. They should establish comprehensive and child-friendly juvenile justice systems, complying with international standards, which aim to rehabilitate children and divert them away from criminalisation and detention.
5. States should: make particular efforts to promote the active participation of boys and men in ending gender discrimination and violence against children.
6. States should: support the appointment of a Special Representative of the UN Secretary General of the Elimination of Violence against Children, with the mandate and resources required to provide leadership and oversight on this issue.[19]

Save the Children Sweden have a history of developing services where gaps exist and supporting these until they become mainstream services with permanent funding. Examples have included services for boys, counselling re internet abuse and for children who are living in war or conflict zones. Of the key recommendations Numbers 2 and 3 are particularly relevant to developing or changing child protection services, services should be comprehensive, well-funded and involve children in their design and implementation.

Victor Vieth
Director American Prosecutors Research Institute (APRI)
and National Child Protection Training Center (NCPTC)

Victor Vieth received his Doctorate of Jurisprudence from Hamline University School of Law. From 1988-1997, he worked as a prosecutor in rural Minnesota where he gained national recognition for his work on addressing child abuse in small communities. In 1997, he became a senior attorney with the American Prosecutors Research Institute's National Center for Prosecution of Child Abuse and, two years later, was appointed director of that program. In 2003, APRI appointed him as director of the National Child Protection Training Center at Winona State University. Today, he oversees both of these national centres and has authored numerous articles on the subject of child abuse and domestic violence. Victor strongly argues that all professionals who deal with child abuse cases including Judges, Attorneys, Police and Social Workers must be trained in working with children or forfeit the privilege of working with them.[20]

Victor has a vision to end child abuse in the United States within three generations. He has a plan and he sees the keepers of this plan as the universities that train front line professionals and, in turn, the front line professionals who serve children in need. Victor is driving the implementation of the plan with partners in the sector and points out that as with many social epidemics, the changes are being driven from the bottom up. "the mobilization on the front lines means there is every reason to expect success."[21] How is this possible? Victor outlines the core components of a battle plan in his article *Unto the Third Generation: A Call to End Child Abuse in the United States within 120 Years (revised and expanded).*

"The first 40 years: 2001-2040

- Every suspected case of child abuse will be reported and every report will be of a high quality
- Every child reported into the system will be interviewed by someone who can competently interview a child about abuse and the investigation of all child abuse allegations will likewise be competently done
- Every substantiated case of egregious abuse must be prosecuted by a child abuse prosecutor skilled at handling these complex cases
- Every child protection worker will be competent to work with child abuse victims and their families from day one
- Every child protection social worker, police officer and prosecutor will be a community leader in preventing child abuse
- Every child protection worker and attorney will have access to ongoing training, technical assistance and publications to constantly refresh and improve their skills."[22]

The next 80 years (2040-2120): Victor sees will be the search for a "tipping point."[23] If all of the above are achieved and sustained, victims will be identified early, problems associated with abuse will be easier to address, prevention efforts will be built at the local level, the cycle of abuse will be broken and well trained and experienced professionals working with families will lead the community in child protection responses. At some point Victor believes the scales will tip, abuse will decline and future generations of professionals will complete this plan and see that it ends.

Victor draws inspiration from Martin Luther King Jr., Mahatma Ghandi and other historical figures who although they did not obtain world peace, in their unyielding efforts toward this end, achieved great things. In the words of Dr. King: "It may not come today or it may not come tomorrow, but it is well that it is within thine heart. It's well that you are trying."[24] Victor's vision is inspiring, he is resolute that it is possible, and is getting on with it, leading a program to develop accredited Forensic Interviewing training programs in each US state (Finding Words: Half a Nation by 2010) and developing partnerships with universities to train tomorrow's professionals (Inaugural program Winona University). We have little to lose and everything to gain by joining him.

In trying to identify key factors that have motivated agencies to work well together, stimulated community involvement, succeeded in securing resourcing from government, private and public sources, inevitably it came back to strong committed leaders who have worked with unshakeable passion and energy for many years in implementing services and improving them continually. I have the utmost admiration for the people mentioned above and many others whom I met on my travels. It is somewhat of an indictment on our society that positive developments in working with children comes down to the persistent advocacy of people who will not give up and who are often working seven days a week to secure the interest of others, to secure funds and to make changes.

3. TRAINING

Throughout my study tour it was evident that all agencies focused on the importance of continual training for professionals. Training packages were incremental from core to advanced levels and were delivered regularly, adequately resourced and sustainable.

The following are examples of robust training being offered by CACs or other agencies:

- Forensic Interviewing: Training of Specialist Interviewers (usually Masters Qualified Social Workers (US) or Social Workers /Detectives and Prosecutors (UK, US, Sweden) and Judges (Poland). Training at Basic and Advanced levels
- Multi-disciplinary Teams: Training in forensic interviewing for Doctors, Nurses, and Prosecutors to enhance their skills and understanding of child development, language, memory, questioning as relevant to their roles (CACs – US)
- Training of all frontline responders, Child Protection Service and Police in responding to child abuse cases (Metropolitan Police (MET) UK)

- Joint Investigation Training for Child Protection Service staff and Police – 1 week (MET UK)
- Training of all Detectives responsible for child abuse cases – 1 week (UK)
- MET Police (UK) have a fantastic facility available for Multi Agency Critical Incident Exercise Training and utilise this for multi agency child protection response training
- The National Children's Advocacy Center offers online training for child abuse professional 22 courses on topics such as investigations; collaboration, consistency and cultural competence; opening statements and closing arguments in child abuse cases; trial strategies; supporting victims and sibling abuse
- Peer Review of Interviews and Mentoring (CACs)
- University Course in child protection for social workers, police, lawyers, allied professionals at Winona University in Minnesota including field work placements for students within CACs
- Thesis reward program, encouraging students to research and study in child abuse topics (Poland)
- The Children's Advocacy Center of Manhattan provides a Medical Elective for students which is available year round for local or international students for a nominal fee (US $100). The elective is in Child Abuse – Identification and Treatment is full-time for 2 – 4 weeks.
- The Care and Evidence Training package funded by the Home Office, and developed by staff from King's College Hospital NHS Trust and the Metropolitan Police is available at www.careandevidnece.org. The website provides information and advice for professionals who may come into contact with victims of sexual assault, as well as two training videos and flow charts
- The Toronto Child Abuse Center (TCAC) provides training through the Making A Difference Program to approximately 5000 adults each year (e.g., child care staff, teachers, nurses, special needs services staff, child and youth workers, community college students, parent groups) to improve community responses to children who are vulnerable and at risk.
- TCAC School-based prevention programs are delivered to several hundred children annually through the I'm a Great Kid! and I'm a Great Little Kid! programs
- In My Shoes (UK) is a computer package that helps professionals communicate with children and learning disabled adults about their experiences, views, wishes and feelings, including potentially distressing experiences such as illness and abuse in home, educational and other settings. An interviewer sits alongside the child and assists, guides and interacts with them through a structured interview process.[25]

Examples

First Witness Child Abuse Resource Center, International Training Center Duluth Minnesota U.S.A.
Advanced Forensic Interview Training: builds on the skills taught in the basic Forensic Interview Training with a focus on reviewing research updates, participant videotapes, and courtroom strategy from both prosecution and defence perspectives. The goal of the training is to enhance participant interview skills, identify strengths and weaknesses and increase the effectiveness of child abuse investigations.

CornerHouse Interagency Child Abuse Evaluation and Training Center Minneapolis Minnesota U.S.A.
This centre has a dedicated training suite located at the CAC with separate entrance for training participants. They offer training in a number of areas including, Forensic Interviewing, Advanced Forensic Interviewing and Mandated Reporter Training. The Training packages may be adapted to the specific request of agencies on topics such as: Trauma and memory, Child witness interviews, Physical abuse interviews, Effective use of interview aids, Managing complex issues, Sexual exploitation, Assessing interviewing skills, Cultural and communicative competence, Suggestibility, Vicarious trauma, Corroboration and Court testimony. All training is provided by experienced practitioners who also maintain their skills in interviewing children by continuing to interview regularly.

4. INTERVIEW MODELS and LEGISLATIVE REFORM

- Sweden and Poland have the most innovative and child focused interview and legal procedures. In each country the child who is victim or complainant in a criminal proceeding does not need to attend court at all. The recorded forensic interview process involves all parties of prosecution and defence (and in Poland the Judiciary) and is the complete record of evidence from child which is then played in the child's absence at court
- In Poland in 2004 it was legislated that Judges will participate in the interviews of children at the time of allegation/investigation. Interviews are observed by a Defence lawyer representative, a Prosecutor and a Child Lawyer. All parties may ask questions of the child (through the ear piece to the Judge, who then vetos or asks questions). The recorded interview is then played in court
- An Extended Forensic Evaluation model has been developed in the U.S. This development recognises the pressure placed on children to tell their story within one forensic interview. This may not be in the best interests of those who have trouble disclosing, where abuse is accidentally discovered, or where family support is lacking. The model has been accepted by prosecutors and MDT members and "appears to be a valuable option for children who do not disclose during the initial interview."[26]
- Most places I visited provide forensic interviews for children witnessing Domestic Violence, Homicide and other Violent Crimes
- Many Jurisdictions have Specialist Prosecution teams with prosecutors trained and experienced in child abuse cases, some had specialised Courts and Judicial Officers. This ensures an increased level of training and experience in communicating with children and in prosecution of crimes against children
- Bi-lingual Interviewers were available in many CACs and the interviews recorded in either English or the Child's preferred language. The interviewer would brief the MDT viewing the interview on the child's story (if the team were not bi-lingual) and the responsibility was on the agencies to transcribe the interview in the child's language and then into English
- Many Forensic Interviewers now routinely ask open ended questions of the child re force used by perpetrators, computers in the home, exposure to sexually explicit material (DVDs, photographs) and videoing or photographs being taken during the abuse. These inclusions have occurred to assist the introduction of the recorded interviews in court under the US legal provisions (specifically force or threats). It has also been found that whilst children do not routinely mention video/cameras this does occur in a significant number of cases.

5. FACILITIES

By definition all CACs are required to provide child friendly environments and facilities. The creativity used by CACs was delightful, from restored and re-furbished buildings to rooms within hospitals, and even the mobile centre, each have adapted the location to become welcoming and relaxing for children and families. Two examples are provided here as they will be useful for communities who have the opportunity to build and design their facilities:

Violence Intervention Program

This service has for 20 years existed in trailers located on the hospital site and in adjacent buildings renovated to provide suitable environments. In 2008 a purpose built suite (14 000 square feet) within the Hospital will open to house the acute response services of the VIP. Given the history, size and experience of this service and of Dr Heger in particular this facility will be well worth visiting for those communities interested in designing a hospital based facility for victims of violence of all ages.

The Childhelp Children's Center of Arizona

The centre, which opened in 1998 is a purpose built state-of-the-art facility (22 00 square feet) which stands alone (not attached to hospital or other major service) and houses more than 60 full-time professionals in the areas of law enforcement, child protective services, medicine, mental

health, and prosecution-all of whom work together as a comprehensive, multi-disciplinary team. The benefits of design, space, planning, colour and creativity where evident at this centre.

Childhelp Children's Center Play room

Childhelp Children's Center Medical Room

6. TRANSFERENCE OF THE CAC MODEL TO OTHER VICTIM SERVICES

As seen within the growth of the Violence Intervention Program the success and benefits of drawing together professionals to respond to issues of child abuse can provide experience and learning for agencies collaborating to provide adult sexual assault, elder abuse and family violence victim services.

Another example of an advocacy model with centralised services can be seen in the San Diego Family Justice Center 'Where Families Come First and Professionals Come Together". Whilst I did

not visit this centre I learnt of this service whilst at the San Diego International Conference on Child and Family Maltreatment and the size and strength of the service is testimony to its importance and effectiveness in the community since its establishment in 2002.

The Family Justice Center houses the San Diego Police Department's entire domestic violence unit, the city attorney's domestic violence unit, and staff from about 20 other community nonprofit domestic violence and sexual assault agencies and county agencies. Victims of domestic violence come to one location to talk to an advocate, get a restraining order, plan for their safety, talk to a police officer, meet with a prosecutor, receive medical assistance, counsel with a chaplain, get help with transportation, and obtain nutrition and pregnancy-services counseling. Today, the centre averages more than 500 clients and 3,000 phone calls per month. Other services include advocacy, childcare, clothing, counseling, court support, dental assistance, emergency housing, and food, forensic documentation of injuries, housing of pets, internet access, locksmith services and support for military families.[27]

7. TEAM DEVELOPMENT AND COOPERATION

Co-location within a CAC does not guarantee good multidisciplinary team work. Some partners may not be able to co-locate together and even if they do, MDT work requires energy and openness to work in a different way with the children and families needs the priority for all. CACs need to build healthy teams, develop a sense of community and sustain team cooperation at the board, team and staff levels.

Indicators of a Healthy Multidisciplinary Team

Jodi Lashley, (currently at CornerHouse in Minnesota) when working at the Children's Advocacy Center of Georgia undertook a project to examine MDTs and how they functioned. The Multidisciplinary Review Team and Facilitator Project in 2002 included site visits to 15 MDTs across that state and the themes for healthy team functioning form the basis for an article and Multidisciplinary Review Team and Facilitator handbook. In her project Jodi found that "communities invested in the team approach to handling child abuse cases know that supporting a healthy, functional, multidisciplinary team is not easy task. Soliciting and maintaining the participation of diverse disciplines is an intricate process requiring dedication and hard work."[28] Jodi found that indicators of a healthy team include;

- Clear purpose
- County child abuse protocols
- Identified meeting facilitator
- Consistent and total representation
- Accountability for the team
- Accountability for team members
- Knowing Roles/Knowing the "why"
- Orientation
- Trust respect and commitment
- Willingness to acknowledge weaknesses and mistakes
- Strategies for dealing with conflict
- Supervisor support
- Burnout prevention
- Celebration
- Evaluation
- Extended MDT concept

"MDTs can accomplish great feats on behalf of abused children when members have foresight and investment."[29] The Manual is available on the Georgia CAC website.

First Witness Child Abuse Resource Center, Duluth Minnesota U.S.A. "Making our community a safe place for children to grow and thrive"

First Witness is a small non-profit agency that has clear roles and responsibilities across a MDT with an overriding commitment that everyone will do whatever it takes to make the day or their service response work. They have undertaken retreats (all fifteen agencies involved) to assess their effectiveness as a team. First Witness has worked determinedly and with purpose on building their team in their community. The have developed a clear vision and their team philosophy details how they will work together. First Witness also stands out as the only CAC in the US that has the Public

Defenders Office as part of the team, they have been involved since the inception of the centre in all things from training, interviewing, case reviews and community outreach. The following are examples of a Mission Statement and Philosophy developed by the First Witness team:

First Witness Mission Statement

To strengthen our community's response to child abuse. We investigate, assess, and educate using a multidisciplinary team approach. We are making our community a safe place for children to grow and thrive.

Team Philosophy

The philosophy of the First Witness Multidisciplinary Team is to conduct child friendly, reliable investigations of reported child abuse. These investigations will be carried out in a spirit of cooperation and collaboration that will enhance services to the child and his or her family, ensure accurate information gathering, and meet the needs of each respective agency in carrying out their mandates. In the spirit of the Multidisciplinary Team approach which puts the child first, allows for the competence of the child and coordinates efforts, the Multidisciplinary Team has agreed to the following principles:

- Confidentiality; respecting the confidentiality of the families and the team members
- Honesty; being able to give honest, open opinions
- Safety; supporting team members and having trust in their personal and professional integrity
- Value of one another; working from a strength based orientation
- Shared leadership; no one agency runs the team
- Dialogue; practices can be discussed
- Respect; meeting professional needs and respect of each members professional knowledge.[30]

8. INDIGENOUS CHILDREN

A paper by the Native American Children's Alliance discusses the strengths of the CAC model and its application within American Indian communities. It concludes "There are model tribal programs already in existence and many programs that are in the developmental stages. As tribal communities decide how to develop an appropriate response to child abuse, the CAC model offers an excellent approach for communities to consider."[31]

In discussing the development of CACs in Indian Country the article emphasises that the design of the CAC program should be determined by the community's needs including "community ownership and commitment to the CAC; sensitivity to culture and tradition; and the need to provide services to a vast geographic area". The authors recommend that successful local programming must be based both on the community's specific needs as well as the culture's specific needs. This includes identifying specific characteristics related to different levels of problem awareness and readiness for change. Bubar (et al) states "an assessment of community readiness is imperative to ensure success of any child abuse programming in tribal communities. It is the tribal community that has primary responsibility for the development of the CAC and it will be the tribal community that will determine the success of a CAC. A commitment to developing a coordinated response of all agencies involved in child sexual abuse cases is essential. It is also important that all agencies of the community involved in the investigation and prosecution of child sexual and severe physical abuse cases be involved in the development of the CAC."[32]

The authors discuss the need for culturally appropriate practices within a CAC model including qualified interviewers who are culturally sensitive with knowledge and experience in language, tradition, and social structure. In addition the involvement of the variety of leaders in a community including elected leaders, traditional leaders, spiritual leaders, and religious leaders is important. For example, spiritual or religious leaders may form part of a treatment "team" which

provides services to child victims. This recommendation is consistent with the philosophy of the Canadian Touchstones of Hope mentioned previously and the 'Child and Family Service Act'[33] which recognises that "Indian and native people should be entitled to provide, wherever possible, their own child and family services and that all services should be provided in a manner that recognises their culture, heritage, traditions and extended family."[34]

In the US and Canada as in Australia there are challenges to providing services in communities that cover large areas. In geographically remote areas professionals and community members will have to develop creative strategies in using the CAC concept to fit their community's needs. For example the benefits of a CAC may be diminished by a child having to travel a long distance to reach the CAC. Other options include creating programs where the children and families use a location physically set-up to reflect community culture with local service providers; or with service providers coming from larger centres when required; or having a mobile van driven to communities when required; or using volunteers to drive the child to closest existing centres to obtain services. The paper by Bubar (et al) urges communities not to be discouraged because of resource concerns including lack of local services, funding resources and lack of available buildings or office space. It encourages communities to see that the heart of any CAC needs to be the commitment to a team approach and that developing a multidisciplinary team, to work on child sexual and severe physical abuse cases, can be the first step in securing a building or service growth.

During my travels I visited the Childhelp Mobile Advocacy Center in Arizona which services five American Indian reservations and the Family Advocacy Center in Bemidji both designed to provide services to Native American children and women in remote areas.

The Family Advocacy Center of Northern Minnesota

This service opened one year ago as a result of the collaboration of the Red Lake Band of Chippewa and non-Indian governments and private entities. The centre serves all citizens of northern Minnesota, including residents of the Red Lake, Leech Lake and White Earth nations. The centre is located at North Country Regional Hospital in Bemidji and is a hospital-based, culturally sensitive center providing specialised physical and mental health treatment to the victims of child abuse, domestic abuse and rape. It also provides forensic interviews of victims, witnesses and non-offending family members, as well as mental health assessments and treatment for victims and their family members.

The centre allows abused children and others to be interviewed in a welcoming environment closer to home. Previously, victims had to travel to the Twin Cities of St Paul or Minneapolis (5 hour drive south) to visit a CAC. The local Indian nations felt most comfortable with providing a service in the context of a medical facility that is routinely visited by families and made the decision to provide services to any victim of family violence, child abuse or sexual assault within the same centre.

The Childhelp Children's Mobile Advocacy Center of Northern Arizona

In partnership with Safe Child Center at Flagstaff Medical Center, the Childhelp Children's Mobile Advocacy Center of Northern Arizona provides a variety of services to abused children in rural and tribal communities. The first of its kind in Arizona, the mobile center offers one-stop multidisciplinary services at selected locations in Northeastern Arizona, reducing investigation time and trauma for abuse victims and their non-offending family members.

The mobile center is a thirty-eight foot specially outfitted motor home divided into three separate, sound proofed, air-conditioned rooms: a forensic interview room, observation/monitoring room and medical exam room, including state of the art telemedicine and recording equipment. In 2003 the cost of purchase and outfitting of the motor home was U.S. $250 000. The service is maintained

by a full-time coordinator who is responsible for the service co-ordination, vehicle maintenance, public relations and driving to locations. The coordinator is accompanied by forensic interviewers and medical staff from the Flagstaff Medical Center when requests from local communities are received. Local communities were involved in planning for the mobile center and the center visited each community to introduce the service prior to any referrals being taken. The CAC response includes planning for the confidentiality of those requiring the service, this has at times meant the van has driven to a community close to but not in the actual location/reservation of the child and at times the van has been hidden within local fire houses. When locating in a town or reservation the van requires a power source and facilities to use as a waiting area for families. Local schools have proven to be good locations.

A well equipped van could provide a variety of services by qualified professionals, not only forensic medical and interviewing. Child examinations, assessments, clinic services, vaccinations and even dental services could occur in such a facility. Consideration of the appropriateness of mobile facilities for rural areas in Australia is recommended.

9. PEER REVIEW/QUALITY ASSURANCE

Case review and peer review mechanisms designed within the CAC model provide quality assurance of the service provided to children and families. For example forensic interviewers are routinely observed as they interview children by MDT members who can provide feedback on their interviewing skills. Observation of interviews also assists in the orientation and training of new interviewers who can learn from experienced staff and who can also be monitored closely and mentored in their early days of interviewing.

The MDT case review processes provide quality assurance in reviewing case progress, decision making and practice. MDT team meetings have been held weekly at the Chadwick Center and Rady's Children's Hospital and Health Center since 1971. Each agency has signed and agreed to guidelines for the meetings including responsibility for chairing the meetings, attendance, legal protection of material discussed, preparation for meetings and decision making. The Objectives of these MDT meetings include

1. To provide a forum where individual cases of suspected child abuse and neglect may be discussed in a confidential, non-discoverable setting by professionals from community agencies that frequently have responsibility in these matters
2. To promote sharing of information on cases that meet criteria for inclusion to ensure that all participants have access to the same information
3. To provide information and clarification on medical or interview information in cases that have been evaluated through Children's Hospital
4. To encourage best practice in the evaluation and investigation of child abuse and best use of available community resources in intervention and prevention
5. To promote training of attendees both through the cross training that occurs during case discussion as well as by occasional formal presentations.[35]

The Rady's Children's Hospital and Health Center MDT have agreed that Case Review is Mandatory in the following cases:

- Severe physical abuse
- Death due to non-accidental trauma (including review of siblings of the deceased)
- Multiple victims or multiple perpetrator case
- Differing opinions on mechanism of injury
- Severe medical neglect that is life threatening
- Cases with numerous risk factors such as factitious disorder by proxy; minors under 12 months with non-accidental injuries

They have agreed that Case Review is Recommended in the following cases:

- Physical abuse with sexual abuse findings
- Severe or complicated sexual abuse
- Day care, pre-school, or foster care cases
- Juvenile perpetrators
- Physical or sexual abuse findings with little or no history
- Ingestions
- Failure to thrive
- burns

10. COMMUNITY INVOLVEMENT

Within the CAC model, connection to community and involvement of community members is a key factor, this may take the form of, but is not limited to

- Prevention and Awareness Campaigns funded or organised by the CAC within their local communities
- Volunteers – who undertake a variety of roles from fund raising, to helping in the CAC, donation of goods or as mentors and tutors
- Involvement in volunteer chapters, which hold regular meetings and organise local events to benefit programs
- Local communities or community leaders design their CACs
- CACs are easily accessible within communities, most have websites that also provide information and some CACs have published and provide to families useful resources booklets or materials
- In-kind donations of products and services by individuals and groups can include: Office supplies, Printing Services, Stamps, Paper products, New clothing, books, games and toys, Tickets to movies, water parks, sporting events, Computer games, Non violent videos, Music, dance or craft lessons

Involving community members, and reaching out to community with events raises the profile of the CAC service and the issue of child abuse itself. Communities are aware of services available to them and how they can help others.

Examples

To guide you through the system. A handbook for parents of sexually abused children. Produced by the Safe Child Center At Flagstaff Medical Center: Information about sexual abuse, how parents sometimes feel, signs shown by abused children, supporting your child, the legal system, investigation, reactions of others, taking care of yourself, resources and reading list.

Parent Handbook – A guide to helping your child heal. Produced by the Chicago Child Advocacy Center may be downloaded from the CCAC website and provides information to parents about: What they may be feeling, what they should know myths and facts, Working together, The day of the interview, Medical support, About the Investigation, How to help the investigation, How to help your child, Finding out about abuse, Your Rights, Legal Terms, contacts and services.[36]

11. PROFESSIONAL SUPPORT AND DEVELOPMENT

National Children's Advocacy Center
The Research Department conducts applied research on programs, practices, and policies that impact professional training and family services for prevention, intervention and treatment of child abuse. The NCAC seeks to model and promote excellence in child abuse response and prevention with program evaluations and original research projects that examine the impact of child maltreatment on family and community systems and on individual child and adolescent development. NCAC conducts several research projects as members of the National Evaluation of Child Advocacy Centers (NECAC) and National Child Traumatic Stress Network (NCTSN), including applied research on models of intervention with children, perpetrators and non-offending caregivers and on forensically sensitive models of therapy for children.[37]

Information about NCAC Research Services including Program Evaluation, Research Design and Data Analysis and Information Services can be found on the website along with information about Research staff, Current projects, Research partners, Internships, and the Research Library.

California Evidence-Based Clearinghouse for Child Welfare
The California Evidence-Based Clearinghouse for Child Welfare (CEBC) website is designed to:

1. Serve as an online connection for child welfare professionals, staff of public and private organisations, academic institutions, and others who are committed to serving children and families.
2. Provide up-to-date information on evidence-based child welfare practices.
3. Facilitate the utilisation of evidence-based practices as a method of achieving improved outcomes of safety, permanency and well-being for children and families involved in the California public child welfare system.[38]

American Prosecutors Research Institute (APRI). The National Child Protection Training Center (NCPTC) and Winona State University (WSU)

The mission of APRI is to be an interdisciplinary resource centre for research and development, technical assistance, training and publications reflecting the highest standards and cutting-edge practices of the prosecutorial profession. In 2003 the APRI entered into a relationship with Winona State University to develop the National Child Protection Training Center it provides technical assistance, training and publications for Attorneys and professionals employed in the field with its primary focus on the civil side of child protection. NCPTC runs national conferences on child abuse, interviewing children and advocacy for trial attorneys and publishs a free monthly newsletter on child protection issues. APRI has also produced a book: 'Investigation and Prosecution of Child Abuse'[39], which advocates for building a coordinated system and response for children who have been harmed.

These agencies have designed a model university curriculum that will better prepare the child protection professionals of tomorrow. The curriculum is entitled *Child Advocacy Studies (CAST)* and consists of three interdisciplinary courses. Beginning in 2008, NCPTC and WSU will assist other public and private universities in adopting this model. The goal is to have the curriculum in place in 100 universities by 2013 and 500 universities by 2018. To learn more about the curriculum, and to receive updates on the development of CAST see the website.[40]

Many of the U.S. agencies I visited have embraced the use of technology to provide training and professional development opportunities to colleagues in remote areas. The equipment for viewing recorded interviews in CACs has been expanded to include remote links to other agencies so that recordings of interviews or physical examinations can be reviewed by specialists in major centres

and interviewers and practitioners are able to consult on cases or receive peer review of their work. Again the investment in and use of technology could greatly improve the access to review, training and professional development opportunities for people in remote parts of Western Australia.

There are many different professional networks across the U.S. and Europe that provide training, on line courses, conferences, newsletters and professional development for individuals and teams. Whilst we do not have the comparative professional population to suggest that a similar level of provision is possible in Australia, the lack of regular professional opportunities for staff working in the area of child protection in Western Australia is intolerable. Government funding needs to accommodate the development of and sustainability of professional networks and training opportunities locally and the participation of professionals in conferences and programs in the Eastern States and Internationally. Geographical isolation is a poor excuse for not attending to the development of professionals in this crucial area of work in our community. The last conference focused on Child Abuse and Neglect held in Perth was in 1999.[41]

Working Group for Cooperation on Children at Risk (WGCC)

The Working Group for Cooperation on Children at Risk was established in 2001 by the Council of the Baltic Sea States (CBSS) officials responsible for Children's Issues. The CBSS has eleven participating countries: Denmark, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, Russia and Sweden. The WGCC is tasked with identifying, supporting and implementing cooperation on children at risk with the states and partner organisations in the region. The WGCC has set five priorities for its work: child sexual exploitation; separated and trafficked children in the region; children in institutions; children in the street; and children that commit crimes and lead a self-destructive life. Latvia is presently chairing the WGCC which as of March 2002 was integrated into the Children's Unit of the Secretariat of the Council of the Baltic Sea States, located in Stockholm.

The Children's Unit organises expert meetings, seminars and other activities within the prioritised areas. The Children's Unit promotes collaboration and contacts, enhancing the sharing of expertise between professionals working with issues related to children at risk both within the public sector and in the non government sector.

The Child Centre is part of the CBSS and serves as a web-based focal point for information and contact between professionals and officials on research, seminars and ongoing projects concerning children at risk in the Baltic Sea region. Its objectives are to increase awareness and knowledge of services and methods to prevent and protect children from violence and abuse and to increase expertise in how to rehabilitate children who have been exposed. Professionals in the region are provided with reliable and comprehensive access to information, publications, research and projects regarding children at risk.[42]

12. THE VOICES OF CHILDREN

I have read many books that speak of the experience of children who are abused and on a daily basis observe (and partake in) a system aiming to provide services to them which currently fails to do so in a child focused, consistent and comprehensive manner. Meeting the needs of these children is the single most important reason to improve services to them. Whilst prosecution of offenders is an important goal, and forensic interviews or medical examinations for this purpose may assist, services need to be designed with the children and young people in mind and become all-inclusive in meeting goals focused on the child's well being in the immediate and long term.

Paul Sheenan in his 2006 book *Girls Like You* outlines the true story of four young girls who are sexually assaulted in Sydney and gives a confronting insight into the failings of the court system to provide justice and to protect children from further harm. "One percent. This statistic dominates

the moral landscape of sexual crimes in Australia. Only about one percent of those who have been sexually assaulted ever see their assailants sent to prison. Only an estimated fifteen per cent of sexual or indecent assaults are reported to police. In the great majority of these cases no charges are ever laid. Every rape victim depicted in the book said she would never again look to the courts for justice should anything similar happen to them again." [43]

We can not rely on police involvement and prosecution to provide closure or resolution for victims. Children and their families need to know where they can turn to for help when they are harmed and they need assistance. They should be provided with an immediate response that caters for all of their needs, emotional support, physical treatment, psychological help, practical services, police intervention, protective assessment, whatever is required. To consider all of the needs of the child is to provide a holistic response. To provide this across agencies in a way that is seamless and does not let people fall through the cracks is the challenge for us as service providers, and should not be the challenge for children and families as service seekers.

In the book *The Truth is Longer Than a Lie* Mudlay and Goddard (2006) capture the voices of children as they comment on services provided to them and their experience of the "system." According to one 12 year old girl, some professionals are just not helpful "The problem with Miss…….. was she didn't want to believe the truth…. They don't want to hear the truth because the truth is so much harder to understand and so much longer than a lie about the truth."[44] Other comments by the children include: feeling abandoned by a system that is frenzied in the early days of disclosure, interview and action, but then does not check up on them; we create helplessness by not involving children in decision making processes about themselves; it is important to children that we show compassion; and that little things like a happy or colourful room to talk in can make a big difference. Children have a lot to teach us about how to provide services to them.

Let's take on the challenge of the United Nations Conventions on the Rights Of the Child and involve children and young people in the planning of services to meet their needs. Article 3.1 states "In all action concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" and Article 12 states "children too have the right to say what they think about anything which affects them. What they say must be listened to carefully."[45]

CONCLUSION

I have worked in the area of child protection for the past twenty years and have also read widely about service models, evaluations and research with children who have been harmed. The Churchill Fellowship enabled me to visit and observe services in action and to meet with leaders in the field who have written articles, developed new techniques and improved services. This was a great honour and an amazing learning opportunity. In assessing specific strategies for cohesive service provision and success in whole of government/agency responses in Australia I strongly recommend the Child Advocacy Centre model as it provides

- child focused services
- a tested multidisciplinary team model
- timely responses
- information sharing and planned joint responses
- comprehensive assessments and service provision and
- case review and tracking, with children being less likely to fall through service gaps.

A key strength of the CAC model is that it is not confined to government service provision. Community involvement, fundraising, benevolent donations and foundations provide creativity in how funds, goods and services in kind can be gathered and applied. This was evident in centres that have amazing art work that is colourful and welcoming for children; media campaigns; websites with web pages for children with games and information; and mentors and tutors who

commit to supporting a child for a few years at a time. Children receive clear messages from CACs that the community is caring for them.

Thinking outside the silos of government funding and allowing blending of core services with community involvement will strengthen services to children in Australia. As Farrow recommends "…the heart of an improved system must be a community partnership for child protection. This is a confederation of parents, other members of the family and community, public and private agencies that over time assumes a far-reaching role in the design and implementation of a service delivery system that protects children."[46] The twenty year history of communities developing CACs around the world provides a wealth of knowledge to us in Australia. Community ownership and commitment to CACs includes sensitivity to culture, tradition and local needs. We can develop CACs focused on child protection or CACs focused on the well-being of any child who is harmed, traumatised, witness to family violence or violent crime, these decisions are for the community that the CAC is to serve. CACs are a tangible service built within a community, informed by the needs of the community who are responsible for ensuring the safety and well being of children.

Dorothy Scott advocates for innovation in the child protection sector, particularly innovations that "have been shown to be effective."[47] Anecdotal evidence and recent evaluations have affirmed the CAC service model as cost effective, child focused and improving outcomes for children. Let us learn from the innovation of CACs elsewhere and modify, develop and nurture CACs in our own communities. Let us then evaluate our CACs and disseminate the information to other communities in Australia and internationally.

Establishing CACs in Australia and developing standards for CACs across the nation will potentially lead to:

- less stress for children and families requiring services
- improved coordination, information sharing, planning and decision making
- improved protection of children
- improved assessment and collection of evidence
- improved prosecution of offenders
- increased expertise in multi-sectoral responses
- increased satisfaction for children and families in the response to their needs
- increased community awareness about accessible services and
- improved quality assurance, case tracking and accountability of service providers.

I was awarded the 40th Anniversary Fellowship in WA for a project of concern to children and young people, I thank the Churchill Trust for sending such a positive message to our community by supporting a project dedicated to improving services to our most vulnerable children. I am committed to inspiring, influencing and implementing change in service delivery for children who have been harmed and developing a vision to end child abuse in Australia and will involve children, the community and colleagues in doing so. As Longfellow wisely stated "All your strength is in union. All your danger is in discord." [48]

RECOMMENDATIONS

1. The Child Advocacy Centre model of integrated service provision across agencies be established in Australia. Local communities are to be encouraged to take ownership and leadership of the design and service provision of each centre in order to meet the needs of local children of all backgrounds and circumstances. Purpose built buildings or co-location of all stakeholders is not essential (although optimal) however absolute multi-agency commitment and collaboration are vital. Let us plan CACs that provide a multi agency response, comprehensive assessment of a child's situation and quality services.
2. Child Advocacy Centres become the visible service within communities for vulnerable children. Funding for service delivery should be sufficient to undertake a wide range of

measures to prevent and respond to all forms of violence and abuse against children, including educational and media campaigns, the provision of child-friendly legal, medical and psychosocial services, and data collection capable of monitoring the prevalence of violence against children.

3. Children and young people are to be involved in the design and implementation of CACs and other strategies to address the violence against them.
4. Indigenous communities are to be involved in planning and developing CAC services, based on community readiness and with consistent support from government particularly in rural and remote areas.
5. Mobile facilities be considered as an excellent alternative for service provision in rural areas. Collaboration across agencies such as Health, Education, Protection and Police could increase the viability of such facilities. A well equipped van could provide a variety of services by qualified professionals, forensic medical and interviewing, health examinations, assessments, clinic services, vaccinations, dental or education services. A mobile facility in rural areas may achieve many purposes and become a welcome visitor to communities throughout the country.
6. Development of a National forum to develop and nurture Child Advocacy Centres across Australia providing technical assistance and support, application of standards, best practice and continual improvement in service provision to children and young people.
7. Share the success of the Child Advocacy Centre model with other sectors and service providers such as Domestic Violence programs and the Office of the Public Advocate. In some communities combined services may be beneficial or preferred.
8. Provision of quality training to professionals in the area of child abuse and maltreatment across all sectors and services, from interviewing expertise, investigations and prosecution to therapeutic interventions, including improved links to universities who are training future doctors, nurses, teachers, social workers, lawyers, psychologists and others who work with children.
9. Expand legislation and resource appropriately the visually recorded interviewing of children witnessing Domestic Violence, Homicide and other Violent Crimes.
10. Implement an Extended Forensic Evaluation model for those children who have trouble disclosing in one interview.
11. Develop Specialist Prosecution teams with prosecutors trained and experienced in child abuse cases, specialised Courts and Judicial Officers. This will improve the level of experience and commitment to communicating with children and prosecuting crimes against them.
12. Legislative reform to remove the need for children to attend court by involving Defence Lawyer representatives or Judicial officers in the recorded interviewing of children. The recorded interview becomes the child's complete evidence.
13. With other leaders across government and non government services and the community, develop a vision for ending child abuse and maltreatment in Australia.

APPENDIX

FULL PROGRAMME

14/1/07 – 21/1/07 NEVADA and CALIFORNIA

Nadine Carter
Claude I. Howard Children's Center
701K North Pecos, Las Vegas, Nevada http://www.co.clark.nv.us/family_services/home.htm

Dr Astrid Heger
Violence Intervention Program
and Everychild Foundation Center for the Vulnerable Child
1721 Griffin Avenue, Los Angeles, California http://www.violenceinterventionprogram.org

21/1/07 – 30/1/07 SAN DIEGO CALFORNIA

21st International Conference on Child and Family Maltreatment
Town and Country Convention Center. http://www.chadwickcenter.org/

Deborah Davies
Chadwick Center for Children and Families
3020 Children's Way San Diego California http://www.chadwickcenter.org/

Laine Alexandra and Cambria Rose
California Evidence Based Clearinghouse for Child Welfare
Chadwick Center for Children and Families http://www.cachildwelfareclearinghouse.org/

31/1/07 – 3/2/07 PHOENIX ARIZONA

Bill Copeland
Childhelp: Children's Center of Arizona
2346 N. Central Ave. Phoenix, Arizona http://www.childhelp.org/regional/arizona

Bob Gillette
Childhelp Children's Mobile Advocacy Center of Northern Arizona
http://www.childhelp.org/regional/arizona
Safe Child Center, Children's Health Center
1200 N. Beaver Street Flagstaff, Arizona http://www.fmcsafechild.com/

3/2/07 – 7/2/07 MINNESOTA

Jane Braun
Midwest Regional Children's Advocacy Center at Midwest Children's Resource Center and MidWest Regional National Children's Alliance
345 N Smith St Paul, Minnesota http://www.childrensmn.org/MRCAC/

Victor Vieth
American Prosecutors Research Institute and National Child Protection Training Center
Winona State University, Winona Minnesota http://www.ndaa-apri.org/apri/index.html

Mark Norman, Carole Madland, Jacqueline Hatlevig
Department of Sociology, Criminal Justice, Social Work and Nursing
Winona State University, Winona Minnesota http://www.winona.edu/

Anne Sand, Sherry Ellefson and Maime Rossbach
Family Advocacy Center of Northern Minnesota,
North Country Regional Hospital, Bemidji Minnesota

Patty Miller
First Witness Child Abuse Resource Center, International Training Center
4 West Fifth Street Duluth, Minnesota http://firstwitness.org/

Jodi Lashley
CornerHouse Interagency Child Abuse Evaluation and Training Center
2502 10th Avenue South Minneapolis http://www.cornerhousemn.org/

8/2/07 – 11/2/07 CHICAGO

Diane Siegel
Chicago Children's Advocacy Center
1240 S. Damen Avenue. Chicago, IL 60608 http://www.ChicagoCAC.org

Matt Stagner
Chapin Hall Center for Children at the University of Chicago
1313 East 60th Street Chicago, Illinois http://www.chapinhall.org.

Dr Bradley Stolbach
Joli Burrell Children's Advocacy Center, La Rabida Children's Hospital
East 65th Street at Lake Michigan Chicago Illinois http://www.larabida.org/

12/2/07 – 15/2/07 TORONTO

Karyn Kennedy and Pearl Rimer
Toronto Child Abuse Center
890 Yonge Street, 11th Floor, Toronto http://www.tcac.on.ca/default.asp

Kenn Richard
Native Child and Family Services of Toronto
295 College St Toronto, Ontario http://www.nativechild.org/

Cindy Blackstock
First Nations Child and Family Caring Society of Canada
75 Albert St., Suite #1001 Ottawa http://www.fncaringsociety.com/home.html

16/2/07 – 22/2/07 NEW YORK

Karel R. Amaranth
The J.E. and Z.B. Butler Child Advocacy Center
718-920-5833 3314 Steuben Avenue Bronx, New York http://www.montekids.org/programs/cpc/

Christine Crowther
The New York Center for Children
333 East 70th Street New York http://www.newyorkcentresforchildren.org

23/2/07 – 3/3/07 LONDON UK
Stanley Ruszczynski: Clinical Director
Portman Clinic – Clinical Team Meeting
Tavistock Centre 120 Belsize Lane London http://www.tavi-port.org/

Robin Watts, Jim Dunn, Mark Dagwell
Metropolitan Police
Specialist Crime Directorate Child Abuse Investigation Command
Partnership and Training Team
SCD5 Training Unit Cobalt Square Cyan Block 1 South Lambeth Road, London
http://www.met.police.uk/scd/specialist_units/child_abuse.htm

Dr Dayna Glaser
Parenting and Child Service
Department of Child and Adolescent Mental Health Great Ormond Street Hospital
Great Ormond Street, London
http://www.ich.ucl.ac.uk/gosh/clinicalservices/DCAMH/Homepage

Dr Jan Welch
Haven at King's College Hospital
Denmark Hill, London 020 3299 1599 http://www.thehavens.co.uk/

4/3/07 – 7/3/07 SWEDEN

Lars Loof
Children's Unit Council of Baltic Sea States
Strömsborg · P.O. Box 2010 · 103 11 Stockholm · Sweden
http://www.cbss.st/
Child Center for Children At Risk in the Baltic Sea Region
http://www.childcentre.info/

Bengt Söderström
The Vasa Clinic
Tideliusgatan 22 Stockholm

Lotta Lindgren
Barnahus Linkoping
US Hagadal Garnisonsvagen Linkoping www.linkoping.se/organisation/socforv/barnahus.htm

Asa Landberg
Save the Children
Landsvägen 39 Stockholm http://www.rb.se/eng/

8/3/07 – 11/3/07 WARSAW

Maria Keller-Hamela
Nobody's Children Foundation
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12/3/07 -14/3/07 HONG KONG

Senior Inspector Celia Kim-ying YIP and Ephraem TSUI Clinical Psychologist
Chief Inspector Queenie Siu-hing WONG,
Hong Kong Child Abuse Unit
12/F Arsenal House Police Headquarters
1 Arsenal Street, Wan Chai, Hong Kong

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