

**HOOD RIVER COUNTY
CHILD MULTI-DISCIPLINARY TEAM
PROTOCOL**

Summer 2025

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I. Overview

The purpose of the Child Abuse Multi-Disciplinary Team (MDT) is to ensure collaboration regarding the investigation of potential child abuse and neglect within Hood River County¹. The MDT will ensure that members and personnel conducting child abuse investigations and interviews receive ongoing training². MDT meetings are confidential³. Decisions regarding the MDT shall rest with the consensus of the participating heads of agencies or their representative, however the District Attorney reserves veto power. Law enforcement and prosecutorial decisions shall not be the responsibility of the MDT.

The MDT will consist of representative personnel from⁴:

- Hood River County District Attorney's Office;
- Oregon Department of Human Services;
- Hood River County Juvenile Department;
- Hood River County Public Health Department;
- Mid-Columbia Center for Living;
- Hood River County School District;
- Department of Justice;
- Hood River Community Corrections (Parole & Probation);
- Hood River County Sheriff's Office;
- Hood River City Police Department;
- Oregon State Police;
- Mid-Columbia Medical Center;
- Helping Hands;
- Children's Advocacy Center: SafeSpace; and
- Victim Advocacy Program.

It should be noted that this PROTOCOL was prepared to serve as a guideline, not to supersede professional discretion, agency policies, or established state/federal laws. Each agency's participation shall be consistent with its commitment to the interests of children within the context of the agency's statutory obligations and shall not conflict with ORS 418.747. These PROTOCOL are a living document which will be reviewed and revised by the team at a minimum every two years to ensure the best and most complete child abuse interventions possible.

¹ See ORS 418.747 to 418.796

² ORS 418.747(3): Each team member and the personnel conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, the dynamics of child abuse, child sexual abuse and rape of children, and forensic interviewing.

³ ORS 418.747(5): All information obtained by the team members and the department in the exercise of their duties is confidential and may be disclosed only when necessary to ensure the safe placement of a child.

⁴ ORS 418.747(1): The district attorney in each county shall be responsible for developing county child abuse multidisciplinary teams to consist of but not be limited to law enforcement personnel, Department of Human Services child protective service workers, school officials, local health department personnel, county mental health department personnel who have experience with children and family mental health issues, child abuse intervention center workers, if available, and juvenile department representatives, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation.

The District Attorney has designated:

MDT Chairperson: Danielle DeCant

The Chairperson oversees the MDT agenda and content of the meetings.

MDT Coordinator: Danielle DeCant, *interim*

MDT Coordinator provides notice of meetings, keeps data relevant from MDT meetings needed for the CAMI grant, provides notice to MDT members of MDT training opportunities and manages the CAMI grant application and reports.

Representative of DA's Office will be available for telephone consultation 24 hours a day to consult with LEA:

Name: Danielle DeCant

Phone Number: 661-300-1899

Each member of the MDT shall review the "What You Need to Know About Karly's Law" video and complete the online training prior to participating in the MDT meeting and annually thereafter.

Case Review Meeting Details

- Case review occurs every second and fourth Monday of each Month, excluding holidays, at 8:30am.
- Case review occurs at the Hood River Sheriff's Office unless otherwise noted. In person appearance is mandatory but virtual attendance may be allowed with prior approval by the MDT Chairperson or Coordinator.
- Cases are typically referred by ODHS; however, MDT members may refer other cases when concerns for child abuse are present by contacting the MDT Chair or Coordinator.
- MDT Coordinator will provide a list of cases for review with ample notice for MDT members to prepare for the case review.

II. Karly's Law

Each member of the MDT shall review the ["What You Need to Know About Karly's Law"](#) video and complete the online training prior to participating in the MDT meeting and annually thereafter.

Karly's Law lists the specific duties of a person conducting a child abuse investigation. Those duties are as follows:

If a person conducting a child abuse investigation under ORS 419B.020 **observes a child who as suffered a *suspicious injury* and the person is certain or has reasonable suspicion that the injury is or may be the result of abuse**, the person shall, in accordance with ORS 419B.023, and with the protocols and procedures of Hood River County MDT perform the following duties:

- 1) Immediately photograph or cause to have photographed the suspicious physical injuries in accordance with ORS 419B.028. Photographs of anal or genital region may be taken ONLY by medical personnel.
 - a. The person taking the photograph or causing the photographs taken shall, **within 48 hours or by the end of the next regular business day (whichever occurs later):**
 - i. Provide hard copies of prints of the photographs and, if available, copies of the photographs in an electronic format to Safe Space's DMPs:
 1. Glen Patrizio
 2. Robin Henson
 3. Lynn Frost
 - ii. Place hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format in any relevant files pertaining to the child maintained by LEA or ODHS.
- 2) LEA and ODHS shall take photos each time they observe a suspicious physical injury during the investigation of a new allegation of child abuse IF the injury was not previously observed by a person conducted a child abuse investigation AND regardless of whether the child has been previously photographed or assessed during an investigation of allegations of abuse.
- 3) Make reasonable efforts to ensure that Safe Space DMP conducts a medical assessment within 48 hours, or sooner if dictated by the child's medical needs.
- 4) If Safe Space DMP is not available, ensure the child is evaluated by a medical professional.
- 5) If the child is evaluated by someone other than Safe Space DMP, the evaluating physician, physician's assistant, or nurse practitioner shall make photographs, clinical notes, diagnostic and testing results and any other relevant materials available to Safe Space SMP for consultation **within 72 hours following the evaluation of the child.**
- 6) Any members of the MDT who is conducting a child abuse investigation, may require a health care provider to permit the inspection and copying of medical records, including but not limited to, prenatal and birth records of the child involved in the investigation without the consent of the child or the parent or guardian of the child⁵.
- 7) Nothing in this section prevents a person conducting a child abuse investigation from seeking immediate treatment from a hospital emergency room or other medical provider for a child who is physically injured or otherwise in need of immediate medical care.
- 8) Nothing in this section limited the rights provided to minors in ORS Chapter 109 or the ability of a minor to refuse to consent to the medical assessment described in this section.

⁵ See ORS 419B.050

The definition of suspicious physical injury includes, **but is not limited to**, the following:

- Burns or scalds
- Extensive bruising or abrasions on any part of the body
- Bruising, swelling, or abrasions on the head, neck, or face
- Fractures on any bone in a child under the age of three
- Multiple fractures in any child of any age
- Dislocations, soft tissue swelling, or moderate to severe cuts
- Loss of the ability to walk or move normally according to the child's developmental ability
- Unconsciousness or difficulty maintaining consciousness
- Multiple injuries of different types
- Injuries causing serious or protected disfigurement or loss or impairment of the function of any bodily organ
- **Any other injury** that threatens the physical well-being of the child

Medical Assessment

A DMP, or their designee, must conduct a medical assessment within 48 hours. However, if after reasonable effort, LEA or ODHS personnel are unable to get the child seen by the DMP or their designee, the child must be seen by an available medical professional

Should the child see anyone **other than** the DMP or their designee, the following requirements and timelines will apply:

- The medical professional shall make photographs, clinical notes, diagnostic and testing results and any other relevant materials available to the DMP within 72 hours following the evaluation of the child⁶.
- The medical professional may consult with and/or obtain records from the child's regular pediatrician or family physician⁷.
- The medical professional may, within 14 days, refer child five years of age or younger for a screening for early intervention services or early childhood special education. This referral may NOT indicate the child is subject to a child abuse investigation.

Early Intervention

If an investigation is being conducted regarding a child under the age of five who is already receiving Early Intervention or Head Start services, the MDT shall invite the person involved in the delivery of those services to participate in the MDT's review of the child's case⁸.

⁶ This disclosure is authorized by HIPPA which provides that covered entities may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse or neglect to the extent that the disclosure is required by law. See 45 CFR 164.512(c)(1).

⁷ See ORS 419B.050

⁸ See ORS 419B.023(6)

MDTs have the option of invited the Early Intervention or Head Start service provider to only those MDT meetings in which the provider is involved in the case, or they may include early intervention service provider in the MDT as a regular or permanent MDT member.

III. Multi-Disciplinary Team⁹

An MDT is a group of professionals from specific, distinct disciplines that collaborate from the point of report and throughout a child and family's involvement with the investigation and/or prosecution or a report of child abuse. MDTs coordinate investigations and service delivery to mitigate potential trauma to children and families, to maintain communication and transparency, to foster trust and to help optimize a quality response overall while preserving and respecting the rights of clients, and the mandates and obligations of each agency.

All MDT members as well as staff and volunteers of MDT member organizations, must adhere to the legal, ethical, and professional standard of practice in their field with regard to confidentiality, specific to their discipline, to include the Health Information Portability and Accountability Act (HIPAA) that govern this practice. Each MDT case review meeting includes a sign-in process in which a confidentiality statement is agreed to by all participants (ORS 192.690). To assure a coordinated response that fully addresses all systemic concerns surrounding child abuse, MDT members and guests may need to share confidential information about children and families. With this purpose in mind, MDT review will remain confidential and will only be disclosed when necessary to carry out the purposes of the child abuse investigation.”

The team will consist of representative personnel from:

- Hood River County District Attorney's Office (DA);
- Oregon Department of Human Services (ODHS);
- Law Enforcement Agencies (LEA):
 - i. Hood River County Sheriff's Office;
 - ii. Hood River City Police Department; and
 - iii. Oregon State Police;
- Hood River County Juvenile Department;
- Hood River County Public Health Department;
- Mid-Columbia Center for Living;
- Hood River County School District;
- Hood River County Educational Service District;
- Hood River Community Corrections (Parole & Probation);
- Department of Justice (DOJ)
- Mid-Columbia Medical Center;
- Helping Hands;
- Children's Advocacy Center: SafeSpace; and

⁹ See National Children's Alliance (NCA) Standard 1

- Victim Advocacy Program.

The active involvement and commitment of each agency's leaders and MDT members is critical to ensure the policies and procedures by which investigations are conducted and services provided are consistently followed.

The MDT has a written interagency agreement signed by authorized representatives of all MDT agencies as listed above that clearly commits the signed parties to its collaborative multidisciplinary response to reports of child abuse and the needs of children and families it serves. The interagency agreement is signed by all above listed disciplines.

Hood River MDT coordinates intervention to reduce potential trauma to children and families to improve services overall, while preserving and respecting the rights, mandates, and obligations of each agency.

All MDT representatives contribute their knowledge, experience, and expertise for a coordinated, comprehensive, compassionate, and professional response by the team. Quality assurance, including review of the effectiveness of the collaborative efforts, is also critical to the MDT response.

An MDT response fosters needed education, support, and treatment for children and families. Such a response can enhance a victim or survivor's ability and willingness to participate as a witness in criminal justice system. In addition, parents and caregivers are empowered to protect and support their children throughout the investigation, prosecution, and beyond. MDT interventions in a neutral, child-focused CAC setting are associated with less anxiety, fewer interviews, and appropriate, timely referrals to needed services.

An MDT Coordinator facilitates and coordinates the day-to-day information sharing and activities of the MDT.

All core members of the MDT, including appropriate CAC staff, are routinely and actively involved in investigations, case management, and/or MDT interventions throughout the life of the criminal case. The purpose of multidisciplinary involvement for all interventions is to ensure that the unique needs of children and families are assessed and addressed. Multidisciplinary involvement allows for informed decision-making to occur at all stages of the case, so that children and families benefit optimally for coordinated response.

Multidisciplinary intervention begins at initial disclosure or report and includes, but is not limited to, child protection and/or law enforcement response, forensic interviews, pre- and post-interview meetings, consultations, advocacy, and medical and mental health services.

MDT members participate in effective information sharing that is consistent with legal, ethical, and professional standards of practice and ensure the timely exchange of case information within the MDT. Regular and effective communications minimizes duplicative efforts, enhances

decision-making, and maximizes the opportunity for children and caretakers to receive the services they need.

MDT members meet twice at month to discuss past and present cases. Members sign an attendance form on entering the meeting that specifically states all information reviewed in the meeting is confidential, including about the child victim, child victim's family and alleged perpetrator, and others. All of this information is provided with the understanding that all MDT business is confidential. Each and every participant on the MDT agrees to not disclose any information provided at the MDT proceeding unless otherwise required or appropriate under the law or court order. Public meetings law does not apply to MDT meetings per ORS 192.610 to 192.690.

All MDT members as well as staff and volunteers of MDT member organizations, must adhere to the legal, ethical, and professional standard of practice in their field with regard to confidentiality, specific to their discipline, to include Health Information Portability and Accountability Act (HIPPA) that govern this practice. Each MDT case review meeting includes a sign-in process in which a confidentiality statement is agreed to by all participants. The statement reads:

“Confidentiality Statement: MDT meetings are confidential and not subject to public meetings laws per ORS 418.747 and ORS 192.690. To assure a coordinated response that fully addresses all systematic concerns surrounding child abuse, MDT members and guests may need to share confidential information about children and families. With this purpose in mind, I agree, in signing this attendance sheet and confidentiality statement that all information disclosed and received during the MDT review will remain confidential and will only be disclosed when necessary to carry out the purposes of the child abuse investigation.”

The CAC provides routine opportunities, both formal and informal, for MDT members to give feedback and suggestions regarding procedures or operations of Hood River MDT. The MDT utilizes the Outcome Measurement Survey tool (which is a survey tool designed by the National Children's Alliance and distributed to its member centers).

The MDT fosters opportunities for open communication to create an atmosphere of trust and respect to enable MDT members to share ideas and raise concerns.

Training Requirements:

The MDT Coordinator completes training that includes a minimum of 8 hours of instruction in team facilitation to ensure a fully inclusive and participatory process that will ultimately benefit the child. MDT Coordinator must also demonstrate participation in continued education in the field of child maltreatment and/or facilitation for a minimum of 8 contract hours every two years.

Examples of training topics could include:

1. Developing and maintaining relationships with and among MDT members
2. Defining roles and responsibilities of team members
3. Defining mission, vision, and values of the MDT
4. Managing change and turnover on the MDT
5. Navigating and resolving conflict
6. Knowledge of evidence-informed team development models
7. Facilitating shared decision-making
8. Ensuring adherence to MDT agreements and protocols
9. Understanding of the various meeting structures that support effective teams
10. Facilitating effective communication processes
11. Creating psychological safety
12. Training in implicit bias and how it impacts the MDT
13. Building resilience for the MDT

Each MDT member and the personnel conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, the dynamics of child abuse, child sexual abuse and rape of children, and forensic interviewing.

The MDT annually provides or facilitates relevant training or other educational opportunities focused on issues relevant to investigation, prosecution, and service provision for children and families. The MDT coordinator documents MDT member participation in annual professional development. Ongoing learning is critical to the successful operation of the MDT. The MDT identifies and/or provides relevant educational opportunities for MDT members that include topics to enhance the skills of MDT members, are cross-discipline in nature, and are MDT-focused.

IV. Diversity, Equity, and Access¹⁰

The MDT provides culturally responsive services for all CAC clients throughout the duration of the case.

Cultural responsiveness is defined as the capacity to function in more than one culture, and requires the ability to appreciate, understand, and interact with members of diverse populations within the local community. Cultural responsiveness is a fundamental component of the MDT and is as central to its operation as developmentally appropriate, child friendly practice. Like developmental considerations, cultural norms influence nearly every aspect of working with children and families, such as welcoming a child and family to the center, employing effective forensic interviewing techniques, assessing the likelihood of abuse, selecting appropriate mental health providers, and securing services that are relevant and accessible to a child and family. To effectively meet clients' needs, MDT partners must be willing and able to understand the clients' worldviews, adapt practices as needed, and offer assistance in a manner in which it can be utilized. Striving towards cultural competence is an important, and ongoing endeavor and an integral part of the MDT's functioning.

¹⁰ See NCA Standard 2

Safe Space in partnership with the MDT conducts a community assessment at a minimum of every 3 years, which includes:

1. Community demographics
2. CAC client demographics
3. Analysis of disparities between these populations
4. Methods the CAC utilizes to identify and address gaps in services
5. Strategies for outreach to unserved or underserved communities with identified disparities
6. A method to monitor the effectiveness of outreach and intervention strategies

The MDT ensures that provisions are made for non-English speaking and deaf or hard of hearing children and their family members throughout the investigation, intervention, and case management processes. The MDT has access to a language line for interpreters for non-English speaking persons. The MDT would seek the assistance of sign language proficient person for deaf children and their family members as needed.

Safe Space services are accessible and tailored to meet the various individualized and unique needs of children and families regarding culture, development, and special needs throughout the investigation, intervention, and case management process.

For information about how the CAC complies with the following, please refer to the CAC policies. The CAC must demonstrate ongoing efforts through formal policies, procedures, and practices to recruit, hire, and retain staff, volunteers, and board members that reflect the community and describe how the CACs ongoing efforts to recruit, hire, and retain staff, volunteers, and board members that reflect the demographics of the community.

Training Requirements

The CAC values Diversity, Equity, and Inclusion (DEI) and requires CAC staff to participate in DEI trainings a minimum of 8 hours every two years, and annually provides MDT members access to DEI training and information. The CAC documents training opportunities and MDT participation.

Examples of training topics could include:

1. Implicit bias
2. Microaggressions
3. Organizational learning
4. Building a culture of inclusion
5. Reducing disparities in services

V. Initial Report¹¹

- When an agency receives a report of child abuse,¹² the receiving agency shall promptly relay the report to ODHS and/or appropriate LEA.
 - i. Appropriate LEA is determined by location where alleged abuse occurred. If the county where the abuse occurred is unknown, then cross report to the LEA in the county where the alleged victim resides. If the county where the alleged victim resides is unknown the cross report to the LEA in the county where the reporter made contact with the alleged victim or alleged perpetrator.
 - 1. Questions regarding appropriate LEA should be referred to the District Attorney's Office (DA) for resolution.
- Agency receiving report of child abuse or neglect will immediately coordinate response with the other agency.
 - i. Contact will occur via telephone, email, fax, or in person.
 - ii. Reports received outside of regular business hours or over the weekend shall be reported the next working morning to the appropriate agency.
 - iii. Direct Contact with team member within agency is preferred.

VI. Investigation

- Priority Determination
 - i. Priority is determined by the apparent or potential risk of physical or psychological harm to the child.
 - 1. ODHS may use a risk assessment checklist.
 - ii. Examples of criteria to determine risk:
 - 1. High Priority:
 - a. Actual physical injury; continued disturbance; violence; suicide threats; failure to thrive; current allegation of sexual abuse where alleged perpetrator has access to child; young child left unattended.
 - 2. Medium Priority:
 - a. Refusal to return home; child(ren) has ability to protect self; need to manipulate time/place of contact with child.
 - 3. Low Priority:
 - a. Child safety assured; stale report; agency assists.
 - 4. Refer to team:
 - a. Custody issue; statute of limitations has passed; out of jurisdiction.
 - iii. Priority determination shall be a joint decision of the Investigative Team using their training and professional judgement. LEA is encouraged to contact ODHS or DA to assist in determining priority.

¹¹ See ORS 419B.015 Report form and content; notice.

¹² See ORS 419B.005

- iv. Investigative Team are persons designated by ODHS and by LEA within jurisdiction.
- Investigation
 - i. Investigations shall be approached as though they will result in prosecution while considering the best interests and needs of the child.
 - ii. Response strategy shall be determined by Investigative Team members considering:
 - 1. Need to re-contact and interview complainant;
 - 2. Need to preserve physical evidence;
 - 3. Logistics of child, witness, and suspect interviews;
 - 4. Need to intervene for child's immediate protection; and
 - 5. Need to videotape or audio record interview.
 - iii. Interviews
 - 1. Child interviews shall occur in a neutral, non-threatening environment. If possible, the interview will be videotaped in accordance with the Oregon Child Forensic Interviewing Guidelines¹³.
 - a. If interviewing at school¹⁴, Investigative Team shall arrange with school administration prior to interviewing child.
 - b. School is required to cooperate with investigation.
 - 2. Duplication of interviews should be avoided.
 - 3. Age-appropriate interview techniques and tools shall be utilized by Investigative Team.
 - 4. Interviews should include:
 - a. Demographic information:
 - i. Name, age, date of birth, residence, parent or guardian, place of employment.
 - b. Details about alleged abuse:
 - i. Date(s), location(s), details about alleged abuse, name of abuser, and any potential witnesses
 - ii. Time(s) and date(s) of disclosure and to whom it was made
 - c. A measure of the child's competency to testify;
 - d. Assessment of child's present need for protection;
 - e. Assessment of child's present need for medical services; and
 - f. Determination of existence of physical or corroborative evidence.
 - 5. Close of Interviews should include:
 - a. Positive reinforcement;
 - b. Plan for follow-up;
 - c. Permission to re-establish contact with interviewers;
 - d. Future court system involvement;

¹³ See Appendix – Oregon Child Forensic Interviewing Guidelines

¹⁴ See ORS 419.045 Investigation conducted on school premises; notification; role of school personnel.

- e. Advisement that child and their family may be contacted in future by members of defense team and their right not to speak with them;
 - f. Discussion of protective procedures;
 - g. Dealing with child's concern regarding alleged offender and family unit;
 - h. Photograph of child.
- iv. In the case of alleged child abuse as described in ORS 419B.005(1)(a)(C), (D), and (E)¹⁵ by a parent, guardian, or caregiver living in the child's home, ODHS may ask the parent, guardian, or caregiver to move from the family's home during the investigation. If the parent, guardian, or caregiver agrees to leave the family home, ODHS shall notify the District Attorney or Deputy District Attorney responsible for the county's child abuse MDT where the child resides.
 - 1. The notification shall be in writing and be provided no later than 3 business days after the departure of the parent, guardian, or caregiver from the family home.
 - 2. A parent, guardian, or caregiver who consents to leave the family home as described above, or the spouse of the parent, guardian, or caregiver may ask the DA responsible for MDT to perform a MDT case review.
 - 3. No later than 90 days after receiving a request under this section, MDT shall:
 - a. Review the case and at least consider:
 - i. Whether the investigation should continue;
 - ii. The welfare of the child and the adults living in the family home;
 - iii. The proposed timeline for completing the investigation; and

¹⁵ (C) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are described in ORS chapter 163.

(D) Sexual abuse, as described in ORS chapter 163.

(E) Sexual exploitation, including but not limited to:

- (i) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163, and any other conduct that allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe or the photographing, filming, tape recording or other exhibition that, in whole or in part, depicts sexual conduct or contact, as defined in ORS 167.002 or described in ORS 163.665 and 163.670, sexual abuse involving a child or rape of a child, but not including any conduct that is part of any investigation conducted pursuant to ORS 419B.020 or that is designed to serve educational or other legitimate purposes; and

- (ii) Allowing, permitting, encouraging or hiring a child to engage in prostitution as described in ORS 167.007 or a commercial sex act as defined in ORS 163.266, to purchase sex with a minor as described in ORS 163.413 or to engage in commercial sexual solicitation as described in ORS 167.008

- iv. Provide to the person who requested the review a summary of the proposed timeline for completing the investigation.
- Physical Exams and Assessments – Sexual Harms
 - i. Physical examinations of children suspected of having experienced sexual harm will be performed under the following circumstances and in compliance with Karly's Law:
 1. Child has disclosed sexual abuse;
 2. Child exhibits behavior that is strongly indicative of sexual harm and/or the child is pre-verbal.
 - ii. Due to their specialized training and access to specialized equipment, trained medical providers should perform examinations on children suspected of experiencing sexual abuse.
 1. If under 15 years old, the child will be taken to the Safe Space Children's Advocacy Center (CAC), the emergency room at Mid-Columbia Medical Center (MCMC), or to Legacy Emanuel Hospital in Portland.
 2. If over 15 years of age, the child will be taken to the Safe Space CAC, the MCMC's emergency room, OHSU Doernbecher Hospital (OHSU), or St. Vincent's Hospital.
 3. The Consultation Center at CARES NW will provide backup exams as determined appropriate.
 4. Nonemergency situations or after 120 hours, the preference is that sex abuse examinations occur at MCMC emergency room or at the child's primary care physician.
 - iii. Examples of Priority / Emergency Circumstances:
 1. Child has made disclosure of abuse within the past 120 hours;
 2. Child has made disclosure of abuse and alleged perpetrator has unrestricted access to child;
 3. Child has been brought to emergency room and family or child appear to be in crisis; or
 4. Family is in denial and wants to postpone examination, which may result in family denying examination of child.
 - iv. If priority circumstances are present, ODHS or LEA are required to request an emergency child sex abuse exam.
 - v. If unclear if priority circumstances exist, Investigative Team will consult Safe Space CAC, Legacy Emanuel, OHSU, St. Vincent's or CARES Northwest regarding whether the exam can wait until regular business hours.
 - vi. Medical providers will follow their regular procedure for obtaining cultures. However, if material is gathered at the request of LEA for testing at the State Crime Laboratory, the medical providers will follow LEA protocol by transferring samples to LEA for submission to the State Crime Laboratory.

- vii. When evidence of abuse is unlikely to be present, examinations will be scheduled on a non-crisis basis. ODHS or LEA will make arrangements to accompany the parent and child to the appointment for the medical exam.
- viii. The expectation is that there will always be an exam if the child makes a disclosure or if there are significant behavioral indicators and/or the child is preverbal, regardless of the extent of the disclosure.
 - 1. Exceptions are to be discussed with the Child Abuse Response Coordinator.
- ix. If there is a question as to whether abuse has occurred, the family will be given the option of having a physical examination of the child. If the family declines the examination, the written assessment should reflect the family's decision.
- x. Fees
 - 1. Child sex abuse examinations will be billed to the family's private insurance carrier, Oregon Health Plan (OHP) or the CAMI account if no other resources are available.
- xi. Physical exams, including fully body skeletal x-rays, for child of alleged physical abuse will be performed under the following circumstances:
 - 1. Previous referrals of physical abuse;
 - 2. Age of child;
 - 3. Any head injury;
 - 4. Injuries inconsistent with given explanation;
 - 5. Discretion of Investigative Team;
 - 6. Any suspicious physical injury:
 - a. Burns or scalds;
 - b. Extensive bruising or abrasions on any part of the body;
 - c. Bruising, swelling, or abrasions on the head, neck, or face;
 - d. Fractures of any bone in a child under 3;
 - e. Multiple fractures in a child of any age;
 - f. Dislocations, soft tissue swelling, or moderate to severe cuts;
 - g. Loss of the ability to walk or move naturally in accordance with the child's developmental ability;
 - h. Unconsciousness or difficulty maintaining consciousness;
 - i. Multiple injuries of different types;
 - j. Injuries causing serious or protracted disfigurement or loss of impairment of the function of any bodily organ; or
 - k. Any injury that threatens the physical well-being of the child.
- Physical Exams and Assessments – Physical Harms
 - i. If child has suffered a serious physical injury and the Investigative Team has reasonable suspicion that the injury may be the result of abuse, the person shall:

1. Immediately photograph or cause to have photographed the suspicious physical injuries in accordance with ORS 419B.028¹⁶; and
2. Ensure that a Designated Medical Professional (DMP) conducts a medical assessment within 48 hours or sooner if dictated by the child's medical needs. This shall apply:
 - a. Each time a suspicious injury is observed by ODHS or LEA agent;
 - b. During the investigation of a new allegation of abuse;
 - c. If the injury was not previously observed by a person investigating under ORS 419B.020¹⁷; and
 - d. Regardless of whether the child has previously been photographed or assessed during an investigation of abuse.
- ii. Child suspected of abuse should be taken to a DMP. If after reasonable efforts a DMP is not available to conduct a medical assessment within 48 hours, the child shall be evaluated by an available physician.
 1. If DMP is not available, child should be taken to Legacy Emanuel, OSHU, St. Vincent's, or emergency room at MCMC.
 2. If the child is evaluated by a physician, physician assistant, or nurse practitioner other than a DMP, the evaluating physician, physician assistant, or nurse practitioner shall make photographs, clinical notes, diagnostic and testing results and any other relevant materials available to the DMP for consultation within 72 hours following the evaluation of the child.
 3. The person conducting the medical assessment may conduct with and obtain records from the child's regular pediatrician or family physician under ORS 419B.050¹⁸.

¹⁶ **419B.028 Photographing child during investigation; photographs as records.**

(1) In carrying out its duties under ORS 419B.020, any law enforcement agency or the Department of Human Services may photograph or cause to have photographed any child subject of the investigation for purposes of preserving evidence of the child's condition at the time of the investigation. Photographs of the anal or genital region may be taken only by medical personnel.

(2) When a child is photographed pursuant to ORS 419B.023, the person taking the photographs or causing to have the photographs taken shall, within 48 hours or by the end of the next regular business day, whichever occurs later:

- (a) Provide hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format to the designated medical professional described in ORS 418.747 (9); and
- (b) Place hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format in any relevant files pertaining to the child maintained by the law enforcement agency or the department.

(3) For purposes of ORS 419B.035, photographs taken under authority of this section shall be considered records. [1993 c.546 §18; 2007 c.674 §5]

¹⁷ **See 419B.020 Duty of department or law enforcement agency receiving report; investigation; notice; physical examination; child's consent; notice at conclusion of investigation.**

¹⁸ **419B.050 Authority of health care provider to disclose information; immunity from liability.**

(1) Upon notice by a law enforcement agency, the Department of Human Services, a member agency of a county child abuse multidisciplinary team or a member of a county child abuse multidisciplinary team that a child abuse investigation is being conducted under ORS 419B.020, a health care provider must permit the law enforcement agency, the department, the member agency of the county child abuse multidisciplinary team or the member of the

- iii. Nothing in this section prevents a person conducting a child abuse investigation from seeking immediate medical treatment from a hospital emergency room or other medical provider for a child who is physically injured or otherwise in need of immediate medical care.
- iv. If the child described in this section is under 5 years of age, the DMP may, within 14 days, refer the child for a screening for early intervention services or early childhood special education. The referral may not indicate the child is subject to a child abuse investigation unless written consent is obtained from the child's parent authorizing such a disclosure. If the child is already receiving those services, or is enrolled in the Head Start program, a person involved in delivery of those services to the child shall be invited to participate in the county's child MDT review of the case and shall be provided with paid time to do so by the person's employer.
- v. If the child described in this section is:
 - 1. Under 15 years age, the child should be taken to SafeSpace CAC or Legacy Emanuel.
 - 2. Over 15 years of age, the child should be taken to SafeSpace CAC, OSHU, or St. Vincent's.
 - 3. If these options are not available, the child should be taken to MCMC for a physical examination, including x-rays.
 - a. This should occur within 24 hours of the first contact of the child by Investigative Team.
- vi. Investigative Team shall consult with the DA's office as part of decision-making process.
- vii. Non-offending family members may accompany the child to medical exams.
- viii. Fees:
 - 1. Child abuse examinations will be billed to the family's private insurance carrier, Oregon Health Plan (OHP) or the CAMI account if no other resources are available.
- ix. Medical records will be collected by the Investigative Team.
- x. Photographs¹⁹:
 - 1. ODHS or LEA may photograph or cause to have photographed any child subject to investigation for the purpose of preserving evidence of the child's condition at the time.
 - a. Photographs of the anal or genital region may only be taken by medical personnel.

county child abuse multidisciplinary team to inspect and copy medical records, including, but not limited to, prenatal and birth records, of the child involved in the investigation without the consent of the child, or the parent or guardian of the child. A health care provider who in good faith disclosed medical records under this section is not civilly or criminally liable for the disclosure.

(2) As used in this section, "health care provider" has the meaning given that term in ORS 192.556. [1997 c.873 §27; 1999 c.537 §3; 2001 c.104 §150; 2005 c.562 §27; 2019 c.141 §27]

¹⁹ See **ORS 419B.028 Photographing child during investigation; photographs as records.**

2. Within 48 hours or by the end of the next business day, whichever occurs later:
 - a. DMP shall be provided printed or electronic copies of the photographs; and
 - b. LEA or ODHS shall save the photographs into their records regarding the child.
- Drug Endangered
 - i. If there is reason to believe a child has been exposed to dangerous chemicals, like drugs, ODHS or LEA shall make arrangements to have the child tested for chemical exposure as soon as possible and not later than 24 hours after learning of the exposure.
- Third Party Reports
 - i. Third party abuse occurs by a person who is not the child's parent, caregiver, member of child's household, or not responsible for the child's care, custody, or control.
 1. Examples: school personnel, daycare providers, coaches, or church personnel.
 - ii. Reports of Third-Party Abuse will be reported to LEA with jurisdiction via fax within 1 hour of receiving the report.
 1. Include "Child Abuse Report" and any other information available to screener.
 - a. Information does not need to be verified before sending to LEA.
 2. Follow-up with phone call to LEA to ensure receipt of report.
 3. Subsequent reports related to the incident shall be provided to LEA within the same working day that information is received.
 - a. May be provided orally.
 - iii. ODHS Screener Steps:
 1. Determine safety status of child;
 2. Identify and determine the safety status of any other children;
 3. Determine need for ODHS to conduct a child safety assessment on child victim, siblings of child victims, siblings or children of alleged abuser, and any other children whom the alleged abuser may have access.
 4. Report information to LEA.
 - iv. LEA is responsible for determining what action to take regarding Third Party Abuse. LEA will utilize DHS to facilitate child-friendly interviews.
 - v. LEA will report to MDT the resolution of Third Party Abuse referrals.
 - vi. Offender Interview
 1. Interviews should occur at LEA location. Interviews should not be conducted in alleged offender's place of employment or residence.
 2. Objective: Admissible confession, admission, corroborating evidence of abuse, or exculpatory information.

- a. Advise suspect of their *Miranda* rights.
- 3. Important information to gather during interview:
 - a. Name, aliases, date of birth, residence, place of employment, and any criminal history;
 - b. Relationship to victim;
 - c. Description of abuse;
 - d. Times, dates, and locations of abuse;
 - e. Assess mental and physical condition of alleged offender;
 - f. Ascertain if there are additional victims.
- 4. Offender shall be apprised of:
 - a. Potential charges. Final charging decisions are placed with the DA or Grand Jury. Timing of this information is at discretion of investigating officer.
 - b. No contact order with victim.
- vii. Witness Interviews:
 - 1. Obtain names, date of birth, residence, place of employment, and contact information;
 - 2. Determine relationship to alleged offender and child;
 - 3. Obtain corroborative or exculpatory information.
- viii. Reports
 - 1. LEA will prepare and forward a completed report to DA, Juvenile Department, and ODHS. Notes or reports prepared by other MDT members will also be provided to the DA.
 - 2. Report:
 - a. Alleged charge;
 - b. Alleged offender's full name, aliases, date of birth, age, physical description, social security number if known, home and employment addresses, telephone number, criminal history;
 - c. Child's full name, date of birth, age, physical description, social security number if known, home address, and telephone number;
 - d. Legal parent or guardian's full name, date of birth, home address, and telephone number;
 - e. List of physical evidence and its location, including chain of custody if applicable;
 - f. Child's statement;
 - g. Alleged offender's statement;
 - h. Witnesses' statements;
 - i. Other corroborating or exculpatory information.
- Child Advocacy Center (CAC)
 - i. It is best practice for child abuse interviews to be conducted at a CAC.

- ii. In the event at the CAC is not available, interview may occur at other neutral locations like the child's school, after-school program, non-offending parent home.

VII. Forensic Interview²⁰

Forensic interviews are coordinated to avoid duplicative interviewing and are conducted in a manner that is legally sound and of a neutral, fact-finding nature. It is best practice for child abuse forensic interviews to be conducted at the local CAC whenever possible. The purpose of a forensic interview is to obtain information from a child about abuse allegations that will support accurate and fair decision making by the MDT within the criminal justice, child protection, and service delivery systems. Forensic interviews are conducted in a manner that is developmentally and culturally sensitive, unbiased, fact-finding, and legally sound. When a child is unable or unwilling to provide information regarding any concern about abuse, other interventions to assess the child's experience and safety are required.

Forensic interviewers adhere to the NCA-approved, research-supported, Oregon Child Forensic Interviewer Training (OCFIT), which is based on the DOJ approved Oregon Interviewing Guidelines (OIGs). The OIGs serve as the basis for statewide training and offer interviewers information and insights to help them conduct skilled, professional, developmentally appropriate, and culturally sensitive interviews with children. However, it should not be taken as a dictate from the state or mandate from any agency that every interview in Oregon must follow this format. While the OIGs can serve as a unifying document to foster statewide consistency in interviewing, it is recognized that nuances in any child abuse investigation can necessitate unique interactions that might not be covered in the OIGs.

Ideally, forensic interviews should be conducted in a child-friendly atmosphere, such as a Children's Advocacy Center. In the event that the CAC is not available or circumstances do not permit referring to the CAC, other neutral interview locations include the child's school, after-school program, non-offending parent home, etc. A neutral, child-friendly interview environment enhances free recall, minimizes interviewer influence, and gathers information needed by all the MDT members in order to avoid duplication of the interview process.

Forensic interviews are provided by SafeSpace CAC staff.

Training Requirements

All forensic interviewers conducting forensic interviews at SafeSpace CAC have completed the NCA approved Oregon Child Forensic Interview Training (OCFIT) or pending completion of OCFIT has successfully completed another NCA approved Forensic Interviewer training that includes the following elements:

1. Minimum of 32 hours of instruction and practice
2. Evidence-supported interview protocol

²⁰ See NCA Standard 3

3. Pre- and post-testing that reflects understanding of the principles of legally sound interviewing
4. Content that includes: child development, question design, implementation of protocol, dynamics of abuse, disclosure process, cultural competency, and suggestibility
5. Practice opportunities with a standardized evaluation process
6. Required reading of current articles specific to the practice of forensic interviewing.
- 7.

Individuals with forensic interviewing responsibilities at SafeSpace CAC must participate in ongoing education in the field of child maltreatment and/or forensic interviewing consisting of a minimum of 8 contact hours every 2 years.

Case acceptance criteria:

1. Case acceptance criteria:

SafeSpace Children's Advocacy Center's acceptance criteria includes:

- A. A referral from a Law Enforcement Agency, Oregon Department of Human Services, or Washington Department of Children, Youth & Families.
- B. SafeSpace requires a phone meeting with the referring person to discuss case and obtain enough information to make a determination if it is appropriate to schedule for an assessment.

2. Criteria for choosing an appropriately trained interviewer (for a specific case):

SafeSpace will choose the appropriate interviewer by choosing an interviewer who speaks the same language as the child. When this is not possible, SafeSpace will use a certified interpreter to be a part of the assessment. Only certified forensic interviewers will conduct interviews. When an advanced trained skill is needed, SafeSpace will only use interviewers who have completed the advanced forensic interviewer training.

3. Personnel expected to attend/observe the interview:

Oregon Cases

- A. Law Enforcement and/or ODHS
- B. SafeSpace medical provider assigned to case
- C. SafeSpace Advocate
- D. In Columbia River Inter-Tribe Cases, a Tribal Advocate may attend

Washington Cases

- A. Law Enforcement and/or DCYF
- B. SafeSpace medical provider assigned to case
- C. SafeSpace Advocate
- D. In Columbia River Inter-Tribe Cases, a Tribal Advocate may attend
- E. Programs for Peaceful Living Assigned Advocate

4. Preparation, information sharing and communication between the MDT and the forensic interviewer:

A. The referring person will have a phone meeting with the SafeSpace scheduler to discuss the case. A determination will be made as to whether the child needs to be seen at SafeSpace. All information known by the referring person will be shared to prepare appropriately for the assessment.

B. Prior to the child being seen for an assessment at SafeSpace, there will be a pre-assessment meeting with the MDT partners assigned to this case.

C. During the forensic interview, the interviewer will typically check in with the MDT group at least once prior to terminating the interview. Exceptions are made when the child refuses to continue the interview.

5. Use of interview aids:

Interview aids typically can include paper, coloring or writing utensils, or playdough. Introduction of evidence can at times be used during an interview depending on the interviewer's training and circumstance.

6. Use of interpreters:

SafeSpace will use a certified interpreter for an assessment when the primary language of the child is not spoken by an interviewer at SafeSpace. For an interview or medical assessment, the certified interpreter may be physically present in the office, or may be present by phone or by videocall.

7. Recording and/or documentation of the interview:

SafeSpace uses Firstline equipment and technology to securely and reliably store interview recordings. Forensic interviews are documentation on SafeSpace's electronic health record system.

8. Interview methodology (i.e., state or nationally recognized forensic interview training model(s)):

Certification in Oregon Child Forensic Interviewing Training is required for a Forensic Interviewer to be able to interview children at SafeSpace. The Oregon Interviewing Guidelines are used in conjunction to this training.

9. Introduction of evidence in the forensic interviewing process:

Introduction of evidence is a tool used at times when children are interviewed at SafeSpace. The pre-assessment meeting would include conversation within the MDT group to discuss any request of introduction of evidence. If the group moves forward with the possibility of having evidence introduced, the interviewer will follow the guidelines for introduction of evidence.

10. Sharing of information among MDT members:

Information sharing among MDT participants can occur in meetings, phone calls, email exchanges, fax exchanges, or text message exchanges.

11. A mechanism for collaborative case coordination:

SafeSpace staff will make themselves available for collaborative case coordination via meetings, phone calls, email exchanges, fax exchanges, or text message exchanges. SafeSpace will make themselves available to answer questions, collaborate, and provide case consults.

12. Determining criteria and process by which a child has a multi-session or subsequent interview:

- A. Cases where a child only received a forensic interview or medical assessment. Efforts will be made so the child can complete the full assessment.
- B. When a child has multiple incidents of abuse to disclose and it makes sense to cover only a certain amount of abuse incidents at once.
- C. If a child is not ready to talk about the incident being disclosed but then becomes ready to talk about the topic of concern.
- D. When a child recants, it may be appropriate to see the child for a subsequent interview depending on the circumstances.

13. The use of technology for remote live observation of the forensic interview using a secure method (if applicable):

SafeSpace does not offer remote observation to community partners due to not being able to secure HIPAA compliance in remote settings. The child's privacy and anonymity also cannot be guaranteed.

14. The criteria and process for the use of tele-forensic interviews (if applicable):

SafeSpace only offers in-person forensic interviews at this time.

The CAC allows for real-time observation of forensic interviews by MDT members. Law Enforcement and Child Welfare with investigative responsibilities on a case must participate in live/real-time observation of the forensic interview(s) taking place at the CAC to ensure necessary preparation, information sharing, and MDT/interviewer coordination throughout the interview and post-interview process. The physician who will conduct a medical examination of the child should also observe the interview to ensure necessary preparation, information sharing and coordination with the medical examination.

For cases meeting SafeSpace's case acceptance criteria as outlined in the MDT guidelines, forensic interviews are conducted at SafeSpace at a minimum of 75% of the time.

Individuals who conduct forensic interviews at the SafeSpace must participate in a structured peer review process for forensic interviewers a minimum of 2 times per year, as a matter of quality assurance. Peer review serves to reinforce the methodologies utilized as well as provide support and problem-solving for shared challenges. Peer review includes participants and facilitators who are trained to conduct child forensic interviews. Structured peer review includes:

- 1. Ongoing opportunities to network and share learning and challenges with peers
- 2. Review and performance feedback of actual interviews in a professional and confidential setting

3. Discussion of current relevant research articles and materials
4. Training opportunities specific to forensic interviewing of children and the CAC- specific methodologies.

SafeSpace staff and MDT partners coordinate information gathering including history taking, assessments, and forensic interview(s) to avoid duplication.

VIII. Victim Support Advocacy²¹

Victim support and advocacy is fundamental to the MDT response. Comprehensive victim support and advocacy services are provided by the MDT including SafeSpace advocates in collaboration with the Hood River County District Attorney's Office Victim Assistance Program advocates.

Victim Advocacy includes the following constellation of services:

1. Crisis assessment and intervention, risk assessment and safety planning and support for children and family members throughout the life of the criminal case;
2. Assessment of individual needs, cultural considerations for child/family, and ensuring those needs are addressed;
3. Presence at CAC during the forensic interview and/or medical evaluation in order to participate in information sharing with other MDT members, inform and support family about the coordinated multidisciplinary response, and assess needs of child and non-offending caregiver;
4. Provision of education and access to victim's rights and crime victim's compensation;
5. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance, civil legal services, etc.);
6. Provision of referrals for trauma focused, evidence supported mental health and specialized medical treatment;
7. Facilitating access to transportation to interviews, court, treatment and other case-related meetings;
8. Engagement in the child's/family's response regarding participation in the investigation/prosecution to help them understand the investigation/prosecution process and help ensure understanding of crime victims' rights
9. Participation in case review for cases under investigation to communicate and discuss the unique needs of the child and family and associated services planning; and help ensure the coordination of identified services and that the child and family's concerns are heard and addressed
10. Provision of updates to the family on case status, continuances, dispositions, sentencing, inmate status notification (including offender release from custody)
11. Provision of court education and support, including court orientation and accompaniment

A SafeSpace Victim Advocate is assigned to every family that comes in for an evaluation at SafeSpace. Upon arrival, a victim advocate meets the child(ren) and non-offending family

²¹ See NCA Standard 4

members in a private waiting area. Advocates are available to provide crisis intervention, support, education on the MDT response, assess needs and provide resources during the evaluation process. They participate in information sharing with the team during both the pre- and post-forensic interview and/or medical evaluation meetings. Continued support, coordination with involved agencies, communication and resources are provided to the family. Active outreach and follow-up services for caregivers consistently occurs. Outreach consists of phone calls and in office meetings when necessary.

Victims whose cases enter the criminal court system will also receive support and advocacy services through the Hood River County Victims' Assistance Program.

Coordinated case management occurs with all individuals providing victim advocacy services to CAC clients. SafeSpace victim advocates regularly communicate and collaborate with representatives from the Victims' Assistance Program. Communication and collaboration about individual cases occurs needed or quarterly.

To ensure all cases reviewed by MDT receive access to all services available, and in order to ensure that the families receive the support necessary to overcome the issues arising from abuse, a SafeSpace Victim Advocate and Victim Advocate from the Hood River County Victims' Assistance Program actively participate at all MDT Case Review meetings.

Training Requirements

All Victim Advocates who provide services to child clients have specialized training in victim advocacy and have successfully completed a minimum of 40 hours of instruction including, but not limited to:

- a. Dynamics of child abuse;
- b. Trauma-informed services,
- c. Crisis assessment and intervention,
- d. Risk assessment and safety planning,
- e. Professional ethics and boundaries,
- f. Understanding the coordinated multidisciplinary response,
- g. Understanding, explaining, and affording victim's legal rights,
- h. Court education, support and accompaniment,
- i. Knowledge of available community and legal resources, referral methods and assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, interpreters, among others as determined for individual clients,
- j. Cultural responsiveness and addressing implicit bias in service delivery
- k. Caregiver resilience
- l. Domestic violence/family violence/children's exposure to domestic violence and poly-victimization

In addition to initial training, individuals who provide victim advocacy services for the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child

maltreatment consisting of a minimum of 8 contact hours every 2 years.

IX. Medical Evaluations²²

The purpose of a medical evaluation is to medically assess the child with concerns of maltreatment in order to ensure the health, safety and wellbeing of the child. This includes the diagnosis and treatment of possible sexual abuse, physical abuse, or neglect. Specialized medical evaluations and treatment services are available at SafeSpace for clients regardless of ability to pay and are coordinated as part of the MDT response.

Children who have experienced various forms of maltreatment benefit from comprehensive forensic medical evaluation by a provider with specialized training to assess injury, infection, physical and emotional well-being. The collection and documentation of possible forensically significant findings are vital. However, the referral of children for medical examinations should NOT be limited to those for whom forensically significant information is anticipated. The purpose of a medical examination is for the diagnosis, treatment, protection and reassurance of the child.

All children who present with concerns of child abuse who are referred to SafeSpace will have access to a medical evaluation. SafeSpace CAC is a medical model CAC and provides medical assessment to all clients. In the event that a medical provider is not available, SafeSpace will assist families in obtaining a medical exam elsewhere.

Medical findings are documented in a written report and photo-documentation. Medical records storage is HIPAA compliant. The medical records storage is secured, sufficiently backed up and accessible to authorized personnel in accordance with all applicable federal and state laws.

SafeSpace uses a HIPAA compliant photo/video machine that digitally stores and secures media. SafeSpace also uses a EHR platform in compliance with HIPAA.

Circumstances under which an emergency medical evaluation for child abuse is recommended:

- Sexual abuse cases: If the sexual abuse is reported within 120 hours of the incident then it is best practice to seek a forensic medical examination immediately.
- Physical abuse: Physical abuse with injuries within 48 hours of the report.

Findings of the medical evaluation are shared with the investigative team in a routine, timely and meaningful manner, as well as presented and discussed at the next scheduled case review. Information about the medical exam is shared with the investigating MDT team at the time of the assessment. A report will be available within one week. The investigating MDT team members can request a copy of the report by email. If labs are pending at the time of the report

²² See NCS Standard 5

being generated, the report will be updated as lab results are reported to SafeSpace.

Professional, Educational, and Training Requirements

Medical evaluations are conducted by health care providers with specific training in child abuse that meets one of the following training standards:

- Child Abuse Pediatrics Sub-board eligibility or certification
- Physicians without board certification or board eligibility in the field of Child Abuse Pediatrics, Advanced Practice Nurses, and Physician Assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse.

Regardless of provider type, all providers should be licensed to practice in Oregon (and be in current good standing) by their corresponding state board of practice regulation.

In addition to the Training and Eligibility Standards for Training (above), the SafeSpace medical providers must also meet Continuous Quality Improvement (CQI) standards described below.

MDT members and SafeSpace staff are trained regarding the purpose and nature of the medical evaluation for concerns of child abuse. Designated MDT members and/or SafeSpace staff educate clients and/or caregivers regarding the medical evaluation.

Continuous Quality Improvement (CQI) for the medical component of SafeSpace includes:

- The medical provider must be familiar and up-to-date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy of Pediatrics Committee on Child Abuse and Neglect, American Professional Society on the Abuse of Children, and the Centers for Disease Control and Prevention.
- Medical professionals providing services to SafeSpace clients must demonstrate continuing education in the field of child abuse consisting of a minimum of 8 hours every 2 years of CEU/CME credits.
- Medical professionals providing child sexual abuse evaluations to SafeSpace clients must demonstrate, that all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone review by an a different medical provider.
- The purpose of a medical evaluation where there are concerns for child abuse extends far beyond providing an evidentiary examination for the purpose of the investigation. The primary goals of the medical evaluation are to:
 - o Help ensure the health, safety, and well-being of the child
 - o Evaluate, document, diagnose, and address medical conditions resulting from abuse
 - o Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
 - o Document, diagnose, and address medical conditions unrelated to abuse

X. Mental Health²³

Without effective therapeutic intervention, many children impacted by trauma are highly likely to experience ongoing or long-term adverse social, emotional, developmental and health outcomes that may impact them throughout their lifetimes. Evidence-based treatments and other practices with strong empirical support reduce the impact of trauma and the risk of future abuse. For these reasons, the MDT's mental health response includes a trauma history, screening, and assessment of trauma and abuse-related symptoms, and evidence-based, trauma-focused mental health services for child victims and caregivers. Mental health services will be made available and accessible to all child clients regardless of ability to pay.

Evidence supported trauma focused mental health services for the child client are consistently available and include:

1. Trauma specific assessment including traumatic events and abuse related trauma symptoms;
2. Use of standardized assessment measures initially to inform treatment and periodically to assess progress and outcome;
3. Individualized treatment plan based on assessments that are periodically reassessed;
4. Individualized evidence supported treatment appropriate for the child clients and other family members;
5. Child and caregiver engagement in treatment;
6. Monitoring of trauma symptom reduction;
7. Referral to other community services as needed.

Mental health services are provided on site at SafeSpace, via telehealth, or in person at Hodd River Valley High School.

In addition, MDT mental health partners provide supportive services for caregivers to address:

1. The safety and well-being of the child;
 2. Caregiver involvement in their child's treatment when appropriate
 3. The emotional impact of abuse allegations;
 4. The risk of future abuse;
- Issues or distress which the allegations may trigger.
(Services are made available onsite or through linkage agreements with other appropriate agencies or providers.)

Mental health providers engage with parents/caregivers as a part of the treatment plan when necessary and when appropriate based on the client's age.

²³ See NCA Standard 6

Professional, Educational, and Training Requirements

Mental health services for children referred by the MDT will be provided by professionals with training in, and who deliver, trauma-focused, evidence-supported, mental health treatment. All mental health providers, whether providing services at the CAC or by referral and linkage agreement with outside individuals and agencies, must meet the following:

Education/License Requirements

Mental health provider(s) must demonstrate they meet at least ONE of the following academic training standards:

- Master's degree/Licensed/certified in a related mental health field.
- Master's degree in a related mental health field and working towards licensure; supervised by a licensed mental health professional.
- Student intern in an accredited mental health related graduate program, when supervised by a licensed/certified mental health professional. Both the student intern and supervising licensed mental health professional must meet the previously indicated 40-hour training requirements. Students who are currently enrolled in a training to deliver an EBT may provide services to children as a part of their EBT training.

Training Requirements

The CAC must demonstrate its mental health provider(s) has completed 40 contact hours in training and consultation calls to deliver an evidence-supported mental health treatment to children who have experienced trauma from abuse. (Examples include TF-CBT, PCIT, AF-CBT, CFTSI, EMDR, CPP — see “Putting Standards into Practice”). Training programs that include fewer than 40 hours (including consultation calls) may be supplemented with contact hours in evidence-based assessment.

Clinicians providing mental health treatment must demonstrate completion of continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 years.

Clinicians providing mental health treatment to SafeSpace clients must participate in ongoing clinical supervision and/or consultation. Need to insert supervision information for this paragraph.

XI. Case Review and Coordination²⁴

Case review, an intentional forum for the purpose of reviewing, collaborating, and coordinating cases under investigation is conducted at least once a month. It is a formal process that enables the MDT to monitor and assess its independent and collective effectiveness to ensure the safety and well-being of children and families. Case review serves multiple purposes:

- Experience and expertise of MDT members is shared and discussed
- Collaborative efforts are fostered

²⁴ See NCA Standard 7

- Formal and informal communications are promoted
- Mutual support is provided
- Protocols and procedures are reviewed and
- Informed, collective decisions are made.

The process encourages mutual accountability and helps to assure that children's needs are met in a sensitive, effective, and timely manner.

Case reviews are coordinated and facilitated by **Danielle DeCant, Deputy District Attorney** with HRDA. Case reviews occur every second and fourth Monday and routinely take place at the Hood River Sheriff's Office at 309 State Street, Hood River, OR. Agency representatives who actively participate in case review must include, at a minimum are SafeSpace staff, LEA personnel/staff from Hood River City Police Department, Hood River Sheriff's Office, ODHS, DA(s) and victim advocate(s) from Hood River District Attorney's Office, medical, forensic interviewer, mental health and victim advocates, Hood River School staff, Hood River County Public Health, County Mental Health, Juvenile Department (if available), Oregon Department of Justice, and Early Intervention personnel when required by Karly's Law. MDT members are strongly encouraged to attend case reviews in person whenever possible. Special arrangements can be made for phone/or virtual attendance when necessary.

The MDT will review cases under investigation based on the following criteria: alleged reports of child abuse or neglect. In addition, any MDT member may refer a case for review when there are concerns for abuse by contacting Hood River County MDT Chair or Coordinator by phone or email.

The MDT Coordinator will notify agency representatives prior to the meeting of cases to be discussed by providing a written agenda with a list of cases to be reviewed and any information regarding upcoming trainings. The MDT Coordinator will provide a virtual link to the meeting for people with permission to appear remotely. ODHS and other MDT members may present cases for that meeting and provide follow up of prior cases as needed. For matters of significant concern, MDT members may alter the MDT Chair who shall provide notice to members of the matters of significance prior to the meeting with sufficient notice to allow members to prepare.

At the beginning of each meeting an MDT Attendance sheet which includes a Confidentiality Statement is distributed. MDT members attending case review are required to sign in with their name, agency, and position to record their attendance and agreement that all information discussed in case review will remain confidential. The following confidentiality statement is signed by Hood River County case review team members when signing into case review meetings.

Confidentiality is essential to the MDT review process. During MDT business, information about the child victim, the child victim's family, alleged perpetrator, and others will be shared. All of this information is provided with the understanding that the MDT business is confidential. Each and every participant in MDT agrees not to disclose any information provided in MDT proceedings unless otherwise required or appropriate under the law or by court order. ORS 192.610 to 192.690, relating to public meetings, does not apply to MDT meetings.

Case Review is an informed decision-making process with input from all MDT partner agency representatives. Review meetings will utilize a standard agenda, which includes opportunities to address the following components of each case:

- Review forensic interview outcomes;
- Discuss the plan and progress of the investigation;
- Review medical evaluations;
- Discuss child safety issues and considerations;
- Provide input on prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and non-offending family members as well as strategies for meeting those needs;
- Discuss family's reaction and response to the child's disclosure and involvement with the criminal justice/child protection service systems;
- Review updates on the criminal and/or dependency cases, ongoing involvement with the child and family, and disposition;
- Discuss responsibility for court education and court support for child and non-offending family members;
- Discuss on-going cultural issues and needs unique to individual children and families including issues pertaining to access to services;
- Review the legal rights and comprehensive services to which all children and families are entitled.
- Discuss how the CAC and MDT intervention is impacting the child and their family including positive changes and challenges.
- Discuss child well-being and outcomes, as available.

After each case review, the MDT Coordinator and/or Facilitator will document the information received without identifiers and expect MDT partners will follow these protocol pursuant to Karly's Law. At the next review, those follow up steps are reviewed to provide updates on the case.

XII. Case Tracking²⁵

Case tracking systems provide essential demographic information, case information, and investigation/intervention outcomes. Case tracking can be used for program evaluation (e.g., Identifying areas for continuous quality improvement and assessing ongoing case progress and outcomes) and generating statistical reports. Effective case tracking systems can also enable MDT members to accurately inform children and families of the status and disposition of their cases.

Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response to final disposition. The Safe Space will oversee the case tracking system.

Hood River MDT tracks statistical information to minimally include the following data:

1. Demographic information about the child and family

²⁵ See NCA Standard 8

2. Demographic information about the alleged offender
3. Type(s) of abuse
4. Relationship of alleged offender to child
5. MDT involvement and outcomes
6. Charges filed and case disposition in criminal court
7. Child protection outcomes
8. Status/follow-through of medical and mental health referrals.

Items listed 1-4 are self reported by client or parent/caregiver. Items 5-8 are a collaboration of the MDT team and partners involved with the case.

MDT partner agencies may access case-specific information when needed to perform their official functions related to the specific case. MDT partners are required to maintain the confidentiality of any such case-specific information. MDT partners may access non-identifying aggregate data for quality assurance, quality improvement, funding and research purposes through the Program Director.

For NCA accreditation purposes, please include the following CLIENT FEEDBACK:

SafeSpace uses OMS client feedback survey to evaluate client service delivery on an ongoing basis. Data from this survey is utilized to improve service delivery. Clients and caregivers accompanying the client have an opportunity to take a survey at the conclusion of their assessment at SafeSpace. In addition, there is a follow-up survey offered one month after their initial visit to SafeSpace.

XIII. Crisis Intervention

- Counseling information should immediately be provided to children of abuse and their non-offending family members.
- Responsibilities:
 - i. ODHS shall provide crisis counseling to families and children victims when appropriate.
 1. Safety and the best interests of the child are paramount.
 - ii. ODHS shall provide emergency shelter care for child victims unable to remain at home.
 - iii. ODHS will refer child and their guardian to the Victim Advocate (VA) at the DA's office.
 - iv. Additional resources shall be made available when appropriate: family therapy, individual & group counseling, and mental health resources.

XIV. Court Preparation

- Until an alleged offender pleads guilty, the assumption should be that the child will be expected to testify in court.
- ODHS will initiate ongoing contact with the DA's office to determine if child will be testifying.
- VA or ODHS will make arrangements for the child to meet the attorney handling the case. The child will be given the opportunity to view the grand jury room and

courtroom. VA and ODHS will be responsible for meeting any special needs of the child.

XV. Prosecution

- Investigation
 - i. The DA has general authority to direct investigation that may lead to criminal prosecution:
 1. The DA shall be advised by the Investigative Team of the nature and status of an investigation of child abuse;
 2. Investigative Team will consult with DA regarding issues arising during the investigation;
 3. The Arrest decision is made by DA in consultation with the Investigative Team;
 4. Investigations and assessments shall be conducted in accordance with the Interagency Child Abuse Protection Team Protocol;
 5. The DA is the only one that can grant the defense attorney access to the child.
- Initiation of Legal Proceedings
 - i. The DA has sole discretion in the initiation of criminal proceedings:
 1. The DA agrees to consult with MDT prior to deciding to initiate criminal proceedings;
 2. The DA's determination to file criminal charges against an alleged offender shall be based on written reports of ODHS and LEA and any other information available to the DA at the time of charging;
 3. The DA may request additional investigation be carried out;
 4. The DA will need to meet the child to assess competency to testify and to establish rapport with the child and their family; and
 5. The DA agrees to suggest other avenues of investigation and legal remedies that may be explored prior to declining prosecution.
- Decline to Prosecute
 - i. The DA shall review a previously declined case upon being advised by MDT of the existence of additional information;
 - ii. The DA may present reason for declining charges orally at MDT meetings.
- Prosecution
 - i. A decision to initiate criminal legal proceedings is at the sole discretion of the DA.
 1. Appropriateness of charges are determined by probable cause or the reasonable likelihood of conviction by a jury or judge at trial.
 2. The DA may consider:
 - a. Nature of conduct;
 - b. Child's competency to testify;
 - c. Statement of child to other people;
 - d. Alleged offender's statements;
 - e. Physical corroboration;

- f. Witness corroboration;
 - g. Availability of expert testimony;
 - h. Legal questions:
 - i. Admissibility of defendant's statements;
 - ii. Statute of limitations; and
 - iii. Venue and jurisdiction;
 - i. Completeness of investigation;
 - j. Ability of ODHS, VA, and other resources to support child during legal proceedings.
- 3. The DA acknowledges that many of these factors weigh against prosecution in other types of cases.
- 4. The DA's decision to charge is independent of whether an alleged offender has been arrested or upon what charges the arrest was based.
- 5. Once charges are filed, the DA is not required to pursue these charges when new or additional factors preclude the likelihood of conviction.
- 6. Generally, once a case is charged, the presumption is that it will proceed to trial.
- ii. Grand Jury Presentment
 - 1. Felony cases must proceed either to a preliminary hearing or grand jury hearing. Grand jury is preferred.
 - 2. Witness preparation:
 - a. Preparation for grand jury is limited due to statutory time constraints;
 - b. Grand jury can have positive therapeutic value for victims;
 - c. When possible, victims shall testify²⁶;
 - d. In limited circumstances, witnesses can have a parent, guardian, or other appropriate person present when them²⁷;
 - i. If granted permission to have a person present during grand jury:
 - 1. The child will chose the person accompanying them; and
 - 2. The person accompanying them shall not participate in any way during the proceeding.

²⁶ ORS 132.320(13): A grand jury, the proceedings of which are recorded pursuant to ORS 132.250 and 132.260, may receive in evidence, through the testimony of a peace officer involved in the criminal investigation under grand jury inquiry, the statement of:

(a) A person who cannot readily understand the proceedings, or who cannot communicate in the proceedings, because of a physical disability or developmental disability; or

(b) A victim under 18 years of age at the time of the proceedings.

²⁷ ORS 132.090(2): Upon a motion filed by the district attorney in the circuit court, the circuit judge may appoint a parent, guardian or other appropriate person 18 years of age or older to accompany any child 12 years of age or younger, or any person with an intellectual disability, during an appearance before the grand jury. The circuit judge, upon the district attorney's showing to the court that it is necessary for the proper examination of a witness appearing before the grand jury, may appoint a guard, medical or other special attendant or nurse, who shall be present in the grand jury room and shall attend such sittings.

3. The prosecuting attorney shall accompany the child to and from Grand Jury and shall be responsible for the child's comfort and safety while the child testifies.
4. The child's caseworker or VA will be responsible for securing child's presence at grand jury, including but not limited to:
 - a. Arranging transportation;
 - b. Arranging a meeting with the prosecuting attorney;
 - c. Explaining the grand jury process; and
 - d. Communicate child's feelings and reactions about testifying at grand jury.
5. If access to child is hindered, MDT will make a decision.
6. The DA's office will advise child and other witnesses as to the outcome of the grand jury proceedings and will cause other concerned agencies to be promptly advised.

iii. Trial

1. Preparation:

- a. Witness preparation shall occur at the discretion of the DA;
- b. Evidentiary considerations are the responsibility of the DA. However, MDT shall cooperate in obtaining additional evidence at the discretion of the DA because the DA has no independent investigative staff.
- c. A child's competency to testify shall be determined by the DA based on information available to them, recommendations of MDT, and opinions of other witnesses and family members.
- d. ODHS shall cooperate with the DA by providing records.

2. Trial:

- a. Presentment of case is prosecuting attorney's responsibility;
- b. MDT shall coordinate and cooperate to advance prosecution.

- Juvenile Cases

- i. The DA, in consultation with the Juvenile Dept. and law enforcement, will review child abuse cases involving youth offenders and make a filing decision based on facts and circumstances of the case.

XVI. Adult Parole and Probation Office

- The role of Hood River Community Corrections, Probation & Parole, (HRCC or P&P) is to supervise felony and qualifying misdemeanors.
- HRCC shall make reports of child abuse and neglect as required by law.
- HRCC will designate representative(s) at MDT meetings.
- HRCC representative will attend meetings if/when their input regarding a particular case would be beneficial.

XVII. Protocol for Investigation of Abuse in Childcare Facilities

- All cases of alleged abuse occurring in a childcare facility shall be investigated by LEA and ODHS.

- Upon receipt of an oral report of alleged abuse, LEA or ODHS shall immediately notify the Childcare Certifier assigned to Hood River County:
 - i. **Oregon Child Care Licensing Division:**
Phone: 1-800-556-6616 or 541-296-5435 x228
General Email: cclcd.customerservice@delc.oregon.gov
 - ii. If alleged abuse occurs in a Family Childcare Home (RWI—Registration Without Inspection), ODHS or LEA shall immediately notify the Central Office of Childcare Division in Salem, Oregon:
Phone: 503-378-3178 or 1-800-556-6616
- When it is clear that alleged abuse occurred in a childcare facility, ODHS or LEA investigators shall make immediate notification to the parents or guardians of all children attending the facility. Notifications should be limited to the following information:
 - i. That an allegation of abuse has been made; and
 - ii. An investigation is in process.
- When any agency receives a report of child abuse, the agency shall immediately notify ODHS or LEA.
- The Childcare Division representative shall attend the MDT review whenever a childcare facility being reviewed.

XVIII. Cross Reporting Child Abuse Allegations²⁸

- Emergency reports require an immediate plan for intervention and safety by ODHS and/or LEA. The following factors should be considered when determining whether emergency circumstances exist:
 - i. Child under 4 years of age, non-accidental injuries or abusive behavior or reports of prior abuse. Injuries do not need to be visible.
 - ii. Child under 6 years of age with disabilities or other special needs, unsupervised or inadequately supervised to the extent that child's immediate needs go unnoticed or unmet, child left in the care of another child(ren) who are too young to protect them, or a child engaged in dangerous activities.
 - iii. Serious physical injuries which create a substantial risk of death, disfigurement, or impairment of physical condition.
 - 1. Examples of serious injuries: fractures, subdural hematoma, dislocation, sprains, internal injuries, burns, extensive welts, bruises, lacerations, and abrasions.

²⁸ 419B.015(b):

(A) When a report of alleged child abuse is received by the department, the department shall notify a law enforcement agency within the county where the alleged abuse occurred or, if that county is unknown, the county where the child resides or, if that county is unknown, the county where the reporter came into contact with the child or the alleged perpetrator of the abuse.

(B) When a report of alleged child abuse is received by a law enforcement agency, the agency shall notify the department by making a report of the alleged child abuse to the centralized child abuse reporting system described in ORS 418.190.

- a. Special consideration given to preschool aged or disabled children.
- iv. Serious illness or life-threatening medical conditions.
 - 1. Examples: suicidal ideations, medically fragile, drug-exposed infants with parent unwilling or unable to obtain medical advice or treatment, maltreatment or neglect—failure to thrive, malnutrition, poisoning, and ingestion of noxious substance.
- v. Cruel, unconscionable, intimidating or terrorizing acts or statements.
 - 1. Examples: deliberate threats to the child's life, intimidating acts with firearms or animals, threats that reflect real and immediate harm to the child's well-being, and grossly inappropriate discipline.
- vi. Allegations of sexual abuse where alleged offender has access to the child.
- vii. Child fatality.
- viii. Parents arrested and child has no other caretaker.
- When Hood River ODHS receives a report of an allegation of child abuse, the intake screener will follow department policy and determine whether the report requires immediate response from ODHS & LEA.
 - i. An appropriate risk assessment will be utilized.
- If an immediate response is required, ODHS will contact LEA by phone and request immediate assistance.
- If immediate response is not required, ODHS will follow department policy regarding notification and inform LEA via email.
- When LEA receives report of child abuse, they will contact ODHS via phone, email, or in person. LEA will request assistance of ODHS if additional follow-up is needed. ODHS will cause a report to be made in the branch.
 - i. If report received outside of regular ODHS hours, LEA will determine if immediate ODHS assistance is needed. LEA will follow established procedures for contacting ODHS.
 - 1. If child safety check performed & LEA deems no safety concerns, LEA will notify ODHS during regular operating hours about their contact. ODHS will write up the contact and follow established guidelines about contacting the family.
 - ii. LEA will provide ODHS all copies of reports concerning domestic violence in homes where children are present. ODHS will decide based on screening guidelines if in-person contact will be made by ODHS.
- All reports of child abuse where ODHS or LEA make contact with a family will be discussed at the next MDT meeting. MDT protocol will be followed to complete any criminal investigations, prosecutions, juvenile court involvement, child protection services, or any mandated community support.
- A cross report must include:
 - i. Information provided by person making child abuse report; and
 - 1. Including: name and contact information for the reporter, names and addresses of the child, names and addresses of the child's parent or

caregiver, child's age, nature and extend of abuse, location of abuse, identity and whereabouts of alleged abuser.

- ii. Name and contact information for the assigned ODHS worker and LEA officer.

XIX. Review of Child Fatality Cases

- Child Fatality Review Team (CFRT) Philosophy:
 - i. The death of any child is a loss to the community. This team is committed to evaluating county systems to look at community agency involvement as a means of improving services and providing a safe community for all children. There is always room for improvement. The Child Fatality Review Team provides an opportunity to honestly evaluate the role of various agencies, systemic issues, and ultimately develop processes that improve the safety of children in Hood River County.
- CFRT will review the deaths of all children under the age of 18 when one or more of the following factors are present:
 - i. Cause of death undetermined after medical examiner's investigation;
 - ii. Head trauma (subdural or subarachnoid) except where the cause is clearly not abuse or neglect;
 - iii. Malnutrition and neglect, including failure to thrive;
 - iv. Bathtub drowning;
 - v. Suffocation or asphyxia;
 - vi. Drug ingestion;
 - vii. Poisoning;
 - viii. Fractures;
 - ix. Blunt force trauma;
 - x. Homicide / child abuse / neglect;
 - xi. Burns except where cause is clearly not abuse or neglect;
 - xii. Sexual abuse;
 - xiii. Gunshot wound; and
 - xiv. Child suicide.
- CFRT may also review deaths of children under the age of 18, when the above criteria are not met, but the DA feels appropriate to have the CFRT review.
- A preventable death occurs when it is determined that reasonable intervention, like medical, educational, social, legal, or psychological, may have precluded the death.
- A non-preventable death includes unpreventable premature birth, Sudden Infant Death Syndrome (SIDS), terminal medical conditions, natural disaster, or unforeseeable medical complications.

XX. Review of Sensitive Cases

- The MDT hereby establishes the following protocol regarding review of sensitive cases:
 - i. A potentially sensitive case may be staffed by MDT to determine whether sensitive case designation is appropriate.

- ii. Upon determination of sensitive case designation, the file shall be forwarded to DA. DA shall assign the matter to a law enforcement officer and ODHS social worker for investigation and review of sensitive case file.
 - iii. If a child abuse investigation is performed outside of Hood River County on behalf of Hood River County, then the outside MDT shall review the case. The Investigative Team of the outside county shall report the results of the investigation to the Hood River DA for review.
 - iv. If the outside county requests review of a sensitive case, the DA of the other county shall assign the matter to a law enforcement officer and ODHS worker for review. The Hood River County offices who participated in the investigation will be available for consultation. Upon completion of review, other county's MDT will notify Hood River DA regarding disposition.
 - v. Parents of the child abuse victim shall be notified that the matter has been sent to another county for review.
- Sensitive cases may include:
 - i. Person or public expresses concern about more than one participating agency in the MDT regarding their practice, and these concerns cannot be resolved by those agencies alone.
 - ii. Member of agency participating in MDT is accused of child abuse.
 - iii. An agency defers their participation in the Investigation Team to a sister agency from another location due to a potential or actual conflict of interest.

XXI. Child Advocacy Center

Hood River County contracts with Safe Space Child Advocacy Center located in Hood River, Oregon. The CAC is committed to building partnership with MDT and providing the best care possible for the children in the communities they serve through evaluations of children possibly abused and neglected and provide forensic interviews and medical examinations in a timely manner so the children do not experience more than one in-depth interview or medical examination.

Organizational Capacity²⁹

SafeSpace designated legal entity is, Columbia Gorge Children's Advocacy Center of the Gorge DBA SafeSpace Children's Advocacy Center of the Gorge non-profit organization established in 2009, that ensures appropriate legal and fiduciary governance and organizational oversight. The role of this governing body is to oversee ongoing business practices of SafeSpace including setting and implementing administrative policies, hiring, and managing personnel, obtaining funding, supervising program and fiscal operations, and long-term planning.

SafeSpace maintains, at a minimum current and general commercial liability, professional liability, directors' and officers' liability, and cyber liability as appropriate for the organization.

²⁹ See NCA Standard 9

SafeSpace has written administrative policies and procedures that govern its administrative operations. Administrative policies and procedures include, at a minimum:

- Personnel policies, procedures, and documents
 - o Job descriptions for all positions
 - o Anti-discrimination policy
 - o Conflict of interest policy
 - o Whistleblower policy
 - o Social media use policy
- Financial management policies and procedures
 - o Accounting policies and procedures that demonstrate adequate internal controls and segregation of duties
 - o Credit card usage policy
- Safety and security policies and procedures
 - o Code of conduct (this should guide behavior between staff, between staff and team members, and between staff/team members and clients)
 - o Child protection policies, including the obligation to report abuse
 - o Emergency response policies
 - o Building security and safety policy and procedures
 - o Anti-Violence in the Workplace policy
 - o Weapons on premises policies and procedures
 - o Drug usage policy
 - o Smoke-free environment
- Information technology policies
 - o Document retention and destruction policies
 - o Data security policies
 - o Confidentiality policies — HIPAA requirements

SafeSpace's budget is between \$200,000 and \$750,000 and therefore must conduct a CPA-completed financial annual review. Confidence in the integrity of the fiscal operations of SafeSpace is critical to the long-term sustainability of the organization. Financial audits and reviews are tools to assess for fiscal soundness and internal controls for financial management.

Due to the sensitive and high-risk nature of the work, SafeSpace has, and demonstrates compliance with, written screening policies for staff board members and volunteers that include national criminal background, sex offender registration, and child abuse registry checks and provides training and supervision to staff and volunteers. In discussion with its Board and MDT, SafeSpace determines what is disqualifying in a background check.

In order to safeguard against unplanned or unexpected changes within the leadership of the organization, SafeSpace has developed a written succession plan to insure the orderly transition and continuance of operation of the center. The plan is specific to the uniqueness of SafeSpace, and includes at a minimum:

- Temporary staffing strategies
- Long-term and/or permanent leadership replacement procedures
- Cross-training plan

- Financial considerations
- Communication plan.

In order to assure long-term viability of the organization, SafeSpace has addressed its sustainability through the implementation of a current strategic plan approved by the governing body.

To reduce employee burnout and improve employee retention, SafeSpace promotes employee well-being by providing training and resources regarding the effects of vicarious trauma, techniques for building resiliency, and maintaining organizational and supervisory strategies to address vicarious trauma and its impact on staff. Training is offered on a yearly basis to SafeSpace staff.

A highly functioning MDT is one in which vicarious trauma can be acknowledged and addressed. While MDT partner agencies have primary responsibility for the health of their workers, SafeSpace promotes MDT well-being by providing access to training and resources on vicarious trauma and building resiliency to MDT members. SafeSpace will offer a survey every six months to the MDT staff that is confidential to learn about how to best serve the MDT group. Yearly training will also be offered to the MDT group.

Child Safety and Protection³⁰

Safe Space CAC has a child-focused setting designed to provide a safe, comfortable, and neutral environment where forensic interviews and other CAC services can be appropriately provided for children and families. Basic safety standards include attending to the physical setting and assuring it meets basic child safety standards, ensuring that alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating an environment that reflects the diversity of clients served. MDT members have access to workspace and equipment on-site to carry out the necessary functions associated with their roles including meeting with families and sharing necessary information. Safe Space communicates, through its design, décor, and materials, that it is a welcoming and child-oriented place for all children and their non-offending family members.

Safe Space is a designated, task-appropriate facility which aligns to the following criteria:

- Maintained in a manner that is physically and psychologically safe for children and their families
- Provides observation or supervision of clients within sight or hearing distance by CAC staff, MDT members, and/or volunteers at all times
- Convenient and accessible to clients and MDT members
- Appropriate for the delivery of CAC services
- Provides age appropriate and culturally diverse toys and other resources that are childproofed, cleaned, and sanitized to be as safe as possible

³⁰ See NCA Standard 10

Safe Space has, and abides by, written policies and procedures that ensure separation of victims and alleged offenders. Safe Space has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and as appropriate throughout delivery of the full array of CAC services.

Safe Space makes reasonable accommodations to make the facility physically accessible:

- Facility is compliant with the Americans Disabilities Act and is physically accessible to clients and family members as needed
- Allows for live observation of interviews by MDT members in a separate space from where the child is being interviewed. The viewing of the forensic interview is provided through audio and video while also being recorded and the medical assessment is provided through audio recordation in real time. There is an established mechanism in place so that MDT members can provide input and feedback during the interview process.

Separate and private areas are available for confidential case consultation and discussion, meetings, and interviews, and for clients awaiting services. MDT members utilize spaces to assure a physically and psychologically safe environment for children and their families, confidentiality, and respect for client privacy.

Safe Space has implemented a code of conduct for staff and MDT members to ensure the safety of children and their families. The code of conduct includes child abuse prevention practices. Staff members must receive and agree to the code of conduct. MDT members must be informed of Safe Space's code of conduct and the expectation that it guides work with Safe Space.

Safe Space conducts child safety assessment annually to ensure that the building and CAC space is safe and child-focused setting for children and their families.

Safe Space staff are mandatory reporters. Safe Space is required to ensure that mandated reporter training is provided to all staff and volunteers. Updates to state statutes and mandated reporter laws are provided to staff and volunteers annually, if applicable.

ROLE OF TEAM MEMBER DISTRICT ATTORNEY

1. The role of the District Attorney is to issue appropriate criminal charges and juvenile petitions and to secure a conviction or a favorable disposition of those matters. Charging decisions shall be based upon the discretion of the District Attorney. The District Attorney shall consult with the MDT when practical before making a charging decision.
2. The protection of the child shall take precedence over criminal prosecution.
3. The District Attorney shall consult with the MDT during the pendency of a case to determine the best disposition and how to lessen the trauma to the child if the matter goes to trial.
4. The District Attorney, or Deputy District Attorney representative, shall chair and facilitate team review meetings.
5. The District Attorney shall have the ultimate responsibility for establishing protocols.
6. The District Attorney shall conduct training for team members.
7. The District Attorney shall, to the extent possible, comply with the protocols developed by the team.

Matthew Ellis
Hood River District Attorney

Date

ROLE OF TEAM MEMBER VICTIM ADVOCATE PROGRAM

1. The Victim Advocate Program (VAP) is located within the DA's office.
2. The role of the Victim Advocate (VA) is to assist the child and child's family through the court process. This may include familiarizing the child with the courthouse, testifying, providing a safe place to wait during court proceedings, providing resources, and being a supportive resource throughout the process.
3. The VA will assist the child and their family with signing up for Crime Victim benefits.
4. The VA will keep the child and their family informed of any court hearings and their rights regarding specific hearings.
5. VAP shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
6. VA will, to the extent possible, comply with the protocols developed by the team.

Kelsey Wellenreiter
Victim Advocate Program Coordinator

Date

ROLE OF TEAM MEMBER HOOD RIVER SHERIFF'S OFFICE

1. The role of the Hood River County Sheriff's Office (HRSO) is to investigate reports of child abuse. Investigative decisions should be based on training and experience and department policies. Law enforcement officers should secure evidence sufficient to issue criminal charges and ultimately obtain a conviction. Consultation with appropriate team members is encouraged.
2. HRSO shall have personnel available 24/7 to conduct investigations into allegations of child abuse and neglect. Designated officers shall be trained in child abuse investigations.
3. HRSO shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
4. When a report is received by LEA, the agency shall immediately notify the local ODHS within the county where the report was made.
5. HRSO will, to the extent possible, comply with the protocols developed by the team.

Matthew English
Hood River County Sheriff

Date

ROLE OF TEAM MEMBER HOOD RIVER POLICE DEPARTMENT

1. The role of the Hood River Police Department (HRPD) is to investigate reports of child abuse. Investigative decisions should be based on training and experience and department policies. Law enforcement officers should secure evidence sufficient to issue criminal charges and ultimately obtain a conviction. Consultation with appropriate team members is encouraged.
2. HRPD shall have personnel available 24/7 to conduct investigations into allegations of child abuse and neglect. Designated officers shall be trained in child abuse investigations.
3. HRPD shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
4. When a report is received by LEA, the agency shall immediately notify the local ODHS within the county where the report was made.
5. HRPD will, to the extent possible, comply with the protocols developed by the team.

Neal Holste
Hood River Chief of Police

Date

ROLE OF TEAM MEMBER OREGON STATE POLICE

1. The role of the Oregon State Police (OSP) is to investigate reports of child abuse. Investigative decisions should be based on training and experience and department policies. Law enforcement officers should secure evidence sufficient to issue criminal charges and ultimately obtain a conviction. Consultation with appropriate team members is encouraged.
2. OSP shall have personnel available 24/7 to conduct investigations into allegations of child abuse and neglect. Designated officers shall be trained in child abuse investigations.
3. OSP shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
4. When a report is received by LEA, the agency shall immediately notify the local ODHS within the county where the report was made.
5. OSP will, to the extent possible, comply with the protocols developed by the team.

XXXXXX
Oregon State Police

Date

ROLE OF TEAM MEMBER JUVENILE DEPARTMENT

1. The role of the Juvenile Department is to provide services to children and youth whose behavior is mainly delinquent in nature.
2. The Juvenile Dept. shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
3. HRSO will, to the extent possible, comply with the protocols developed by the team.

Robbie Johnson
Juvenile Department

Date

ROLE OF TEAM MEMBER OREGON DEPARTMENT OF HUMAN SERVICES

1. The role of the Oregon Department of Human Services (ODHS) is to protect children. Investigative and social support decisions made concerning the protection of children shall be based on professional judgement of ODHS worker and ODHS policies. Consultation with MDT is encouraged.
2. ODHS will assign at least one caseworker to assist the investigation and assessment of child abuse and neglect cases. This person shall be trained in risk assessment and protect appropriate Child Protection Intervention.
3. ODHS shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
4. When a report is received by ODHS, ODHS shall immediately notify the LEA within the county where the report was made.
5. ODHS will, to the extent possible, comply with the protocols developed by the team.

Stephanie Campbell
Department of Human Services

Date

ROLE OF TEAM MEMBER HOOD RIVER COUNTY SCHOOL DISTRICT

1. The role of the Hood River County School District (HRSD) is to implement policy and training so that school employees can identify signs of abuse or neglect among the student body.
2. HRSD shall ensure that all HRSD employees understand and comply with mandatory reporting requirements.
3. HRSD employees shall cooperate with LEA and ODHS investigations.
4. HRSD shall designate a representative at MDT meetings. They are expected to participate to the extent that their input regarding a particular case would be beneficial. The representative shall participate in policy decisions. To the extent possible, the representative will be the same person each meeting.
5. HRSD will, to the extent possible, comply with the protocols developed by the team.

Anne Carloss
Hood River School District

Date

ROLE OF TEAM MEMBER HOOD RIVER COUNTY COMMUNITY CORRECTIONS

1. The role of the Hood River County Community Corrections (HRCC) is to supervise felony and certain misdemeanor parole and probationers. HRCC shall make reports of child abuse or neglect as required by law.
2. HRCC shall designate a representative at MDT meetings. They are expected to participate to the extent that their input regarding a particular case would be beneficial. The representative shall participate in policy decisions. To the extent possible, the representative will be the same person each meeting.
3. HRCC will, to the extent possible, comply with the protocols developed by the team.

Jamie Hepner
Hood River County Community Corrections

Date

ROLE OF TEAM MEMBER CENTER FOR LIVING

1. The role of the Center for Living (CFL) is to provide assessment of treatment needs for the child.
2. CFL will provide intake for supportive treatment for non-offending parent.
3. CFL may designate a representative at MDT meetings. They are expected to participate to the extent that their input regarding a particular case would be beneficial. The representative shall participate in policy decisions. To the extent possible, the representative will be the same person each meeting.
4. CFL will, to the extent possible, comply with the protocols developed by the team.

XXXXXXXXX
Center for Living

Date

ROLE OF TEAM MEMBER HELPING HANDS

1. Helping Hands is a community resource for victims of domestic violence.
2. Helping Hands shall designate a representative at MDT meetings. They are expected to actively participate in case screening and policy decisions. To the extent possible, the representative will be the same person each meeting.
3. Helping Hands will assist the MDT, as requested, in providing assistance to victims of domestic violence.
4. Helping Hands will, to the extent possible, comply with the protocols developed by the team.

XXXXXXXXXXXXX
Helping Hands

Date

CONFIDENTIALITY & PROFESSIONALISM AGREEMENT

Child Multi-Disciplinary Team (MDT) meetings are confidential and not subject to public meeting laws per ORS 418.747³¹ and ORS 192.690³². To assure a coordinated response that fully addresses all systemic concerns surrounding child abuse. MDT members and guests may need to share confidential information about children and families. With this purpose in mind, I agree, in signing this confidentiality agreement, that all information disclosed and received during the MDT review will remain confidential and will only be disclosed when necessary to carry out the purposes of the child abuse investigation.

MDT is a group of professionals from specific and distinct disciplines that collaborate from the point of report and throughout a child and family's involvement with the investigation and/or prosecution of child abuse. MDT fosters open communication, creating an atmosphere of trust and respect that enable MDT members to share ideas and raise concerns.

Team Member

Date

³¹ ORS 418.747(5): To ensure the protection and safe placement of a child, the Department of Human Services may request that team members obtain criminal history information on any person who is part of the household where the department may place or has placed a child who is in the department's custody. All information obtained by the team members and the department in the exercise of their duties is confidential and may be disclosed only when necessary to ensure the safe placement of a child.

³² ORS 192.690(1)(f) & (g) Public Meetings requirements in ORS 192.610 to 192.705 do not apply to:

(f) Meetings of county child abuse multidisciplinary teams required to review child abuse cases in accordance with the provisions of ORS 418.747.

(g) Meetings of child fatality review teams required to review child fatalities in accordance with the provisions of ORS 418.785.

**HOOD RIVER COUNTY CHILD ABUSE MULTIDISCIPLINARY
INTERVENTION ATTENDANCE**

Date _____

Confidentiality Statement: MDT meetings are confidential and not subject to public meetings laws per ORS 418.747 and ORS 192.690. To assure a coordinated response that fully addresses all systematic concerns surrounding child abuse, MDT members and guests may need to share confidential information about children and families. With this purpose in mind, I agree, in signing this attendance sheet and confidentiality statement that all information disclosed and received during the MDT review will remain confidential and will only be disclosed when necessary to carry out the purposes of the child abuse investigation.

[illegible]

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Chapter 418

INVESTIGATION OF CHILD ABUSE, RAPE AND SUICIDE

418.746 Child Abuse Multidisciplinary Intervention Account; uses; eligibility determination; plans; rules.

(1) The Child Abuse Multidisciplinary Intervention Account is established separate and distinct from the General Fund. Interest earned, if any, shall inure to the benefit of the account. All moneys deposited in the account are continuously appropriated to the Department of Justice for the purposes of ORS 418.751 and this section.

(2) The Child Abuse Multidisciplinary Intervention Program, with the advice of the Advisory Council on Child Abuse Assessment, created by ORS 418.784, shall allocate moneys from the Child Abuse Multidisciplinary Intervention Account to eligible county child abuse multidisciplinary teams formed under ORS 418.747, or entities designated by the teams, serving the counties from which the moneys were collected. The program may award only one grant per county. The moneys shall be allocated by the same formula as, or a formula similar to, the formula used by the Attorney General for equitable distribution of the fund for victim's assistance programs under ORS 147.227 (1). Moneys allocated under this subsection may not be used as replacement revenues for currently available funds previously allocated by the county for child abuse intervention.

(3) The Child Abuse Multidisciplinary Intervention Program shall determine eligibility of the applicants and:

- (a) Allocate funds if the applicant is deemed eligible;
- (b) Conditionally allocate funds, with appropriate conditions, when necessary to establish eligibility; or
- (c) Deny funding.

(4) In making the eligibility determination, the Child Abuse Multidisciplinary Intervention Program shall consider the following nonexclusive list of factors:

- (a) Whether the services offered by an applicant substantially further the goals and purposes of ORS 418.747, 418.790 and 418.792;
- (b) Whether the county child abuse multidisciplinary team or the entity designated by the team has properly allocated other available funds;
- (c) Any evaluations of previously funded services as required by subsection (7) of this section;
- (d) The extent to which the county's coordinated child abuse multidisciplinary intervention plan provides for comprehensive services to the victims of child abuse;
- (e) Whether the funds are being used as replacement revenues as prohibited by subsection (2) of this section;
- (f) Whether there is a children's advocacy center or similar advocacy center in existence or proposed for the county; and
- (g) The extent to which funding a children's advocacy center is given priority in the intervention plan as required under subsection (5) of this section.

(5)(a) At least once a biennium, the county child abuse multidisciplinary team shall submit to the Child Abuse Multidisciplinary Intervention Program a coordinated child abuse multidisciplinary intervention plan. The intervention plan must:

- (A) Describe all sources of funding, other than moneys that may be allocated from the Child Abuse Multidisciplinary Intervention Account, including in-kind contributions that are available for the intervention plan;
 - (B) Describe the critical needs of victims of child abuse in the county, including but not limited to child abuse assessment, advocacy and treatment, and how the intervention plan addresses those needs in a comprehensive manner;
 - (C) Include the county's written protocol and agreements required by ORS 418.747 (2) and 418.785; and
 - (D) Describe how the intervention plan gives priority to funding a children's advocacy center and how the funding supports the center.
- (b) When submitting the intervention plan, the county child abuse multidisciplinary team shall also submit:
- (A) Those applications for funding received from entities under subsection (6) of this section that the team determines best meet the needs of the county's intervention plan and a recommendation that the applications for funding be granted; and
 - (B) If the team is seeking funding from the Child Abuse Multidisciplinary Intervention Program, an application setting forth the information required by rule of the program.
- (6) An entity wishing to apply for funding from the Child Abuse Multidisciplinary Intervention Program shall submit an application to the county child abuse multidisciplinary team for the county in which the entity proposes to provide services. The application shall:
- (a) Describe the services to be funded with moneys from the Child Abuse Multidisciplinary Intervention Program according to the coordinated child abuse multidisciplinary intervention plan and the anticipated outcomes in terms of benefits to children and families; and
 - (b) Describe how the services further the goals and purposes of ORS 418.747, 418.790 and 418.792.
- (7)(a) A designated entity providing services according to a coordinated child abuse multidisciplinary intervention plan funded with moneys from the Child Abuse Multidisciplinary Intervention Program shall submit an annual report to the county child abuse multidisciplinary team. A county child abuse multidisciplinary team shall submit an annual report to the Child Abuse Multidisciplinary Intervention Program.
- (b) The annual report filed by the county child abuse multidisciplinary team must:
 - (A) Document how the moneys were utilized and describe to what extent the services were able to meet anticipated outcomes in terms of benefits to children and families.
 - (B) Include local and state issues and recommendations relating to the prevention of child fatalities identified in the fatality review process under ORS 418.785.
 - (c) A county child abuse multidisciplinary team receiving a report from a designated entity shall review the report and take into account success of the entity at meeting service outcomes before making future recommendations regarding allocation of moneys.
 - (d) The Child Abuse Multidisciplinary Intervention Program shall review reports received under this section before making future eligibility and allocation decisions and when evaluating services funded under this section.

(8) Two or more county child abuse multidisciplinary teams may join together to develop joint child abuse multidisciplinary intervention plans. The joint intervention plans shall be submitted as provided in subsection (5) of this section.

(9) The Child Abuse Multidisciplinary Intervention Program may adopt rules to carry out the provisions of ORS 418.751 and this section including, but not limited to, the following:

- (a) Notices and time limits for applications;
- (b) Method of review and the role of advisory bodies; and
- (c) Reallocation of moneys not applied for or disbursed. [1993 c.637 §§3,7; 1997 c.872 §31; 2001 c.624 §4; 2001 c.829 §8; 2003 c.354 §1; 2005 c.562 §5; 2019 c.141 §16]

Note: 418.746 to 418.796 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.747 County teams for investigation; duties; training; method of investigation; designated medical professional.

(1) The district attorney in each county shall be responsible for developing county child abuse multidisciplinary teams to consist of but not be limited to law enforcement personnel, Department of Human Services child protective service workers, school officials, local health department personnel, county mental health department personnel who have experience with children and family mental health issues, child abuse intervention center workers, if available, and juvenile department representatives, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation.

(2) The teams shall develop a written protocol for immediate investigation of and notification procedures for child abuse cases, including child sexual abuse, and for interviewing child abuse victims. Each team also shall develop written agreements signed by member agencies that are represented on the team that specify:

- (a) The role of each agency;
- (b) Procedures to be followed to assess risks to the child;
- (c) Guidelines for timely communication between member agencies;
- (d) Guidelines for completion of responsibilities by member agencies;
- (e) That upon clear disclosure that the alleged child abuse occurred in a child care facility as defined in ORS 329A.250, immediate notification of parents or guardians of children attending the child care facility is required regarding any abuse allegation and pending investigation; and
- (f) Criteria and procedures to be followed when removal of the child is necessary for the child's safety.

(3) Each team member and the personnel conducting child abuse investigations and interviews of child abuse victims shall be trained in risk assessment, the dynamics of child abuse, child sexual abuse and rape of children, and forensic interviewing.

(4) All investigations of child abuse and interviews of child abuse victims shall be carried out by appropriate personnel using the protocols and procedures called for in this section. If trained personnel are not available in a timely fashion and, in the judgment of a law enforcement officer or child protective services worker, there is reasonable cause to believe a delay in investigation or interview of the child abuse victim could place the child in jeopardy of physical harm, the investigation may proceed without full participation of all personnel. This authority applies only

for as long as reasonable danger to the child exists. A law enforcement officer or child protective services worker shall make a reasonable effort to find and provide a trained investigator or interviewer.

(5) To ensure the protection and safe placement of a child, the Department of Human Services may request that team members obtain criminal history information on any person who is part of the household where the department may place or has placed a child who is in the department's custody. All information obtained by the team members and the department in the exercise of their duties is confidential and may be disclosed only when necessary to ensure the safe placement of a child.

(6) Each team shall classify, assess and review cases under investigation.

(7)(a) Each team shall develop and implement procedures for evaluating and reporting compliance of member agencies with the protocols and procedures required under this section. Each team shall submit to the administrator of the Child Abuse Multidisciplinary Intervention Program copies of the protocols and procedures required under this section and the results of the evaluation as requested.

(b) The administrator may:

(A) Consider the evaluation results when making eligibility determinations under ORS 418.746 (3);

(B) If requested by the Advisory Council on Child Abuse Assessment, ask a team to revise the protocols and procedures being used by the team based on the evaluation results; or

(C) Ask a team to evaluate the team's compliance with the protocols and procedures in a particular case.

(c) The information and records compiled under this subsection are exempt from ORS 192.311 to 192.478.

(8) Each team shall develop policies that provide for an independent review of investigation procedures of sensitive cases after completion of court actions on particular cases. The policies shall include independent citizen input. Parents of child abuse victims shall be notified of the review procedure.

(9) Each team shall designate at least one physician, physician assistant or nurse practitioner who has been trained to conduct child abuse assessments, as defined in ORS 418.782, and who is, or who may designate another physician, physician assistant or nurse practitioner who is, regularly available to conduct the medical assessment described in ORS 419B.023.

(10) If photographs are taken pursuant to ORS 419B.028, and if the team meets to discuss the case, the photographs shall be made available to each member of the team at the first meeting regarding the child's case following the taking of the photographs.

(11) No later than September 1, 2008, each team shall submit to the Department of Justice a written summary identifying the designated medical professional described in subsection (9) of this section. After that date, this information shall be included in each regular report to the Department of Justice.

(12) If, after reasonable effort, the team is not able to identify a designated medical professional described in subsection (9) of this section, the team shall develop a written plan outlining the necessary steps, recruitment and training needed to make such a medical professional available to the children of the county. The team shall also develop a written strategy to ensure that each child in the county who is a suspected victim of child abuse will receive a medical assessment in compliance with ORS 419B.023. This strategy, and the estimated fiscal impact of any necessary

recruitment and training, shall be submitted to the Department of Justice no later than September 1, 2008. This information shall be included in each regular report to the Department of Justice for each reporting period in which a team is not able to identify a designated medical professional described in subsection (9) of this section. [1989 c.998 §4; 1991 c.451 §1; 1993 c.622 §5; 1995 c.134 §1; 1997 c.703 §2; 2001 c.900 §121; 2003 c.354 §2; 2005 c.562 §6; 2007 c.674 §6; 2015 c.736 §63; 2017 c.356 §40; 2019 c.141 §17]

Note: See note under 418.746.

418.748 Statewide team on child abuse and suicide.

(1) The Oregon Health Authority, in collaboration with the Department of Human Services, shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations and take actions involving statewide issues.

(2) The statewide interdisciplinary team may recommend specific cases to a child fatality review team for its review under ORS 418.785.

(3) The statewide interdisciplinary team shall provide recommendations to child fatality review teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases. [1989 c.998 §5; 1991 c.451 §4; 1997 c.714 §2; 2005 c.562 §7; 2013 c.14 §8]

Note: See note under 418.746.

418.749 [1989 c.998 §6; 1993 c.546 §104; 1993 c.622 §6; renumbered 418.702 in 2005]

418.750 [1971 c.451 §3; 1973 c.110 §2; 1975 c.644 §4; 1981 c.892 §94; repealed by 1993 c.546 §141]

418.751 Training and education for persons investigating child abuse.

(1) The Department of Human Services, as provided in ORS 418.702, and the Department of Justice shall ensure that training and education are provided for persons, other than law enforcement officers, who are required to investigate allegations of child abuse.

(2)(a) The Department of Human Services shall provide trauma-informed training for employees within the department who are responsible for licensing, certifying or otherwise authorizing child-caring agencies and foster homes and for employees who investigate such agencies and homes. The training provided under this subsection must include the following:

- (A) Interview models and practices that are informed by policy, research and practice guidelines, with an emphasis on avoiding retraumatization by interview;
- (B) Recognizing characteristic signs and symptoms of child traumatic stress in children of different developmental ages and cultural backgrounds;
- (C) The impact of trauma on a child's safety, permanency and well-being;
- (D) Using and administering trauma-informed assessment tools, instruments and practice strategies;
- (E) Collection of information on a child's trauma history;
- (F) Techniques that promote children's recovery and resiliency; and

(G) Methods for improving placement stability by reducing the number of placements, shortening length of stays in care and reducing the number of placement moves.

(b) Subject to the availability of funds, the Director of Human Services may extend trauma-informed training to other persons in the child welfare system including caseworkers, foster parents, parents, medical examiners and educators.

(3) The Department of Human Services shall work to develop a written set of guidelines for trauma-informed practices for department employees who work with programs for children that can be shared with other entities, including but not limited to the Oregon Health Authority, the Oregon Youth Authority and the Board on Public Safety Standards and Training.

(4) The Department of Human Services and the Department of Justice shall work with the Board on Public Safety Standards and Training to ensure that the training that is offered to persons under subsection (1) of this section and ORS 418.702 is coordinated with the training given to law enforcement officers. [1993 c.637 §§6,12; 2001 c.624 §5; 2005 c.562 §8; 2012 c.37 §57; 2017 c.498 §1]

Note: See note under 418.746.

418.753 [1995 c.757 §1; 1997 c.714 §3; 2005 c.562 §9; renumbered 418.706 in 2005]

418.755 [1971 c.451 §4; 1975 c.644 §7; 1977 c.741 §1; repealed by 1993 c.546 §141]

418.756 [1997 c.714 §1; renumbered 418.704 in 2005]

418.760 [1971 c.451 §5; 1975 c.644 §8; 1977 c.741 §2; 1983 c.815 §13; 1985 c.723 §2; 1989 c.998 §2; repealed by 1993 c.546 §141]

418.762 [1975 c.644 §6; repealed by 1993 c.546 §141]

418.764 [1977 c.97 §2; repealed by 1993 c.546 §141]

418.765 [1971 c.451 §6; 1973 c.306 §1; 1975 c.644 §9; 1977 c.741 §3; 1989 c.371 §1; repealed by 1993 c.546 §141]

418.770 [1971 c.451 §7; 1973 c.306 §2; 1975 c.644 §10; 1977 c.741 §4; 1983 c.153 §1; 1985 c.601 §1; 1987 c.906 §8; 1993 c.33 §330; repealed by 1993 c.546 §141]

418.775 [Formerly 146.770; 1973 c.110 §1; 1975 c.644 §11; 1981 c.892 §95; repealed by 1993 c.546 §141]

CHILDREN'S ADVOCACY CENTERS

418.780 Purpose.

- (1) The Legislative Assembly recognizes that:
 - (a) Protection of the child is of primary importance.
 - (b) A serious need exists for a coordinated multidisciplinary approach to the prevention and investigation of child abuse, for intervention and for the treatment of children who are victims of child abuse in a manner that is sensitive to the needs of children. No child in this state should be denied access to a child abuse assessment because of an inability to pay. The cost of not assessing and treating abused children with the aid of specially trained personnel is too high.
- (2) The purpose of ORS 418.746 to 418.796 is to establish and maintain:
 - (a) Sufficient county child abuse multidisciplinary teams to conduct timely investigations of allegations of child abuse and provide comprehensive services to victims of child abuse through coordinated child abuse multidisciplinary intervention plans.
 - (b) Sufficient children's advocacy centers and regional children's advocacy centers in Oregon to ensure that every child referred to a center for concerns of neglect or abuse receives a skilled, complete and forensically sound child abuse assessment.
 - (c) Sufficient coordination, expertise and support to provide training and technical assistance to county child abuse multidisciplinary teams. [1991 c.898 §1; 1993 c.33 §331; 1997 c.872 §32; 2001 c.624 §6; 2005 c.562 §4; 2019 c.141 §2]

Note: See note under 418.746.

418.782 Definitions for ORS 418.746 to 418.796. As used in ORS 418.746 to 418.796:

- (1) "Child abuse" means "abuse" as defined by ORS 419B.005.
- (2) "Child abuse assessment" means services provided by a children's advocacy center for the purpose of determining whether or not a child has been abused and identifying the appropriate treatment or referral for follow-up for the child. "Child abuse assessment" may include one or more of the following:
 - (a) A medical assessment;
 - (b) A forensic interview;
 - (c) Care coordination; or
 - (d) Family support.
- (3) "Children's advocacy center" means a facility that meets the facility standards described in ORS 418.788, to which a child from the community may be referred to receive a thorough child abuse assessment for the purpose of determining whether the child has been abused or neglected, and that facilitates a coordinated, comprehensive and multidisciplinary response to cases of child abuse.
- (4) "Forensic interview" means an interview that is conducted by an individual who has completed training described in ORS 418.788 for the purpose of preserving a child's statements and that is conducted in a manner that is legally sound, age appropriate, of a neutral, fact-finding nature and coordinated to avoid duplicative interviewing.
- (5) "Medical assessment" means the taking of a child's thorough medical history and a complete physical examination of the child, for the purpose of making a medical diagnosis, by or under the

direction of an individual trained in the evaluation, diagnosis and treatment of child abuse who is a licensed physician, physician assistant or nurse practitioner.

(6) “Regional children’s advocacy center” means a facility operated by a children’s advocacy center that meets the facility standards described in ORS 418.788 and is selected by the Child Abuse Multidisciplinary Intervention Program to provide training and complex case assistance.

(7) “Training and complex case assistance” includes one or more of the following:

- (a) Consultation;
- (b) Education;
- (c) Referral;
- (d) Technical assistance; and
- (e) If authorized by the Department of Justice, other services as needed. [1991 c.898 §2; 1993 c.546 §105; 1993 c.622 §8; 1997 c.872 §33; 1997 c.873 §32; 2005 c.562 §10; 2019 c.141 §1]

Note: See note under 418.746.

418.783 Child Abuse Multidisciplinary Intervention Program.

(1) The Child Abuse Multidisciplinary Intervention Program is established in the Department of Justice. The purpose of the program is to:

- (a) Establish and maintain a coordinated multidisciplinary community-based system for responding to allegations of child abuse that is sensitive to the needs of children;
- (b) Ensure the safety and health of children who are victims of child abuse to the greatest extent possible; and
- (c) Administer the grant programs established under ORS 418.746 and 418.786.

(2) The Attorney General or the Attorney General’s designee is the administrator of the Child Abuse Multidisciplinary Intervention Program and of the Child Abuse Multidisciplinary Intervention Account established in ORS 418.746. [2005 c.562 §2]

Note: See note under 418.746.

418.784 Advisory Council on Child Abuse Assessment; membership; officers; meetings; quorum.

(1) There is created the Advisory Council on Child Abuse Assessment, consisting of at least nine members appointed by the Attorney General. The Attorney General shall serve as an ex officio member of the council. The council shall direct the administrator of the Child Abuse Multidisciplinary Intervention Program on the administration of funds to establish and maintain children’s advocacy centers or regional children’s advocacy centers under ORS 418.746 to 418.796.

(2) Of the members appointed to the council:

- (a) One member shall be an employee of the Department of Human Services with duties related to child protective services;
- (b) One member shall be a physician licensed to practice medicine in Oregon who specializes in children and families;
- (c) One member shall be a person having experience dealing with child abuse;
- (d) One member shall be a district attorney or the designee of a district attorney;

- (e) One member shall be an employee of a law enforcement agency, in addition to the member who is a district attorney or the designee of a district attorney;
 - (f) One member shall be from an operating regional children's advocacy center; and
 - (g) At least three members shall be citizens with appropriate interest in advocating for the medical interest of abused children.
- (3) Members of the council who are not state employees:
- (a) Are not entitled to compensation; and
 - (b) Are entitled to reimbursement for actual and necessary travel expenses incurred by them in the performance of their official duties as members of the council if there are sufficient funds available in the Child Abuse Multidisciplinary Intervention Account established in ORS 418.746.
- (4) Members of the council who are state employees carrying out their state employment functions are entitled to compensation and reimbursement by their employing agencies for actual and necessary travel and other expenses incurred by them in the performance of their official duties as members of the council.
- (5) The council shall elect one of its members to serve as chairperson, for such terms and with such duties and powers as the council determines.
- (6) The council shall meet at least four times per year at a place, day and hour determined by the council.
- (7) A majority of the members of the council constitutes a quorum for the transaction of business. [1991 c.898 §3; 1993 c.33 §332; 1997 c.872 §34; 1999 c.59 §115; 2001 c.624 §7; 2003 c.354 §3; 2005 c.562 §25; 2019 c.141 §18]

Note: See note under 418.746.

418.785 Child fatality review teams.

- (1) Each county child abuse multidisciplinary team shall establish a child fatality review team to conduct child fatality reviews. The purpose of the review process is to help prevent severe and fatal child abuse and neglect by:
- (a) Identifying local and state issues related to preventable child fatalities; and
 - (b) Promoting implementation of recommendations at the county level.
- (2) In establishing the review process and carrying out reviews, the child fatality review team shall be assisted by the county medical examiner or local health officer as well as other professionals who are specially trained in areas relevant to the purpose of the team.
- (3) The categories of fatalities reviewed by the child fatality review team include:
- (a) Child fatalities in which child abuse or neglect may have occurred at any time prior to death or may have been a factor in the fatality;
 - (b) Any category established by the county child abuse multidisciplinary team;
 - (c) All child fatalities where the child is less than 18 years of age and there is an autopsy performed by the medical examiner; and
 - (d) Any specific cases recommended for local review by the statewide interdisciplinary team established under ORS 418.748.
- (4) A child fatality review team shall develop a written protocol for review of child fatalities. The protocol shall be designed to facilitate communication and the exchange of information between persons who perform autopsies and those professionals and agencies concerned with the prevention, investigation and treatment of child abuse and neglect.

(5) Within the guidelines, and in a format, established by the statewide interdisciplinary team established under ORS 418.748, the child fatality review team shall provide the statewide interdisciplinary team with information regarding the categories of child fatalities described under subsection (3) of this section.

(6) Upon the conclusion of a criminal case involving a child fatality, or upon the conclusion of a direct appeal if one is taken, the district attorney may submit a letter to the Governor and the Director of Human Services outlining recommendations for the systemic improvement of child abuse investigations. [2005 c.562 §20; 2007 c.674 §8; 2015 c.736 §64; 2019 c.141 §19]

Note: See note under 418.746.

418.786 Grant program. To accomplish the purpose described in ORS 418.780, with the assistance of the Advisory Council on Child Abuse Assessment, the administrator of the Child Abuse Multidisciplinary Intervention Program shall develop and administer a grant program to establish and maintain children's advocacy centers and regional children's advocacy centers, *to support training and technical assistance efforts for county child abuse multidisciplinary teams and children's advocacy centers* and to provide coordination and support for the work of regional children's advocacy centers. [1991 c.898 §4; 1993 c.33 §333; 1997 c.872 §35; 2001 c.624 §8; 2005 c.562 §11; 2019 c.141 §3]

Note: See note under 418.746.

418.788 Grant application; criteria for awarding grants; rules.

(1) Subject to the availability of funds under the provisions of ORS 418.796, the administrator of the Child Abuse Multidisciplinary Intervention Program shall make grants for the establishment and maintenance of children's advocacy centers or regional children's advocacy centers.

(2)(a) A public or private agency may apply to the administrator for a grant to:

(A) Establish and maintain a children's advocacy center or regional children's advocacy center;

(B) Provide training and technical assistance to children's advocacy centers or county child abuse multidisciplinary teams; or

(C) Provide coordination and support to regional children's advocacy centers.

(b) The administrator may consolidate applications from more than one public or private agency or may return the application with the recommendation that the application be consolidated.

(3) The administrator shall by rule establish criteria for awarding grants to establish and maintain children's advocacy centers or regional children's advocacy centers, including but not limited to:

(a) Expenses eligible for reimbursement from funds under ORS 418.796;

(b) The extent to which the applicant's proposal will best accomplish the purposes of ORS 418.746 to 418.796;

(c) The extent to which an applicant meets criteria for receiving a grant to:

(A) Establish and maintain a children's advocacy center or regional children's advocacy center;

(B) Provide training and technical assistance to children's advocacy centers and county child abuse multidisciplinary teams; or

(C) Provide coordination and support to regional children's advocacy centers;

- (d) Minimum facility standards for children's advocacy centers and regional children's advocacy centers consistent with national accreditation standards to ensure that children receive consistent, evidence-based intervention services statewide;
 - (e) Minimum forensic interview training standards that are consistent with national forensic interview training standards, evidence-based and supported by current forensic interview research; and
 - (f) For a regional children's advocacy center, the extent to which the applicant's proposal meets the documented needs of the communities, children's advocacy centers and county child abuse multidisciplinary teams in the region or regions to be served by the center.
- (4) The administrator is not required to fund any grant in the total amount requested in the application. [1991 c.898 §5; 1993 c.33 §334; 1997 c.872 §36; 2001 c.624 §9; 2003 c.354 §4; 2005 c.562 §12; 2019 c.141 §4]

Note: See note under 418.746.

418.790 Application contents for regional centers; rules. Each application for funds to establish or maintain a regional children's advocacy center or to provide training and technical assistance to children's advocacy centers or county child abuse multidisciplinary teams shall include information required by the rules of the Department of Justice and any other information requested by the department. [1991 c.898 §§6,8; 1993 c.33 §335; 1997 c.872 §37; 2001 c.104 §147; 2001 c.624 §14; 2003 c.354 §5; 2005 c.562 §13; 2009 c.296 §2; 2019 c.141 §5]

Note: See note under 418.746.

418.792 Application contents for children's advocacy center. Each application for funds to establish and maintain a children's advocacy center shall include:

- (1) Evidence indicating that the applicant has at least one medical practitioner trained in the evaluation, diagnosis and treatment of child abuse and neglect.
- (2) A commitment by the medical practitioner:
 - (a) To attend annual continuing education courses regarding evaluation and diagnosis of child abuse and neglect; and
 - (b) To refer complex cases, as defined by the Advisory Council on Child Abuse Assessment by rule, to a regional children's advocacy center.
- (3) Evidence indicating the proposed children's advocacy center has access to special equipment used in the evaluation of child abuse.
- (4) A description of where the children's advocacy center is to be located, including but not limited to a hospital, medical clinic or other appropriate public or private agency. However, the proposed center may not be located in an office of the Department of Human Services or in the office of any law enforcement agency.
- (5) The level of support available to the proposed children's advocacy center through in-kind contributions from the community.
- (6) A description of procedures to be followed by the proposed children's advocacy center, including the availability of personnel from the children's advocacy center to testify in cases involving alleged abuse of children evaluated by the center. [1991 c.898 §7; 1997 c.130 §10; 1997 c.872 §38; 2005 c.562 §14; 2019 c.141 §20]

Note: See note under 418.746.

418.793 Report to Child Abuse Multidisciplinary Intervention Program; rules. Once each year, each recipient of a grant from the Child Abuse Multidisciplinary Intervention Program shall submit a report to the program describing how the grant recipient has met the purposes of ORS 418.746 to 418.796. The program may prescribe by rule a form for the report. [2001 c.624 §12; 2005 c.562 §15; 2019 c.141 §6]

Note: See note under 418.746.

418.794 Confidentiality of video recordings. Video recordings produced pursuant to ORS 418.746 to 418.796 shall remain in the custody of the children's advocacy center or the regional children's advocacy center and shall remain confidential and not subject to public disclosure except under a lawfully issued subpoena and protective order. [1991 c.898 §9; 1993 c.33 §336; 2005 c.562 §16; 2019 c.141 §21]

Note: See note under 418.746.

418.795 Confidentiality of information and records.

(1) All information and records acquired by a county child abuse multidisciplinary team established under ORS 418.747 or a child fatality review team established under ORS 418.785 in the exercise of its duties are confidential and may be disclosed only when necessary to carry out the purposes of the child abuse investigation or the child fatality review process.

(2) A member agency of a county child abuse multidisciplinary team or a member of the team may use or disclose protected health information without obtaining an authorization from an individual or a personal representative of the individual if use or disclosure is necessary for public health purposes, including the prevention, investigation and treatment of child abuse.

(3) A child fatality review team shall have access to and subpoena power to obtain all medical records, hospital records and records maintained by any state, county or local agency, including, but not limited to, police investigative data, coroner or medical examiner investigative data and social services records, as necessary to complete a child abuse investigation or a review of a specific fatality under ORS 418.785.

(4) As used in this section, "personal representative" and "protected health information" have the meanings given those terms in ORS 192.556. [2005 c.562 §19; 2019 c.141 §22]

Note: See note under 418.746.

418.796 Authority of council to solicit and accept contributions. The Advisory Council on Child Abuse Assessment may solicit and accept contributions of funds and assistance from the United States, its agencies or from other sources, public or private, and agree to conditions not inconsistent with the purposes of ORS 418.746 to 418.796. All funds received are to aid in financing the functions of the advisory council and the purposes of ORS 418.746 to 418.796 and shall be deposited in the General Fund of the State Treasury to the credit of a separate account and are continuously appropriated to the Child Abuse Multidisciplinary Intervention Program established by ORS 418.783 for the purposes of ORS 418.746 to 418.796. [1991 c.898 §10; 1993 c.33 §337; 1997 c.872 §39; 2001 c.624 §10; 2005 c.562 §17]

Note: See note under 418.746.

418.800 Review of certain cases by county child abuse multidisciplinary team.

(1) If, in a case of alleged child sexual abuse as described in ORS 419B.005 (1)(a)(C), (D) or (E) by a parent, guardian or caregiver living in the child's home, the Department of Human Services asks the parent, guardian or caregiver to move from the family home during the investigation and the parent, guardian or caregiver consents to leave the family home, the department shall notify the district attorney responsible for the county child abuse multidisciplinary team for the county in which the child resides about the case. The notification shall be in writing and be given no later than three business days after the departure of the parent, guardian or caregiver from the family home.

(2) A parent, guardian or caregiver who consents to leave the family home as described in subsection (1) of this section or the spouse of the parent, guardian or caregiver may ask the district attorney responsible for the county child abuse multidisciplinary team for a review of the case by the team.

(3) No later than 90 days after receiving a request under subsection (2) of this section, the county child abuse multidisciplinary team shall:

(a) Review the case and consider at least the following:

(A) Whether the investigation should continue;

(B) The welfare of the child and the adults living in the family home; and

(C) The proposed timeline for completing the investigation; and

(b) Provide to the person who requested the review a summary of the proposed timeline for completing the investigation.

(4)(a) This section may not be construed to create a new private right of action against a district attorney or any member of a county child abuse multidisciplinary team.

(b) A district attorney and members of a county child abuse multidisciplinary team reviewing a case under subsection (2) of this section are immune from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to reviewing a case, failing to review a case referred to the team under subsection (2) of this section or providing to the person who requested the review a summary of the proposed timeline for completing the investigation.

(c) The act of reviewing a case or failing to review a case referred to the county child abuse multidisciplinary team under subsection (2) of this section or providing or failing to provide a summary to the person who requested the review may not be used by a defendant in any subsequent criminal prosecution or juvenile proceeding. [2005 c.499 §2; 2019 c.141 §23]

Note: 418.800 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

CRITICAL INCIDENT REVIEW TEAMS

418.804 Short title. ORS 418.806 to 418.816 and 419B.023 shall be known and may be cited as “Karly’s Law.” [Formerly 419B.022]

Note: 418.804 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.805 [1969 c.641 §1; 1977 c.717 §20; 1979 c.745 §1; 1987 c.794 §1; renumbered 657A.250 in 1993]

418.806 Policy.

(1) The purpose of the Critical Incident Review Teams under ORS 418.806 to 418.816 is to increase child safety by:

- (a) Rapidly drawing lessons from a particular critical incident for the improvement of systems administered by the Department of Human Services;
- (b) Increasing the department’s accountability to the public;
- (c) Evaluating and learning from cases designated as critical incidents;
- (d) Ensuring timely responses by the department with respect to critical incidents and recommendations that result from critical incident reviews; and
- (e) Increasing the department’s ability to address and recommend necessary changes to child welfare systems.

(2) Reviews conducted by teams under ORS 418.806 to 418.816 are in addition to and separate from reviews conducted by county multidisciplinary child abuse teams formed under ORS 418.747, statewide interdisciplinary teams formed under ORS 418.748 and the department’s child welfare protocols regarding Notification and Review of Child Fatalities and Notification and Review of Sensitive Issues. [2019 c.555 §3]

Note: 418.806 to 418.816 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 418 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

418.808 Critical incident. As used in ORS 418.806 to 418.816, “critical incident” means an incident that resulted in the death of a child if the Department of Human Services reasonably believes the death was the result of child abuse and:

- (1) The child was in the custody of the department at the time of death;
- (2) The child, the child’s sibling or any other child living in the household with the child was the subject of a child protective services assessment by the department within the 12 months preceding the fatality;
- (3) The child, the child’s sibling or any other child living in the household with the child had a pending child welfare or adoption case with the department within the 12 months preceding the fatality; or
- (4) The child, the child’s sibling or any other child living in the household with the child was the subject of a report of abuse or neglect made to the department or a law enforcement agency

within the 12 months preceding the fatality, whether or not the report was closed at screening without an investigation being commenced. [2019 c.555 §2]

Note: See note under 418.806.

418.810 [1969 c.641 §2; 1971 c.401 §48; 1975 c.311 §1; 1987 c.794 §4; 1993 c.344 §31; 1993 c.469 §6; renumbered 657A.280 in 1993]

418.811 Team assignment and membership; rules.

- (1) When the Department of Human Services becomes aware of a critical incident, the department shall assign a Critical Incident Review Team.
- (2) The department shall assign the team required under subsection (1) of this section no later than the earlier of:
 - (a) Ten days after the department becomes aware of a fatality that the department reasonably believes is the result of child abuse; or
 - (b) Seven days after the department causes an investigation under ORS 419B.020 to be made into the nature and cause of a fatality when the department reasonably believes the fatality is the result of child abuse.
- (3)(a) Members of the team shall include, at a minimum, the following:
 - (A) The Director of Human Services or a deputy director of the department;
 - (B) The lead department personnel responsible for the administration and oversight of the child welfare system within the department or the lead personnel's deputy; and
 - (C) The department personnel responsible for media and communications.
- (b) Members of the team may include:
 - (A) Members of the public, appointed by the director, as appropriate;
 - (B) A juvenile court judge appointed by the Chief Justice of the Supreme Court;
 - (C) A member of a local citizen review board established under ORS 419A.090 whose service area does not include the location where the critical incident occurred; or
 - (D) If the director determines it is appropriate to include one or more legislators as members of the team, up to one state Senator appointed by the President of the Senate and one state Representative appointed by the Speaker of the House of Representatives. A person is ineligible for appointment to a team under this subparagraph if the critical incident occurred in the person's district, the person had prior contact with or knowledge of the deceased child or the deceased child's family, or the person is a family member of any person associated with the case.
- (4)(a) During the course of its review of the case, the team may include or consult with the district attorney from the county in which the critical incident occurred.
 - (b) All members of the team must attend meetings of the team in person, by telephone or by other two-way electronic communication device. A team member may not send a delegate to meetings of the team to appear on the member's behalf. Notwithstanding the provisions of this paragraph, a meeting of the team may be convened and held even if one or more members are unable to attend the meeting.
- (5)(a) All information and records available to the department regarding the critical incident shall be provided to team members. Information and records under this subsection include, but are not

limited to, medical records, hospital records, records maintained by any state, county or local agency, police investigative data, coroner or medical examiner investigative data and social services records, as necessary to complete a case review under this section.

(b) Information and records provided to team members are confidential and may be disclosed only as necessary to carry out the purposes of the team's case review.

(6) In reviewing the case to which the team has been assigned, the team shall, with the assistance and cooperation of the department:

(a) Review the case with the primary focus on the history of the safety and well-being of the child who was involved in the critical incident and any other children who may be impacted by the circumstances surrounding the critical incident.

(b) Document and make a part of the record of the case review all team conclusions and decisions.

(c) Complete the case review even if:

(A) The team concludes that the critical incident was the result of the actions of one or more department employees or staff and that such actions were inconsistent with department policy or administrative rule; or

(B) The department's investigation into the critical incident results in a finding that the report of child abuse is unfounded or cannot be determined, as described in ORS 419B.026.

(d) Prepare and submit the final report required under ORS 418.813.

(7) If the team concludes that the critical incident involves personnel matters relevant to the department, the department shall refer the matters to the human resources or personnel divisions of the department.

(8) The team may meet, upon conclusion of a criminal investigation or prosecution arising out of a child fatality to which the team was assigned for review, with members of law enforcement that investigated the child fatality or with the prosecuting attorneys who prosecuted the case for the purpose of reviewing the conclusions and recommendations of the team and the reports prepared and submitted by the team.

(9) The department shall adopt rules necessary to carry out the provisions of ORS 418.806 to 418.816. The rules adopted by the department shall substantially conform with the department's child welfare protocol regarding Notification and Review of Critical Incidents. [Formerly 419B.024]

Note: See note under 418.806.

418.813 Report.

(1) Subject to subsection (2)(b) of this section, each Critical Incident Review Team assigned under ORS 418.811 shall submit a detailed, written final report to the Department of Human Services no later than the 100th day following the date the department assigned the team.

(2)(a) Prior to publishing a final report under this section, the department shall take into consideration the following:

(A) Whether publication of the report is likely to compromise an ongoing investigation of a law enforcement agency, after the team has communicated with and obtained agreement of appropriate law enforcement agency representatives and the district attorney;

- (B) Whether the report can be modified so as to permit publication of the report without compromising a law enforcement agency investigation; and
 - (C) Whether, as determined by the team with the advice and consultation of the Director of Human Services, the public interest outweighs the potential consequences to a law enforcement agency investigation as provided in ORS 192.345 (3).
- (b) The director may extend the deadline for publication of the final report if the director determines that the report, even if modified, will compromise a law enforcement agency investigation and the public interest does not outweigh the potential consequences.
- (3) Each final report must include, to the extent determined, at a minimum:
 - (a) A description of the critical incident.
 - (b) The date of the critical incident.
 - (c) The date the department first became aware of the fatality.
 - (d) The date the department or a law enforcement agency caused an investigation to be made under ORS 419B.020 to determine the nature and cause of the fatality.
 - (e) The date the findings in the case were entered under ORS 419B.026.
 - (f) The date the department assigned the team.
 - (g) The dates of, and number of members in attendance at, each meeting of the team.
 - (h) Whether the director appointed members of the public to the team.
 - (i) The date the team submitted the final report to the department.
 - (j) A description of all department contacts with the deceased child regarding the critical incident, including contacts with the deceased child's siblings or the deceased child's parents, foster parents or other caretakers. The description of the department's contacts under this paragraph must include a description of any relevant prior reports of abuse the department received involving the individuals identified in this paragraph. The description of relevant prior reports of abuse must include:
 - (A) A summary of the specific nature of any allegations of abuse;
 - (B) A summary of the assessment or investigation activities related to any allegations of abuse; and
 - (C) The disposition of the reports, including whether the reports were assigned for assessment or investigation.
 - (k) A description of any concerns the team has regarding actions taken or not taken by the department or law enforcement agencies in response to the critical incident or to the events that led to the critical incident.
 - (L) Any recommendations for improvements in the administration and oversight of the child welfare system that are specific to the critical incident and any historical information reviewed by the team.
- (4) A final report under this section may include the team's recommendations regarding training and intervention to support the department personnel involved in responding to critical incidents.
- (5) Each final report shall be written in a manner that respects the dignity of the child, the child's family and those involved in the critical incident case. Details about individuals involved in the case may not be included in the report unless the details are relevant to:
 - (a) The history of alleged abuse and neglect of the deceased child and the history of relevant alleged abuse and neglect of other children in the deceased child's home at the time of the critical incident and the deceased child's siblings.

- (b) The exposure of the deceased child or any other children in the deceased child's home at the time of the critical incident to domestic violence or substance abuse.
 - (c) The history of the department's involvement with the family.
 - (d) The goal of constructively informing public policy related to child welfare, which may include public policies related to health care coordination, public health, suicide prevention, mental health and addiction services, poverty, law enforcement, chronic neglect, prevention services or other issues that affect the safety and well-being of Oregon families.
- (6) A final report may not include the names of any person assigned to the team or any personally identifiable information regarding any person involved in the critical incident case, including but not limited to employees of the department, the Oregon Health Authority or law enforcement.
- (7) Any statements contained in a final report or document created solely for the critical incident review process that are or may be construed as an admission of error, liability or violation of law, policy or practice are not admissible as evidence in any civil or administrative proceeding. This restriction does not apply to any document that existed prior to its use and consideration in a critical incident review or that is created independently of the critical incident review process. [2019 c.555 §4]

Note: See note under 418.806.

418.815 [1969 c.641 §3; 1971 c.401 §49; 1985 c.792 §2; 1991 c.390 §3; 1993 c.344 §32; renumbered 657A.290 in 1993]

418.816 Critical Incident Review Team website.

- (1) After assigning a Critical Incident Review Team under ORS 418.811, the Department of Human Services shall immediately make the following information regarding the critical incident available on the department's website:
- (a) The date of the critical incident and the age of the deceased child.
 - (b) Whether the child was in the custody of the department at the time of the critical incident or the fatality.
 - (c) Whether there was an open abuse investigation under ORS 419B.020 regarding the child at the time of the critical incident or the fatality.
 - (d) The date the department assigned the team.
 - (e) The due date for the team's final report under ORS 418.813.
- (2)(a) The department shall publish the final report on the department's website no later than 10 days after the department receives the report from the team.
- (b) The department may redact the final report for purposes of publication only as necessary to remove any confidential information or records that may not be disclosed under state or federal law.
 - (c) If the Director of Human Services delays the publication of a final report under ORS 418.813 (2)(b), the department shall publish on the department's website:
 - (A) The status of and expected publication date for the report.
 - (B) Any information in the report that the department determines:
 - (i) Will not compromise a law enforcement agency investigation.

(ii) Does not require redaction under paragraph (b) of this subsection.
[2019 c.555 §5]

Note: See note under 418.806.

418.817 [1987 c.621 §12; 1987 c.794 §3; renumbered 657A.440 in 1993]

418.820 [1969 c.641 §4; 1975 c.268 §1; 1985 c.792 §3; 1989 c.439 §2; 1991 c.390 §2; 1993 c.344 §33; renumbered 657A.260 in 1993]

418.825 [1969 c.641 §5; 1971 c.401 §50; 1993 c.344 §34; renumbered 657A.300 in 1993]

418.830 [1969 c.641 §6; 1971 c.401 §51; 1975 c.311 §2; 1993 c.344 §35; renumbered 657A.310 in 1993]

418.835 [1969 c.641 §7; 1971 c.401 §52; 1993 c.344 §36; 1993 c.733 §4; renumbered 657A.270 in 1993]

418.840 [1969 c.641 §8; 1975 c.268 §2; 1993 c.344 §37; 1993 c.733 §5; renumbered 657A.350 in 1993]

418.845 [1969 c.641 §9; 1971 c.401 §53; 1973 c.612 §19; 1993 c.344 §38; 1993 c.733 §6; renumbered 657A.360 in 1993]

418.850 [1969 c.641 §11; 1971 c.401 §54; 1975 c.311 §3; 1993 c.344 §39; renumbered 657A.390 in 1993]

418.855 [1969 c.641 §12; 1971 c.401 §55; 1987 c.794 §6; 1993 c.344 §40; renumbered 657A.400 in 1993]

418.860 [1969 c.641 §13; 1971 c.401 §56; 1993 c.344 §41; renumbered 657A.410 in 1993]

418.865 [1969 c.641 §15; 1971 c.401 §57; 1993 c.344 §42; renumbered 657A.420 in 1993]

418.870 [1969 c.641 §14; 1971 c.401 §58; 1993 c.344 §43; renumbered 657A.370 in 1993]

418.875 [1969 c.641 §4a; 1971 c.401 §59; repealed by 1975 c.352 §2]

418.880 [1969 c.641 §§4b,4c; 1971 c.401 §60; repealed by 1975 c.352 §2]

418.885 [1969 c.641 §10; 1971 c.401 §61; 1993 c.344 §44; renumbered 657A.450 in 1993]

418.890 [1979 c.745 §2; renumbered 657A.460 in 1993]

418.900 [1979 c.524 §1; 1989 c.302 §1; renumbered 657A.500 in 1993]

418.905 [1979 c.524 §2; 1985 c.650 §1; 1987 c.585 §2; 1989 c.302 §2; 1993 c.344 §45; renumbered 657A.510 in 1993]

418.910 [1979 c.524 §3; 1989 c.302 §3; 1993 c.344 §46; renumbered 657A.520 in 1993]

418.915 [1979 c.524 §4; 1991 c.67 §109; 1993 c.344 §47; renumbered 657A.530 in 1993]

418.920 [1979 c.524 §5; 1991 c.67 §110; repealed by 1993 c.344 §49]

Chapter 419B

REPORTING AND INVESTIGATION OF CHILD ABUSE

419B.005 Definitions. As used in ORS 419B.005 to 419B.050, unless the context requires otherwise:

(1)(a) “Abuse” means:

(A) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child that has been caused by other than accidental means, including any injury that appears to be at variance with the explanation given of the injury.

(B) Any mental injury to a child, which shall include only cruel or unconscionable acts or statements made, or threatened to be made, to a child if the acts, statements or threats result in severe harm to the child’s psychological, cognitive, emotional or social well-being and functioning.

(C) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are described in ORS chapter 163.

(D) Sexual abuse, as described in ORS chapter 163.

(E) Sexual exploitation, including but not limited to:

- (i) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163, and any other conduct that allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe or the photographing, filming, tape recording or other exhibition that, in whole or in part, depicts sexual conduct or contact, as defined in ORS 167.002 or described in ORS 163.665 and 163.670, sexual abuse involving a child or rape of a child, but not including any conduct that is part of any investigation conducted pursuant to ORS 419B.020 or that is designed to serve educational or other legitimate purposes; and
- (ii) Allowing, permitting, encouraging or hiring a child to engage in prostitution as described in ORS 167.007 or a commercial sex act as defined in ORS 163.266, to purchase sex with a minor as described in ORS 163.413 or to engage in commercial sexual solicitation as described in ORS 167.008.

(F) Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child.

(G) Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child’s health or welfare.

(H) Buying or selling a person under 18 years of age as described in ORS 163.537.

(I) Permitting a person under 18 years of age to enter or remain in or upon premises where methamphetamines are being manufactured.

(J) Unlawful exposure to a controlled substance, as defined in ORS 475.005, or to the unlawful manufacturing of a cannabinoid extract, as defined in ORS 475C.009, that subjects a child to a substantial risk of harm to the child’s health or safety.

- (K) The restraint or seclusion of a child in violation of ORS 339.285, 339.288, 339.291, 339.303 or 339.308.
- (L) The infliction of corporal punishment on a child in violation of ORS 339.250 (9).
- (b) “Abuse” does not include reasonable discipline unless the discipline results in one of the conditions described in paragraph (a) of this subsection.
- (2) “Child” means an unmarried person who:
 - (a) Is under 18 years of age; or
 - (b) Is a child in care, as defined in ORS 418.257.
- (3) “Higher education institution” means:
 - (a) A community college as defined in ORS 341.005;
 - (b) A public university listed in ORS 352.002;
 - (c) The Oregon Health and Science University; and
 - (d) A private institution of higher education located in Oregon.
- (4)(a) “Investigation” means a detailed inquiry into or assessment of the safety of a child alleged to have experienced abuse.
 - (b) “Investigation” does not include screening activities conducted upon the receipt of a report.
- (5) “Law enforcement agency” means:
 - (a) A city or municipal police department.
 - (b) A county sheriff’s office.
 - (c) The Oregon State Police.
 - (d) A police department established by a university under ORS 352.121 or 353.125.
 - (e) A county juvenile department.
- (6) “Public or private official” means:
 - (a) Physician or physician assistant licensed under ORS chapter 677 or naturopathic physician, including any intern or resident.
 - (b) Dentist.
 - (c) School employee, including an employee of a higher education institution.
 - (d) Licensed practical nurse, registered nurse, nurse practitioner, nurse’s aide, home health aide or employee of an in-home health service.
 - (e) Employee of the Department of Human Services, Oregon Health Authority, Department of Early Learning and Care, Department of Education, Youth Development Division, the Oregon Youth Authority, a local health department, a community mental health program, a community developmental disabilities program, a county juvenile department, a child-caring agency as that term is defined in ORS 418.205 or an alcohol and drug treatment program.
 - (f) Peace officer.
 - (g) Psychologist.
 - (h) Member of the clergy.
 - (i) Regulated social worker.
 - (j) Optometrist.
 - (k) Chiropractor.
 - (L) Certified provider of foster care, or an employee thereof.
 - (m) Attorney.
 - (n) Licensed professional counselor.

- (o) Licensed marriage and family therapist.
- (p) Firefighter or emergency medical services provider.
- (q) Court appointed special advocate, as defined in ORS 419A.004.
- (r) Child care provider registered or certified under ORS 329A.250 to 329A.450.
- (s) Elected official of a branch of government of this state or a state agency, board, commission or department of a branch of government of this state or of a city, county or other political subdivision in this state.
- (t) Physical, speech or occupational therapist.
- (u) Audiologist.
- (v) Speech-language pathologist.
- (w) Employee of the Teacher Standards and Practices Commission directly involved in investigations or discipline by the commission.
- (x) Pharmacist.
- (y) Operator of a preschool recorded program under ORS 329A.255.
- (z) Operator of a school-age recorded program under ORS 329A.255.
- (aa) Employee of a private agency or organization facilitating the provision of respite services, as defined in ORS 418.205, for parents pursuant to a properly executed power of attorney under ORS 109.056.
- (bb) Employee of a public or private organization providing child-related services or activities:
 - (A) Including but not limited to an employee of a:
 - (i) Youth group or center;
 - (ii) Scout group or camp;
 - (iii) Summer or day camp;
 - (iv) Survival camp; or
 - (v) Group, center or camp that is operated under the guidance, supervision or auspices of a religious, public or private educational system or a community service organization; and
 - (B) Excluding an employee of a qualified victim services program as defined in ORS 147.600 that provides confidential, direct services to victims of domestic violence, sexual assault, stalking or human trafficking.
- (cc) Coach, assistant coach or trainer of an amateur, semiprofessional or professional athlete, if compensated and if the athlete is a child.
- (dd) Personal support worker, as defined in ORS 410.600.
- (ee) Home care worker, as defined in ORS 410.600.
- (ff) Animal control officer, as defined in ORS 609.500.
- (gg) Member of a school district board, an education service district board or a public charter school governing body.
- (hh) Individual who is paid by a public body, in accordance with ORS 430.215, to provide a service identified in an individualized service plan of a child with a developmental disability.
- (ii) Referral agent, as defined in ORS 418.351.
- (jj) Parole and probation officer, as defined in ORS 181A.355.
- (kk) Behavior analyst or assistant behavior analyst licensed under ORS 676.810 or behavior analysis interventionist registered by the Health Licensing Office under ORS 676.815. [1993 c.546 §12; 1993 c.622 §1a; 1995 c.278 §50; 1995 c.766 §1; 1997 c.127

§1; 1997 c.561 §3; 1997 c.703 §3; 1997 c.873 §30; 1999 c.743 §22; 1999 c.954 §4; 2001 c.104 §148; 2003 c.191 §1; 2005 c.562 §26; 2005 c.708 §4; 2009 c.199 §1; 2009 c.442 §36; 2009 c.518 §1; 2009 c.570 §6; 2009 c.595 §364; 2009 c.633 §10; 2009 c.708 §3; 2010 c.60 §§4,5; 2011 c.151 §12; 2011 c.506 §38; 2011 c.703 §34; 2012 c.37 §60; 2012 c.92 §1; 2013 c.129 §26; 2013 c.180 §40; 2013 c.623 §17; 2013 c.624 §82; 2013 c.720 §11; 2015 c.98 §7; 2015 c.179 §1; 2015 c.736 §65; 2016 c.106 §39; 2017 c.21 §55; 2018 c.75 §21; 2019 c.137 §§1,2; 2019 c.176 §§1,2; 2019 c.455 §§3,4; 2019 c.618 §§16,17; 2021 c.97 §44; 2021 c.214 §1; 2021 c.251 §2; 2021 c.391 §4; 2021 c.590 §4; 2021 c.631 §58; 2022 c.27 §16; 2022 c.90 §§7,8; 2023 c.9 §§28,29; 2023 c.267 §§5,6; 2023 c.500 §§8,9; 2023 c.554 §52; 2023 c.581 §§3,4]

Note: The amendments to 419B.005 by section 6, chapter 581, Oregon Laws 2023, become operative July 1, 2028, and apply to incidents occurring on or after July 1, 2028. See sections 13 and 14, chapter 581, Oregon Laws 2023. The text that is operative on and after July 1, 2028, is set forth for the user’s convenience.

419B.005. As used in ORS 419B.005 to 419B.050, unless the context requires otherwise:

(1)(a) “Abuse” means:

(A) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child that has been caused by other than accidental means, including any injury that appears to be at variance with the explanation given of the injury.

(B) Any mental injury to a child, which shall include only cruel or unconscionable acts or statements made, or threatened to be made, to a child if the acts, statements or threats result in severe harm to the child’s psychological, cognitive, emotional or social well-being and functioning. (C) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are described in ORS chapter 163.

(D) Sexual abuse, as described in ORS chapter 163.

(E) Sexual exploitation, including but not limited to:

- (i) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163, and any other conduct that allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe or the photographing, filming, tape recording or other exhibition that, in whole or in part, depicts sexual conduct or contact, as defined in ORS 167.002 or described in ORS 163.665 and 163.670, sexual abuse involving a child or rape of a child, but not including any conduct that is part of any investigation conducted pursuant to ORS 419B.020 or that is designed to serve educational or other legitimate purposes; and
- (ii) Allowing, permitting, encouraging or hiring a child to engage in prostitution as described in ORS 167.007 or a commercial sex act as defined in ORS 163.266, to purchase sex with a minor as described in ORS 163.413 or to engage in commercial sexual solicitation as described in ORS 167.008.

(F) Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child.

- (G) Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare.
 - (H) Buying or selling a person under 18 years of age as described in ORS 163.537.
 - (I) Permitting a person under 18 years of age to enter or remain in or upon premises where methamphetamines are being manufactured.
 - (J) Unlawful exposure to a controlled substance, as defined in ORS 475.005, or to the unlawful manufacturing of a cannabinoid extract, as defined in ORS 475C.009, that subjects a child to a substantial risk of harm to the child's health or safety.
 - (K) The infliction of corporal punishment on a child in violation of ORS 339.250 (9).
- (b) "Abuse" does not include reasonable discipline unless the discipline results in one of the conditions described in paragraph (a) of this subsection.
- (2) "Child" means an unmarried person who:
- (a) Is under 18 years of age; or
 - (b) Is a child in care, as defined in ORS 418.257.
- (3) "Higher education institution" means:
- (a) A community college as defined in ORS 341.005;
 - (b) A public university listed in ORS 352.002;
 - (c) The Oregon Health and Science University; and
 - (d) A private institution of higher education located in Oregon.
- (4)(a) "Investigation" means a detailed inquiry into or assessment of the safety of a child alleged to have experienced abuse.
- (b) "Investigation" does not include screening activities conducted upon the receipt of a report.
- (5) "Law enforcement agency" means:
- (a) A city or municipal police department.
 - (b) A county sheriff's office.
 - (c) The Oregon State Police.
 - (d) A police department established by a university under ORS 352.121 or 353.125.
 - (e) A county juvenile department.
- (6) "Public or private official" means:
- (a) Physician or physician assistant licensed under ORS chapter 677 or naturopathic physician, including any intern or resident.
 - (b) Dentist.
 - (c) School employee, including an employee of a higher education institution.
 - (d) Licensed practical nurse, registered nurse, nurse practitioner, nurse's aide, home health aide or employee of an in-home health service.
 - (e) Employee of the Department of Human Services, Oregon Health Authority, Department of Early Learning and Care, Department of Education, Youth Development Division, the Oregon Youth Authority, a local health department, a community mental health program, a community developmental disabilities program, a county juvenile department, a child-caring agency as that term is defined in ORS 418.205 or an alcohol and drug treatment program.
 - (f) Peace officer.

- (g) Psychologist.
- (h) Member of the clergy.
- (i) Regulated social worker.
- (j) Optometrist.
- (k) Chiropractor.
- (L) Certified provider of foster care, or an employee thereof.
- (m) Attorney.
- (n) Licensed professional counselor.
- (o) Licensed marriage and family therapist.
- (p) Firefighter or emergency medical services provider.
- (q) Court appointed special advocate, as defined in ORS 419A.004.
- (r) Child care provider registered or certified under ORS 329A.250 to 329A.450.
- (s) Elected official of a branch of government of this state or a state agency, board, commission or department of a branch of government of this state or of a city, county or other political subdivision in this state.
- (t) Physical, speech or occupational therapist.
- (u) Audiologist.
- (v) Speech-language pathologist.
- (w) Employee of the Teacher Standards and Practices Commission directly involved in investigations or discipline by the commission.
- (x) Pharmacist.
- (y) Operator of a preschool recorded program under ORS 329A.255.
- (z) Operator of a school-age recorded program under ORS 329A.255.
- (aa) Employee of a private agency or organization facilitating the provision of respite services, as defined in ORS 418.205, for parents pursuant to a properly executed power of attorney under ORS 109.056.
- (bb) Employee of a public or private organization providing child-related services or activities:
 - (A) Including but not limited to an employee of a:
 - (i) Youth group or center;
 - (ii) Scout group or camp;
 - (iii) Summer or day camp;
 - (iv) Survival camp; or
 - (v) Group, center or camp that is operated under the guidance, supervision or auspices of a religious, public or private educational system or a community service organization; and
 - (B) Excluding an employee of a qualified victim services program as defined in ORS 147.600 that provides confidential, direct services to victims of domestic violence, sexual assault, stalking or human trafficking.
- (cc) Coach, assistant coach or trainer of an amateur, semiprofessional or professional athlete, if compensated and if the athlete is a child.
- (dd) Personal support worker, as defined in ORS 410.600.
- (ee) Home care worker, as defined in ORS 410.600.
- (ff) Animal control officer, as defined in ORS 609.500.
- (gg) Member of a school district board, an education service district board or a public charter school governing body.

(hh) Individual who is paid by a public body, in accordance with ORS 430.215, to provide a service identified in an individualized service plan of a child with a developmental disability.

(ii) Referral agent, as defined in ORS 418.351.

(jj) Parole and probation officer, as defined in ORS 181A.355.

(kk) Behavior analyst or assistant behavior analyst licensed under ORS 676.810 or behavior analysis interventionist registered by the Health Licensing Office under ORS 676.815.

419B.007 Policy. The Legislative Assembly finds that for the purpose of facilitating the use of protective social services to prevent further abuse, safeguard and enhance the welfare of abused children, and preserve family life when consistent with the protection of the child by stabilizing the family and improving parental capacity, it is necessary and in the public interest to require mandatory reports and investigations of abuse of children and to encourage voluntary reports. [1993 c.546 §13]

419B.010 Duty of officials to report child abuse; exceptions; penalty.

(1) Any public or private official having reasonable cause to believe that any child with whom the official comes in contact has suffered abuse or that any person with whom the official comes in contact has abused a child shall immediately report or cause a report to be made in the manner required in ORS 419B.015. Nothing contained in ORS 40.225 to 40.295 or 419B.234 (6) affects the duty to report imposed by this section, except that a psychiatrist, psychologist, member of the clergy, attorney or guardian ad litem appointed under ORS 419B.231 is not required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295 or 419B.234 (6). An attorney is not required to make a report under this section by reason of information communicated to the attorney in the course of representing a client if disclosure of the information would be detrimental to the client.

(2) Notwithstanding subsection (1) of this section, a report need not be made under this section if the public or private official acquires information relating to abuse by reason of a report made under this section, or by reason of a proceeding arising out of a report made under this section, and the public or private official reasonably believes that the information is already known by a law enforcement agency or the Department of Human Services.

(3) The duty to report under this section is personal to the public or private official alone, regardless of whether the official is employed by, a volunteer of or a representative or agent for any type of entity or organization that employs persons or uses persons as volunteers who are public or private officials in its operations.

(4) The duty to report under this section exists regardless of whether the entity or organization that employs the public or private official or uses the official as a volunteer has its own procedures or policies for reporting abuse internally within the entity or organization.

(5) A person who violates subsection (1) of this section commits a Class A violation. Prosecution under this subsection shall be commenced at any time within 18 months after commission of the offense. [1993 c.546 §14; 1999 c.1051 §180; 2001 c.104 §149; 2001 c.904 §15; 2005 c.450 §7; 2012 c.92 §11]

419B.015 Report form and content; notice.

(1)(a) A person making a voluntary report of child abuse shall make an oral report to the Department of Human Services by telephone to the child abuse reporting hotline described in ORS 418.190 or to a law enforcement agency within the county where the person making the

report is located at the time of the contact. A person making a report of child abuse that is required by ORS 419B.010 shall make the report to the department through the centralized child abuse reporting system described in ORS 418.190 or to a law enforcement agency within the county where the person making the report is located at the time of the contact. The report must contain, if known, the names and addresses of the child and the parents of the child or other persons responsible for care of the child, the child's age, the nature and extent of the abuse, including any evidence of previous abuse, the explanation given for the abuse and any other information that the person making the report believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator.

(b)(A) When a report of alleged child abuse is received by the department, the department shall notify a law enforcement agency within the county where the alleged abuse occurred or, if that county is unknown, the county where the child resides or, if that county is unknown, the county where the reporter came into contact with the child or the alleged perpetrator of the abuse.

(B) When a report of alleged child abuse is received by a law enforcement agency, the agency shall notify the department by making a report of the alleged child abuse to the centralized child abuse reporting system described in ORS 418.190.

(c) When a report of alleged child abuse is received by the department or by a law enforcement agency, the department or law enforcement agency, or both, may collect information concerning the military status of the parent or guardian of the child who is the subject of the report and may share the information with the appropriate military authorities. Disclosure of information under this paragraph is subject to ORS 419B.035 (7).

(2) When a report of alleged child abuse is received under subsection (1)(a) of this section, the entity receiving the report shall make the notification required by subsection (1)(b) of this section according to rules adopted by the department under ORS 419B.017.

(3)(a) When a report alleging that a child or ward in substitute care may have been subjected to abuse is received by the department, the department shall notify the attorney for the child or ward, the child's or ward's court appointed special advocate, the parents of the child or ward and any attorney representing a parent of the child or ward that a report has been received.

(b) The name and address of and other identifying information about the person who made the report may not be disclosed under this subsection. Any person or entity to whom notification is made under this subsection may not release any information not authorized by this subsection.

(c) The department shall make the notification required by this subsection within three business days of receiving the report of alleged child abuse.

(d) Notwithstanding the obligation imposed by this subsection, the department is not required under this subsection to notify the parent or parent's attorney that a report of alleged child abuse has been received if the notification may interfere with an investigation or assessment or jeopardize the child's or ward's safety. [1993 c.546 §15; 1993 c.734 §1a; 2005 c.250 §1; 2007 c.237 §1; 2017 c.210 §1; 2019 c.181 §1; 2023 c.132 §2]

419B.016 Offense of false report of child abuse.

- (1) A person commits the offense of making a false report of child abuse if, with the intent to influence a custody, parenting time, visitation or child support decision, the person:
 - (a) Makes a false report of child abuse to the Department of Human Services or a law enforcement agency, knowing that the report is false; or
 - (b) With the intent that a public or private official make a report of child abuse to the Department of Human Services or a law enforcement agency, makes a false report of child abuse to the public or private official, knowing that the report is false.
- (2) Making a false report of child abuse is a Class A violation. [2011 c.606 §2]

Note: 419B.016 was added to and made a part of 419B.005 to 419B.050 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

419B.017 Time limits for notification between law enforcement agencies and Department of Human Services; rules.

- (1) The Department of Human Services shall adopt rules establishing:
 - (a) The time within which the notification required by ORS 419B.015 (1)(b) must be made. At a minimum, the rules shall:
 - (A) Establish which reports of child abuse require notification within 24 hours after receipt;
 - (B) Provide that all other reports of child abuse require notification within 10 days after receipt; and
 - (C) Establish criteria that enable the department or a law enforcement agency to quickly and easily identify reports that require notification within 24 hours after receipt.
 - (b) How the notification is to be made.
- (2) The department shall appoint an advisory committee to advise the department in adopting rules required by this section. The department shall include as members of the advisory committee representatives of law enforcement agencies and multidisciplinary teams formed pursuant to ORS 418.747 and other interested parties.
- (3) The department may recommend practices and procedures to local law enforcement agencies to meet the requirements of rules adopted under this section. [2005 c.250 §3; 2019 c.181 §2; 2023 c.132 §6]

Note: 419B.017 was added to and made a part of 419B.005 to 419B.050 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

419B.019 Investigation of report involving school; notification; report to Legislative Assembly; rules.

- (1) As used in this section:
 - (a) “Agent” means a person who:
 - (A) Acts as an agent for an education provider in a manner that requires the person to have direct, unsupervised contact with children; and
 - (B) Interacts with a child because of the person’s status as an agent for an education provider.

- (b) “Contractor” means a person who:
 - (A) Provides services to an education provider under a contract in a manner that requires the person to have direct, unsupervised contact with children; and
 - (B) Interacts with a child because of the person’s status as a contractor for an education provider.
 - (c) “Education provider” has the meaning given that term in ORS 339.370.
 - (d) “School employee” means a person who:
 - (A) Is an employee of an education provider; and
 - (B) Interacts with a child because of the person’s status as an employee of an education provider.
 - (e) “Volunteer” means a person who:
 - (A) Acts as a volunteer for an education provider in a manner that requires the person to have direct, unsupervised contact with children; and
 - (B) Interacts with a child because of the person’s status as a volunteer of an education provider.
- (2) A law enforcement agency or the Department of Human Services must conduct an investigation as provided by ORS 419B.020 if the law enforcement agency or department receives a report of abuse that involves a child and a person who is a school employee, contractor, agent or volunteer.
- (3) A law enforcement agency shall notify the department as provided by ORS 419B.015 if the law enforcement agency receives a report described in subsection (2) of this section. The department shall notify a law enforcement agency as provided by ORS 419B.015 if the department receives a report described in subsection (2) of this section. The department shall ensure that an investigation related to the report is conducted if the report is not investigated by a law enforcement agency.
- (4)(a) Within three business days of receiving a report or notification of a report described in subsection (2) of this section, the department shall notify:
- (A) The appropriate education provider to ensure the safety of the child, if the department believes the report of suspected abuse involves the child and a person who is a school employee, contractor, agent or volunteer;
 - (B) The Teacher Standards and Practices Commission, if the department believes the school employee, contractor, agent or volunteer is licensed, registered or certified by the commission; or
 - (C) The Department of Education, if the Department of Human Services believes the report of suspected abuse:
 - (i) Occurred in a school or was related to a school-sponsored activity; or
 - (ii) Involves a child and a person who is a school employee, contractor, agent or volunteer and whose conduct may be subject to actions taken by the Department of Education under ORS 339.370 to 339.400.
- (b) For the purpose of notification made under this subsection, the Department of Human Services may not disclose the name and address of, and other identifying information about, the person who made the report, but the department shall make available any information necessary to ensure the safety of the child, including the name of the school and the name of the person who may have conducted the suspected abuse. Except as provided by ORS 339.389, any person or entity to whom notification is made under this subsection may not release any information not authorized by this subsection.

- (c) When the Department of Education receives notification under this subsection, the department shall act under, and is subject to, ORS 339.389.
- (5) The Department of Human Services shall submit a report on the first day of every calendar quarter to the committees or interim committees of the Legislative Assembly related to child welfare, for the purposes of public review and oversight of the quality and safety of education providers. Information provided in reports under this subsection may not contain the name of a child or any identifying information about a child. The reports must contain all of the following information about each investigation described in subsection (2) of this section that resulted in a finding, during the preceding quarter, that the report of abuse was substantiated:
- (a) The name of the education provider where the department conducted the investigation;
 - (b) The approximate date that the abuse occurred;
 - (c) The nature of the abuse and a brief narrative description of the abuse that occurred; and
 - (d) Whether a reportable injury, sexual abuse or death resulted from the abuse.
- (6) The department may adopt any rules necessary for the administration of this section. [2019 c.618 §14; 2021 c.386 §5; 2023 c.570 §14; 2023 c.581 §7]

Note: 419B.019 was added to and made a part of 419B.005 to 419B.050 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

419B.020 Duty of department or law enforcement agency receiving report; investigation; notice; physical examination; child's consent; notice at conclusion of investigation.

- (1) If the Department of Human Services or a law enforcement agency receives a report of child abuse, the department or the agency shall immediately:
- (a) Cause an investigation to be made to determine the nature and cause of the abuse of the child; and
 - (b) Make the following notifications:
 - (A) To the Department of Early Learning and Care if the alleged child abuse occurred in a child care facility as defined in ORS 329A.250; or
 - (B) To the Department of Education if the alleged child abuse occurred in a school, was related to a school-sponsored activity or was conduct that may be subject to actions taken by the Department of Education under ORS 339.370 to 339.400.
- (2) The Department of Human Services shall ensure that an investigation required by subsection (1) of this section is completed if the report is not investigated by a law enforcement agency.
- (3) If the alleged child abuse reported in subsection (1) of this section occurred at a child care facility or in a school, was related to a school-sponsored activity or was conduct that may be subject to actions taken by the Department of Education under ORS 339.370 to 339.400:
- (a) The Department of Human Services and the law enforcement agency shall jointly determine the roles and responsibilities of the Department of Human Services and the agency in their respective investigations; and
 - (b) The Department of Human Services and the agency shall each report the outcomes of their investigations:

- (A) To the Department of Early Learning and Care if the alleged child abuse occurred in a child care facility as defined in ORS 329A.250; or
 - (B) To the Department of Education if the alleged child abuse:
 - (i) Occurred in a school;
 - (ii) Was related to a school-sponsored activity; or
 - (iii) Was conduct that may be subject to actions taken by the Department of Education under ORS 339.370 to 339.400.
- (4) If the law enforcement agency conducting the investigation finds reasonable cause to believe that abuse has occurred, the law enforcement agency shall notify the Department of Human Services by making an oral report followed by a written report to the centralized child abuse reporting system described in ORS 418.190. The department shall provide protective social services of its own or of other available social agencies if necessary to prevent further abuses to the child or to safeguard the child's welfare.
- (5) If a child is taken into protective custody by the Department of Human Services, the department shall promptly make reasonable efforts to ascertain the name and address of the child's parents or guardian.
- (6)(a) If a child is taken into protective custody by the Department of Human Services or a law enforcement official, the department or law enforcement official shall, if possible, make reasonable efforts to advise the parents or guardian immediately, regardless of the time of day, that the child has been taken into custody, the reasons the child has been taken into custody and general information about the child's placement, and the telephone number of the local office of the department and any after-hours telephone numbers.
- (b) Notice may be given by any means reasonably certain of notifying the parents or guardian, including but not limited to written, telephonic or in-person oral notification. If the initial notification is not in writing, the information required by paragraph (a) of this subsection also shall be provided to the parents or guardian in writing as soon as possible.
 - (c) The department also shall make a reasonable effort to notify the noncustodial parent of the information required by paragraph (a) of this subsection in a timely manner.
 - (d) If a child is taken into custody while under the care and supervision of a person or organization other than the parent, the department, if possible, shall immediately notify the person or organization that the child has been taken into protective custody.
- (7) If a law enforcement officer or the Department of Human Services, when taking a child into protective custody, has reasonable cause to believe that the child has been affected by sexual abuse and rape of a child as defined in ORS 419B.005 (1)(a)(C) and that physical evidence of the abuse exists and is likely to disappear, the court may authorize a physical examination for the purposes of preserving evidence if the court finds that it is in the best interest of the child to have such an examination. Nothing in this section affects the authority of the department to consent to physical examinations of the child at other times.
- (8) A minor child of 12 years of age or older may refuse to consent to the examination described in subsection (7) of this section. The examination shall be conducted by or under the supervision of a physician licensed under ORS chapter 677, a physician assistant licensed under ORS 677.505 to 677.525 or a nurse practitioner licensed under ORS chapter 678 and, whenever practicable, trained in conducting such examinations.
- (9) When the Department of Human Services completes an investigation under this section, if the person who made the report of child abuse provided contact information to the department, the department shall notify the person about whether contact with the child was made, whether the

department determined that child abuse occurred and whether services will be provided. The department is not required to disclose information under this subsection if the department determines that disclosure is not permitted under ORS 419B.035.

(10) When the Department of Education receives a notification under subsection (1) of this section or a report on the outcomes of an investigation under subsection (3) of this section, the Department of Education shall act under, and is subject to, ORS 339.389. [1993 c.546 §16; 1993 c.622 §7a; 1997 c.130 §13; 1997 c.703 §1; 1997 c.873 §33; 2007 c.501 §4; 2007 c.781 §1; 2013 c.624 §83; 2014 c.45 §41; 2017 c.356 §41; 2019 c.141 §24; 2019 c.618 §18; 2021 c.386 §6; 2023 c.132 §7; 2023 c.554 §53; 2023 c.570 §13]

419B.021 Degree requirements for persons conducting investigation or making determination regarding child.

(1) Except as provided in subsection (2) of this section, a person who conducts an investigation under ORS 419B.020, makes a determination that a child must be taken into protective custody under ORS 419B.150 or 419B.152 or makes a determination that a child should not be released to the child's parent or other responsible person under ORS 419B.165 (1)(b) must have:

(a) At least a bachelor's degree in:

(A) Human services or a field related to human services; or

(B) A field other than one described in subparagraph (A) of this paragraph, if the Department of Human Services determines by rule that the coursework completed by the person is equivalent to a bachelor's degree in human services and that the person has sufficient training in providing human services; or

(b) An associate degree with additional training or additional certification in human services or a field related to human services, as determined by the department by rule.

(2) Subsection (1) of this section does not apply to a law enforcement official as defined in ORS 147.005. [2011 c.431 §1; 2019 c.153 §1; 2019 c.594 §6a; 2019 c.631 §3]

Note: 419B.021 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 419B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

419B.022 [2007 c.674 §1; 2019 c.555 §7; renumbered 418.804 in 2019]

419B.023 Duties of person conducting investigation under ORS 419B.020.

(1) As used in this section:

(a) "Designated medical professional" means the person described in ORS 418.747 (9) or the person's designee.

(b) "Medical assessment" has the meaning given that term in ORS 418.782.

(c) "Suspicious physical injury" includes, but is not limited to:

(A) Burns or scalds;

(B) Extensive bruising or abrasions on any part of the body;

(C) Bruising, swelling or abrasions on the head, neck or face;

(D) Fractures of any bone in a child under the age of three;

(E) Multiple fractures in a child of any age;

(F) Dislocations, soft tissue swelling or moderate to severe cuts;

- (G) Loss of the ability to walk or move normally according to the child's developmental ability;
 - (H) Unconsciousness or difficulty maintaining consciousness;
 - (I) Multiple injuries of different types;
 - (J) Injuries causing serious or protracted disfigurement or loss or impairment of the function of any bodily organ; or
 - (K) Any other injury that threatens the physical well-being of the child.
- (2)(a) If a person conducting an investigation under ORS 419B.020 observes a child who has suffered suspicious physical injury and the person is certain or has a reasonable suspicion that the injury is or may be the result of abuse, the person shall, in accordance with the protocols and procedures of the county child abuse multidisciplinary team described in ORS 418.747:
- (A) Immediately photograph or cause to have photographed the suspicious physical injuries in accordance with ORS 419B.028; and
 - (B) Ensure that a designated medical professional conducts a medical assessment within 48 hours, or sooner if dictated by the child's medical needs.
- (b) Notwithstanding ORS 419B.150, the person described in paragraph (a) of this subsection may take the child into protective custody, without a court order, only for the period of time necessary to ensure compliance with the requirements of this subsection.
- (3) The requirement of subsection (2) of this section shall apply:
- (a) Each time suspicious physical injury is observed by Department of Human Services or law enforcement personnel:
 - (A) During the investigation of a new allegation of abuse; or
 - (B) If the injury was not previously observed by a person conducting an investigation under ORS 419B.020; and
 - (b) Regardless of whether the child has previously been photographed or assessed during an investigation of an allegation of abuse.
- (4)(a) Department or law enforcement personnel shall make a reasonable effort to locate a designated medical professional. If after reasonable efforts a designated medical professional is not available to conduct a medical assessment within 48 hours, the child shall be evaluated by an available physician, a physician assistant licensed under ORS 677.505 to 677.525 or a nurse practitioner licensed under ORS 678.375 to 678.390.
- (b) If the child is evaluated by a health care provider as defined in ORS 127.505 other than a designated medical professional, the health care provider shall make photographs, clinical notes, diagnostic and testing results and any other relevant materials available to the designated medical professional for consultation within 72 hours following evaluation of the child.
 - (c) The person conducting the medical assessment may consult with and obtain records from the child's health care provider under ORS 419B.050.
- (5) Nothing in this section prevents a person conducting a child abuse investigation from seeking immediate medical treatment from a hospital emergency room or other medical provider for a child who is physically injured or otherwise in need of immediate medical care.
- (6) If the child described in subsection (2) of this section is less than five years of age, the designated medical professional may, within 14 days, refer the child for a screening for early intervention services or early childhood special education, as those terms are defined in ORS 343.035. The referral may not indicate the child is subject to a child abuse investigation unless written consent is obtained from the child's parent authorizing such disclosure. If the child is

already receiving those services, or is enrolled in the Head Start program, a person involved in the delivery of those services to the child shall be invited to participate in the county child abuse multidisciplinary team's review of the case and shall be provided with paid time to do so by the person's employer.

(7) Nothing in this section limits the rights provided to minors in ORS chapter 109 or the ability of a minor to refuse to consent to the medical assessment described in this section. [2007 c.674 §3; 2009 c.296 §1; 2014 c.45 §42; 2017 c.356 §42; 2019 c.141 §25; 2019 c.594 §5]

Note: 419B.023 was added to and made a part of 419B.005 to 419B.050 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

419B.024 [2007 c.674 §4; 2017 c.469 §1; 2019 c.555 §6; renumbered 418.811 in 2019]

419B.025 Immunity of person making report in good faith. Anyone participating in good faith in the making of a report of child abuse and who has reasonable grounds for the making thereof shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed with respect to the making or content of such report. Any such participant shall have the same immunity with respect to participating in any judicial proceeding resulting from such report. [1993 c.546 §17]

419B.026 Required findings for investigation conducted under ORS 419B.020.

(1) An investigation conducted under ORS 419B.020 must conclude in one of the following findings:

- (a) That the report of child abuse is founded;
- (b) That the report of child abuse is unfounded; or
- (c) That the report of child abuse cannot be determined.

(2) All investigations conducted under ORS 419B.020 must be conducted in accordance with ORS 419B.005 to 419B.050 and result in the findings described in subsection (1) of this section until all of the following criteria have been met:

- (a) The child welfare workload model for the Department of Human Services is staffed at 95 percent or greater;
- (b) A centralized, statewide child abuse hotline has been established and in operation for at least six consecutive months;
- (c) The department has completed investigations within timelines mandated by law and rule at least 90 percent of the time for at least six consecutive months;
- (d) The department has conducted in-person contacts with children who are the subject of reports of child abuse, as mandated by law and rule, in at least 90 percent of the reports of child abuse for at least six consecutive months; and
- (e) The reabuse rate for children in this state is below the national average. [2017 c.740 §2]

Note: 419B.026 was added to and made a part of 419B.005 to 419B.050 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

419B.027 Notice of founded disposition. Whenever an investigation conducted under ORS 419B.020 results in a notice of founded disposition being delivered to the person identified as the perpetrator in the founded disposition, the notice must also be provided to the person's attorney, if applicable. [2023 c.188 §1]

Note: 419B.027 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 419B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

Note: Sections 8 and 12, chapter 581, Oregon Laws 2023, provide:

Sec. 8. Exception against substantiation of allegation of abuse by public education program personnel.

(1) Notwithstanding ORS 419B.005 (1)(a)(K), at the conclusion of an investigation under ORS 419B.020, the Department of Human Services may not substantiate an allegation of abuse against personnel of a public education program who have not been trained to the standard established in ORS 339.300 but who impose a restraint on a student if:

(a) The restraint is imposed in response to an imminent risk of serious bodily injury of any person;

(b) The person imposing the restraint does not act with reckless disregard for student safety; and

(c) The restraint does not impose a significant risk of impeding the student's breathing.

(2) Nothing in this section prohibits the department from finding that the public education program is responsible under section 2 of this 2023 Act [339.296] for abuse arising from the untrained personnel's inappropriate use of restraint.

(3) As used in this section, "public education program" and "restraint" have the meanings given those terms in ORS 339.285. [2023 c.581 §8]

Sec. 12. Section 8 of this 2023 Act is repealed on June 30, 2028. [2023 c.581 §12]

419B.028 Photographing child during investigation; photographs as records.

(1) In carrying out its duties under ORS 419B.020, any law enforcement agency or the Department of Human Services may photograph or cause to have photographed any child subject of the investigation for purposes of preserving evidence of the child's condition at the time of the investigation. Photographs of the anal or genital region may be taken only by medical personnel.

(2) When a child is photographed pursuant to ORS 419B.023, the person taking the photographs or causing to have the photographs taken shall, within 48 hours or by the end of the next regular business day, whichever occurs later:

(a) Provide hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format to the designated medical professional described in ORS 418.747 (9); and

(b) Place hard copies or prints of the photographs and, if available, copies of the photographs in an electronic format in any relevant files pertaining to the child maintained by the law enforcement agency or the department.

(3) For purposes of ORS 419B.035, photographs taken under authority of this section shall be considered records. [1993 c.546 §18; 2007 c.674 §5]

419B.029 Power to subpoena documents and records in child abuse investigations. In connection with an investigation under ORS 419B.020, the Director of Human Services may by subpoena compel the production of documents and records, including audio records, video records, photographs and student records, that the director deems relevant or material to the investigation. [2023 c.195 §1]

Note: 419B.029 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 419B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

419B.030 Central registry of reports.

(1) A central state registry shall be established and maintained by the Department of Human Services. The local offices of the department shall report to the state registry in writing when an investigation has shown reasonable cause to believe that a child's condition was the result of abuse even if the cause remains unknown. Each registry shall contain current information from reports cataloged both as to the name of the child and the name of the family.

(2) When the department provides specific case information from the central state registry, the department shall include a notice that the information does not necessarily reflect any subsequent proceedings that are not within the jurisdiction of the department. [1993 c.546 §19]

419B.035 Confidentiality of records; when available to others; rules.

(1) Notwithstanding the provisions of ORS 192.001 to 192.170, 192.210 to 192.478 and 192.610 to 192.810 relating to confidentiality and accessibility for public inspection of public records and public documents, reports and records compiled under the provisions of ORS 419B.010 to 419B.050 are confidential and may not be disclosed except as provided in this section. The Department of Human Services shall make the records available to:

- (a) Any law enforcement agency or a child abuse registry in any other state for the purpose of subsequent investigation of child abuse;
- (b) Any physician, physician assistant licensed under ORS 677.505 to 677.525 or nurse practitioner licensed under ORS 678.375 to 678.390, at the request of the physician, physician assistant or nurse practitioner, regarding any child brought to the physician, physician assistant or nurse practitioner or coming before the physician, physician assistant or nurse practitioner for examination, care or treatment;
- (c) Attorneys of record for the child or child's parent or guardian in any juvenile court proceeding;
- (d) Citizen review boards established by the Judicial Department for the purpose of periodically reviewing the status of children, youths and adjudicated youths under the jurisdiction of the juvenile court under ORS 419B.100 and 419C.005. Citizen review boards may make such records available to participants in case reviews;
- (e) A court appointed special advocate in any juvenile court proceeding in which it is alleged that a child has been subjected to child abuse or neglect;
- (f) The Department of Early Learning and Care for the purpose of carrying out the functions of the department, including the certification, registration or regulation of child care facilities and child care providers and the administration of enrollment in the Central Background Registry;
- (g) The Office of Children's Advocate;

- (h) The Teacher Standards and Practices Commission for investigations conducted under ORS 339.390 or 342.176 involving any child or any student;
 - (i) Any person, upon request to the Department of Human Services, if the reports or records requested regard an incident in which a child, as the result of abuse, died or suffered serious physical injury as defined in ORS 161.015. Reports or records disclosed under this paragraph must be disclosed in accordance with ORS 192.311 to 192.478;
 - (j) The Department of Early Learning and Care for purposes of applications described in ORS 329A.030 (11)(c)(G) to (J);
 - (k) With respect to a report of abuse occurring at a school or in an educational setting that involves a child with a disability, Disability Rights Oregon;
 - (L) The Department of Education for purposes of investigations conducted under ORS 339.391;
 - (m) An education provider for the purpose of making determinations under ORS 339.388; and
 - (n) A national nonprofit organization designated by the Department of Human Services that provides assistance with locating, recovering or providing services to children or youth determined by the department to be missing.
- (2)(a) When disclosing reports and records pursuant to subsection (1)(i) of this section, the Department of Human Services may exempt from disclosure the names, addresses and other identifying information about other children, witnesses, victims or other persons named in the report or record if the department determines, in written findings, that the safety or well-being of a person named in the report or record may be jeopardized by disclosure of the names, addresses or other identifying information, and if that concern outweighs the public's interest in the disclosure of that information.
- (b) If the Department of Human Services does not have a report or record of abuse regarding a child who, as the result of abuse, died or suffered serious physical injury as defined in ORS 161.015, the department may disclose that information.
- (3) The Department of Human Services may make reports and records compiled under the provisions of ORS 419B.010 to 419B.050 available to any person, administrative hearings officer, court, agency, organization or other entity when the department determines that such disclosure is necessary to administer its child welfare services and is in the best interests of the affected child, or that such disclosure is necessary to investigate, prevent or treat child abuse and neglect, to protect children from abuse and neglect or for research when the Director of Human Services gives prior written approval. The Department of Human Services shall adopt rules setting forth the procedures by which it will make the disclosures authorized under this subsection or subsection (1) or (2) of this section. The name, address and other identifying information about the person who made the report may not be disclosed pursuant to this subsection and subsection (1) of this section.
- (4) A law enforcement agency may make reports and records compiled under the provisions of ORS 419B.010 to 419B.050 available to other law enforcement agencies, district attorneys, city attorneys with criminal prosecutorial functions and the Attorney General when the law enforcement agency determines that disclosure is necessary for the investigation or enforcement of laws relating to child abuse and neglect or necessary to determine a claim for crime victim compensation under ORS 147.005 to 147.367.

(5)(a) A law enforcement agency, upon completing an investigation and closing the file in a specific case relating to child abuse or neglect, shall make reports and records in the case available upon request to:

- (A) Any law enforcement agency or community corrections agency in this state, to the Department of Corrections, to the Oregon Youth Authority or to the State Board of Parole and Post-Prison Supervision for the purpose of managing and supervising offenders in custody or on probation, parole, post-prison supervision or other form of conditional or supervised release; and
- (B) The Teacher Standards and Practices Commission for investigations conducted under ORS 339.390 and 342.176.

(b) A law enforcement agency may make reports and records compiled under the provisions of ORS 419B.010 to 419B.050 available to the Oregon Youth Authority, the Teacher Standards and Practices Commission for investigations conducted under ORS 339.390 and 342.176, law enforcement, community corrections, corrections or parole agencies in an open case when the law enforcement agency determines that the disclosure will not interfere with an ongoing investigation in the case.

(c) The name, address and other identifying information about the person who made the report may not be disclosed under this subsection or subsection (6)(b) of this section.

(6)(a) Any record made available to a law enforcement agency or community corrections agency in this state, to the Department of Corrections, the Oregon Youth Authority, the State Board of Parole and Post-Prison Supervision or the Teacher Standards and Practices Commission or to a physician, physician assistant or nurse practitioner in this state, as authorized by subsections (1) to (5) of this section, shall be kept confidential by the agency, department, board, commission, physician, physician assistant or nurse practitioner. Any record or report disclosed by the Department of Human Services to other persons or entities pursuant to subsections (1) and (3) of this section shall be kept confidential.

(b) Notwithstanding paragraph (a) of this subsection:

- (A) A law enforcement agency, a community corrections agency, the Department of Corrections, the Oregon Youth Authority and the State Board of Parole and Post-Prison Supervision may disclose records made available to them under subsection (5) of this section to each other, to law enforcement, community corrections, corrections and parole agencies of other states and to authorized treatment providers for the purpose of managing and supervising offenders in custody or on probation, parole, post-prison supervision or other form of conditional or supervised release.
- (B) The Department of Corrections and the Oregon Youth Authority may disclose records made available to them under subsection (5) of this section regarding a person in the custody of the Department of Corrections or the Oregon Youth Authority to each other, to the court, to the district attorney and to the person's attorney for the purpose of the person's hearing under ORS 420A.200 to 420A.206.
- (C) A person may disclose records made available to the person under subsection (1)(i) of this section if the records are disclosed for the purpose of advancing the public interest.

(7) Except as provided by ORS 339.389, an officer or employee of the Department of Human Services or of a law enforcement agency or any person or entity to whom disclosure is made

pursuant to subsections (1) to (6) of this section may not release any information not authorized by subsections (1) to (6) of this section.

(8) A record of sexual orientation, gender identity or gender expression, as defined in ORS 409.225, is exempt from disclosure under subsection (1) of this section unless:

- (a) The department determines, in written findings, that failure to disclose the record is reasonably likely to jeopardize the child's safety or well-being;
- (b) The department determines, in written findings, that disclosure of the record is necessary to provide services to the child or the child's family; or
- (c) The child consents to the disclosure.

(9) As used in this section, "law enforcement agency" has the meaning given that term in ORS 181A.010.

(10) A person who violates subsection (6)(a) or (7) of this section commits a Class A violation. [1993 c.546 §§20,20a; 1995 c.278 §51; 1997 c.328 §8; 1999 c.1051 §181; 2003 c.14 §224; 2003 c.412 §1; 2003 c.591 §8; 2005 c.317 §1; 2005 c.659 §2; 2009 c.348 §§3,4; 2009 c.393 §1; 2012 c.3 §2; 2013 c.624 §84; 2014 c.45 §43; 2017 c.108 §5; 2017 c.356 §43; 2017 c.377 §1; 2017 c.616 §2; 2019 c.141 §26; 2019 c.618 §19; 2021 c.194 §1; 2021 c.386 §7; 2021 c.489 §57; 2022 c.27 §10; 2022 c.90 §9; 2023 c.129 §2; 2023 c.131 §2; 2023 c.267 §7; 2023 c.554 §54]

419B.040 Certain privileges not grounds for excluding evidence in court proceedings on child abuse.

(1) In the case of abuse of a child, the privileges created in ORS 40.230 to 40.255, including the psychotherapist-patient privilege, the physician-patient privilege, the privileges extended to nurses, to staff members of schools and to regulated social workers and the spousal privilege, shall not be a ground for excluding evidence regarding a child's abuse, or the cause thereof, in any judicial proceeding resulting from a report made pursuant to ORS 419B.010 to 419B.050.

(2) In any judicial proceedings resulting from a report made pursuant to ORS 419B.010 to 419B.050, either spouse shall be a competent and compellable witness against the other. [1993 c.546 §21; 2009 c.442 §37; 2015 c.629 §49]

419B.045 Investigation conducted on school premises; notification; role of school personnel.

(1) The Department of Human Services or a law enforcement agency has the authority to conduct an investigation, on school premises, of a report of child abuse.

(2) When an investigation of a report of child abuse is conducted on school premises, the school administrator shall first be notified that the investigation is to take place, unless the school administrator is a subject of the investigation.

(3) The department or the law enforcement agency conducting the investigation shall present adequate identification to school staff members.

(4) After the department or law enforcement agency presents adequate identification, school staff members shall cooperate with the investigation by, at a minimum:

- (a) Allowing the department or law enforcement agency access to the child who is the suspected victim in the report of child abuse; and
- (b) Providing a private space in which to conduct an interview of the child.

(5) The department or the law enforcement agency conducting the investigation is not required to reveal information about the investigation to the school as a condition of conducting the investigation.

- (6) The school administrator or a school staff member designated by the administrator may, at the investigator's discretion, be present to facilitate the investigation.
- (7) The investigator shall be advised by a school administrator or a school staff member of the child's disabling conditions, if any, prior to any interview with the child.
- (8)(a) A school administrator or school staff member may not notify any person, including the child's parents or guardian, other than the department or law enforcement agency and any school employee necessary to enable the investigation, of an investigation described in this section and may not disclose any information obtained during an investigation.
- (b) Information obtained during an investigation is not part of the child's school records.
- (9) A school administrator or school staff member may testify at any subsequent court proceeding relating to the investigation and may be interviewed by the respective litigants prior to any court proceeding.
- (10) A school district, school administrator or school staff member may not be held liable for civil damages as a result of compliance with this section.
- (11) This section applies solely to an investigation that involves an interview of the suspected victim in the report of child abuse or witnesses and does not apply to an investigation or interview of a person who is suspected of having committed the abuse that is the subject of the report. [1993 c.546 §22; 2003 c.14 §225; 2017 c.515 §1; 2018 c.77 §1]

419B.050 Authority of health care provider to disclose information; immunity from liability.

- (1) Upon notice by a law enforcement agency, the Department of Human Services, a member agency of a county child abuse multidisciplinary team or a member of a county child abuse multidisciplinary team that a child abuse investigation is being conducted under ORS 419B.020, a health care provider must permit the law enforcement agency, the department, the member agency of the county child abuse multidisciplinary team or the member of the county child abuse multidisciplinary team to inspect and copy medical records, including, but not limited to, prenatal and birth records, of the child involved in the investigation without the consent of the child, or the parent or guardian of the child. A health care provider who in good faith disclosed medical records under this section is not civilly or criminally liable for the disclosure.
- (2) As used in this section, "health care provider" has the meaning given that term in ORS 192.556. [1997 c.873 §27; 1999 c.537 §3; 2001 c.104 §150; 2005 c.562 §27; 2019 c.141 §27]

419B.055 Action by Attorney General for protective order on behalf of department employee; written request; eligible employees.

- (1) The Attorney General may bring an action in a circuit court for a citation or a stalking protective order under ORS 30.866 or 163.730 to 163.750 on behalf of an employee of the Department of Human Services who, because of being involved in the conduct described in subsection (3) of this section, is the subject of repeated and unwanted contact by another person that causes alarm or coercion to the employee. The Attorney General's responsibility under this subsection is limited to circumstances in which an employee of the department submits a written request to the Attorney General that:
- (a) Has been approved in writing by the Director of Human Services or the director's designee;
 - (b) Sets forth sufficient facts and evidence, the truth of which has been affirmed by the employee; and

- (c) Based solely upon the opinion of the Attorney General, is an action that is likely to succeed.
- (2) The action brought under this section may not include a request for:
 - (a) Special and general damages, including damages for emotional distress;
 - (b) Economic or noneconomic damages;
 - (c) Punitive damages; or
 - (d) Attorney fees and costs.
- (3) Departmental employees on whose behalf the citation or stalking protective order may be obtained under subsection (1) of this section include employees who:
 - (a) Conduct a child abuse investigation under ORS 419B.020;
 - (b) Make a determination that a child must be taken into protective custody under ORS 419B.150 or 419B.152;
 - (c) Make a determination that a child should not be released to the child's parent or other responsible person under ORS 419B.165 (1)(b); and
 - (d) Are involved in developing a case plan or making a placement decision for a child in the legal custody of the department. [2015 c.653 §1; 2019 c.594 §7; 2019 c.631 §4]

Note: 419B.055 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 419B or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

OREGON CHILD FORENSIC INTERVIEWING GUIDELINES

FIFTH EDITION

**Oregon Department of Justice
Crime Victim and Survivor Services Division
Child Abuse Multidisciplinary Intervention (CAMI) Program
Salem, Oregon
August 2024**

Oregon Child Abuse Solutions operates its program, services and activities in compliance with federal nondiscrimination laws. No person shall, on the basis of race, color, national origin (including limited English proficiency), disability, religion, sex, gender identity, sexual orientation, or age, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any of our programs.

The production of this document was supported by the Children's Justice Act grant from the Children's Bureau. Its contents are solely the responsibility of the Oregon Department of Justice and do not necessarily represent the official views of the Children's Bureau.

FOREWORD

This is the fifth edition of the Oregon Child Forensic Interviewing Guidelines (OIG), which provides a general framework for conducting child forensic interviews in Oregon. The guidelines were originally developed by six distinguished professionals at the request of the Health Advisory Council on Child Abuse, a group convened by the Oregon State Legislature to ensure that child abuse evaluators in Oregon be highly skilled and well-trained.

The original edition of the OIG, published in 1998, was created by Wendy Bourg, PhD; Ray Broderick, BS; Robin Flagor, BSW; Donna Kelly, JD; Diane Ervin, LCSW; and Judy Butler, Med. Since then, the OIG has been revised periodically to ensure it includes the latest research, forensic guidelines, and best practices.

The second edition of the OIG, published in 2004, was updated and expanded to address all professionals who conduct interviews with children. The third edition, published in 2012, was further expanded to incorporate new research and distinguish between forensic interviews and field interviews. The fourth edition, published in 2018 and updated in 2021, provided updated information in multiple sections and a clarification regarding the purpose of initial responder interviews.*

Significant updates to this fifth edition of the OIG include updating the name of the OIG, from “Oregon Interviewing Guidelines” to “Oregon Child Forensic Interviewing Guidelines,” and adding information on the commercial sexual exploitation of children (CSEC).

The updates and revisions to the fifth edition were made by five expert forensic interviewers: Cari Allen, BS, Interviewer, Children’s Advocacy Center of Jackson County; Samantha Fenner, MS, Clinical Manager, Klamath-Lake CARES; Katie Greathouse, LCSW, Interviewer, Mt. Emily Safe Center; Nichole Schumann, MS, Interviewer, Kids FIRST; and Jennifer Wheeler, LPC, Interviewer, CARES NW.

The following individuals reviewed and provided critical feedback on the updates to the fifth edition: Kevin Barton, Washington County DA; John Casalino, Klamath County Acting DA, Supervising AAG ODOJ; Katie Green, AAG ODOJ; Tina Morgan, Consultant – Reviewer and Project Manager; Stacy Neil, DDA Deschutes County, Member CAMI Council and CJA Task Force; Robin Reimer, ODOJ CAMI Grant Coordinator; Linda Cordisco Steele, National Expert Forensic Interviewer, NCAC; and Hannah Vaughn, Attorney in Charge, ODOJ.

A special thank you to Oregon Child Abuse Solutions (formerly Oregon Network of Child Abuse Intervention Centers) for its vision, project management, and valuable input and expertise. Thanks also to Linda Cordisco-Steele—a nationally recognized expert in this field—for her expertise and input, and to the National Children’s Advocacy Center and the Children’s Justice Act Task Force for their dedication and support of this project. Without Children’s Justice Act funding, this project would not have been possible.

** The electronic version distributed in September 2024 mistakenly listed the publication date as 2021. We regret the error.*

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INTRODUCTION

The primary purpose of the Oregon Child Forensic Interviewing Guidelines (Fifth Edition), or OIG, is to promote consistency in the quality of care provided to Oregon children who are forensically interviewed when there are concerns of abuse or neglect. Forensic interview practice is informed by research and practice knowledge.

Regional forensic interviewers developed the guidelines after a thorough research and literature review, taking their collective experience into consideration as well. These guidelines have been vetted by local and national experts who support the practice recommendations suggested herein. In addition, the Oregon Child Forensic Interview Training (OCFIT), which is based on the OIG, has been approved through the National Children's Alliance. The OIG and OCFIT should be used in conjunction and are not independent of one another. OCFIT expands on the OIG and focuses on the practical application. Both are necessary for forensic interviewers across the state.

Child abuse investigations and child forensic interviews are not conducted in the same manner in all communities. Each community has particular needs that influence the ways in which forensic interviews are handled. Thus, a variety of interviewing models and protocols have been developed across the United States to fit communities' unique needs related to child abuse investigations and child forensic interviews. The OIG incorporates best-practice suggestions from a large body of research and literature in the field of forensic interviewing, as well as from a number of widely used national models (see Appendix E for examples of the most-established models).

The Oregon Interviewing Guidelines takes into account the many levels of knowledge, practical application and decision making involved when interviewing children about concerns of abuse. Although interviewing children about possible abuse should always be grounded in research, the practice of interviewing involves human interaction, and the best interests of the child should always be the priority. Interviewers should keep in mind that there is no "perfect" interview and there should be no presumed conclusions. Interviewers must be knowledgeable of practice guidelines, research, and foundational topics related to children and adolescents, and they should be prepared to support their decisions in individual cases.

The OIG is revised in response to evolving needs identified by multidisciplinary team (MDT) professionals throughout Oregon and to the training requirements of the National Children's Alliance Standards for forensic interviewing. The OIG should be considered a working document, to be updated further as researchers and practitioners expand scientific knowledge about child interviewing and child development.

The OIG provides a general framework for conducting a child forensic interview in Oregon and serves as the foundation for statewide trainings. OCFIT is the practical application of the information in the OIG. The combination of the OIG and OCFIT offers interviewers information and insights to help them conduct skilled, professional, developmentally appropriate, trauma-informed, and culturally sensitive interviews with children. However, it should not be taken as a dictate from the state or mandate from any agency that every interview in Oregon must follow this format or that a different format may not be appropriate in a particular situation.

While the OIG can serve as a unifying document to foster statewide consistency, the contributors recognize that nuances in any child abuse investigation can necessitate unique interactions that might not be covered in this or any edition.

I. INTERVIEW SETTING AT A CHILDREN’S ADVOCACY CENTER (CAC)

The interview setting can influence and may be directly related to the amount and quality of the information obtained. Research indicates that stress interferes with recall. Providing a child with an opportunity to be interviewed in a safe, neutral, child-centered environment minimizes the possibility of further trauma, maximizes the quality and quantity of information shared, and reduces the introduction of contaminating influences, thereby improving the accuracy of information provided while maintaining the integrity of the interview.

CAC ENVIRONMENT

- The CAC intake process gathers information from referral sources and clients to ascertain cultural, linguistic, and physical accessibility needs throughout the investigation, intervention, and case management processes. Services are individually tailored and implemented in ways that address the identified needs of children and families.
- The CAC facility is accessible to children and family members with physical disabilities. If physical barriers at the CAC cannot be overcome, there must be a plan in place to accommodate the physical needs of all clients by providing all CAC services at an alternate and accessible location.
- Postings and relevant informational materials are provided in a variety of languages when, and if, possible.
- While every center may look different, there are specific ways that the environment can help children and families feel physically and psychologically safe and comfortable.

CHILD-FRIENDLY INTERVIEW ROOM

- **Furniture:** Furniture should be comfortable and inviting. It may be helpful for the interviewer to be seated at the same level as the child.
- **Sound-proofing:** The room should be quiet, with as few distractions as possible. Turn off or silence phones. Sound-proofing the walls or putting a white-noise machine just outside the room may be helpful.
- **Walls and décor:** If the interview room is used for multiple purposes, remove as many items as possible prior to bringing the child into the room to avoid distractions. Minimize the use of fantasy in the images or items present in the environment.
- **Tools for the interview:** Any items used (e.g., writing utensils, blank paper, pictures for coloring, Play-Doh) should be readily available in the room and limited so as not to overwhelm or distract the child.
- **The room should be safe:** Do not include any breakable items, sharp edges, or toys with small parts that could pose a choking hazard to very young children, and cover electrical outlets.
- **Audio/video:** If the camera is in the room, ensure that it is out of reach of young children. Regardless of how the camera is positioned, the child must be informed that they are being audio/video recorded, and that people are observing. Any interview conducted at a CAC should be audio/video recorded.

ROLE OF SUPPORTIVE CAREGIVERS

The presence of parents, school personnel, private therapists, caretakers, or other family members in the interview room should be avoided. Even supportive adults can intentionally or unintentionally coach or nonverbally cue a child, potentially influencing the interview. There are rare possible exceptions to the standard of excluding a support person; these should be discussed on a case-by-case basis by the multidisciplinary team (MDT) members participating in the interview process. For example, children with disabilities or extremely traumatized children who cannot separate from a supportive caregiver may be an exception or may need additional rapport building prior to the formal forensic interview.

OBSERVERS OUTSIDE THE ROOM

It is best practice to have those professionals with investigative responsibility, such as law enforcement officers, Oregon Department of Human Services Child Welfare Personnel (CWP), or Office of Training, Investigation and Safety (OTIS) personnel, observe the interviews when possible. At some centers, other MDT members, such as medical providers, regularly observe. It is ideal to have MDT partners observing on-site in a separate room. Some CACs may have the capacity, in special circumstances, to accommodate remote viewing for MDT partners. The local MDT or CAC may develop a written protocol for allowable observers during the child's interview.

PRESERVATION—VIDEO RECORDING

Follow your county protocol for preserving video recordings of interviews, such as ensuring that appropriate identifying information is attached to the recorded interview. Identifying information may include the child's name, date of birth, date of interview, name of interviewer, and CAC where the interview was conducted. Each MDT has a responsibility to follow all state and federal laws regarding confidentiality and disclosure.

INTERVIEWING DURING SPECIAL CIRCUMSTANCES

During natural disasters, crises, or pandemics, forensic interviewing practices may shift to accommodate safety, accessibility, and best practices. These situations pose challenges, including decisions regarding case triaging, following health and safety protocols, and meeting best practice standards. Please refer to your MDT for additional information and guidance.

National guidelines have been created to guide new practices and decision making:

- **Zero Abuse Project:** *Conducting and Defending a Pandemic-Era Forensic Interview.*
zeroabuseproject.org/conducting-and-defending-pandemic-era-forensic-interview
- **National Children's Alliance:** *Emergency Tele-Forensic Interview Guidelines.*
learn.nationalchildrensalliance.org/telefi

II. PRE-INTERVIEWS

The amount and type of history gathered in pre-interviews depends on the role of the evaluation and investigation teams. Often, gathering some history is relevant and helpful for both the interviewer and investigative team.

If possible, obtain and review any documentation and information regarding the disclosures made by the child for this reported incident. This may include initial law enforcement, Oregon Department of Human Services (ODHS), school, mental health, and/or medical reports/records. If multidisciplinary team (MDT) partners have case information or evidence, the interviewer should ideally have access to this before the interview. Presentation of evidence within the interview should be discussed prior to the interview with MDT partners and in accordance with MDT/county protocols. If an investigator has thoroughly interviewed the child in the field, assess whether a Children's Advocacy Center (CAC)–based forensic interview is in the child's best interest and what the goal/purpose is for an additional interview.

When possible, the interviewer should review background information obtained by law enforcement and ODHS before the interview. This information may inform the interviewer about the child's environment and culture, as well as any other factors relevant to both the child's ability to participate in a formal interview and the interviewer's approach to the child. It is important to balance having the interview occur close in time to the report of abuse with collecting collateral information ahead of time.

Below are examples of information interviewers may consider during pre-interviews:

- Child knowledge or understanding of CAC visit
- Disclosure history
- Any relevant emotional or behavioral concerns
- Sources of sexual knowledge
- Daily routines
- Level of support the child receives from primary caregiver(s)
- History of custody issues or family discord
- Demographic information
- Developmental considerations
- Disability and accommodations, if applicable
- The alleged perpetrator's access to the child and the relationship with the child
- Family risk factors, which may include family violence, drug/alcohol use, criminal activity, ODHS history, historical abuse/trauma, and mental health issues
- System information that could be accessed by an investigator
- Language spoken in the home
- Possible evidence available (refer to MDT protocols and best practices of evidence introduction)

III. FORENSIC INTERVIEWS

The purpose of a forensic interview is for a skilled and trained professional to gather as much reliable information as possible from a child about their experiences when there is concern of maltreatment. The forensic interview process is based on research, literature, and best practice standards. A forensic interview is conducted by an individual who has completed training described in ORS 418.788 for the purpose of preserving a child's statements. Per ORS 418.782(4), a forensic interview "is conducted in a manner that is legally sound, age appropriate, of a neutral, fact-finding nature, and coordinated to avoid duplicative interviewing." Forensic interviews are also conducted in a manner that is trauma informed and takes into account developmental considerations.

In the state of Oregon, forensic interviews are audio and video recorded to preserve statements, capture the child's presentation, and document the interaction between the child and the forensic interviewer. These interviews may be used for the purposes of medical treatment, child safety planning, and criminal investigations.

Specially trained forensic interviewers at Children's Advocacy Centers (CACs) in Oregon interview children for the following concerns/allegations: sexual abuse, physical abuse, neglect, exposure to domestic violence, witness to crime or abuse, drug endangerment, emotional or psychological abuse, commercial sexual exploitation of a child (CSEC), child sexual abuse material (CSAM), and other forms of abuse or maltreatment. For some of these specialized cases, there are guidelines that interviewers may utilize while conducting forensic interviews.

QUESTION TYPES

The forensic interviewer should use a continuum of questioning to gather the most accurate and complete information about the child's experience, and to assist in their disclosure process. Throughout the interview, interviewers should use the most open-ended questions/prompts possible and navigate through the question types as appropriate.

The following are definitions of question types. The context and nature of how these question types are used throughout interviews may vary from child to child, as well as from interview to interview. Interviewers should decide which question types to use based on child development, presentation, and the child's responses to questions.

- **Open-ended:** Open-ended questions attempt to elicit a free narrative response from recall memory.
Examples include: "Tell me what you are here to talk about today," and "Tell me everything that happened." Open-ended questions are followed by prompts for more information such as, "What happened next?" and "Then what happened?"
- **Focused:** Focused questions are used to elicit further information on a particular topic, place, or person. They are often used to elicit information by cueing a child to provide further information or more specific detail after a child has exhausted narrative recall. They can also be used to elicit thoughts and feelings/sensory details. Reluctance, developmental considerations, and trauma

may be reasons to use focused questions. Focused questions may be referred to as “Wh-questions” and “Suppositional wh-questions.”

Examples include: “Where were you when [X] happened?”; “What did Grandpa spank you with?”; “What were his hands doing?”; “What did he say?”; “How did that make your body feel?”; and “What were you feeling?”

- **Closed-ended:** Closed-ended questions, such as multiple choice and yes/no questions, pose limited options and are used to clarify a disclosure or information already provided. Closed-ended questions should be used sparingly. Closed-ended questions can also be used to clarify a previous question that seems confusing to the child. They can be helpful in gathering contextual information, particularly from young children.

Examples of multiple-choice questions: “Did it happen in the living room, bedroom, or someplace else?” A yes/no example: “Did your mom want other people to find out what happened?”

Once the child has provided a response to a closed-ended question, return to open-ended questions.

QUESTION TYPES TO AVOID

- **Leading:** Leading questions introduce information with a question in which the actor, an act, and a tag are included and may suggest to the child a desired response.

An example is: “Your dad touched your pee-pee, didn’t he?”

- **Coercive:** Coercive questions or statements are those that pressure the child physically or emotionally to do or say something.

Examples include: “If you tell me what I want to know, you can leave the room,” or “If you don’t tell me what happened, I can’t help you.”

SUPPORTIVE INTERVIEWER

A forensic interviewer can maintain neutrality while being supportive of the child. A supportive interviewer uses techniques such as rapport building throughout the entire interview, regardless of disclosure. The interviewer allows for the child to express their emotions regarding the incidence of abuse, as well as their feelings about the interview process, without pressure. Emotional expressiveness is associated with increased information sharing. Supportive interviewers provide a child-friendly and trauma-informed environment to increase emotional well-being and willingness to talk.

NONVERBAL LANGUAGE

Nonverbal communication can play a role in a forensic interview. It may involve emotional expressions, actions, body language, and even silence. The interviewer should be aware of the impact that nonverbal communication may have on the child and interview process. This includes nonverbal communication by both the interviewer and the child.

Nonverbal cues can include gestures, facial expressions, spatial distance, and vocal tones. Nonverbal communication can be influenced by cultural norms.

- **Gestures:** One of the most common forms of nonverbal communication used by children is gesturing. A gesture can be anything that incorporates a movement of the body and signifies a message. Some children shrug their shoulders, throw their hands up in the air, or storm off with heavy feet to show they are angry or upset. Gestures are typically paired with verbal communication, but they do not have to be. Each child is different, so it is important to inquire in order to learn the child's gestures and meanings.
- **Facial expressions:** Paying close attention to a child's facial expressions and asking questions helps the interviewer understand more deeply what the child is thinking or feeling.
- **Spatial distance:** A child will typically learn a "normal" spatial distance (personal space) from their family, upbringing, and cultural environment. Everyone has personal space, including children. Recognizing spatial distance differences will help the interviewer understand and relate to each child while also reinforcing appropriate boundaries when necessary. For example, if a child demonstrates inappropriate personal space boundaries such as lap sitting, gently reinforce an appropriate boundary by guiding the child to a seat.
- **Vocal tones:** A child's tone of voice can help decode the message they are sending. Pay attention if a child's tone is incongruent with their words. Changes in voice tone, volume, and pacing can indicate changes in the child's emotional state and motivation to participate in the interview. This may cue the interviewer to check in with the child regarding the incongruence.

BEGINNING THE INTERVIEW

The goal during the beginning of the interview is to establish rapport and obtain information about the child's developmental and communication abilities. Rapport development is associated with greater accuracy in event reports. Rapport begins the moment the interviewer meets the child and continues throughout the course of the interview. During this phase, the forensic interviewer should make introductions, establish roles, give instructions, explain expectations of the interview, observe the child's development, set a precedent of eliciting narrative responses, and create a relaxed and friendly environment.

Introductions

The forensic interviewer will first introduce themselves and explain their role. The child should be oriented to the room, which includes informing the child that an audio/video recording is being made and that others may be observing. The explanation may vary depending upon the child's age and developmental level. It is helpful to give the child a sense of control by giving them choices whenever possible and appropriate. For example, tell the child they can take a break any time they need to or use the bathroom whenever needed. The child should also be allowed the opportunity to ask questions about the interview room and process.

Instructions

Research suggests that a series of instructions decrease suggestibility and increase accuracy in reporting.

Standard instructions and examples include:

- **Telling the Truth:** “It’s important to tell the truth,” or “We don’t do pretending or make-believe in this room. We are going to discuss true things today.” If the child is unable to demonstrate, then the forensic interviewer should repeat the instruction and move on.
- **Correcting the Interviewer:** “Correct me if I get something wrong,” or “Let me know if I make a mistake.”
- **Check for Child’s Understanding:** “Let me know if you don’t understand my questions,” or “If I say something that doesn’t make sense, let me know.”
- **Don’t Guess:** “If you don’t know, then it’s okay to say, ‘I don’t know,’” and “If you do know the answer, tell me.”

For children ages 3–6, or when developmentally appropriate, consider asking them to demonstrate their ability to follow the instructions above. When the child successfully demonstrates their ability to follow the instructions above, positive reinforcement may be used to highlight their ability. If the child is unable to demonstrate, then the forensic interviewer should repeat the instruction and move on. Younger children may do better with a limited number of rules and practice. Older children may be able to handle more and may not need to practice.

Narrative Practice

Narrative practice is when the forensic interviewer uses open-ended questions/prompts to ask the child to talk about a neutral, salient event (such as a recent school event). Examples of eliciting a narrative practice include: “Tell me about your last [salient event],” “Tell me everything that happened,” and “Tell me what happened from the beginning to the end.”

Narrative practice establishes the precedent that the child provides narrative responses to the interviewer’s questions. It supports the continuation of rapport building and it allows the interviewer to assess the child’s developmental level, cognitive functioning, and language abilities. Research shows that conducting a practice narrative using open-ended questions increases the amount of reliable information the child provides later in the interview.

TRANSITION TO TOPIC OF CONCERN

The transition to the “topic of concern” or “allegation-focused portion” of the interview should occur in the most open-ended, non-suggestive way possible. This can be achieved in multiple ways.

Spontaneous disclosure may occur during the early stages of the interview, allowing a natural transition to the topic of concern. For example, during narrative practice, the child describes that the police recently came to the house. At that time, the interviewer would request a narrative of the incident.

In the absence of a spontaneous disclosure, the interviewer should give an open-ended prompt, such as “Tell me what you are here to talk about today,” or “Tell me what you know about being here today.”

If there continues to be an absence of disclosure, the interviewer can use a continuum of questioning as outlined below. This continuum is a guide and not an absolute; honor the process and individuality of each child and interview, as well as the integrity of the interview. Use the child’s language whenever possible. For example:

“Is someone worried about you?” If the answer is yes, follow with, “Tell me what [X] is worried about.”

“I heard you talked to [X]. Tell me what you talked to [X] about.”

“I heard that something may have happened to you. Tell me what happened.”

Gathering Details

Various strategies inform the interviewer’s question types. Once the child has made a disclosure, the forensic interviewer will attempt to use questions that are as open-ended as possible to encourage free narrative without interrupting. The interviewer will listen for cues to follow-up on when the child has exhausted the narrative. The interviewer continues to use the continuum of questioning to gather further details regarding the abusive event(s) and the context. Additional details to be gathered may include contextual, sensory, thoughts and emotions, and temporal details.

Framing is a technique that anchors the child’s memory to a previously made statement before asking an open-ended question about that information to provide contextual details. For example, “You said [X] happened—tell me more about [X].”

Scaffolding is a technique to help with sequencing. For example, “What is the first thing that happened when you went into the bedroom?” Use questions such as, “What happened next?” or “Then what happened?” to continue prompting the child until the narrative is exhausted.

Types of Details

- **Contextual:** The interviewer can ask questions to gain a better understanding of the context of what the child is disclosing. This can include questions about clothing, body positions, location, relationships, and statements made. Examples include, “What were you wearing when the touching happened?” or “Who was home when that happened?” or “What were his hands doing?”
- **Sensory Details:** The interviewer can ask questions about the five senses. For example, “Tell me everything you saw,” or “What did you hear?”
- **Thoughts and Feelings:** Interviewers can ask the child about their feelings, both emotional and physical. This may elicit emotional feelings as well as physical sensations experienced during an event, providing an opportunity for further exploration and information gathering. Examples include: “Tell me about how you felt when [X] was happening,” or “Tell me about how your body felt when [X] was happening.” When developmentally appropriate, the child can be asked about their thoughts during and after the event.
- **Temporal Details:** When a child uses terms such as “usually” or “sometimes,” these are cues that the event happened more than one time. The child can be prompted to tell more about an event based on episodic cues they provide. If the child does not provide episodic cues, the interviewer may ask questions such as, “Tell me what happened the first time” or “Tell me what happened the last time” to elicit episodic details. If during the child’s narrative the timing is unclear, the child may be asked when something occurred, though not with the expectation of a date, but rather, to obtain contextual clues. For example, a child may be asked when an abusive event occurred and report that “It happened when my little sister was being born in the

hospital.” The timing of the event, as well as where the family lived, can be gleaned from this information. Asking about different locations, the location of other people, or a time something different happened are examples of ways to differentiate between events and gather valuable information regarding time and frequency.

Interviewers should refrain from asking a child about frequency or duration, as children will not likely be able to accurately provide this information. Instead, the child may be asked “What happened first?” “What happened next?” and “What made it stop?” to elicit contextual details.

USE OF TOOLS

Tools/media aids are items that are introduced by the child or interviewer to assist in the disclosure process. There are various reasons tools may be used during an interview, including facilitation of a disclosure and clarification of details. Before introducing any particular tool in an interview, the interviewer should be trained in their application, benefits, and limitations. Any drawings, photographs, videos, or other tools used by the child should be preserved. The interviewer should be aware of their local multidisciplinary team (MDT) protocols and CAC guidelines regarding use of tools, including evidence preservation procedures. Interviewers can utilize more than one tool at a time and should be prepared to abandon the use of the tool if it results in discomfort or a negative reaction from the child or becomes a distraction.

Examples of tools include:

- **Writing:** A child can use paper and pen to write about an abuse experience when it is too difficult or embarrassing (for the child) to verbalize. The writing may be read back to the child for agreement that it is accurate. Additional questions may then be asked.
- **Drawing/Mapping:** Help provide the child with an opportunity to describe the detail or event. Examples include a child drawing body parts, body positions, or objects, or mapping a room or landscape.
- **Demonstration:** Physical demonstrations by the child can include the child showing how something occurred, pointing to a body part, or demonstrating body positioning. Interviewers may ask the child to gesture, or the child may provide a gesture spontaneously. When a child gestures, ask for additional clarification.
- **External Information/Evidence:** The forensic interviewer, at the request of and in collaboration with MDT partners, uses some type of known information and introduces this information to the child. This can be verbal or material. Interviewers should only use information that they know to be factual and accurate. Interviewers may use this information to prompt the child to discuss topics that have not come up during the narrative and information-gathering phases of the interview. There is a continuum with regard to the type of information presented, ranging from verbal to child abuse images. Consideration of the victim’s needs are most important when choosing the type and quantity of evidence to introduce. Generally, during the interview, attempts should first be made to elicit a narrative without introducing evidence. If those attempts are not successful, the interviewer may choose to proceed using physical evidence to assist in clarification or eliciting disclosure. It is never the purpose of the interview to get information at the expense of the youth’s emotional and psychological well-being. Evidence

introduction of any type should be carefully considered; many counties have developed a process and/or MDT protocol to assist in this process.

The child may also use, or bring into the interview, their own media, journals, writing, etc., or technology to show the interviewer what may be considered evidence. Interviewers should work with their MDT partners regarding preservation of the information the child introduces.

ENDING THE INTERVIEW

The forensic interview may be concluded when no further information can be gathered, or the child is unwilling or unable to participate further in the interview.

Prior to ending the interview, the interviewer seeks input from MDT observers who may have questions or need additional clarification. It is the interviewer's responsibility to collaborate with MDT partners and incorporate their suggestions into the interview. The interviewer will determine how the question is worded or presented based on best practices and the best interests of the child. If leaving the room, explain why to the child, and keep the camera running.

If the child is unwilling or unable to continue participating in the interview, the interviewer should attempt to determine why and respond appropriately. The child's best interests should always be the first priority. The child should not be pressured to stay in the interview room; that pressure could result in the child making inaccurate statements and could also adversely affect their well-being. In cases in which relevant information has not been obtained from the child, the interviewer may need to explore other options such as a therapy referral or additional interviews.

Closing Components of an Interview

Allow the child to discuss topics, issues, and concerns they feel are important, including topics not previously addressed. This provides the child with the opportunity to communicate information that they deem important, which could be something the interview questions did not address or information the child did not relate to the questions that were asked. Give the child an opportunity to ask questions. Answer questions honestly, providing information, if able, and deferring to the appropriate MDT team members when necessary. Do not make promises or guarantees as to what may or may not occur after the interview.

Ask questions such as: "Are there any questions that I forgot to ask you today?"; "Is there anything else you think is important for me to know today?"; or "Are there any questions you'd like to ask me about what we talked about today?"

If appropriate, the interviewer may choose to transition the child to a discussion of neutral topics prior to leaving the interview room. This may include talking with the child about their plans following the interview, or about pets, school, or other topics discussed during the beginning of the interview. This process may vary in length depending upon the child's needs. Some children may be well-served with a short conversation around a neutral topic. Other children may need more time to transition, and it is important to make the appropriate accommodations.

The interviewer should thank the child for their participation in the interview, which relays that their statements are important. Thank the child for their participation whether or not a disclosure was made. Thanking the child should not include any reinforcement of specific information disclosed.

In certain circumstances, the interviewer may invite the child to return for an additional interview.

CONSIDERATIONS DURING THE FORENSIC INTERVIEW

There are certain things to consider throughout the forensic interview process, including:

- **Facilitating Communication:** It is important to refrain from obvious emotional responses to a child's disclosures. The forensic interviewer can provide support by engaging in active listening, such as nodding the head, saying "Uh-huh," or repeating the last few words of the child's statement. Periodically using the child's name also shows the child that you're listening. It's important to allow for, and be comfortable with, silence. Give the child time to process the question and formulate an answer. Avoid correcting behavior unless doing so is necessary for safety purposes.
- **Acknowledging the Child's Feelings:** Many children do not manifest emotional reactions or express emotional feelings during an interview. However, other children may experience or display a strong emotional response. Interviewers may choose to acknowledge the child's emotional state with a comment such as, "I see that you have tears in your eyes. Tell me about your tears." In doing so, be careful not to make judgments or interpretations that suggest the child is feeling a certain way, such as, "I see you have tears in your eyes—you must be sad."
- **Safety Factors and Other Circumstances:** In some cases, when relevant and appropriate, the interviewer may ask additional questions about risk factors and experiences with other types of abuse, or other safety issues that could impact the child's disclosures or disclosure process. Topics may include family dynamics, exposure to violence, drug and alcohol abuse, animal abuse, pornography, weapons, and other issues. Individual CAC or MDT protocols may provide additional direction to determine whether and when to explore these topics.
- **Alternative Explanations/Hypothesis:** During the course of investigating alleged abuse, the investigative team may consider alternative explanations/hypotheses regarding the child's disclosure; perhaps the allegation is a misinterpretation, or a false allegation made by either the child or someone else. The exploration of alternative explanations/hypotheses can occur throughout the entire investigation and may evolve as additional information is gathered to determine outcomes.

During the interview, the interviewer may attempt to explore alternative explanations by asking questions that provide context to the disclosure. The interviewer may do this by exploring sensory details; possible source-monitoring information; circumstances surrounding the disclosure such as how the disclosure arose, reactions to it, or discussions about it; family dynamics; secondary gain; or other pertinent factors. There is no set list of questions used by interviewers to explore alternative explanations; questions may differ depending on circumstances of the case or may not be asked at all.

COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC) AND CHILD SEXUAL ABUSE MATERIAL (CSAM)

CSEC is the sexual abuse or exploitation of a child for financial benefit or in exchange for anything of value. CSAM is imagery or videos that show a child engaged in, or depicted as being engaged in, explicit sexual activity. These abuse concerns require the use of specialized interview techniques and additional considerations. While there are advanced models for interviewing in these cases, the best practices contained in these guidelines should still be used. Consult your MDT for information regarding protocols or guidance. Interviewers are encouraged to have training and experience, as well as a level of comfort, to conduct these interviews.

MULTIPLE NON-DUPLICATIVE FORENSIC INTERVIEWS

One comprehensive interview may be sufficient. However, research and practice have evolved to support the efficacy of conducting more than one interview in some situations. Nationally and in research, the terms “additional,” “multiple,” “subsequent,” and “multisession” may be used interchangeably to refer to another interview being conducted. In Oregon, we refer to these as ‘additional forensic interviews.’

Additional forensic interviews are different than Extended Forensic Interviews (EFIs), recantation interviews, and interviews regarding new cases or allegations. Ideally, the decision to pursue additional interviews should be made in consultation with the MDT. Consult your local CAC or MDT for guidance.

- **Additional forensic Interview:** When a child returns for another forensic interview regarding the same or similar concerns, when one interview is not sufficient for various reasons.
- **Recantation Interview:** A forensic interview where a child returns and the recantation is explored.

IV. DIVERSITY, EQUITY, AND ACCESS

Local multidisciplinary teams (MDTs) and Children's Advocacy Centers (CACs) may have their own diversity, equity, and inclusion/access statements that guide local policies and practice. Please refer to your local MDT and CAC protocols and guidelines. In Oregon, we recognize that forensic interviewers should practice cultural responsiveness, and that every child and their family have the right to access meaningful services.

According to the National Children's Alliance (NCA 2023 Standards):

Cultural responsiveness is the ability to understand and consider different cultural backgrounds of the clients to whom you offer services. It also demonstrates the capacity to learn from and relate respectfully with people from both similar and different cultural backgrounds, requiring the ability to appreciate, understand and interact with members of diverse populations within the local community. Cultural responsiveness is a fundamental component of the CAC philosophy and is as central to operations as developmentally appropriate, child-focused, and trauma-informed practice. Like developmental considerations, cultural norms influence nearly every aspect of working with children and families, such as welcoming a child and family to the child advocacy center, employing effective forensic interviewing techniques, assessing the likelihood of abuse, selecting appropriate mental health providers, and securing services that are relevant and accessible to a child and family. To effectively meet clients' needs, the CAC and MDT must be willing and able to understand the clients' worldviews adapt practices as needed, and offer assistance in a manner in which it can be utilized. Striving toward culturally responsive services is an important and ongoing endeavor and an integral part of a CAC's operations and service delivery.

USING AN INTERPRETER

Every child has a right to ethical, professional, accurate, and confidential interpretation. Interpreters facilitate the cross-cultural communication necessary by converting one language into another. These language specialists do more than simply translate words—they must thoroughly understand their role in order to accurately convey information, concepts, and ideas from one language to another. In addition, they must be sensitive to the cultures associated with their languages of expertise. Ideally, an interpreter would be certified and be prepared to testify in court. Interpreters may be live, in-person, or virtual (phone or video). Refer to your MDT or CAC protocols for further guidance.

During the forensic interview, it may be tempting to use a family's relative or friend to interpret or translate information, but this should be avoided. A family member or friend may not have the necessary fluency in the languages involved and/or the ability to interpret accurately. Additionally, this person may be biased and is not bound by formal ethical guidelines and confidentiality.

Because of the delicate nature of some of the information disclosed by a child or parent regarding suspected abuse, it is strongly recommended that interpreters for each CAC be prepared and able to appropriately deal with a variety of sensitive topics related to child maltreatment.

Prior to the forensic interview, it is important to prepare both the interpreter and the family of the expectation of confidentiality, the child abuse evaluation process, the interpreter's role, and any additional issues that may be relevant, such as the possibility of a subpoena for court testimony. When setting up the interview room, consider the positioning of the interpreter. The interpreter should be visible on camera and positioned in a way that will keep the child engaged with the interviewer and not the interpreter. Allow more time for the entire interview process.

V. INTERVIEWING CHILDREN WITH DISABILITIES

Disabilities affecting children can be numerous and complex. The most important thing to remember when interviewing a child with disabilities is that the child is first and foremost a child; the disability should not define the child. All children have strengths and limitations. Building on the child's strengths and making accommodations for limitations shows respect and allows for the most successful interview.

Interviewers should educate themselves about various disabilities and put aside any potential biases, fears, and assumptions about children with disabilities. Shifting the focus away from the diagnosis or label and focusing instead on four common categories of disabilities will lead to more successful interviews of children. The four categories of disabilities are: communication, intellectual, social/emotional, and physical. The child's disability can be a medical, educational, or psychological condition that interferes with their ability to:

- Speak, understand, and use language (Communication Disabilities)
- Think and reason (Intellectual Disabilities)
- Behave appropriately, socially and emotionally, in most settings (Social/Emotional Disabilities)
- See, hear, move, and be healthy (Physical Disabilities)

Below is a set of questions the interviewer can ask prior to the interview to help think about the disability's potential impact on the child's ability to report abusive events and what accommodations might be useful. By utilizing these questions, the interviewer can quickly identify and organize what is known and what would be helpful to know before proceeding.

- Does this child have a disability or difficulty in any of the four domains of functioning?
- How does the disability or difficulty affect the child?
- What strengths or abilities does the child have?
- What else is necessary to know about the child and the disability or difficulty?
- What accommodations can be made for a successful interview?

Prior to any interview of a child with disabilities, the interviewer should:

- Attempt to gather history about the child's preferred communication style, level of functioning, and any medical or educational information. Caregivers, school personnel, and Oregon Department of Human Services (ODHS) caseworkers often have insight into the child's strengths and the most successful ways to communicate with the child. There may be a community expert who can provide consultation.
- Ensure that appropriate accommodations have been made to the environment with regards to the needs of the child.
- Provide a clear description of the interview process, possibly showing the interview room to the child before the interview.

For additional information on interviewing children with disabilities in Oregon, refer to *Project Ability: A Reference Guide for Interviewing Children with Disabilities* (Rev. 2017), a reference guide that provides instruction on how to develop appropriate accommodations for children with disabilities. The reference guide is available at doj.state.or.us/wp-content/uploads/2018/02/Project_Ability_Reference_Guide.pdf

VI. CHILD DEVELOPMENT

It is important for interviewers to understand both the chronological and developmental ages of children. Chronological and developmental age affect the types of questions used, how the child participates in the interview, the timing and pacing of the interview, the language used by the child, and the child's ability to understand the interview process. Therefore, it's important for forensic interviewers to have foundational knowledge of child development. Interviewers have to make a determination about a child's developmental ability to participate in a forensic interview.

Child development is a very robust topic, with its own research and literature, and area of academia. The intent of this document is to provide information that is relevant to the forensic interview. Below you will find four primary developmental domains: physical development; language and cognitive development; social and emotional development; and sexual development.

A child's linguistic ability depends on age and experience, individual growth patterns, and familiarity and practice. Children may be inconsistent in their use of words. Children practice using concepts before they master actual word usage. Children may use words correctly or incorrectly without having a full understanding of the meaning.

Similarly, no two children develop at the same rate. Chronological and developmental age are not always the same. A child's development progresses in a sequential manner through stages, with variations in what is normal, and is highly influenced by their environment.

TODDLERS: AGES 18 MONTHS TO 2 YEARS

Note: This section applies mostly to children age 2.

Characteristics for children ages 1.5–2 years:

Physical Development

- Walks well, goes up and down steps alone, runs, and can seat self on chair
- Is developing toileting and other self-help skills
- Attempts to dress self

Language and Cognitive Development

- Says words, phrases, and simple sentences
- Has a limited vocabulary
- Exhibits short attention span
- Can identify simple pictures
- Uses receptive language that is superior to expressive language
- Holds an egocentric view of life
- Is a concrete thinker
- Shows difficulties with classification and sequencing
- Demonstrates difficulty with source monitoring and source attribution

Social and Emotional Development

- Enjoys solitary play
- Depends upon guidance from adults
- Refers to self in the third person
- Is socially immature
- Has a limited concept of others as people
- Is developing a sense of personal identity
- Is developing and asserting independence

Behaviors Related to Sexual Development

- Explores own body
- Is interested in toileting behaviors
- Touches/rubs own genitals
- May experience pleasure when touching own genital areas
- Is developing an awareness of differences between male and female bodies
- May exhibit uninhibited behaviors

PRESCHOOL: AGES 3 TO 4 YEARS

While eliciting a narrative is essential in forensic interviews, it is important to recognize that children ages 3-4 have difficulty providing complete narration of an event. Children in this developmental range have a limited ability to provide information regarding time and sequencing. Anchoring the child's memory to a specific episode can help to organize and move the narrative forward. Children in this age group are suggestible to a higher degree than older children and adults. It is important to note that despite challenges, children in this age group are still able to provide accurate and reliable information about their life events.

Characteristics for children ages 3-4:

Physical Development

- Shows improved balance
- Is developing the ability to dress self
- Runs well, rides tricycle, skips, dances, kicks, and throws balls
- Demonstrates improvement in drawing; may be able to make shapes, people, and scenes
- Is able to feed self

Language and Cognitive Development

- Is capable of short sentences
- Vocabulary is increasing

- Tells simple stories
- Is highly imaginative
- Demonstrates dramatic behaviors and language
- Uses receptive language that is superior to expressive language
- Has an egocentric view of life
- Shows difficulty with classification and sequencing
- Has a poor understanding of time
- Demonstrates difficulty with source monitoring and source attribution
- Is learning to generalize
- Is developing understanding of truth and lie

Social and Emotional Development

- Better understands own gender (age 3)
- Concept of gender identity is better developed and becomes important (age 4)
- Is less resistant to change
- Has a greater sense of personal identity
- Demonstrates and asserts more independence
- Enjoys helping others
- Is developing the ability to take turns
- Conducts parallel play (age 3)
- Participates in cooperative play (age 4)
- Is developing relationships and extending social network

Behaviors Related to Sexual Development

- Touches and rubs own genitals
- Is developing curiosity about own body functions
- Exhibits interest in the difference between male and female bodies
- Enjoys being nude
- May display both serious and silly behaviors regarding genitals and bodily functions
- Acts out gender roles during play

KINDERGARTEN: AGES 5 TO 6 YEARS

This population continues to have limited time and sequencing abilities. While this age group has an increased ability to provide narrative, they may still struggle with providing narrative in a complete and sequential manner. Interviewers can assist in this process by offering open ended questions and prompts that allow for the child to engage in as much narrative as possible. Interviewers should ask supplemental questions that assist in further narration. This population is developing a sense of morality

and understanding of rules, they may be protective of and identify with caregivers. Interviewers should be thoughtful about how this impacts a child's engagement in the interview process.

Characteristics for children ages 5–6:

Physical Development

- Shows improved gross motor coordination—can skip, hop, kick, and throw
- Has improved balance
- Demonstrates improved dexterity
- Vision has reached maturity
- Exhibits improved self-help skills—better able to feed, dress, bathe, and use toilet on own

Language and Cognitive Development

- Demonstrates a better understanding of genders
- Understands colors and counting
- Better understands classifying and sequencing
- Shows incomplete understanding of time
- Is developing understanding of truth and lie
- Engages in complex symbolic play
- Is still somewhat egocentric
- Makes causal links
- Is better able to differentiate between fantasy and reality
- Is beginning to understand “same” and “different”

Social and Emotional Development

- Appreciates and responds to praise and encouragement
- Has an improved ability to interpret, predict, and influence others' emotional reactions
- Can express empathy
- Demonstrates a more thorough use of language
- Is better able to solve social problems
- Is developing a sense of morally relevant rules and behaviors
- Has a wider social network
- Enjoys imitating caregivers
- Identifies with and can be protective of caregivers

Behaviors Related to Sexual Development

- Touches and rubs own genitals; may engage in this behavior when tense, excited, or afraid
- Plays house; may engage in role playing of household members

- Is interested in own body parts and those of others, including the genitals
- Is interested in having babies and birthing
- Engages in funny and serious behaviors/language regarding genitals
- Asks questions regarding adult toileting and adult sexual behaviors

ELEMENTARY SCHOOL: AGES 7 TO 10 YEARS

Children in this age group may experience internal conflicts and mixed emotions, and there is the potential for external conflicts. Further, they are developing a better understanding of morality, fairness, and rules. All of these factors impact the disclosure process. Children in this age group are developing the ability to self-reflect. While children in this age group can provide better narrative with fewer verbal cues, it is important to remember that they are still challenged to define timelines regarding when a well-remembered event occurred.

Characteristics for children ages 7–10:

Physical Development

- Has rapidly improving fine motor skills
- Gross motor skills are becoming more fluid, but there is clumsiness and difficulty with muscle control
- Experiences high levels of energy, sometimes followed by fatigue
- May be beginning the onset of puberty

Language and Cognitive Development

- Has an improved ability to understand and express some abstract concepts
- Can separate fantasy from reality
- Verbal development is demonstrated in both males and females; males are typically less verbal than same-age females
- Is more capable of sequencing events forward in time; may have difficulty going backward in time
- Can comprehend complex relationships
- Beginning to develop the concept of time; however, may have difficulty recalling the timing of past events
- Thinking is becoming less egocentric

Social and Emotional Development

- Has an increased understanding and sense of morality, justice, and fairness
- May begin to experience conflict between family and peer values
- Is capable of expressing a wide range of emotions, both through verbal and nonverbal language
- Is increasingly sophisticated in managing emotions

Behaviors Related to Sexual Development

- Engages in body exploration
- Has a developing sense of modesty; may express need for privacy
- Is developing romantic feelings
- May show interest in looking at nude pictures or at people while undressing
- Has an increased perception of gender differences
- Is developing strong connections and friendships with the same sex

EARLY ADOLESCENCE: AGES 11 TO 13 YEARS

This population can provide more detailed narrative with fewer verbal cues from the interviewer. Children in this age group may experience feelings of shame, guilt, and embarrassment during the interview process. They may also have worries about not being believed. Children in this age group have an increased ability to self-reflect when asked questions regarding feelings, thoughts, and decisions. Questions regarding the child's disclosure process may be used.

Characteristics of children ages 11–13:

Physical Development

- Has hormones that are becoming active with puberty (average onset of puberty for males is age 12; for females, it is age 10)
- Demonstrates improved coordination, endurance, balance, and physical tolerance
- Is experiencing rapid physical growth, including gains in weight and height
- Has greater sexual interest

Language and Cognitive Development

- Shows greater awareness of others; is beginning to imagine what others may be thinking
- Is less suggestible
- Viewpoint begins to grow beyond nuclear family
- Is interested in the present, with limited thoughts of the future
- Has a growing capacity for abstract thought
- Intellectual interests are expanding and becoming more important
- Engages in deeper moral thinking

Social and Emotional Development

- Struggles with sense of identity
- Is developing concern for others/empathy
- Focuses on social relationships and expectations, worries about being “normal”
- Is increasingly influenced by peer group
- Is developing feelings of responsibility and guilt

- Has increased worries and anxiety, resulting in more questions
- Sexuality may be a source of embarrassment
- Is beginning to withdraw from family, move toward independence
- Has a tendency to return to “childish” behavior, particularly when stressed

Behaviors Related to Sexual Development

- Interested in sexuality
- May engage in viewing of nude pictures, videos, etc.
- May experience feelings of arousal and or attraction
- May stimulate own body for curiosity of exploration
- Has the capacity to learn about intimate, loving, long-term relationships
- Understands that they are sexual; is beginning to understand the options and consequences of sexual expression

MIDDLE TO LATE ADOLESCENCE: AGES 14 TO 18 YEARS

Children in this age group may experience intense feelings of love and affection toward the alleged offender. In some cases, children may perceive the abusive events as part of a relationship. Children in this age group may appreciate/require additional information regarding what to expect during and after the forensic interview process. This population may not always ask for clarification or express when they don't understand a concept or when something is unclear to them. Though they are more advanced than their younger peers, children in this age range are still developing the ability to encode, store, and retrieve information, as well as the ability to recall information for time, sequence, and duration.

Characteristics of children ages 14–18:

Physical Development

- Puberty is completed or near completion
- Brain continuing to develop
- Physical growth slows for females, continues for males

Language and Cognitive Development

- Shows continued growth of capacity for abstract thought
- Exhibits new form of egocentrism beginning to emerge
- Tends to believe others are thinking about them
- May misread facial expressions based upon egocentric thinking
- Has a greater capacity for setting goals
- Is interested in moral reasoning

Social and Emotional Development

- Exhibits intense self-involvement, high expectations, and poor self-concept

- Continues to adjust to changing body, worries about being normal
- Has a tendency to distance self from parents, strives for independence
- Relies on friends to a greater degree; places importance on popularity
- Experiences feelings of love and passion

Behaviors Related to Sexual Development

- Interest in sexuality intensifies
- Exploration of sexuality
- Expresses sexuality/sexual interest in a variety of ways
- May engage in consensual sexual activities
- May experience intense feeling of arousal and/or attraction

VII. DYNAMICS AND PROCESS OF DISCLOSURE

Disclosure is a process, not typically a one-time event. How and when children disclose is an individual process and influenced by a variety of factors. It is not uncommon for children who have experienced abuse or trauma to delay disclosures or minimize or deny abuse altogether. While somewhat less common, recantation of prior statements can occur. To facilitate and maximize the opportunity for children to disclose, it is important to understand the reasons that delayed disclosure or recantation may occur. The interviewer can then identify effective ways to reduce denials and minimizations.

GROOMING AND MANIPULATION

Grooming is a process by which the offender deliberately manipulates the child, significant adults in the child's life, and the environment for the abuse of a child. Grooming behaviors can only be identified retrospectively, after the abuse has occurred, because many of the behaviors may be pro-social in nature. Grooming/manipulation is cyclical; it includes gaining access and maintaining compliance, concealment, and justification of the abuse. The cycle continues with the ultimate goal of continued abuse and non-disclosure.

Online grooming/manipulation is when an offender gains access to a child or adolescent for the purpose of perpetrating sexual abuse or violence online, with the use of electronic devices or other technology. Terminology, as well as our understanding of the dynamics of these types of abuse, is evolving, and therefore may change over time or even rapidly.

There are multiple types of online sexual abuse, including the most commonly known, which is image-based sexual abuse. Recent research suggests that, similar to in-person abuse, a considerable amount of online grooming and abuse is perpetrated by those known to the child or adolescent offline, rather than by an adult stranger. Many offenders are youths — either peers, acquaintances, or intimate partners. Victims of online abuse experience a significant emotional impact regardless of who the offender is.

In cases where the offender is unknown to the child, there may be a higher degree of deception used, and potentially a greater use of threats. Online offenders may move rapidly from neutral content to talking about sexual topics, to engaging in online sexual behavior, to meeting in person, although some may never attempt an in-person meeting. In cases of online adult grooming, and possibly with other offenders, there may be a higher degree of reluctance to disclose, and the child may experience higher levels of self-blame and shame than with in-person grooming; however, there is need for further research in these areas.

In any case of online abuse and violence, parents and professionals may have difficulty understanding why a child did not just walk away or turn off the device. However, with unknown adults, the child may see the offender as all-powerful and be unable to disengage or seek help. With peers, acquaintances, or intimate partners, the same dynamics of in-person abuse are typically present and the child may also be experiencing in-person abuse by the offender.

THE DISCLOSURE PROCESS

Disclosure happens on a continuum ranging from denial to fully detailed disclosure. Where children are in their disclosure process may impact how they present in a forensic interview. Disclosure can be purposeful, accidental, or elicited. The following are general ways that children disclose:

- **Purposeful:** The child makes a conscious decision to tell someone about the abuse; the disclosure is intentional and deliberate.
- **Accidental:** The child makes statements without forethought or conscious intent. Accidental disclosures may also occur when a child makes statements without the developmental ability to understand that they are disclosing abuse or making concerning statements. The child may tell another person (such as a friend) without the intent of the abuse being reported to the authorities.
- **Elicited:** The child is questioned or spoken to, and a disclosure of abuse occurs as a result. The disclosure may happen after the child is provided with information, education, or knowledge about their body. The disclosure may also happen after someone else witnesses the abuse or there is other evidence.

BARRIERS TO DISCLOSURE

There are many reasons that a child may be unwilling or unable to disclose. External and internal factors may influence a child's ability to disclose. For some children, many of these factors can happen at the same time.

- **Age:** Younger children may not understand that the abuse was wrong.
- **Gender:** Research indicates that males are less likely to disclose than females. This is typically due to factors such as societal expectations of masculinity, not wanting to be seen as victims, and worries about how this affects their sexuality.
- **Real or Perceived Threats:** Direct or overt threats made to the child or the child's perception of negative consequences, as well as past behavior.
- **Family Response:** Family members may not believe the child and/or may blame them for unintentional consequences, such as loss of financial stability, the offender being removed from the home or arrested, and other post-disclosure family divisions.
- **Relationship with Alleged Offender:** The child's feelings of loyalty or affection toward the alleged perpetrator.
 - The perpetrator is a family member or caregiver, or is residing in the home.
 - The child has feelings of shame, self-blame, or fear.
 - The child fears they will not be believed.
 - The child lacks support from a non-offending caregiver.
 - The child disclosed abuse before, but the response was inadequate to keep them safe (i.e., a previous system response failure).
- **Family Dynamics:** This includes factors such as rigid gender roles, social isolation, chaotic family structure, and other forms of abuse in the home.

- **Biases:** There are also societal and cultural biases.

FACILITATORS TO DISCLOSURE

According to current research, there are two key dynamics that help children tell: the need to tell and being provided the opportunity to tell. Just like barriers, there are internal and external factors that aid in disclosure. Factors that increase the likelihood that a child will disclose have been researched less than barriers, though some common themes have been identified. The following factors may apply to the child, the child's environment, or their circumstances. Again, many of these factors overlap and can happen at the same time.

Children are more likely to tell if:

- The child is older.
- The child is female.
- The offender is not in the home or there is no contact with the child.
- Symptoms become unbearable and the child is unable to cope with emotional distress.
- The child realizes the abuse was wrong.
- The child has access to a trusted adult.
- The child has access to prevention education programs.
- The child has a supportive caregiver.
- The offender did not build trust.
- The offender is unknown to the child.
- There is evidence or an eyewitness.
- There is a forensic interview.

RECATANTION

Many reasons for recantation are similar to the barriers to disclosure noted above. Children at the highest risk of recantation are 8–10 years old; have an unsupportive, non-offending caregiver; and the alleged offender continues to have access to the child or resides in the home. To prevent recantation, the forensic interviewer and multidisciplinary team (MDT) partners should work collaboratively to minimize trauma, educate and support the child and non-offending caregiver, corroborate the child's original statements, and minimize the number of duplicative interviews. When a child recants, evaluate the recantation carefully with MDT partners.

VIII. MEMORY AND TRAUMA

MEMORY

Memory refers to the capacity to bring elements of an experience from one moment in time to another. The subject of memory is complex. However, it is important for interviewers to have an understanding of the basic principles of memory as it relates to forensic interviewing. Children in various stages of development perceive, remember, and report events in different ways. The interviewer's fundamental task is to cue the child's memory to an event that occurred in the past without tainting the memory or adversely affecting the way it is reported. The interviewer must take into consideration the child's age, development, possible disability, any trauma associated with the event, and external social and cultural influences.

Event details stored in long-term memory are influenced by age, gender, possible disability, culture, family dynamics, social interaction, salience, and contextual knowledge. Memory develops over time as children age. Events that happen when a child is older are easier to remember than events that occur at a younger age. Memories are stored at the age that they occurred, so the recounting will likely be in the language the child had at the time of the event. Children should not be expected to recall and talk about memories as succinctly as adults. Just like with adults, however, memories may lose detail and accuracy as time passes. It is important to note that highly salient or traumatic events are remembered well over time.

Autobiographical memories are those that are unique to an individual. They include semantic memories and episodic memories. Semantic memories include general knowledge and facts about the world. Episodic memories are personal experiences, people, and events experienced at a particular time or place. Episodic memories can be recalled through script or episodic representation.

A scripted representation recalls the "typical features" of repeated events that occur frequently over a period of time. The account includes several memories blended together to form a "gist memory," a generalized statement about how the event usually occurs. Key words that cue the interviewer include "always," "usually," "every time," and "generally."

Episodic representations are recalled in individual or unique accounts and relate to events that occur one time or that include a unique set of defining circumstances, such as the time it occurred in the car when it usually would happen in the bedroom.

Recall memory is usually reflective of what is salient or important for the child. It is accessed by open-ended questions or prompts. It is most accurate but usually incomplete. Recognition memory is accessed by focused or closed-ended questions. It may be more prone to errors or omissions.

SUGGESTIBILITY AND SOURCE MONITORING

Suggestibility refers to the degree to which an individual's memory or recounting of events may be susceptible to suggestive, leading, or biased information. A child's suggestibility is influenced by their age, the salience of their memory, source monitoring, and the potential sources of contamination. Research shows that preschool-age children are potentially more suggestible, though they are able to

give reliable information about their experiences. By the time children reach ages 10–12, they are generally no more suggestible than adults.

Suggestibility is less likely to be a risk when the memory includes strong, salient details that are personal, meaningful, and have a direct impact on the child. Recollection of peripheral or mundane details may be more susceptible to suggestion. Memory recall accuracy may decline with repeated, suggestive retrieval attempts; however, details and accuracy may improve when an open-ended, non-leading approach is used. When there are concerns of suggestibility, evaluate the interview in its entirety rather than on a question-by-question basis.

Source monitoring is the ability to distinguish how, where, or from whom a piece of information is acquired. Preschool-age children particularly may have difficulty explaining how they acquired knowledge. It is unlikely that a child will be knowledgeable of abusive events unless that child has witnessed the activity, is told how the activity occurs, or participated directly in the activity. Proper source monitoring inquiries may help the interviewer distinguish between situations in which the child observed, experienced, or was told about an event. It may also help clarify concerns of coached, inconsistent, or misunderstood statements.

TIME

Time, duration, and frequency are difficult concepts for children of all ages, particularly younger children. Children’s knowledge of current time (their age, date, etc.) does not predict their ability to estimate when an event occurred in the past. Children have difficulty with numerical estimates in general, and they are not likely to remember their age when describing remote events or the frequency of an event. Therefore, asking children how old they were when an event happened, the number of times an event occurred, or if an event occurred one time or more than one time should be avoided or done with caution. It is preferable to have the child describe individual episodes, and to rely on contextual information given to later determine timing.

TRAUMA

Childhood trauma is an event or events occurring in childhood where there is a real or perceived threat to a person’s life or their physical integrity. It can include serious bodily injury or sexual violation. It causes an overwhelming sense of terror, helplessness, and horror. Traumatic experiences often produce intense physical effects such as pounding heart, rapid breathing, trembling, or dizziness. The child may directly experience the event, witness the event, or learn that the event happened to a loved one. Sexual abuse, physical abuse, neglect, and witnessing domestic violence are all potentially traumatic events in a child’s life.

It is important to remember that trauma is personal, defined by the one experiencing it. Therefore, what is traumatic to one is not necessarily traumatic to another. Many factors may influence the effects of trauma on a child, including but not limited to: age, gender, culture, past trauma, level of caregiver support, caregivers’ response to the trauma, and the system’s response to the trauma.

Children who have experienced trauma may experience a variety of symptoms and present in a multitude of ways. Many of these reactions and presentations may be mistaken for other mental health or behavioral issues. During an interview, a child may present angry, have a flat or odd/incongruent

affect, or be distractible, inattentive, or fatigued/lethargic. The child may provide minimal details, test limits and boundaries, or seem disorganized in their thinking. They may even appear to have a possible developmental disability. Children who have been through trauma may need more control, more reassurance, and more information to feel psychologically and physically safe.

Traumatic memories are stored differently in the brain than non-traumatic memories. These memories are more likely to be stored as sensations and emotions. The child's recall may lack a verbal narrative, appear disorganized, and lack contextual details.

Interviewers should have an awareness of the prevalence of trauma, as well as knowledge about how trauma affects one's physical, emotional, and mental health, so as not to re-traumatize the child or family. In addition, it is important for interviewers to be aware of the secondary traumatic stress that may result when an individual hears about the firsthand trauma experiences of another.

SECONDARY TRAUMATIC STRESS/VICARIOUS TRAUMA

Secondary Traumatic Stress (STS) refers to the impact of helping professionals' indirect trauma exposure. Symptoms of STS can mimic those of post-traumatic stress disorder (PTSD). Vicarious Trauma (VT) is often used interchangeably with STS. The risk of STS is higher for those with larger caseloads, those who are socially or organizationally isolated, or those who feel professionally compromised due to inadequate training.

Many professionals have their own history of trauma that also may factor into their risk of developing STS. Professionals working with children and families regarding abuse, such as forensic interviewers, should be aware of the risk of developing STS/VT. Your agency may have supports or services in place to assist when needed. Contact your regional Children's Advocacy Center (CAC) provider for more information.

IX. PEER REVIEW

The purpose of peer review is to provide a quality assurance mechanism for forensic interviewers that reinforces the methodologies used and provides support, constructive feedback, and reinforcement of best practice standards. Feedback plays an essential role in forensic interviewing and can occur one-on-one or in a group setting. Peer review offers an opportunity for forensic interviewers to share knowledge, discuss new research and updates in practice, and address vicarious trauma.

Group peer review sessions should be made up of experienced and beginner interviewers presenting and discussing one another's video-recorded interviews. Peer review sessions may also involve those who conduct video-recorded interviews outside of the Children's Advocacy Center (CAC) setting. Depending on the volume of children seen within the setting, peer review/consultation should be accomplished on a regularly scheduled basis, which may be weekly, monthly, or quarterly. National accreditation requires that forensic interviewers participate in a structured peer-review process a minimum of two times per year. Regional CACs offer regular opportunities for peer reviews, and additional sessions can be requested.

X. INITIAL RESPONDER INTERVIEWS

The Oregon Child Forensic Interviewing Guidelines (OIG) is not intended for initial responder interviews; however, best practices in talking with children still apply. While initial responders should follow their own protocols, this section offers recommendations on how to conduct an initial responder interview. The recommendations work collaboratively with the forensic interview and the multidisciplinary team (MDT) process.

An interview by an initial responder is used to collect the minimal amount of information necessary regarding alleged incidents of child abuse to establish safety, determine if a criminal investigation is needed, and assess the need for an immediate medical evaluation. Initial responders, law enforcement officers, and Oregon Department of Human Services Child Welfare personnel typically conduct this interview during their initial contact with the child/family. If appropriate, this interview is followed by a formal, in-depth forensic interview conducted in a child-friendly atmosphere such as that of a Children's Advocacy Center (CAC).

The initial responder interview must be flexible to permit the initial responder to use common sense in following individual guidelines/policies of the associated MDT. For example, if the child volunteers detailed information, that information should be clearly documented, and the report should reflect the circumstances under which the child made the disclosures. If the child is not volunteering information, the initial responder should avoid further questioning, and the information needed should be obtained from sources other than the child whenever possible. Do not ask the child why the abuse happened, as it implies to the child that they are to blame.

Initial responders should make every effort to limit the number of times a child is talked with about the allegations. In some cases, enough facts may be gathered from the reporting source, thereby eliminating the need for an initial responder interview with the child.

INFORMATION TO BE OBTAINED REGARDING THE ALLEGATION

- If there is a concern of abuse
- Where the alleged abuse took place, determining jurisdiction and whether additional evidence may need to be gathered
- When approximately the last incident occurred. This will aid in determining whether immediate medical attention is necessary. If medical attention is necessary, initial responders should follow their county's MDT protocol for acute physical and sexual abuse medical evaluations
- Names, dates of birth, addresses, and description of the alleged perpetrator(s)
- Names of anyone else who may have witnessed, been present, or been involved with the alleged abuse
- Whether there are immediate safety concerns for the child or other children

FACTS TO BE DOCUMENTED

- Start and end time of the initial responder interview

- Location of the interview
- Those present during the interview
- How the disclosure arose, if it did
- Questions the child was asked
- The child's answers to questions, documented as close to verbatim as possible. Do not change words of the child or offer alternative vocabulary.

The first concern of any investigation must be the safety of the child. While it is best practice for a child to be interviewed at a CAC, the initial responder may determine that expansion of the initial interview is necessary. If it is deemed necessary for a more in-depth interview to be conducted in the field, investigators should always use neutral, open-ended, non-leading question types to elicit information.

XI. RESOURCES

To create this fifth edition of the Oregon Child Forensic Interviewing Guidelines (OIG), expert contributors drew on the following materials. These resources and many more are available at the Child Abuse Library Online (CALiO) at calio.org.

I. INTERVIEW SETTING AT A CHILDREN’S ADVOCACY CENTER (CAC)

- Davis, S. L., & Bottoms, B. L. (2002). The effects of social support on the accuracy of children’s reports: Implications for the forensic interview. In M. L. Eisen, J. A. Quas, & G. S. Goodman (Eds.), *Memory and suggestibility in the forensic interview* (pp. 437-457). Mahwah, NJ: Lawrence Erlbaum Associates.
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- Saywitz, K. J., Lyon, T. D., and Goodwin, G. S. (2017). When Interviewing Children: A Review and Update. In J. E. B. Myers (Ed.), *APSAC handbook on child maltreatment* (4th ed., pp. 310–329). Newbury Park, CA: Sage Publications.

II. PRE-INTERVIEWS

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III. FORENSIC INTERVIEWS

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XII. APPENDIX

APPENDIX A.

NATIONAL CHILDREN’S ALLIANCE FORENSIC INTERVIEWS ACCREDITATION STANDARD

The National Children’s Alliance (NCA) sets and maintains standards for NCA-accredited Children’s Advocacy Centers, including a standard specific to forensic interviewing. The NCA standards may be viewed online at nationalchildrensalliance.org/ncas-standards-for-accredited-members

APPENDIX B.

MINIMUM EDUCATIONAL QUALIFICATIONS FOR CENTER-BASED FORENSIC INTERVIEWERS

Minimum educational qualifications exist for forensic interviewers employed or contracted by, or serving in a voluntary capacity for, Children's Advocacy Centers.

Forensic interviewers must meet at least one of the following qualifications:

- Must be or have been a law enforcement officer or a DHS-Child Welfare worker
- Have a master's degree in a related field with at least two years of experience working with children
- Have a bachelor's degree in a related field with at least four years of experience working with children
- Have a combination of education and experience at least equivalent to the above as determined by the Children's Advocacy Center where the forensic interviewer is employed or volunteers

In addition, the forensic interviewer must do all of the following:

- Complete the Oregon Child Forensic Interviewer Training
- Complete at least eight hours of training in child maltreatment and/or forensic interviewing every two years
- Participate in peer review at least semi-annually, or more frequently if required by the Children's Advocacy Center

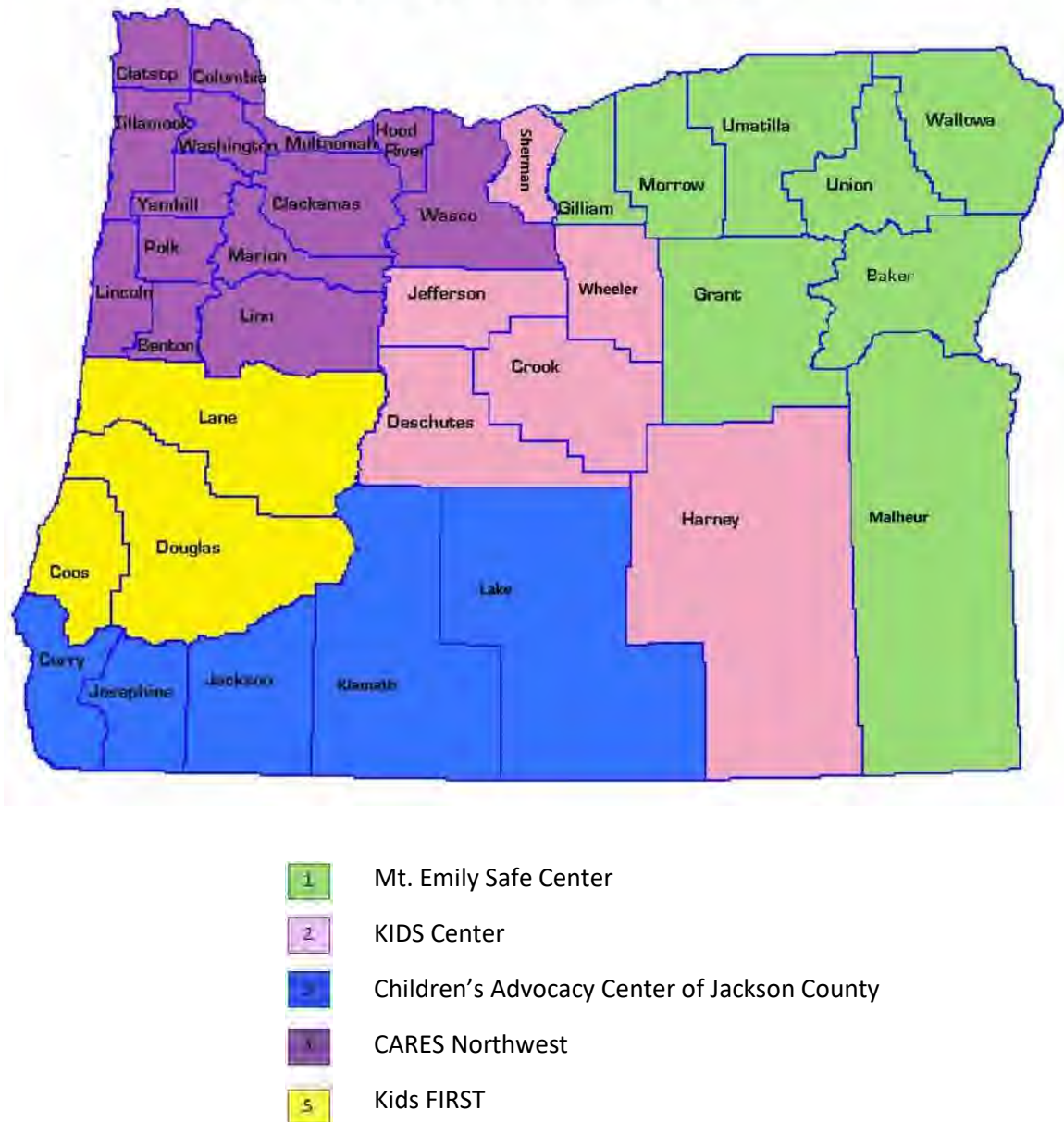
The Child Abuse Multidisciplinary Intervention (CAMI) Program may impose additional training and peer review requirements as a condition of an applicant receiving grant funding.

APPENDIX C.
OREGON CHILDREN’S ADVOCACY CENTERS (CACs)

An up-to-date map and searchable list of CACs can be found on the Oregon Child Abuse Solutions website: oregoncas.org. An up-to-date map and more information about Oregon’s Regional Children’s Advocacy Centers (RCACs) can be found on the CAMI RCAC website: doj.state.or.us/crime-victims/grant-funds-programs/child-abuse-multidisciplinary-intervention-cami-fund/cami-regional-service-providers

The map of Oregon’s RCACs:

CAMI Regional Service Provider Map



APPENDIX D.

OVERVIEW OF NATIONAL MODELS FOR FORENSIC INTERVIEWS

Although various models and protocols are used throughout the United States, they are all designed to obtain reliable information from the child in a way that meets the child's developmental needs, while reducing interviewer contamination. One of the most distinguishable differences among models used across the nation is the degree of structure within the questioning format. Interview protocols range from flexible questioning to highly structured questioning. However, most experts and professionals agree that various models are more similar than different.

American Professional Society on the Abuse of Children (APSAC) Guidelines for Practice

APSAC has developed best-practice guidelines for professionals conducting forensic interviews with children in suspected abuse cases. For information on APSAC guidelines and APSAC forensic interviewing clinics, visit apsac.org.

CornerHouse Interagency Child Abuse Evaluation and Training Center Forensic Interview Model

CornerHouse promotes a semi-structured interview process in which each interview is geared toward the child's age and cognitive, social, and emotional development. For information on the CornerHouse forensic interview model, visit cornerhousemn.org/training. For information on the National Child Protection Center, now in partnership with Zero Abuse Project, visit zeroabuseproject.org.

National Children's Advocacy Center (NCAC) Child Forensic Interview Structure

The NCAC Child Forensic Interview Structure (CFIS) provides guidelines for best practices based on research and expertise demonstrated in the field. Information on the NCAC model and training resources can be accessed at nationalcac.org.

National Institute of Child Health and Human Development (NICHD) Protocol

Published in 2000, the NICHD protocol promotes a structured, scripted approach to the interview. To learn more about the NICHD protocol, visit nichd.nih.gov.

Other forensic interview protocols and models are in use in the United States. The contributors to the Oregon Child Forensic Interviewing Guidelines do not intend to suggest or recommend that the above-mentioned models/protocols should be used.

National Standards of Accreditation

for Children's Advocacy Centers

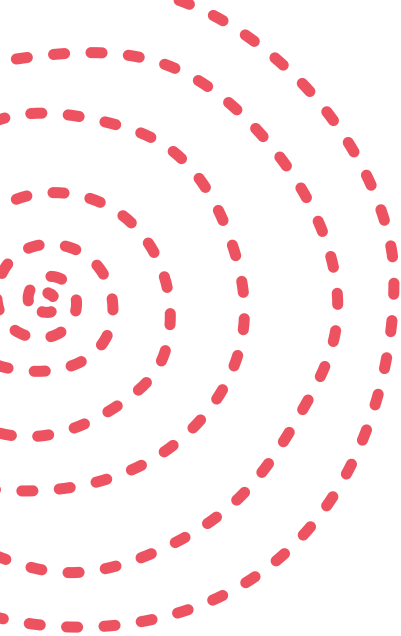
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Guiding Principles

The Standards for Accreditation for Children's Advocacy Centers represent the evidence-supported core competencies of the Children's Advocacy Center (CAC) model. State Chapters may have additional requirements that CACs are encouraged to meet. They are explicitly developed, revised, and guided by the ways in which CACs are organized, sponsored, structured, staffed, resourced, and housed in accordance with the unique factors in their respective communities.

With continued growth in CACs throughout the United States, the Standards also seek to balance the goal of serving greater numbers of children and families with the critical need

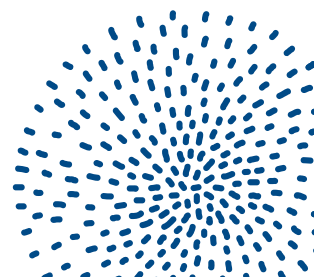
to sustain the integrity of the CAC model and its associated professional credibility. Furthermore, National Children's Alliance (referred to hereafter as NCA) is committed to ensuring a fair, transparent, and equitable review process that recognizes the Standards as minimum standards of operation that are evidence supported, measurable, reviewed, and revised over time as research progresses and service needs evolve. In making the Standards measurable and the basis of measurement clear, NCA promotes the field's recognition of the importance the Standards have for ensuring the delivery of high-quality, relevant, and accessible services to children and families served by CACs.

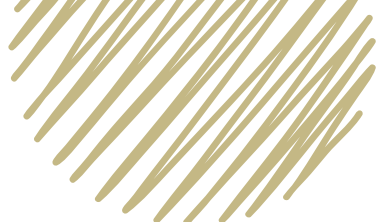
Purpose of the Standards for Accredited Members:

The Standards help ensure that all children across the U.S. served by Children's Advocacy Centers receive consistent evidence-based and evidence-supported interventions that help them pursue safety, healing, and justice. In addition, the Standards also have several secondary purposes:

1. to serve as a valuable roadmap for new CACs as they develop;
2. to assist existing CACs in improving their services to children and families;
3. to demonstrate the high-quality work of Accredited CACs to stakeholders; and
4. to provide a compass to guide CACs, MDTs, boards, and other stakeholders in strategic planning and through leadership transitions.

It is important to note that there is no hierarchy among the National Standards for Accreditation—all are equally important to the healthy functioning of a Children's Advocacy Center. Therefore, the order in this Standards document is not a rank ordering of importance. Careful attention should be given by CACs to each Essential Component, as they serve as a ladder of success to the Standard as a whole.





Standards Revision Process

NCA's Standards for Accredited Members are reviewed through a process coordinated by the Accreditation Department every five , consistent with the five-year period after which reaccreditation is required. NCA conducts regular reviews of the current Standards to ensure that they reflect relevant advances in evidence-based practices and are clear, concise, and set at appropriate thresholds.

The first step of the process was the commission and publication by NCA of the Annotated Bibliography of the Empirical and Scholarly Literature Supporting the Standards for Accredited Members (hereafter referred to as the "Annotated Bibliography"). It was first published in 2011, reviewed and republished in the 2013 second edition and, most recently, reviewed and republished again in a 2019 third edition. (Relevant research published in the interim period was reviewed and added to the draft bibliography.) Research support for all existing standards was identified, providing good evidence that the existing standards and extant research were in alignment and pointed in new areas in which an evidence base has now developed.

In addition to the 9 core CAC National Standards, and based on feedback from the field, NCA's Board of Directors directed the Standards revision process to determine whether sufficient evidence existed to establish practice standards and guide CAC services in Commercial Sexual Exploitation of Children (CSEC), Prevention, and Physical Abuse. Since every CAC does not provide these services, and yet practice standards are needed for those that do, the NCA Board determined that these three new standards will guide CAC services in these key areas at the discretion of the individual CAC seeking accreditation or reaccreditation. This means that these three Standards may be included in the review of site reviewers and CACs must opt-in for

such additional review. These topic areas are included in the 2019 third edition of the Annotated Bibliography.

Beginning in July 2020, NCA conducted a stakeholder survey of Accredited CAC members, accreditation site reviewers, Regional CAC leaders, State Chapter directors, and NCA Board members and staff seeking feedback on the existing Standards as well as requesting input on additional areas of inquiry. During this time, the NCA's Accreditation Department also reviewed accreditation outcome and evaluation data from the period between January 2017 and June 2020 to identify areas requiring further inquiry or clarification.

After the collection, review and approval of the final bibliography and the outcome and evaluation data, the Accreditation Committee convened seven Standards Task Forces to examine the following individual or groupings of related standards:

1. Organizational Capacity, Case Tracking, and Child Safety and Protection (formerly Child-Focused Setting);
2. Multidisciplinary Team, Case Review and Coordination (formerly Case Review), and Forensic Interview;
3. Victim Services & Advocacy;
4. Medical Evaluation and Physical Abuse;
5. Mental Health;
6. Prevention; and
7. Commercial Sexual Exploitation of Children (CSEC).

Each Task Force was composed of subject matter experts and representatives from Regional CACs, Chapters, NCA member CACs, NCA site reviewers and NCA senior staff. Special care was taken to ensure that each Task Force included representatives who are experienced with CACs of diverse organizational structure, caseload, geography, and service population size and demographics. Each Task Force met monthly to discuss proposed revisions to their assigned Standards, completing this work in the spring of 2021.

A final review period of the full set of revisions was conducted in spring of 2021 by a Readers' Pool selected from across all seven Task Forces. Feedback from the Readers' Pool was reviewed by NCA's Accreditation Department and senior staff. The final draft version of the revised Standards was submitted to NCA's Executive Committee, which reviewed it in

May 2021 for any final revisions. It was then submitted to the full Board of Directors for a vote at their June 2021 meeting. At that time, the 2023 Edition of the Standards for Accredited Members was approved, and it was subsequently announced at NCA's 2021 Leadership Conference. This allows a number of months for CACs to complete their accreditation process before the revised Standards become effective for all CACs on January 1, 2023.

All CACs seeking accreditation for the first time, whether applying as a brand-new center or as a center in another membership category, will be reviewed and evaluated based on the Standards in effect during the year in which they apply. Accredited Centers will continue to need to engage in reaccreditation every five years on a rolling basis from their previous accreditation.

Accreditation Process

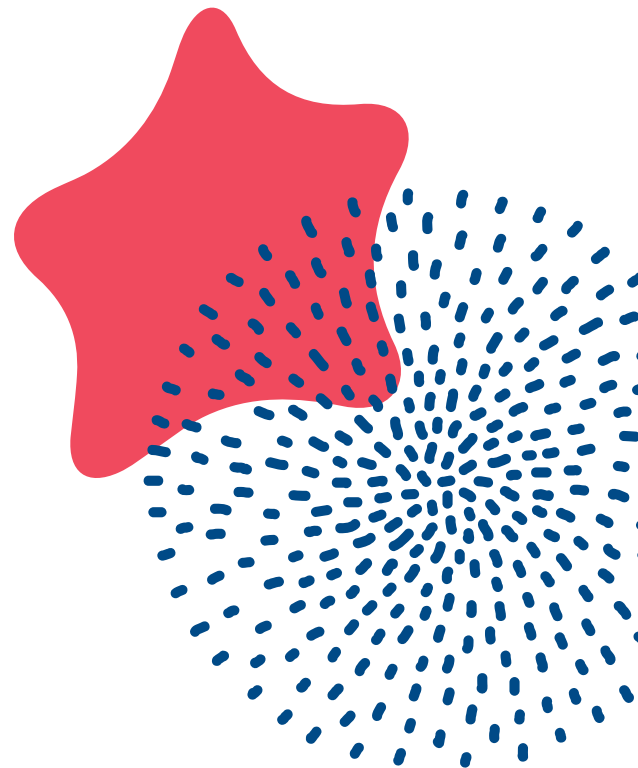
CACs applying for new accreditation or reaccreditation begin by filling out a comprehensive application detailing how the center meets each Standard. This application must include the required documentation that demonstrates how it meets the Standards. NCA staff then screen the application for completeness and provide it to a two-person site review team. The two site reviewers will review the application, contact the CAC director, and send any questions or requests for additional information before the scheduled site visit.

The two-person site review team will conduct an on-site or virtual review within six months of submission of the application. The site review will include a meeting with board members, staff, and MDT members to review practices and documentation that demonstrate compliance with the Standards. Based upon their findings, the site review team completes a scoring form and makes a recommendation regarding the CAC's accreditation status.

NCA's Accreditation Department reviews pending status recommendations, which occur when the CAC is deemed to have

had deficits in one or more of the Standards. NCA's Board of Directors reviews the findings and, if in agreement, approves the site reviewer recommendations and awards accreditation. Centers are notified of the outcome of the review process at this time.

CAC's who are accorded pending status are given a one-year period to implement and document a corrective action plan that demonstrates compliance. At the end of this pending period, the corrective action plan documentation is reviewed by the original two site reviewers, the Accreditation Department, and NCA's Board of Directors. The Board makes the final determination regarding compliance and either awards or denies accreditation accordingly. Centers denied accreditation have the option to appeal the denial decision or begin a new accreditation process.



Contributors

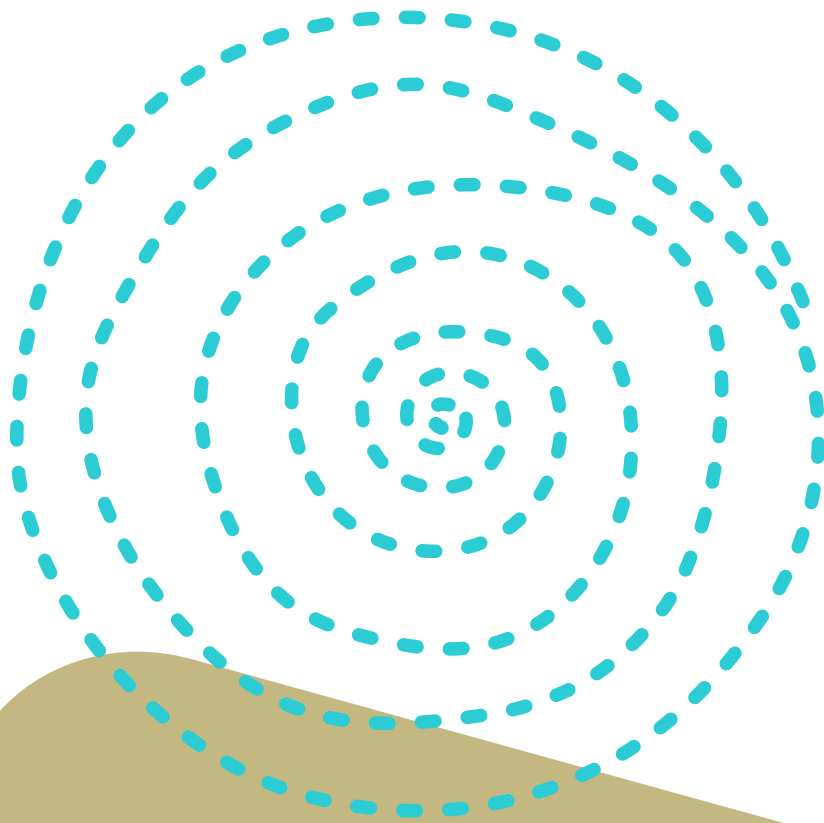
Name	Employer
Abbie Newman, JD	Mission Kids Child Advocacy Center
Adebimpe Adewusi, MD	CARES Northwest
Althea Miller	Harford County Child Advocacy Center
Amelia Siders, Ph. D.	Children's Advocacy Centers of Michigan
Amy Russell, JD	Arthur D. Curtis Children's Justice Center
Antoinette Laskey, MD	University of Utah, Primary Children's Hospital
April Leming	Children's Advocacy Centers of Texas
Betti Mucha	Perry-Jackson Child Advocacy Center
Billie Larkin	NCA Site Reviewer
Brenda George	Children's Alliance of Montana
Caitlin Bentley	Ohio Network of Children's Advocacy Centers
Caitlin Massey	Strafford County Child Advocacy Center
Cameo Stanick	Hathaway-Sycamores Child and Family Services of Los Angeles
Carole Swieckie	Dee Norton Child Advocacy Center
Carrie Little	Children's Advocacy Centers of Oklahoma
Cathy Brittis	CAC at Children's Hospital at Dartmouth
Channing Petrak, MD	Pediatric Resource Center
Char Rivette	Chicago Children's Advocacy Center
Charles Wilson	Consultant
Chelsea Churchill	Children's Advocacy Centers of Texas
Chris Kirchner	Children's Advocacy Centers of Pennsylvania
Chris Newlin	National Children's Advocacy Center
Claudnyse Holloman	Voices for Children Advocacy Center
Corey Brodsky	Midwest Regional Children's Advocacy Center
Crimson Barocca	Baltimore Child Abuse Center
Dana Sawyer	Western Regional Children's Advocacy Center
Darby Geller	SAFE Center
David Finkelhor, Ph. D.	Crimes against Children Research Center, University of New Hampshire
Deana Joy	Children's Advocacy Centers of North Carolina

Name	Employer
Debra Poole, Ph. D.	Central Michigan Univeristy
Diana Schunn	Child Advocacy Center of Sedgwick County
Dominic Prophete, JD	Wynona's House Child Advocacy Center
Dr. Trinity Ingram-Jones	The Cottage
Eileen Caraker	Gloucester County Children's Advocacy Center
Elizabeth LeTourneau, Ph. D.	Johns Hopkins University
Ellen Morrissey	Children's Advocacy Centers of Texas
Ernestine Briggs-King, Ph. D.	Duke University
Gene Klein	Project Harmony
Greg Flett	Southern Regional Children's Advocacy Center
Isha Metzger, Ph. D.	University of Georgia, The EMPOWER Lab
Jane Braun	NCA Site Reviewer
Janet Fine	NCA Site Reviewer
Jasmine Mau-Mukai	Hawaii State Chapter of Children's Justice Centers
Jeffrey Wherry, Ph. D.	UT Health Science Center at Tyler
Jessica Miller	The Gingerbread House
Johanna Hager	Braveheart Children's Advocacy Center
John Pizzuro	Commander New Jersey State Police
Jordan Benning	Midwest Regional Children's Advocacy Center
Joyce Moran	Southern Virginia Child Advocacy Center
Julie Porterfield	Emerald Coast Children's Advocacy Center
Julie Stauffer	CornerHouse
Karen Farst, MD	University of Arkansas for Medical Sciences
Karen Hangartner	Southern Regional Children's Advocacy Center
Karla Tye	Children's Advocacy Centers of Mississippi
Kasey Jackson	Children's Advocacy Centers of Texas
Kathryn Flack	West Virginia Child Advocacy Network
Katie Connell	Federal Bureau of Investigations
Kelly DaCunha	Baltimore Child Abuse Center
Kelly Kinnish	Georgia Center for Child Avocacy
Kimberly Mangiaracino	Children's Advocacy Centers Of Illinois
Kori Stephens	Resonance Rising
Kristy Brodeur Dermody	CALICO Center, Children's Advocacy Centers of California

Name	Employer
Laura Gapske	First Witness Child Advocacy Center
Laura Ng	Chicago Children's Advocacy Center
Leigh Bolin	Resource Center for Parents & Children
Libby Nicholson	CARE House
Libby Ralston	Dee Norton Child Advocacy Center
Linda Cordisco Steele	National Children's Advocacy Center
Lindsay Jordan	Children's Advocacy Centers of Texas
Lisa Conradi	The Chadwick Center at Rady Children's Hospital
Lori Frasier, MD	PinnacleHealth Children's Resource Center
Luis Acuna-Pilgrim	Children's Advocacy Centers of Texas
Marcia Milliken	Minnesota Children's Alliance
Mark Hudson, MD	Midwest Regional Children's Advocacy Center
Maureen Fitzgerald	Children's Advocacy Centers of Washington
Maureen O'Connell	Midwest Regional Children's Advocacy Center
Melissa Brunner	Southern Regional Children's Advocacy Center
Melissa Ewer	New Mexico Children's Alliance
Melissa Snow	National Center for Missing & Exploited Children
Michele Mullen	Northeast Regional Children's Advocacy Centers
Michelle Thames	SafeSpot Children's Advocacy Center
Nydia Monagas, Psy. D.	New Jersey Children's Alliance
Pam Karalunas	NCA Site Reviewer
Patti Terzian	Western Regional Children's Advocacy Center
Paul DiLorenzo	Philadelphia Children's Alliance
Paula Condol	Dakota Children's Advocacy Center
Peter Boser	New Jersey Children's Alliance
Rachel Niemiec	Massachusetts SANE Program/Norfolk Advocates for Children
Regan Stewart, Ph. D.	Medical University of South Carolina
Rita Farrell	Zero Abuse Project
Ruby Nelson	Prince Georges County Department of Social Services Child Advocacy Center
Sabina Alic	Nebraska Alliance of Children's Advocacy Centers
Salli Kerr	Western Regional Children's Advocacy Center
Sara Lee	Midwest Regional Children's Advocacy Center

Name	Employer
Sarah Forrest	Nebraska Alliance of Children's Advocacy Centers
Shawna Pagano	Pat's Place Child Advocacy Center
Stacie LeBlanc, JD	The Up Institute - APSAC
Sue Ascione	Northeast Regional Children's Advocacy Center
Susan Goldfarb	Children's Advocacy Center of Suffolk County
Suzanne Starling, MD	The Chadwick Center at Rady Children's Hospital
Tammi Pitzen	Children's Advocacy Center of Jackson County
Ted Cross, Ph. D.	The Children & Family Research Center, University of Illinois
Teresa Smith, Ph. D.	Northeast Regional Children's Advocacy Centers
Terri Covington	Consultant
Tifanie Petro	Children's Home Child Advocacy Center
Tina Morgan	NCA Site Reviewer
Tom Knapp	South Carolina Network of Children's Advocacy Centers
Tomiko D. Mackey	Family Crisis Services of Northwest Mississippi
Tony DeVincenzo	Northeast Regional Children's Advocacy Center
Tracey Tabott	Utah Children's Justice Centers
Vickie Melvin	Philadelphia Children's Alliance
Vicky Gwiasda	Western Regional Children's Advocacy Center
Victor Vieth, JD	Zero Abuse Project
Wendy Lane, MD	Baltimore Child Abuse Center; Howard County Child Advocacy Center
Wendy Loomis	Child First Advocacy Center
Teresa Huizar	National Children's Alliance
Kim Day	National Children's Alliance
Kristie McKenney	National Children's Alliance
Alyson MacKenzie	National Children's Alliance
Alyssa Todd	National Children's Alliance
Blake Warenik	National Children's Alliance
Michelle Miller, Ph. D.	National Children's Alliance
Jan Lutz	Indiana Chapter of National Children's Alliance





Standard 01

Multidisciplinary Team

A multidisciplinary team response to child abuse allegations includes representation from the following:

- Law enforcement
- Child protective services
- Prosecution
- Medical
- Mental Health
- Victim Advocacy
- Children's Advocacy Center



01. Multidisciplinary Team

Rationale

A committed and effective multidisciplinary team (MDT) with a shared common goal is the foundation of a Children's Advocacy Center (CAC). An MDT is a group of professionals from specific and distinct disciplines that collaborates from the point of report and throughout a child and family's involvement with the CAC. MDTs coordinate investigations and service delivery to mitigate potential trauma to children and families, to keep open the lines of communication and maintain transparency and foster trust, and to help optimize a quality response overall, while preserving and respecting the rights of the clients, and the mandates and obligations of each agency.

A CAC is an agency or organization that facilitates the interagency coordinated response. All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate response that is relevant and accessible to its clients. Quality assurance and a review of the effectiveness of the MDT's collaborative efforts are also critical aspects of the MDT response.

The core MDT must be composed of representatives from law enforcement, child protective services, prosecution, medical providers, mental health providers, victim advocates, MDT leadership, and CAC staff. CAC staff may provide any of the above functions, or additional functions, such as forensic interviewers. Some CACs, including those in small or otherwise under-resourced rural communities, may employ one person to fill multiple roles. For example, the CAC director may also serve as the victim advocate, or a CPS worker may function as a forensic interviewer and a caseworker. What is important is that clear boundaries

are maintained between each function, and that the MDT response is inclusive of and utilizes all of the required functions outlined in these Standards.

MDTs may be expanded to include professionals with other relevant roles and responsibilities, including guardians ad litem, adult and juvenile probation officers, dependency (civil) attorneys, out-of-home care licensing personnel, federal investigators, school personnel, domestic violence providers and others as deemed necessary and appropriate for an individual child, family or community on a case-by-case or routine basis.

Generally, a coordinated MDT approach results in efficient interagency communication and information sharing, ongoing collaboration of key individuals, and a network of support for children and families. Each agency benefits from the knowledge and expertise of MDT colleagues, thorough and shared information, and improved and timely gathering of evidence that guide individual and collective interventions and help ensure the most efficacious outcomes for the clients and all of the MDT partners. CACs function within a trauma-informed framework designed to reduce harm and support healing. MDT interventions in a neutral, child-focused CAC setting are associated with clients experiencing less anxiety, having to undergo fewer interviews, and seeing more appropriate and timely referrals for needed services and meaningful participation by clients in the protective services, criminal justice, and other systems where applicable. In addition, a coordinated MDT response can empower parents and other caregivers to protect and support their children throughout the life of the case and beyond.

BENEFITS OF THE MDT APPROACH BY MDT FUNCTION

Law Enforcement

- May generate additional evidence to create a stronger case that is less reliant on only the victim's disclosure.
- Support and advocacy functions are attended to by other MDT partners, leaving law enforcement personnel more time to focus on their investigatory role.
- Enhanced collaboration between investigative partners results in a better understanding of family dynamics and improved response to child protection issues.

CPS

- Contributes historical family information, which enhances MDT's abilities to foster child safety and provide parental support and assistance with service plans, minimizing need for escalated CPS interventions.
- Provides additional support and intervention in cases where safety cannot be assured.

Medical Providers

- History and other information obtained during the coordinated forensic interview prevents unnecessary duplication of effort and guides medical decisions.
- Provide consultation on specialized medical evaluations and interpretation of medical findings and reports.

Mental Health Providers

- Contribute valuable information to the MDT regarding the child's emotional state, treatment, and other service

needs, and are able to participate in the criminal justice process and other systems where necessary.

- Help ensure that trauma-informed and culturally relevant assessment, treatment, and related services are routinely made available and accessible to children and families.

Victim Advocates

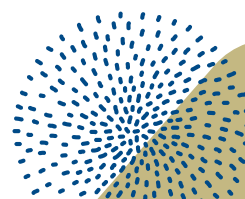
- Provide crisis assessment and intervention, safety planning, referrals for additional services, ongoing support, information and case updates, and court advocacy where necessary in a timely manner.
- Help ensure the MDT's ability to anticipate and respond effectively to the specific needs of children and their families; lessen the stress of, and afford legal rights and meaningful participation in, various systems and the court process; and increase access to services and resources for the child and family, including crime victims' compensation.

Prosecutors

- Provide information about the criminal justice process, victim rights, and seek input from children and families to inform decisions.
- Integrate input from MDT members to optimize ability to hold offenders accountable and ensure community safety.

Children's Advocacy Center

- Coordinates the MDT response to ensure the child and family are receiving nonduplicative services.
- Offers a child-focused setting where trained professionals conduct forensic interviews and other needed services are provided.



Essential Component A:

The MDT Coordinator/Facilitator coordinates and facilitates the day-to-day information sharing and activities of the MDT. The MDT facilitator/coordinator must complete training that includes a minimum of eight hours of instruction. **(This may be the same or different from the person who facilitates case review sessions, as some case reviews are facilitated by MDT members.)**

Training topics which cover the function of the MDT Coordinator/Facilitator may include:

- Developing and maintaining relationships with and among MDT members
- Defining roles and responsibilities of team members
- Defining mission, vision, and values of the MDT
- Managing change and turnover on the MDT
- Navigating and resolving conflict
- Knowledge of evidence-informed team development models
- Facilitating shared decision-making
- Ensuring adherence to MDT agreements and protocols
- Understanding of the various meeting structures that support effective teams
- Facilitating effective communication processes
- Creating psychological safety
- Building resilience for the MDT

STATEMENT OF INTENT:

The person designated to coordinate and facilitate the MDT should have training experience in team facilitation to ensure a participatory process that

will ultimately benefit the child client MDT coordinators/facilitators may come from a variety of professional backgrounds. Often they have subject matter expertise in child abuse, child abuse investigations, or other human services occupations. However, facilitating a team of multidisciplinary professionals is a unique skill set. It requires an understanding of group dynamics, conflict resolution techniques, and team problemsolving. This requires specialized training in order to set the MDT Facilitator/Coordinator up for success. The MDT Facilitator/Coordinator may be a person employed by the CAC who has another role in addition (such as an Executive Director, forensic interviewer, or victim advocate) or may exclusively act as the MDT Coordinator/Facilitator. In some CACs this person also facilitates case review. In others, an MDT member may facilitate case review while the MDT Coordinator/Facilitator is responsible for coordinating day to day information-sharing. However, it is constructed the CAC must be able to identify this role, who fills, it and the role must be viewed by the team as the go-to by MDT members for case coordination, information-sharing among team members, and addressing team functioning. The CAC employee who fills this role must have the required baseline training. In the rare instance in which someone outside the CAC plays this vital role, the training requirement does not apply (though is highly encouraged).

Essential Component B

The designated MDT facilitator must demonstrate participation in continued education in the field of child maltreatment and/or facilitation for a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC must provide ongoing opportunities for the MDT facilitator/coordinator employed by the CAC to receive ongoing training. It is important that team facilitators remain current

on developments in facilitation and other relevant fields of practice to further enhance their expertise.

Essential Component C

The CAC/MDT has, and facilitates, a written interagency agreement signed by authorized representatives of all MDT members that clearly commits the signed parties to its collaborative multidisciplinary response to reports of child abuse and the needs of children and families it serves. The interagency agreement must include:

1. Law enforcement
2. Child protective services
3. Prosecution
4. Mental health
5. Medical
6. Victim advocacy
7. Children's Advocacy Center

STATEMENT OF INTENT:

Written agreements formalize commitment to the overall CAC mission and goals, interagency cooperation and collaboration, and adherence to CAC/MDT policies ensuring consistent, high quality, trauma-informed and culturally relevant practice. Whether written agreements are referred to as memoranda of understanding (MOUs) or interagency agreements (IAs), or something else, they must be signed by the leadership of participating agencies (e.g., police chiefs, prosecuting attorney, agency directors or department heads, supervisors, etc.) or their authorized designees. These documents should be developed with input from the MDT, reviewed annually, and revised and re-executed when necessary to reflect changes in leadership/signatories, practice, or policy.

Essential Component D

Written protocols and/or guidelines address the functions of the MDT, the roles and responsibilities of each discipline/role and their interaction with the CAC throughout the life of the case, including the role of the MDT facilitator/coordinator. Protocols are developed with input from the MDT, updated and signed by all MDT partner agencies minimally every three years. The protocols should be reviewed annually and updated as needed to reflect current practice between three-year signing cycles.

STATEMENT OF INTENT:

The active involvement and commitment of all of the MDT agency leaders and their representatives are critical to ensuring that the policies and protocols by which investigations are conducted and services provided are consistently followed.

Essential Component E

All core members of the MDT, including appropriate CAC staff, are routinely and actively involved in investigations, case management and/or MDT interventions throughout the life of the case, in accordance with the defined needs of children and families and the case.

STATEMENT OF INTENT:

The purpose of multidisciplinary involvement for all interventions is to assure the unique needs of children and families are assessed and addressed. Coordination and collaboration among MDT members allow for informed decision-making to occur at all stages of the case to ensure optimal benefit to children and families. Multidisciplinary intervention begins at initial report and includes, but is not limited to, child protection and/or law enforcement response, forensic interviews, pre- and post-forensic interview meetings, consultations, advocacy, medical and mental health screening,

assessment and treatment, referrals for other services, case review and possible prosecution.

Essential Component F

CAC/MDT members participate in effective information sharing that is consistent with legal, ethical, and professional standards of practice and ensures the timely exchange of case information within the MDT.

STATEMENT OF INTENT:

Regular and effective communication and information sharing minimizes duplicative efforts, enhances decision-making, and maximizes the opportunity for children and families to receive the services they need. Understanding of issues of confidentiality and privacy and relevant legal and ethical obligations must be considered and respected.

Essential Component G

The CAC has written documentation describing how information sharing is communicated among MDT members and how confidential information is protected.

STATEMENT OF INTENT:

Most professions represented on the MDT have legal, ethical, and professional standards of practice with regard to client privacy, confidentiality and privileged communications. The standards and requirements may differ across disciplines. States may have relevant laws in addition to the federal Health Information Portability and Accountability Act (HIPAA) that govern such practices. The CAC/MDT must create written confidentiality and information-sharing guidance that align to these standards and specifically apply to the MDT members, staff, and volunteers.

Essential Component H

The CAC provides routine opportunities for MDT members to give feedback and suggestions regarding procedures and operations of the CAC/MDT. The CAC has a formal process for reviewing and assessing the information provided.

STATEMENT OF INTENT:

CACs should have both formal and informal mechanisms for eliciting regular feedback from MDT members regarding the operations and administration of the CAC (e.g., transportation for clients, use of the facility, equipment upgrades, etc.) and MDT issues (e.g., communication, case decision-making, documentation and record-keeping, conflict resolution, training, etc.).

CACs should foster opportunities for open communication in order to create an atmosphere of trust and respect and to enable MDT members to share responsibility for enhancing the quality of the MDT response with their ideas and concerns. Various methods for eliciting feedback and/or suggestions from MDT members may be utilized, including the Outcome Measurement Survey (OMS) tool team satisfaction survey, suggestion boxes and MDT meetings specifically scheduled for this purpose, among others.

Essential Component I

The CAC/MDT annually provides and/or facilitates relevant training or other educational opportunities focused on issues relevant to investigation, prosecution, and service provision to children and their nonoffending caregivers. The CAC demonstrates documented MDT member participation in this annual professional development.

STATEMENT OF INTENT:

Ongoing learning is critical to the successful operation of CAC/MDTs. The CAC identifies and/or provides relevant educational opportunities for MDT members, including topics that enhance the knowledge and skills of MDT members, collaborative work across disciplines and a deeper understanding of each discipline's role in service provision. This may include directly providing training to MDT members, sharing opportunities to attend conferences, and/or online training opportunities offered by the State Chapter, Regional CACs, or state or national training providers.

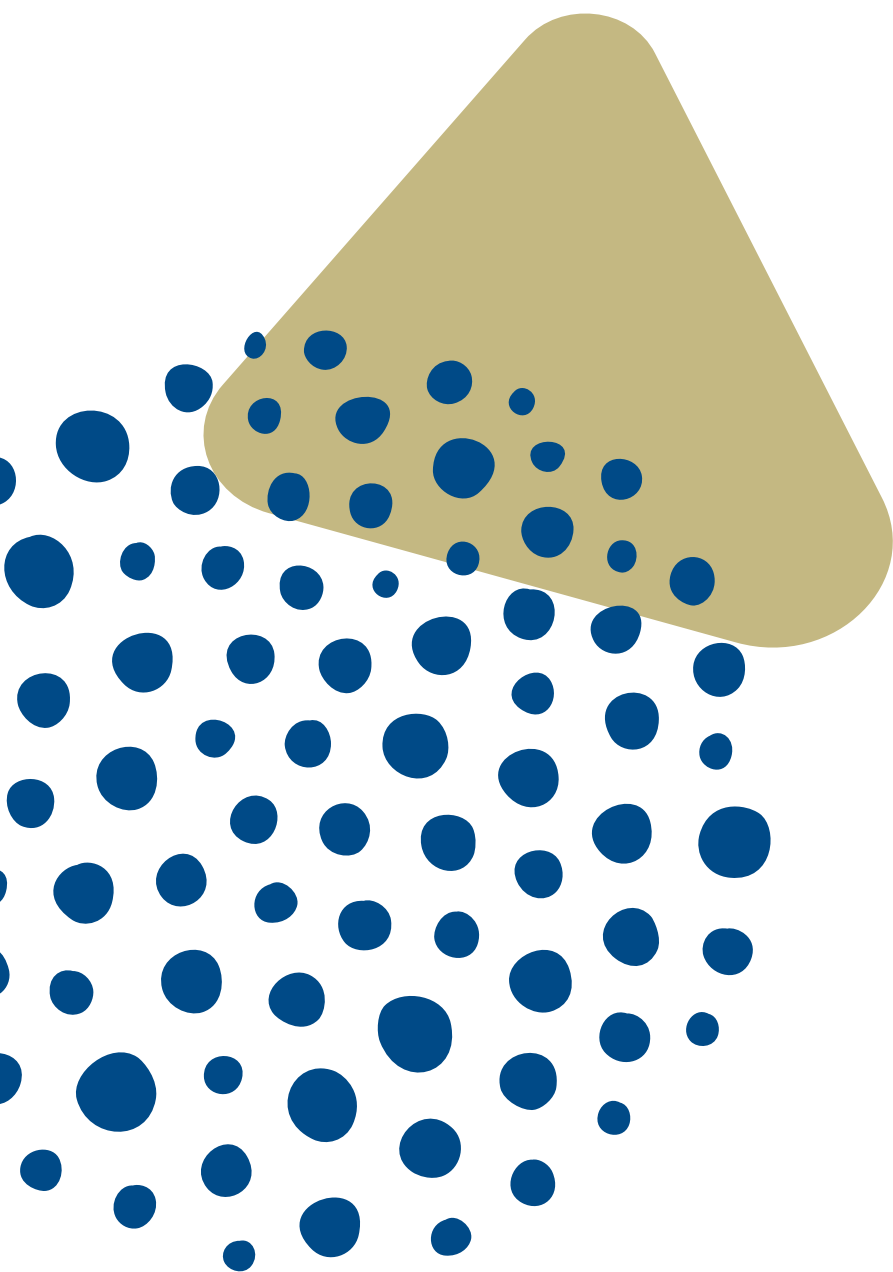
Essential Component J

The CAC/MDT provides formal orientation for new MDT members regarding CAC/MDT process, policies and procedures, and code of conduct.

STATEMENT OF INTENT:

New MDT members arrive experienced in their profession but often inexperienced with multidisciplinary team principles and practice. Providing an orientation for new MDT members ensures that they understand how the team functions, what is expected of their role, and how each member of the team contributes to the case and to better child outcomes. Orienting team members well at the beginning can reduce confusion and conflict and contribute to better overall team function.





Standard 02

Forensic Interview

Forensic interviews are coordinated to avoid duplicative interviewing and are conducted in a manner that is legally sound and of a neutral, fact-finding nature.



02. Forensic Interview

Rationale

The purpose of CAC forensic interviews is to facilitate information gathering from children to determine whether abuse occurred and, if so, the nature of the allegations. This information is intended to contribute to accurate and fair decision-making by the MDT members relative to the criminal justice, child protection and relevant service delivery systems. Forensic interviews are conducted in a manner that is developmentally responsive, unbiased, fact-finding and legally sound. When a child is unable to provide information regarding any concern of abuse through the forensic interview process, other interventions to assess the child's safety and well-being are required.

The CAC/MDT must adhere to research-based forensic interview guidelines that create an interview environment that enables free recall, minimizes interviewer influence, and gathers information needed by all the MDT members in order to avoid duplication of the interview process. The CAC/MDT must monitor these guidelines over time to ensure they reflect current research-based practice, and CAC/MDT protocols and practices need to be congruent.

Forensic interviews are the foundation for multiple CAC/MDT functions, including child protection and criminal investigations, prosecution, and implementation of services critical to helping ensure children and families' paths toward safety, healing, and justice. The child's experience during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to, the ensuing steps in the various aspects of the intervention process.

Skilled forensic interviewing by appropriately trained individuals requires an appropriate neutral setting and effective communication among MDT members. While CACs vary with regard to who conducts forensic interviews, the role must be fulfilled by an appropriately trained, qualified, supervised professional who engages in peer review and ongoing professional development. This may include a CAC-employed forensic interviewer, law enforcement officers (local, state, and/or federal), CPS workers, or others determined by the CAC/MDT in accordance with the resources available in their respective communities. At a minimum, any professional in the role of a forensic interviewer must have initial and ongoing formal forensic interviewer training that is approved by National Children's Alliance (NCA) for purposes of accreditation. State laws may also dictate which professionals can or should conduct forensic interviews.

The CAC/MDT's written documents must include the general interview protocol, guidelines for selecting an appropriately trained interviewer, specifications for sharing of interview information among MDT members, and a mechanism for collaborative case planning, peer review and continuing education. Additionally, for CACs that conduct Extended Forensic Evaluations, an additional protocol for this purpose must also be articulated.

Essential Component A

Forensic interviews are provided by MDT/CAC staff with specialized training in conducting forensic interviews.

The CAC must demonstrate that all forensic interviewer(s) have successfully completed

training that includes the following elements:

1. Minimum of 32 hours of instruction and practice
2. Evidence-supported interview protocol
3. Pre- and post-testing that reflects understanding of the principles of legally sound interviewing
4. Child development; question design; implementation of protocol; dynamics of abuse; disclosure process; and suggestibility
5. Practice opportunities with a standardized evaluation process
6. Required reading of current articles specific to the practice of forensic interviewing

Curriculum must be included on NCA's approved list of nationally or state-recognized forensic interview trainings or submitted with the accreditation application for review and approval.

STATEMENT OF INTENT:

The CAC/MDT must have a process to ensure initial forensic interview training for anyone conducting a forensic interview at the CAC. While MDT members may have received general interview training, conducting forensic interviews of children in the context of an MDT response requires specialized training and qualifications.

Essential Component B

Individuals who conduct forensic interviews must demonstrate participation in ongoing education in the field of child maltreatment and/or forensic interviewing for a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC/MDT must provide ongoing opportunities for professionals who conduct forensic interviews to receive specialized

training. It is vitally important that forensic interviewers remain current on developments in forensic interviewing and other relevant fields of practice to further enhance their expertise.

Essential Component C

CAC/MDT forensic interview protocols must reflect the following items:

1. Case acceptance criteria
2. Criteria for choosing an appropriately trained interviewer (for a specific case)
3. Personnel expected to attend/observe the interview on-site, specifically including those with investigative responsibilities for the case
4. Information sharing and communication between the MDT and the forensic interviewer before and after the interview
5. Use of interview aids
6. Use of interpreters
7. Recording and/or documentation of the interview
8. Interview methodology (i.e., state- or nationally recognized forensic interview training models)
9. Introduction of evidence in the forensic interviewing process
10. Sharing of information among MDT members
11. A mechanism for collaborative case coordination
12. Criteria and process for conducting a multi-session or subsequent interview
13. The use of technology for remote live observation of the forensic interview using a secure method (if applicable)
14. The criteria and process for the use of tele-forensic interviews (if applicable)

STATEMENT OF INTENT:

The forensic interview process must be described in comprehensive detail in the agency's written guidelines or agreements. These guidelines help ensure consistency and quality of interviews, inform MDT discussions pre-and post-interview, and support subsequent decision-making. Technology now makes it possible to both conduct and observe (in real time) forensic interviews online and remotely. Centers that wish to do either or both should clearly identify in the written guidelines or agreements the circumstances in which this is allowed and the process for doing so. Children who receive a tele-forensic interview must be afforded the full range of CAC services and MDT interventions as with any other clients. Care must be taken that the use of remote live observation does not result in the need for repeated interviews or miscommunication between team members. And any use of remote live observation requires the team's written guidelines and agreements to outline who may do so, and under what circumstances.

Essential Component D

The CAC allows for real-time observation of forensic interviews by MDT members.

STATEMENT OF INTENT:

In order to create a psychologically safe space and lessen or eliminate the need for duplicative interviews, interviewers should be observed by MDT members in a space other than the interview room. The MDT should also have the ability to communicate with the interviewer in some manner to provide input and feedback during the real-time interview with the child to reduce the need for additional interviews.

Essential Component E

MDT members with investigative responsibilities on a case must participate in live/real-time observation of forensic interviews to ensure necessary preparation,

information sharing and MDT/interviewer coordination throughout the interview and post-interview process.

STATEMENT OF INTENT:

MDT members, as defined by the needs of the case, are present to observe the forensic interview and participate in pre- and postinterview discussions. This practice provides MDT members with access to the information necessary to fulfill their respective investigatory and related professional roles. MDT members who are present for forensic interviews typically include local, state, federal or tribal child protective services, and law enforcement; others may vary based on the circumstances of each case.

Essential Component F

Cases meeting the CAC case acceptance criteria, as outlined in the MDT protocol, have forensic interviews conducted at the CAC, or through a secure tele-forensic method, a minimum of 75% of the time.

STATEMENT OF INTENT:

Forensic interviews of children, as defined in the CAC/MDT's written protocols, will be conducted at the CAC, where the MDT is best equipped to meet the child's needs during the interview.

Written protocols must also address the rare occasions when interviews may need to take place outside the CAC with the agreed-upon forensic interview guidelines utilized. Some CACs have established interview rooms outside of the primary CAC, such as at a satellite office. In an alternate setting, MDT members must assure the child's comfort, privacy and protection from alleged offenders and others who may unduly influence the child. Remote or tele-forensic interviews may also occur when appropriate and/or necessary to increase access and utilization of CAC forensic interviews. All such alternatives must be agreed upon by the MDT and codified in the written protocols. And

any alternative must continue to afford child clients the full range of CAC services.

CACs are encouraged to develop policies that will provide the most comprehensive services and benefits to all children in their communities. Case acceptance criteria may include various types of abuse, other forms of direct or indirect exposure to violence/trauma, jurisdictional issues, and the ages of children, among others.

Essential Component G

Individuals who conduct forensic interviews must participate in a structured forensic interviewer peer review process a minimum of two times per year. Peer review serves as a quality assurance mechanism that reinforces the methodologies utilized and provides support and problem solving for participants. Structured peer review includes:

1. Ongoing opportunities to network with, and share learning and challenges with, peers
2. Review and performance feedback on actual interviews in a professional and confidential setting
3. Discussion of current relevant research articles and materials and implications for forensic interview practice
4. Training opportunities specific to forensic interviewing of children and CAC-specific methodologies.

STATEMENT OF INTENT:

Participation in peer review is vital for quality assurance of forensic interviewers and allows for the further development and enhancement of their skills based on new research and developments in the field. Peer review is a complement, not a substitute, for supervision, as well as multidisciplinary case review and case planning.

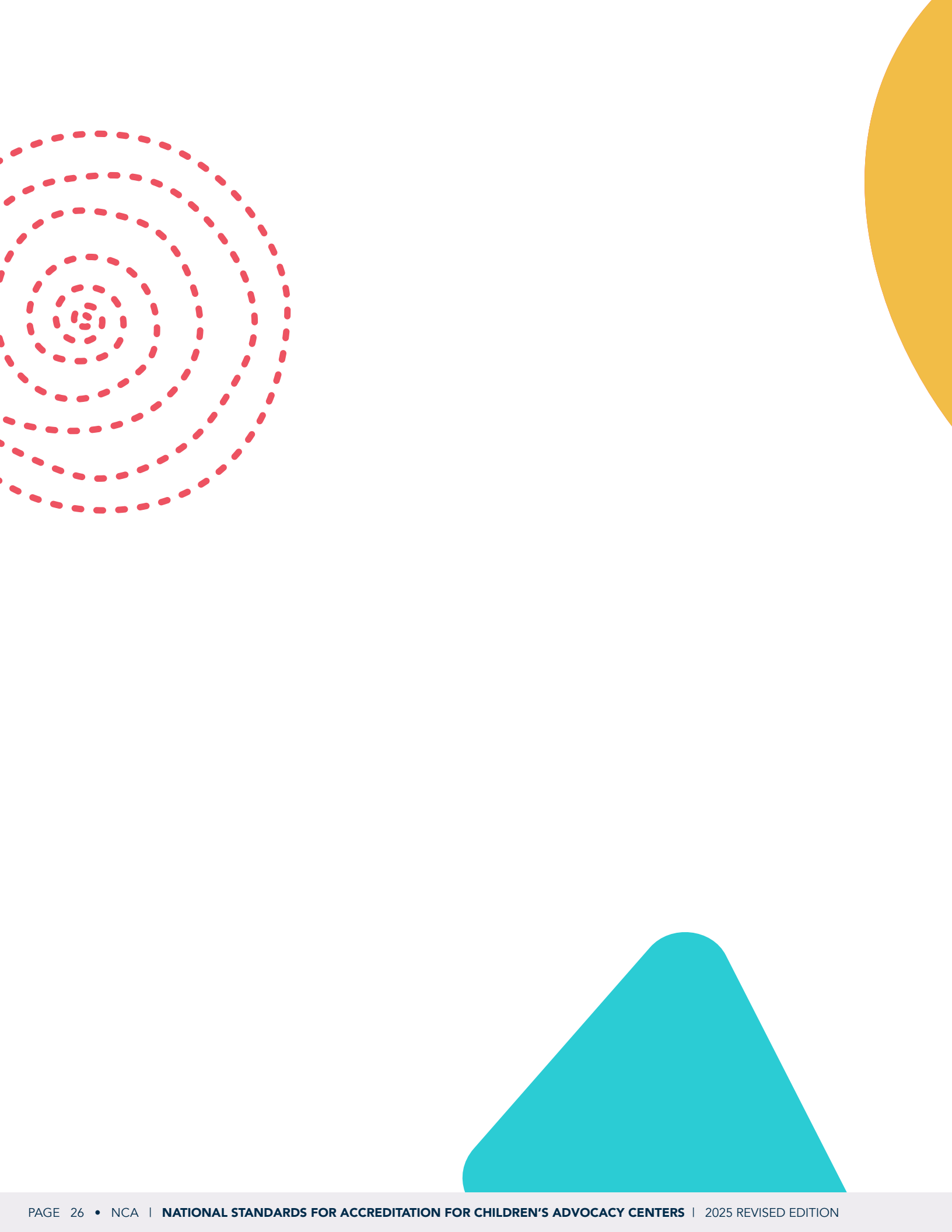
Essential Component H

The CAC/MDT coordinates information gathering, including history taking, assessments and forensic interview(s) to avoid duplication.

STATEMENT OF INTENT:

All members of the MDT need information to complete their respective assessments and evaluations. Whether it is initial information gathered prior to the forensic interview, history taken by the medical provider, or intake by the mental health or victim services provider, every effort should be made to avoid unnecessary duplication of information gathering from the child and family members and ensure effective information sharing among MDT members.





Standard 03

Victim Support and Advocacy

Victim support and advocacy services are provided to all CAC clients and their caregivers as part of the multidisciplinary team response.



03. Victim Support and Advocacy

Rationale

Research demonstrates that parent/caregiver support is essential to reducing trauma and improving outcomes for children and family members. Client access to, and participation in, investigation, prosecution, treatment, and support services are core components of MDT response, and are informed and supported by coordinated victim advocacy services. Up-to-date information and ongoing access to comprehensive services are critical to a child and family's well-being and ability to participate in an ongoing investigation, possible prosecution, intervention, and treatment.

Victim support and advocacy responsibilities are implemented consistent with legal and, where relevant, state constitutional victims' rights and the complement of services in the CAC's coverage area. Many members of the MDT may advocate for children and families within their discipline systems or agencies. However, victim advocacy is a discipline unto itself with a distinct and central role on the MDT. Victim advocates provide services and resources to ensure a consistent and coordinated comprehensive network of support for each child and family.

Children and families in crisis need assistance in navigating the multiple systems involved in the CAC response. More than one victim advocate may perform these functions at different points throughout a case, requiring continuity and consistency in service delivery. Coordination of victim support is the responsibility of the CAC and must be defined in the CAC/MDT's written documents, including understanding of relevant statutes and ethics regarding confidentiality and privilege. Specific victim support services may be provided in a variety of ways, as dictated by the needs of the CAC clients and case, such as:

- Employing staff members with varying job titles to perform advocacy functions (e.g., family advocates, care coordinators, victim advocates and child life specialists, among others)
- Linking with local community-based advocates, including, but not limited to domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates
- Linking with system-based advocates (e.g., law enforcement victim advocates, prosecutor-based victim witness coordinators)
- Combining victim support services depending upon the individual needs of children and families

All advocates who serve on the MDT and are providing services to CAC clients must meet the prescribed training and supervision requirements. This includes advocates on staff at the CAC and/or advocates from outside organizations providing advocacy services and serving as members of the MDT.

Essential Component A

Comprehensive, coordinated victim support and advocacy services are provided by designated individual(s) who have specialized training that includes a minimum of 24 hours of instruction, including, but not limited to:

1. Dynamics of child abuse
2. Trauma-informed services
3. Crisis assessment and intervention
4. Risk assessment and safety planning

5. Professional ethics and boundaries
6. Understanding the coordinated multidisciplinary response
7. Understanding, explaining, and affording of victim's legal rights
8. Court education, support, and accompaniment
9. Knowledge of available community and legal resources, referral methods and assistance with access to treatment and other services, including protective orders, housing, public assistance, domestic violence intervention, transportation, financial assistance, and interpreters, among others as determined for individual clients
10. Caregiver resilience
11. Domestic violence/family violence/ children's exposure to domestic violence and poly-victimization

STATEMENT OF INTENT:

Victim support and advocacy is fundamental to the MDT response. These professional support/advocacy responsibilities may be filled by a designated victim advocate who is an employee of the CAC or another victim-serving agency. Another MDT member with appropriate experience and training in victim advocacy may also serve in this role; however, in doing so, it must not conflict with the other MDT functions they may have.

Essential Component B

Individuals who provide victim advocacy services for the CAC must demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

The CAC and/or MDT must provide initial and ongoing opportunities for professionals who provide advocacy services to receive specialized training and peer support. As with all other disciplines represented on the MDT and serving CAC clients, it is vitally important that victim advocates remain current on developments in fields relevant to their delivery of services to children and families.

Essential Component C

Victim advocates serving CAC clients must provide the following constellation of services:

1. Crisis assessment and intervention, risk assessment and safety planning and support for children and family members at all stages of involvement with the CAC
2. Assessment of individual needs for child/family and help to ensure those needs are being addressed in concert with the MDT and other service providers
3. Presence at the CAC during the forensic interview in order to participate in information sharing with other MDT members, inform and support the family regarding the coordinated, multidisciplinary response, and assess needs of children and nonoffending caregivers
4. Provision of education and assistance in ensuring access to victim's rights and crime victim's compensation
5. Assistance in procuring concrete services (housing, protective orders, domestic violence intervention, food, transportation, public assistance, civil legal services, etc.)
6. Provision of referrals for trauma-focused, evidence-supported mental health and specialized medical treatment, if not provided at the CAC

7. Facilitating access to transportation to interviews, court, treatment, and other case-related meetings
8. Engagement with the child and family to help them understand the investigation/prosecution process and help ensure understanding of crime victims' rights
9. Participation in case review to communicate and discuss the unique needs of the child and family and associated services planning; and help ensure the coordination of identified services and that the child and family's concerns are heard and addressed
10. Provision of case status updates to the family, including investigations, court date, continuances, dispositions, sentencing and inmate status notification (including offender release from custody)
11. Provision of court education and support, including court orientation and accompaniment

STATEMENT OF INTENT:

While the particular combination of services required will vary based upon the child and family's unique needs and the legal requirements of any civil and/or criminal cases, all children and families need support in navigating the various systems they encounter that are often unfamiliar to them. Crisis and risk assessments and intervention, advocacy, and support services will help to identify the child and family's unique needs, reduce fear and anxiety, and expedite access to appropriate services and resources. Families can be assisted with crisis management, including problem solving, access to critical treatment and other services, and ongoing education, information, and support. Crises may recur with various precipitating or triggering events, including, but not limited to, financial hardships, child placement, arrest, change/delay in court proceedings and preparation for court testimony. Children may experience crisis and trauma, including suicidal ideation, at unanticipated times. Many CACs provide advocacy services for children and their family

members on-site and/or through linkage agreements with other community agencies or system-based providers.

State and federal laws require that victims of crime, including victims of child abuse, are informed of their rights as crime victims, including information about, and eligibility for, crime victim compensation. Caregivers who are affected by the crime are also entitled to services and may be eligible for victim compensation. Generally, children and their families will be unfamiliar with their legal rights. Therefore, information regarding rights and services should be routinely and repeatedly explained at the outset of their involvement with the CAC/MDT and made available to all children and their caregivers.

Essential Component D

Active outreach and follow-up support services for caregivers consistently occurs.

STATEMENT OF INTENT:

Often, families have never been involved in this multi-system response, which can prove intimidating and confusing. Active outreach requires follow-up with families beyond initial investigation, assessment, and crisis response. Follow-up services after the initial contact at the CAC must include ongoing, regular contact until the CAC concludes its involvement with the case.

In the aftermath of victimization, the child and family typically feel a significant loss of control. Education provides information that is empowering. Victim education must be ongoing and even repetitive as needed, as families may be unable to process so much information at one time, particularly in the midst of a crisis. The family may be dealing with immediate safety issues and may be coping with the emotional impact of the initial report and ensuing forensic interview and investigation process. They may need a variety of concrete medical, mental health, and social services. As the case dynamics change, and as the case proceeds through the

various systems, the needs of the child and family will also change. It is important that their needs continue to be assessed, so that additional relevant information, support, and services can be offered and so that said services are accessed and relevant.

Essential Component E

The CAC/MDT's written protocols/guidelines include availability of victim support and advocacy services for all CAC clients throughout the life of the case and participation of victim advocate(s) in the MDT case review. This participation must be in accordance with legal requirements regarding confidentiality.

STATEMENT OF INTENT:

Because victim support/advocacy is a central function of the CAC response, the availability and provision of ongoing victim support and advocacy by designated, trained individuals must be included in the CAC/MDT's written documents. Service coordination, both within and outside the CAC, must be clearly defined, including the role of the victim advocate during the interview process, follow-up, and case review.

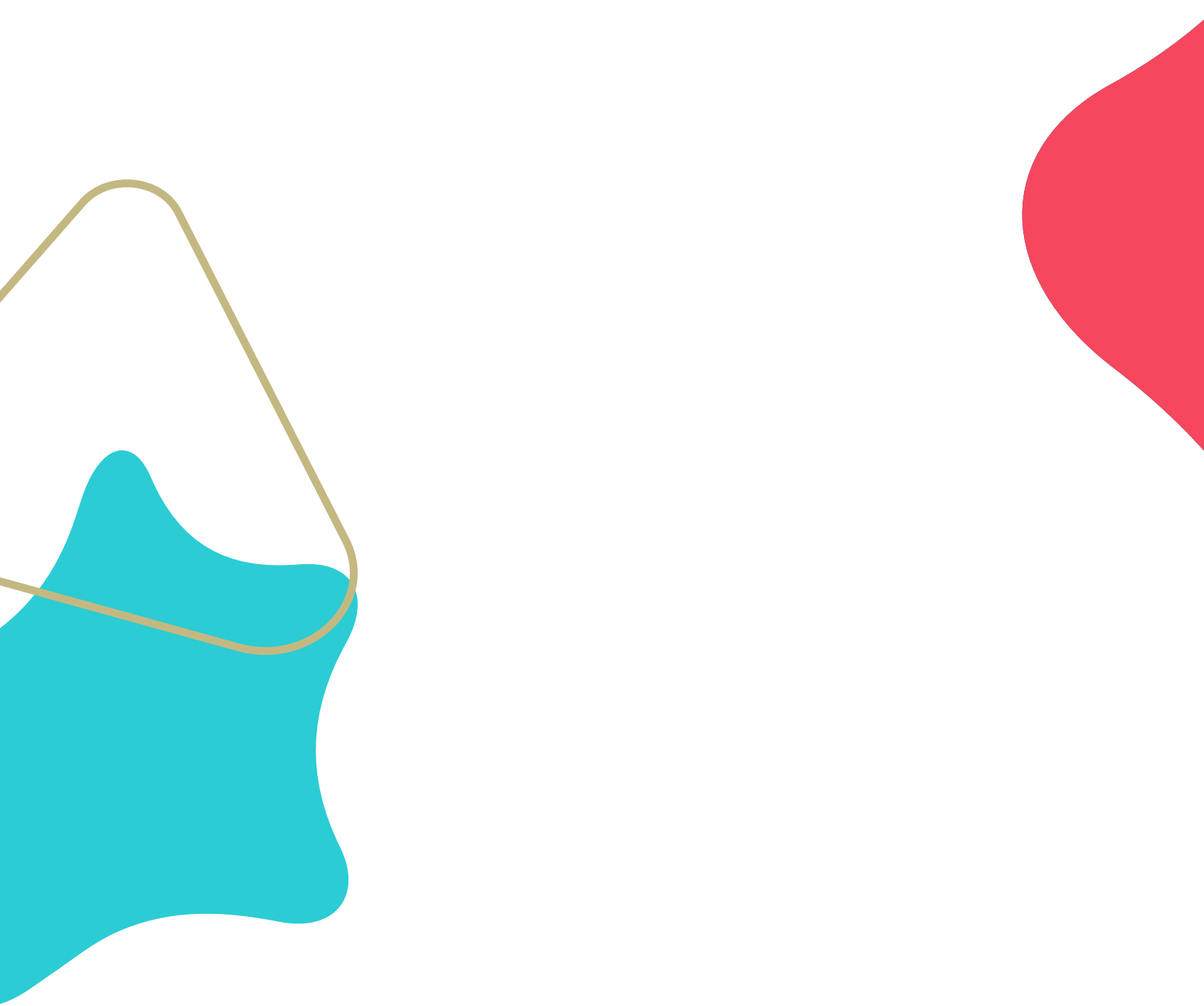
Essential Component F

Coordinated case management must occur with all individuals providing victim advocacy services to CAC clients.

STATEMENT OF INTENT:

If multiple advocacy agencies share the delivery of services, the CAC is responsible for establishing protocols and linkage agreements agreed upon by the MDT that clearly define the victim advocacy roles and ensure seamless coordination of victim advocacy services.

In any community or jurisdiction a CAC serves, there may be various agencies and programs providing advocacy and support services to child and adult victims and survivors who have experienced abuse and trauma. In addition to victim advocates who may be employed by the CAC, there may be advocates on staff in law enforcement agencies, prosecutors' offices, domestic and sexual violence communitybased agencies, hospitals, and CASA programs, among others. While specific job titles may vary, children and families engaged with the CAC/MDT may also be receiving services from some or all of these agencies/ programs. To better understand each other's roles, optimize cross-referrals for CAC clients, avoid unnecessary duplication and ensure meaningful coordination of services, the CAC must develop a process for achieving these goals in collaboration with one another. This process will need to include understanding and respect for issues of confidentiality and methods for sharing case-specific information accordingly.



Standard 04

Medical Evaluation

Specialized medical evaluation and treatment services are available to all CAC clients and are coordinated as part of the multidisciplinary team response.



04. Medical Evaluation

Rationale

All children who are suspected victims of child sexual abuse are entitled to a medical evaluation by a health care provider with specialized training and expertise. The collection and documentation of forensic findings are vital. However, the referral of children for medical examinations should NOT be limited to those where forensically significant findings are anticipated. Medical evaluations should be prioritized as emergent, urgent, and non-urgent based on specific screening criteria. Said criteria must be developed by specially trained and skilled medical providers, who may be those serving on local multidisciplinary teams. Additional considerations include the ability to conduct follow-up examinations to reassess findings and conduct further testing where deemed necessary.

A medical evaluation holds an important place in the multidisciplinary assessment of child abuse. An accurate and complete history is essential in making medical diagnoses and determining appropriate treatment of child abuse. Recognizing that there are several acceptable models that can be used to obtain a history of the abuse allegations, and that forensic interview techniques are specialized skills that require training, information gathering must be coordinated with the MDT to avoid duplication. Because many children are familiar with the helping role of doctors and nurses, they may disclose information to medical personnel that they might not share with investigators. In fact, some children are able to describe residual physical symptoms to medical providers even when no injury is seen. If a nonmedical member of the MDT is conducting the in-depth forensic interview, further medical history will still likely be needed from the caregiver and/or child to complete the medical

evaluation. As such, information gathering and sharing must be coordinated to avoid duplication and help ensure a comprehensive response (see Med-Appendix 1 for an example of Components of Medical History for Child Sexual Abuse Evaluation).

Essential Component A

Medical evaluations are conducted by health care providers with specific training in child sexual abuse who meet at least ONE of the following training standards:

1. Child Abuse Pediatrics Subboard eligibility or certification
2. Physicians without board certification or eligibility in the field of child abuse pediatrics, advanced practice nurses, and physician assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse (see Med-Appendix 2)
3. Sexual assault nurse examiners (SANEs) without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency-based clinical preceptorship with an experienced provider in a clinical setting, where the SANE can demonstrate competency in performing exams (see Med-Appendix 2 or IAFN guidelines)

STATEMENT OF INTENT:

Physicians, advanced practice nurses, physician assistants and SANEs without advanced practice training may all engage in medical evaluations of child abuse. Due to differences

in foundational training in pediatric assessment by provider type (see Med-Appendix 2), the above training and eligibility standards must be met by the health care provider of a CAC (regardless of whether the exams are occurring on- or off-site).

All providers should be licensed to practice and be in current good standing by their corresponding state board of practice regulation. Nurses must practice within the scope of their applicable state nurse practice acts. A medical director (physician or advanced practice nurse) is needed for non-advanced practice nurses to assist with the development of practice protocols and the treatment needs of the patient, including referrals for other medical or mental health issues that are discovered during the evaluation. The medical director may or may not also meet qualifications as an “advanced medical consultant” (as defined in the “Continuous Quality Improvement” section) who can perform review of examination findings. If the medical director does not also serve as a medical provider for the CAC, this person should, at a minimum, be familiar with the essential components of the medical standard and the mission of the CAC.

Some CACs have qualified medical providers as full- or part-time staff, while others provide this service through affiliation and linkage agreements with local providers or regional facilities. Whether the exams occur on-site or off-site, or by CAC staff or via a linkage agreement, the medical provider must meet the Training and Eligibility Standards for Training (above) and Continuous Quality Improvement.

Continuous quality improvement (CQI) for the CAC’s medical component:

The medical provider must be familiar and up to date with published research studies on findings in abused and non-abused children, sexual transmission of infections in children, and current medical guidelines and recommendations from national professional organizations such as the American Academy

of Pediatrics Committee on Child Abuse and Neglect, the American Professional Society on the Abuse of Children, and the Centers for Disease Control and Prevention. Accuracy in interpretation of examination findings is vitally important to the child, family, and the MDT as a whole. The medical provider must provide documentation of participation in CQI activities, including continuing education and expert review of positive findings with an “advanced medical consultant” in order to stay current in the field of child sexual abuse.

Essential Component B

Medical professionals providing services to CAC clients must demonstrate continuing education in the field of child abuse consisting of a minimum of eight contact hours every two years.

Teaching experience in the area of child abuse that is approved to provide CEU or CME activity also qualifies for ongoing education credit.

Essential Component C

Medical professionals providing child sexual abuse evaluations to CAC clients must demonstrate that all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone expert review by an “advanced medical consultant.”

- Expert review with a child abuse pediatrician is preferred and can occur in multiple ways, including via a direct linkage agreement with a specific provider, through myCasereview sponsored by the Midwest Regional CAC, or through other identified state-based medical expert review systems that have access to an “advanced medical consultant.”
- Physicians or advanced practice nurses can also provide said review if they have the following qualifications:

- Meet the minimum training standards outlined for a CAC medical provider
- Have performed at least 100 child sexual abuse exams
- Are current in CQI requirements

The CAC and medical provider must work collaboratively to establish a method to track de-identified case information as part of the CQI process (see Med-Appendix 3).

STATEMENT OF INTENT:

The accuracy and integrity of forensic medical evaluation findings is critically important in child sexual abuse cases. While a small percentage of medical evaluations result in a positive or diagnostic finding for sexual abuse (about 3–5% in the literature), it is critical to both the future safety of the child and the integrity of any criminal justice case that the findings are accurate. Research indicates that the most important in diagnostic accuracy over time is consistent review. Because a false positive (“overcalling”) can lead to a miscarriage of justice, given the reliance of MDT members on medical findings in making charging decisions and the reliance on such findings at trial, it is essential to have 100% of all medical findings diagnostic for child sexual abuse reviewed by an advanced medical consultant.

The medical provider must be able to provide documentation of participation in expert review with an “advanced medical consultant” on all abnormal sexual abuse exams for the purpose of CAC case-tracking information that could be requested for review in the accreditation process.

The providers who qualify as “advanced medical consultants” to offer expert review of examination findings are listed above in the essential component, as is the critical importance of collaboratively establishing the required CQI process.

Essential Component D

Specialized medical evaluations for child clients are available on-site or through linkage agreements with other appropriate institutions, agencies, or providers.

STATEMENT OF INTENT:

Specialized medical evaluations can be provided in a number of ways. Some CACs have a qualified medical provider who comes to the center on a scheduled basis, while in other communities, the child is referred to a medical clinic or health care agency for this service. CACs need not be the primary care provider, but they must have protocols in place outlining and facilitating the linkages to a facility with a qualified medical provider and other needed health care services.

Essential Component E

Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.

STATEMENT OF INTENT:

In many communities, the cost of a medical evaluation is covered by public funds. In other settings, limited public funding requires that individuals who can pay or are insured cover the cost of their own examinations, or for those clients who require support, MDT members can help facilitate reimbursement through victim compensation. Regardless of the source of funding for the examinations, ability to pay should never be a factor in determining who is offered and able to access a medical evaluation.

Essential Component F

CAC/MDT written protocols and guidelines include access to appropriate medical evaluation and treatment for all CAC clients.

STATEMENT OF INTENT:

Because medical evaluations are a critical component of the CAC's multidisciplinary response, the CAC's written protocols must detail how its clients access these services. Many CACs provide services to victims of physical abuse and neglect as well as to victims of sexual abuse. All CACs must have written protocols and agreements outlining how medical evaluations for all types of abuse and neglect should occur. CACs that provide medical evaluations for sexual abuse, but not specifically for physical abuse or neglect, must include written procedures for how to access medical evaluations for alleged physical abuse or neglect, including treatment for injuries and management of emergency or life-threatening conditions that may become evident during a sexual assault exam.

Essential Component G

CAC/MDT written protocols and guidelines include the circumstances under which a medical evaluation for child sexual abuse is recommended, provided, and accessed.

STATEMENT OF INTENT:

The purpose of a medical evaluation in suspected child abuse extends far beyond providing an evidentiary examination for the purpose of the investigation. The primary goals of the medical evaluation are to:

- Help ensure the health, safety, and wellbeing of the child
- Evaluate, document, diagnose and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral issues needing further evaluation and treatment and make referrals as necessary

- Educate the child and family regarding all aspects of the medical examination and outcomes
- Provide support relative to any recommended next steps and reassurance regarding child's overall health and wellbeing
- Make recommendations regarding mental health and other services to address trauma related to the abuse/assault in coordination with other members of the MDT/CAC

CACs differ in their practices for how medical evaluations are made available. The MDT's written protocols or agreement must include qualified medical input to define the referral process and how, when and where examinations are made available. Examinations can be differentiated between those needed emergently (without delay), urgently (scheduled as soon as possible with a qualified provider), or nonurgently (scheduled at the convenience of family and provider but ideally within 1–2 weeks). Some patients may also benefit from a follow-up examination (see Med-Appendix 4). CACs are responsible for ensuring that exams are performed by experienced, qualified medical providers at the appropriate location and time, and that examinations are photo-documented to minimize unnecessary repeat examinations. This often requires initial conversations with emergency departments and primary care providers to develop a process for referral to the specialized medical provider as defined by the needs of the child.

Essential Component H

Documentation of medical findings is maintained by written record and photodocumentation. Medical records storage must be HIPAA compliant. The medical records storage must be secured, sufficiently backed up and accessible to authorized personnel in accordance with all applicable federal and state laws.

STATEMENT OF INTENT:

The medical history and physical examination findings must be carefully, thoroughly, and legibly documented in the medical record. The medical record should also include a statement as to the significance of the findings and treatment plan. Medical records should be maintained in compliance with federal rules governing protection of patient privacy. Medical records may be made available to other medical providers for the purpose of needed treatment of the patient and to those agencies mandated to respond to a report of suspected child abuse. Even in situations where the medical record can legally be provided without separate written consent or court order, a log of disclosures should be maintained with the medical record in accordance with federal privacy rules (see Med-Appendix 5).

Diagnostic-quality photographic documentation of the ano-genital exam findings should be obtained in all cases of suspected sexual abuse using still and/or video documentation. This is particularly important if the examination findings are thought to be abnormal. Photographic documentation allows for review for CQI and for obtaining consultation or second opinion and may also obviate the need for a repeat examination of the child. CACs should have policies in place for storage and release of examination images that protect the sensitive nature of the material. In the uncommon exception that photodocumentation is not possible due to the child's discomfort with the equipment or equipment malfunction, diagram drawings with detailed written description of findings should occur.

Detailed procedures for the documentation and preservation of evidence (labeling, processing, and storing) in written protocols and agreements can help to assure the quality and consistency of medical evaluations. Such protocols can also serve as a checklist and training document for new medical providers. Many states have mandated forms for recording findings of a sexual assault exam and guidelines for the preservation of evidence.

Essential Component I

MDT Members and CAC staff are trained regarding the purpose and nature of the medical evaluation for suspected sexual abuse. Designated MDT members and/or CAC staff educate children and caregivers regarding the medical evaluation.

STATEMENT OF INTENT:

The medical evaluation for suspected child sexual abuse often raises significant anxiety in children and their caregivers, usually due to misconceptions about how the examination is conducted and what findings, or lack of findings, mean. An appropriately trained medical provider performing the examination typically addresses this anxiety. In many CAC settings, the client is introduced to the examination by nonmedical personnel. Therefore, it is essential for nonmedical MDT members and CAC staff to have the training needed to explain the nature and purpose of a medical evaluation, and to respond to common questions, concerns, and misconceptions, to similarly ease anxiety.

Essential Component J

Findings of medical evaluations are shared with the MDT in a routine, timely and meaningful manner.

STATEMENT OF INTENT:

Because the medical evaluation is an important part of the response to suspected child abuse and neglect, findings of the medical evaluation should be shared with, and explained to, the MDT in a routine and timely manner to facilitate discussion of concerns, and ensure case decisions can be made effectively. The legal duty to report findings of suspected child abuse to child protective services is an exception outlined by the HIPAA privacy requirements, allowing for ongoing relevant communications between and among the members of the MDT.

Standard 05

Mental Health

Evidence-based, trauma-focused mental health services, designed to meet the unique needs of the child and caregivers, are consistently available as part of the multidisciplinary team response.



05. Mental Health

Rationale

A CAC's mission is to promote and foster safety, healing and justice for children and families. The common focus of the MDT is to foster healing and avoid potential retraumatization of children and families by the systems designed to respond to their needs. The CAC's response begins at first contact with the child and family. Without effective therapeutic intervention, many children who have experienced trauma may suffer ongoing or long-term adverse social, emotional, developmental and health outcomes. Evidence-based treatments and other practices with strong empirical support help reduce the impact of trauma and the risk of future abuse and other negative consequences. For these reasons, an MDT response must include screening for trauma exposure and/or symptoms by identified members of the MDT as part of the MDT response, who then use that information to link to mental health services for assessment and trauma-focused mental health treatment for child victims and caregivers.

Evidence shows parental/family support is often the key to the child's recovery and ongoing protection, and mental health services are often an important factor in a caregiver's capacity to support their children. Therefore, family members may benefit from counseling and support that aids in addressing the emotional impact of abuse allegations and related emotional triggers, and in reducing or eliminating the risk of future abuse. Mental health treatment for caregivers is a critical component of CAC services, given that many may have trauma histories themselves or are current victims of intimate partner violence. Such services include information, support and coping strategies for themselves and their children about sexual abuse, dealing

with issues of self-blame and grief, family dynamics, parenting education and the impact of abuse and trauma histories. Siblings, other children in the family such as cousins, and, in some cases, extended family members may also benefit from opportunities to discuss their own reactions and experiences and to address family issues within a confidential therapeutic setting. The nature of the impact on children and families underscores the importance of collaboration with community providers to improve outcomes for their health and wellbeing. The CAC case review process provides a vehicle for these collaborative discussions.

Essential Component A

Mental health services are provided by professionals trained in delivering traumafocused, evidence-supported mental health treatment. All mental health providers for CAC clients, whether providing services onsite or by referral and linkage agreement with outside individuals and agencies, must meet the following training and education/license requirements:

EDUCATION/LICENSE REQUIREMENT

1. The CAC must demonstrate that its mental health provider(s) meets at least ONE of the following academic training standards:
 - A. Master's degree/licensed/certified in a related mental health field.
 - B. Master's degree in a related mental health field and working toward licensure; supervised by a licensed mental health professional.

- C. Student intern in an accredited mental health related graduate program, when supervised by a licensed/certified mental health professional. Both the student intern and supervising licensed mental health professional must meet the indicated 40-hour training requirements. Students who are currently enrolled in a training to deliver an EBT may provide services to children as a part of their EBT training.

TRAINING REQUIREMENT

- 2. The CAC must demonstrate its mental health provider(s) has completed 40 contact hours in training and consultation calls to deliver an evidence-supported mental health treatment to children who have experienced trauma from abuse. (Examples include TF-CBT, PCIT, AF-CBT, CFTSI, EMDR — see “Putting Standards into Practice”). Training programs that include fewer than 40 hours (including consultation calls) may be supplemented with contact hours in evidence-based assessment.

Essential Component B

Clinicians providing mental health treatments to CAC clients must demonstrate completion of continuing education in the field of child abuse, trauma, and/or clinical practice consisting of a minimum of eight contact hours every two years.

STATEMENT OF INTENT:

Because new research constantly emerges regarding the efficacy of mental health treatment modalities of said services, it is vital for clinicians to remain updated about new research, evidence-supported treatment methods, and developments in the field that would help ensure the delivery of high-quality, relevant, and accessible services to clients.

Essential Component C

Evidence-supported, trauma-focused mental health services for the child client are consistently available and include:

1. Trauma-specific assessment of traumatic events and abuse-related trauma symptoms to determine the need for treatment;
2. Evidence-based assessments to inform treatment;
3. Individualized treatment plan based on assessments that are periodically reassessed;
4. Individualized evidence-supported treatment appropriate for the child clients and other family members;
5. Child and caregiver engagement in treatment;
6. Monitoring of trauma symptom reduction;
7. Referral to other community services as needed.

STATEMENT OF INTENT:

The above description of services should guide discussions about expectations with all professionals who may provide mental health services, whether on-site or by referral and linkage agreement. This will ensure that appropriate, relevant, and accessible services are available for child clients and that the services are outlined in linkage agreements.

Essential Component D

Mental health services are available and accessible to all CAC clients regardless of their ability to pay.

STATEMENT OF INTENT:

CACs have a responsibility to identify and secure alternative funding sources to ensure all children and caregivers have access to appropriate, specialized mental health services.

Essential Component E

The CAC/MDT’s Interagency Agreement/ MOU or written protocols and guidelines include access to appropriate trauma-informed mental health assessment and treatment for all CAC clients.

STATEMENT OF INTENT:

Because mental health is a core component of a CAC’s multidisciplinary team response, the CAC/MDT’s Interagency Agreement/MOU or written protocols and guidelines must detail how such care may be provided and accessed by all CAC clients.

Essential Component F

The CAC/MDT’s written protocols and guidelines define the role and responsibility of the mental health professional(s) on the MDT, to include:

- 1. Attending and actively participating in MDT case review and case management
- 2. Sharing relevant information with the MDT while protecting the clients’ right to confidentiality and the mental health professional’s legal and ethical requirements
- 3. Serving as a clinical consultant to the MDT regarding child trauma and evidence-based treatment
- 4. Monitoring and sharing with the MDT the child’s and caregiver’s engagement in, and completion of, treatment.

STATEMENT OF INTENT:

Evidence shows the importance of collaboration among community professionals serving children

and families to improve outcomes. A trained mental health professional participating in the MDT case review process assures that the child’s and caregiver’s treatment needs and mental health can be monitored, assessed and reassessed, and taken into account as the MDT makes case decisions. In some CACs, the child’s and caregiver’s treatment provider(s) serves in this role; in others, it may be a mental health consultant.

Essential Component G

The CAC/MDT’s written protocols and guidelines include provisions about the sharing of mental health information and how client confidentiality and mental health records are protected in accordance with state and federal laws.

STATEMENT OF INTENT:

The forensic process of gathering evidentiary information and determining what the child may have experienced is separate from mental health treatment processes. Mental health treatment is a clinical process designed to assess and mitigate the long-term adverse impacts of trauma and/or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Each CAC must be aware that medical and mental health treatment records containing identifiable protected health information (PHI) are protected by HIPAA. Records pertaining directly to an investigation of child abuse can be exempt from HIPAA and do not require caregiver consent for release. The CAC should maintain a log of disclosures of medical and mental health treatment information per HIPAA regulations.

MDT protocol must include specific guidelines for the MDT and mental health providers regarding what and how information can be shared with the MDT during case review, in accordance with state laws and professional ethical practice standards.

Essential Component H

The CAC must provide services for caregivers to address:

1. Safety and well-being of the child
2. Caregiver involvement in their child's treatment when appropriate
3. Emotional impact of abuse allegations
4. Risk of future abuse
5. Issues or distress that the allegations may trigger, including own history of trauma and/or current experience of abuse, violence and/or other trauma

These services may be provided directly by the CAC and/or with linkage agreements with other appropriate providers.

STATEMENT OF INTENT:

Evidence clearly demonstrates that caregiver support is essential to sibling support, the recovery of children directly experiencing or exposed to abuse and violence, and overall family functioning and well-being. CACs have long provided such supportive services for caregivers and siblings through support groups, mental health services and ongoing follow-up, either on-site or by linkage agreement.

It is important to consider the range of mental health issues that could impact the child's recovery or safety with particular attention to the caregiver's mental health, substance abuse, domestic violence, and other trauma history. Caregivers, siblings, and other family members may benefit from assessment, support, and mental health treatment to address the emotional impact of abuse allegations, reduce or eliminate the risk of future abuse, and address issues that the allegations may trigger. Assessments and supports may be provided by clinicians, victim advocates or others, either on staff at the CAC or via linkage agreement.

Essential Component I

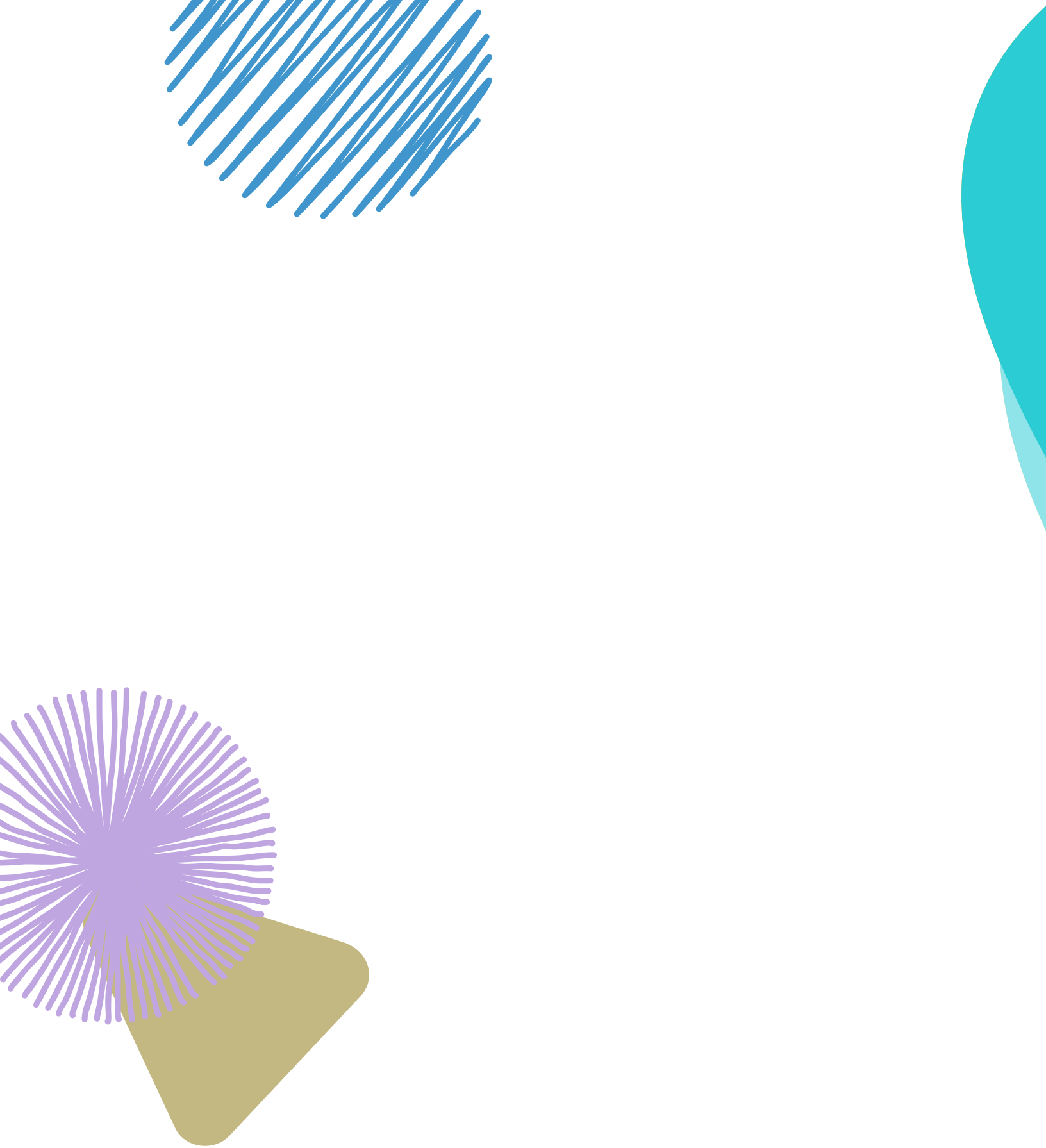
Clinicians providing mental health treatment services to CAC clients must participate in ongoing clinical supervision and/or consultation.

STATEMENT OF INTENT:

Clinical supervision and/or consultation with others trained in evidence-based treatment is necessary to ensure appropriate and quality services to the clients. Moreover, this clinical supervision is required for licensure in many states. Individual and/or group supervision options for meeting this standard include:

- Supervision by a senior clinician on staff at the CAC
- Supervision with a senior clinician in the community who serves children and families and accepts referrals from the CAC (when a CAC does not have more than one clinician)
- Participation in a supervision call with mental health providers from other CACs within the state, either individually or as a group
- Participation in a State Chapter or one or more CAC contracts with a senior clinician to provide supervision and consultation calls

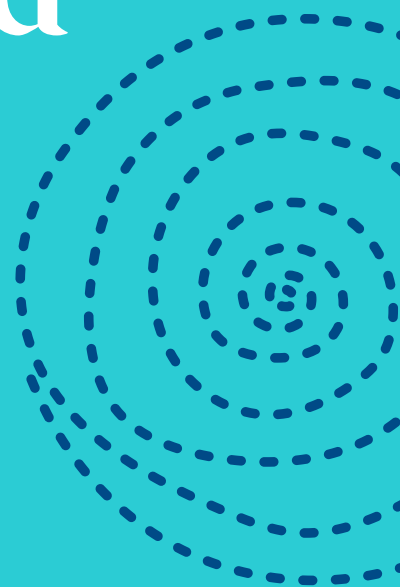
Most clinical professions (i.e., clinical social workers, licensed professional counselors, marriage, and family therapists, etc.) have a structure for clinicians to become clinical supervisors. CACs may wish to investigate this option in their state. CACs can also negotiate Trauma-Focused Cognitive Behavior Therapy (TF-CBT) master trainers for ongoing clinical consultation. As supervision for one evidence-based treatment does not necessarily encompass all the clinical interventions needed within a CAC, comprehensive interventions will need to be addressed throughout ongoing clinical supervision.



Standard 06

Case Review and Coordination

A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis.



06. Case Review and Coordination

Rationale

Case review is the formal process that enables the MDT to monitor and assess its independent and collective effectiveness so as to ensure the safety and well-being of children and families. The process encourages mutual accountability and helps to assure that children's and families' needs are met sensitively, effectively and in a timely manner. Case review serves multiple purposes:

- Experience and expertise of MDT members is shared and discussed
- Collaborative efforts are fostered
- Formal and informal communications are promoted
- Mutual support is provided
- Protocols and procedures are reviewed
- Informed, collective decisions are made
- Services are coordinated

Case review must occur at least once a month. Its focus is on planning and monitoring current cases. It is a formal process that serves as a complement to ongoing case discussions among the MDT partners. Every CAC must implement a defined process and set the case criteria for review. The method and timing of case review may vary to fit the unique needs of a CAC community. For example, some CACs review every open case, while others review only complex or problematic cases or cases involved in prosecution. Representatives from each core discipline on the MDT must participate and provide input at case review. Confidentiality should be addressed in the

CAC's written protocols or guideline, in keeping with state and/or federal laws and professional ethics that govern information sharing among MDT members, including during case review.

Essential Component A

The CAC/MDT's written protocols/guidelines include criteria for case review and case review procedures.

The CAC/MDT's written documents must include:

1. Purpose of meetings
2. Frequency of meetings
3. Designated attendees
4. Case selection criteria and process for developing case review agenda
5. Designated facilitator and/or coordinator
6. Mechanism for distribution of agenda and cases to be discussed
7. Procedures for addressing follow-up recommendations
8. Location of the meeting — may be in person or virtual

STATEMENT OF INTENT:

To maximize efficiency and to enhance the quality of a comprehensive case review, the CAC's written documents clearly define the process and expectations for all MDT partners.

Essential Component B

An intentional forum for the purpose of reviewing, collaborating, and coordinating cases is conducted at least once a month.

STATEMENT OF INTENT:

Case review affords the MDT the opportunity to review active cases, provide updated case information, address obstacles to effective investigations and service delivery, and coordinate interventions. It is a planned, regularly scheduled meeting of all MDT partners and occurs at least once a month for cases coming from the CAC's primary service area. Case review is a formal process that is conducted in addition to informal discussions and pre- and post-interview meetings.

Essential Component C

MDT partner agency representatives actively participating in case review must include, at a minimum:

1. Law enforcement
2. Child protective services
3. Prosecution
4. Medical
5. Mental health
6. Victim advocacy
7. Children's Advocacy Center

STATEMENT OF INTENT:

Full MDT participation at case review allows for the contributions of diverse professional perspectives and expertise to optimize informed decision-making, case planning and coordinated service delivery. Case review must be attended by the identified agency representatives capable of making, informing and/or advocating for independent and collective decisions and providing the team with knowledge and expertise of their specific professions. All those participating should

be familiar with the CAC/MDT process and the purpose and expectations of case review. Forensic interviewers, irrespective of which agency employs them, must be present at case review. Moreover, it is strongly encouraged that case review participants be those who are actively working on the cases under review in order to ensure direct communication between all parties. This does not preclude additional agency representatives or supervisors from participating as well. Participation in person is optimum; however, participation can be accomplished virtually as necessary to ensure the participation of all required disciplines and to respond to public health emergencies

Essential Component D

Case review is an informed and collaborative decision-making process with input from all MDT partner agency representatives.

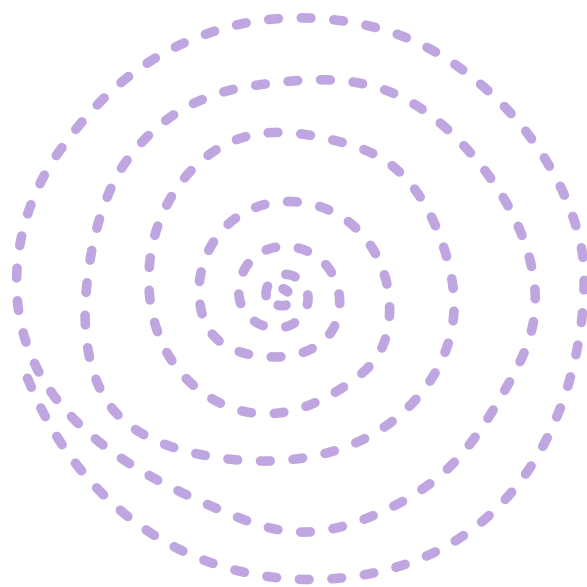
Generally, the case review process should include:

- Review of forensic interview outcomes
- Discussion, planning and monitoring of the progress of the investigation
- Review of medical evaluation findings
- Discussion of child protection and other safety issues
- Input for prosecution and sentencing decisions
- Discussion of emotional support and treatment needs of children and family members and strategies for meeting those needs
- Assessment of the family's reaction and response to the child's disclosure and involvement in the criminal justice and/or child protection systems
- Review of criminal and civil (dependency) case updates and ongoing involvement with the child and family as well as disposition

- Provisions for court education and court support and accompaniment
- Ensuring that all children and families are afforded the legal rights and comprehensive services to which they are entitled
- Discussion of how the CAC and MDT intervention is impacting the child and their family, including positive changes and challenges
- Child well-being and outcomes, as available

STATEMENT OF INTENT:

In order to make informed case decisions, optimize service delivery and improve client outcomes, essential information and professional expertise are required from all disciplines. Decisions and interventions must be made with the input, discussion and support of all involved professionals, and efforts must be coordinated, comprehensive and nonduplicative. The process and facilitation must ensure there is participation and discussion among all MDT members to adequately address their respective and shared goals, mandates, interventions and services, questions, concerns, and outcomes.



Standard 07

Case-Tracking

Children's Advocacy Centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.



07. Case-Tracking

Rationale

Case-tracking systems are able to collect and document essential demographic and case information and investigation/ intervention outcomes as well as generate statistical reports. The data collected is useful for monitoring ongoing case progress and program evaluation to inform continuous quality improvement, enabling MDT members to provide accurate information on the current status and disposition of cases to clients, and providing critical support for seeking funding and responding to grant requirements.

Data collected nationally from all local programs, relevant statewide and regionally, are useful for advocacy, research, and legislative purposes to advance the field of child maltreatment. It may also be required for federal funding reporting requirements. Each CAC utilizes the case-tracking system that suits its determined needs and is able to be supported by its available resources. Any case-tracking system implemented must be compliant with all applicable privacy and confidentiality requirements.

Essential Component A

The CAC/MDT's written protocols/guidelines includes the case-tracking process and information gathered through case closure at the CAC, including final civil and/or criminal disposition.

STATEMENT OF INTENT:

Case tracking provides a mechanism for monitoring case progress throughout the multidisciplinary interagency response.

Often, MDT members will have a system to collect their own agency data; however, the MDT response requires the sharing of this information among its members to better inform individual and collective decisionmaking, ensure accurate updates to children and families, and inform quality improvements in coordinated service delivery. The CAC/ MDT's written documents must detail the CAC's purpose, information to include, and a process for case tracking.

Essential Component B

The CAC tracks and, at a minimum, is able to retrieve and report NCA Statistical Information.

NCA statistical information includes the following data:

1. Demographic information about the child and family
2. Demographic information about the alleged offender
3. Type(s) of alleged abuse
4. Relationship of alleged offender to child
5. MDT members' involvement with children and families and relevant outcomes
6. Criminal charges filed and case dispositions
7. Child protection outcomes
8. Status/follow-through of medical and mental health referrals

STATEMENT OF INTENT:

CACs are required to demonstrate the ability to collect and retrieve case-specific information for all CAC clients. This includes basic demographic information, services provided, and outcome information contributed by MDT partner agencies in a thorough and timely fashion. Codifying case-tracking procedures in CAC/MDT's written documents underscores its importance and helps to assure the MDT members are accountable to each other and, ultimately, to the children and families they individually and collectively serve.

Essential Component C

An individual is identified to implement the case-tracking process.

STATEMENT OF INTENT:

Case tracking is an important function of the CAC that requires dedicated time and accuracy in its implementation. A designated individual(s) must be identified to implement and/or oversee the case-tracking process, and the number and type of individual(s) charged with this responsibility is determined by the CAC's staffing and case volume. Some CACs define case tracking as part of the MDT coordinator's or case manager's role. Some dedicate a staff position, part- or full-time, for data collection and database maintenance, or assign the responsibility to an administrative assistant. Other programs utilize trained volunteers (who have signed confidentiality agreements) to input data.

Essential Component D

The CAC/MDT's written protocols/guidelines must outline how MDT partner agencies can access case-specific information and aggregate data for quality assurance, quality improvement, funding, and research purposes.

STATEMENT OF INTENT:

Because case data may be useful to MDT members for a variety of purposes, it is important that all members have access to aggregate and/or specific case information as determined through discussions with all participating agencies. Policies must also include how the release of this data to participating agencies and other parties complies with confidentiality requirements.

Essential Component E

The CAC collects client feedback to inform client service delivery.

STATEMENT OF INTENT:

Continuous quality assurance is the hallmark of a well-functioning CAC. This requires seeking feedback directly from clients regarding their experiences with all aspects of CAC services so that improvements may be made as needed on an ongoing basis. Soliciting client feedback can be accomplished through the use of various tools including, but not limited to, client satisfaction surveys. To optimize the quality of the feedback received, survey instruments need to be valid and reliable. CACs that actively participate in NCA's Outcome Measurement System (OMS) can be assured they meet and exceed this requirement.



Standard 08

Organizational Capacity

A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.



08. Organizational Capacity

Rationale

Every CAC must have a designated legal entity responsible for the governance and implementation of its operations. This entity oversees ongoing business practices of the CAC, including setting and implementing administrative policies, hiring, and managing personnel, obtaining funding, supervising program and fiscal operations, and longterm planning. CAC organizational structure depends upon the unique needs and resources of its community; it may be an independent nonprofit agency, a component of an umbrella organization such as a hospital or nonprofit human service or victim service agency, or part of a governmental entity, such as prosecution, social services, or law enforcement. Each of these options has strengths, limitations and implications for collaboration, planning, governance, community partnerships and resource development. Regardless of where the program is housed or under what legal auspices, all CACs must create a structure such that participating agencies feel equal investment in, and collaborative responsibility for, its operations and services.

Essential Component A

The CAC is an incorporated, private nonprofit organization, government-based agency, tribal entity, or a component of such an organization, agency, or tribal entity.

STATEMENT OF INTENT:

The CAC has a defined organizational identity that ensures appropriate legal and fiduciary governance and organizational oversight. This is critical to the ability to maintain, grow and ensure sustainability of the CAC and all of its components and services.

Essential Component B

The CAC maintains, at a minimum, current general commercial liability, professional liability, directors' and officers' liability, and cyber liability insurance as appropriate for its organization.

STATEMENT OF INTENT:

Every CAC must provide appropriate insurance for the protection of the organization and its personnel. Nonprofit CACs, including those that are a component of an umbrella nonprofit or nonprofit hospital, must carry, at a minimum, general commercial liability, professional liability, cyber liability, and directors' and officers' liability insurance. Governmentbased CACs must carry, at a minimum, general commercial liability, professional liability, and cyber liability insurance or provide documentation of comparable coverage through self-insurance. CACs should consult with appropriate risk management professionals to determine appropriate types of insurance and any additional levels of coverage needed, including renters, property owners and automobile insurance, depending upon their individual needs.

Essential Component C

The CAC has administrative policies and procedures that apply to staff, board members, volunteers, and clients.

Every CAC must have written policies and procedures that govern its administrative operations. Administrative policies and procedures must include, at a minimum:

1. Personnel policies, procedures, and documents

- A. Job descriptions for all positions
 - B. Anti-discrimination policy
 - C. Conflict of interest policy
 - D. Whistleblower policy
 - E. Social media use policy
2. Financial management policies and procedures
- A. Accounting policies and procedures that demonstrate adequate internal controls and segregation of duties
 - B. Credit card usage policy
3. Safety and security policies and procedures
- A. Code of conduct (this should guide behavior between staff, between staff and team members, and between staff/team members and clients)
 - B. Child protection policies, including the obligation to report abuse
 - C. Emergency response policies
 - D. Building security and safety policy and procedures
 - E. Anti-Violence in the Workplace policy
 - F. Weapons on premises policies and procedures
 - G. Drug usage policy
 - H. Smoke-free environment
4. Information technology policies
- A. Document retention and destruction policies
 - B. Data security policies
 - C. Confidentiality policies — HIPAA requirements

STATEMENT OF INTENT:

The CAC has clearly developed organizational policies and procedures that ensure appropriate administrative governance. This is critical to the ability to maintain, grow and ensure sustainability of the CAC and all of its components and services.

Essential Component D

The CAC is required to conduct an annual independent financial audit when its annual actual expenses meet or exceed \$750,000. Organizations whose annual gross expenses fall below \$750,000 and meet or exceed \$200,000 must conduct a CPA-completed financial review. Those organizations with gross annual expenses below \$200,000 must provide their Board-approved financial statements.

STATEMENT OF INTENT:

Confidence in the integrity of the fiscal operations of the CAC is critical to the longterm sustainability of the organization. An annual independent audit is one tool to assess for fiscal soundness and internal controls for financial management. A financial review is sufficient for those CACs with annual actual expenses equal are less than \$750,000 and that meet or exceed \$200,000. CACs with annual budgets below \$200,000 must provide their Board-approved financial statements.

Reporting Requirements for Audited Financial Statements: All centers with annual actual expenses (as determined by United States generally accepted accounting principles) that meet or exceed \$750,000 are required to have an audit of their financial statements. If a management letter is prepared by the independent accountant (CPA), it should be included with the audit report.

Reporting Requirements for Reviewed Financial Statements: All centers with annual actual expenses (as determined by United States generally accepted accounting principles) less than \$750,000 that meet or exceed \$200,000

are required to have a review of their financial statements. The review must be in compliance with SSARS 19. If a management letter is prepared by the independent accountant (CPA), it should be included with the review report.

Essential Component E

The CAC has, and demonstrates compliance with, written screening policies for staff, board members and volunteers that include national criminal background, sex offender registration, and child abuse registry checks, and it provides training and supervision to staff and on-site and/or ongoing volunteers. In discussion with its Board and MDT, a CAC must determine what is a disqualifying finding in a background check.

STATEMENT OF INTENT:

Due to the sensitive and high-risk nature of CAC work, it is imperative that the CAC conduct a formal screening process for staff. This process should be documented in a written policy. Staff must receive initial and ongoing training and supervision relevant to their role.

In addition, volunteers perform a wide variety of functions within CACs, and CACs can attract volunteers who are emotionally unprepared for the nature and expectations of the work and/or individuals who have potential to be, or have current or past histories as, offenders. Due to the sensitive and high-risk nature of CAC work, it is imperative that the CAC also conducts a formal screening process for on-site volunteers. Upon placement, volunteers must receive training and supervision relevant to their roles.

For similar reasons, screening must be conducted for board members as they serve and publicly represent the CAC in a variety of ways, both on- and off-site.

Essential Component F

The CAC has a written succession plan to ensure the orderly transition and continued operation of the CAC.

STATEMENT OF INTENT:

A succession plan assists in guiding the CAC through, and safeguarding the CAC against, unplanned or unexpected changes. This kind of risk management, mission and business continuity is equally important in facilitating a smooth transition when leadership change is predictable and planned. A succession plan outlines leadership development and emergency responsibilities for the CAC, and it reflects its commitment and helps ensure a sustained, healthy functioning organization. The plan should be developed specific to the uniqueness of the CAC and include, at a minimum:

- Temporary staffing strategies
- Long-term and/or permanent leadership replacement procedures
- Cross-training plan
- Financial considerations
- Communication plan
- Key positions/functions essential to the operation of the CAC

Essential Component G

The CAC has addressed its sustainability through the implementation of a current strategic plan approved by the governing entity of the CAC.

STATEMENT OF INTENT:

In order to assure long-term viability of the organization, the CAC must have a plan that addresses programmatic and operational needs. The governing entity for such a plan

may be an oversight committee or a board of directors, as appropriate for the individual CAC's organizational structure and needs.

In general, in order to be considered current, a strategic plan should be no more than three to five years old. It should be actively implemented, and there should be a mechanism in place to monitor the progress on the plan.

Plan should include at, a minimum:

- Stakeholder input in plan creation
- Goals, objectives, and timeline
- Review and approval by CAC board or relevant governing body

Essential Component H

The CAC promotes employee well-being by providing training and resources regarding the effects of vicarious trauma, providing techniques for building resiliency, and maintaining organizational and supervisory strategies to address vicarious trauma and its impact on staff.

STATEMENT OF INTENT:

To help ensure the health and well-being of all employees and improve employee retention, the CAC must raise awareness about the impact of work-related trauma exposure through training and develop organizational practices that identify and mitigate against negative consequences for staff, the delivery of quality of services, and staff turnover. This includes identifying the risk of vicarious trauma for frontline staff and those exposed to the associated trauma of the work more indirectly. It also includes providing techniques for individual self-care and resiliency building as well as integrating and maintaining organizational and supervisory strategies to address and respond to vicarious trauma among all staff.

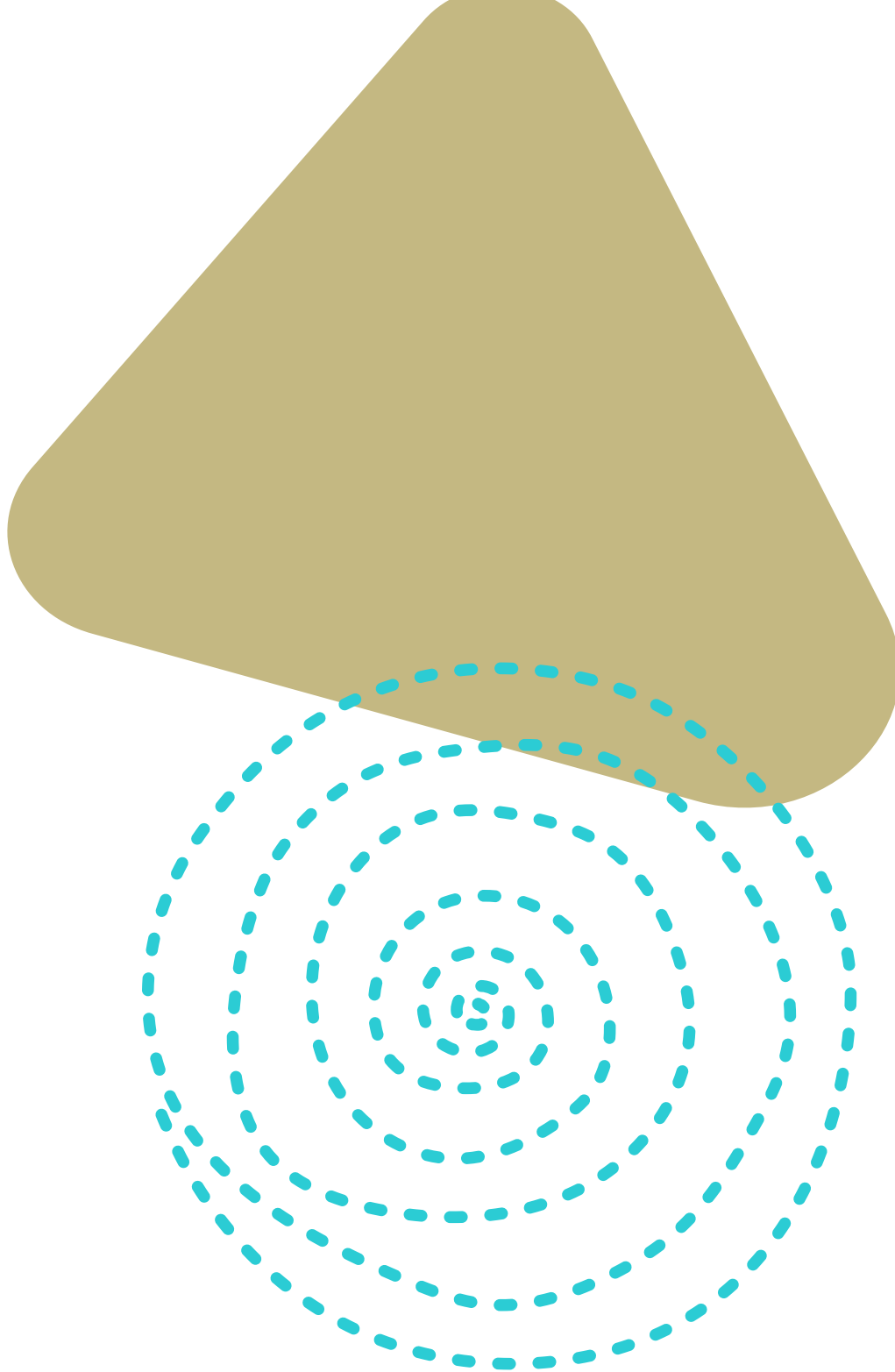
Essential Component I

The CAC provides training opportunities and resources on vicarious trauma and building resiliency to all MDT members.

STATEMENT OF INTENT:

CACs have a primary role in building and enhancing the functioning of the MDT. A highly functioning MDT assures vicarious trauma is acknowledged and addressed and has an awareness and understanding of the importance of work-related trauma exposure and its potential consequences. While MDT partner agencies have primary responsibility for the health and well-being of their respective staff, the CAC is responsible for providing access to training, ongoing recognition, and discussion and strategies to collaboratively address vicarious trauma and help build team members' resiliency. Moreover, the health of the MDT as a whole directly impacts service delivery to children and families. Therefore, attention to this issue is important for helping to ensure high-quality services and improve outcomes for abused children and families.





Standard 09

Child Safety and Protection

The CAC is comfortable, private and both physically and psychologically safe for populations of children and their family members.



09. Child Safety and Protection

Rationale

A CAC requires a separate, child/youth-focused setting that provides a safe, comfortable, and neutral place where forensic interviews and other CAC services can be appropriately provided for children and families. While every center may look different, the criteria below help define specific ways the environment can help children and families feel physically and psychologically safe and comfortable. These include making sure the physical setting meets basic child safety standards, ensuring alleged offenders do not have access to the CAC, providing adequate supervision of children and families while they are on the premises, and creating a welcoming environment that reflects the diversity of clients served.

There is no one right way to build, design or decorate a CAC. The CAC should have adequate square footage for its determined on-site operations and conform to generally accepted safety and accessibility guidelines, fire codes, etc. Consideration should be given to future growth and the need for additional space as caseloads increase and additional program components are needed. Care should be taken to ensure MDT members have access to workspace and equipment on-site to carry out the necessary functions associated with their roles on the MDT, including, but not limited to, meeting with families, participating in forensic interviews and sharing necessary information.

Special attention should be given to designing and decorating the client service areas to reflect the community's population. The appearance of the CAC can help facilitate the participation of children and families in the

process, largely by helping alleviate anxiety and instill confidence and comfort in the intervention system. It should communicate, through its design, decor, and materials, that the CAC is a welcoming place for all children and their nonoffending family members.

Essential Component A

The CAC is a designated, task-appropriate facility or space that:

1. Is maintained in a manner that is physically and psychologically safe for children and families
2. Provides observation or supervision of clients within sight or hearing distance by CAC staff, MDT members or volunteers at all times
3. Is convenient and accessible to clients and MDT members
4. Is appropriate for the delivery of CAC services
5. Provides age-appropriate toys and other resources that are childproofed, cleaned, and sanitized to be as safe as possible.

STATEMENT OF INTENT:

The CAC is a child focused setting that ensure both physical and psychological safety for all children and families. Special attention should be paid to the location, design and accessibility of the CAC for the children, families and MDT members that utilize the center.

Essential Component B

The CAC has, and abides by, written policies and procedures that ensure separation of victims and alleged adult offenders during the investigative process and throughout delivery of services at the CAC. CACs may provide services to youth with problematic sexual behaviors, but they must have developed and implemented appropriate safety protocols to protect other children receiving services at the CAC.

STATEMENT OF INTENT:

The CAC has written policies and procedures that ensure the separation of victims and alleged offenders during the investigative process and throughout delivery of the full array of CAC services. During the investigative process, logic dictates that children will not feel free to disclose abuse if an alleged offender accompanies them to the interview and/or remains on location throughout the duration of intervention. This separation of children from alleged offenders should also extend to children and perpetrators in unrelated cases. In addition, caregivers may also be at risk of abuse and violence by alleged offenders and are in need of physical and psychological safety for themselves and their children. If a CAC shares space with an existing agency that provides services to offenders, facility features and scheduling must assure separation between children and family members and alleged offenders.

Many CACs serve a vital role in their communities by providing services for children with problematic sexual behaviors. CACs that offer services to this population should have policies and procedures in place to maintain physical and psychological safety for other child victims and their families visiting the CAC.

Essential Component C

The CAC makes reasonable accommodations to make the facility physically accessible.

STATEMENT OF INTENT:

This requirement is for new buildings and custom-designed facilities. CACs operating in older buildings or facilities must make reasonable accommodations to make the facility physically accessible to clients and family members, CAC staff and MDT members. If the CAC cannot be structurally modified, arrangements for equivalent services should be made at alternate locations within or outside the facility. CACs must be in compliance with guidelines stipulated in the Americans with Disabilities Act (ADA) and/or state legislation.

Essential Component D

Separate and private area(s) are available for confidential case consultation and discussion, for meetings or interviews, and for clients awaiting services.

STATEMENT OF INTENT:

To ensure a physically and psychologically safe environment for children and families, confidentiality and respect for client privacy is of paramount concern in a CAC. CAC staff and MDT members require privacy to discuss cases with children or families in a location where visitors or others not directly involved with the case may overhear them. Separate areas should also be available for private family member interviews and so that individual family members may privately discuss aspects of their case with staff and MDT members. Care should be taken to ensure that private meeting areas are not only physically separate but also soundproofed, so conversations cannot be overheard. Some centers place soundproofing materials in or on walls when building or refurbishing their centers. Others place stereos or sound machines in rooms to block sound.

Essential Component E

CACs are required to implement a code of conduct for staff and MDT members ensuring the safety of children and families. The code of conduct must include child abuse prevention practices. Staff members must have received and agreed to the code of conduct. MDT members must be informed of the CAC's code of conduct and the expectation that it guides work within the CAC.

Code of conduct content must include:

- Child safety and well-being as a primary priority and value in the CAC and one that guides policy and practice decisions.
- Contact not related to CAC service provision between staff and a child/client is prohibited.
- Physical contact between child/client and staff/MDT members must be consistent with the safety and well-being of the child/ client.
- Staff interaction with child clients should be interruptible and/or observable.
- It is the duty of staff to report suspected child abuse.

STATEMENT OF INTENT:

A code of conduct is a set of rules around the behavior for CAC staff and MDT members, and it acts as an explicit expression of personal and professional expectations in their work with one another and with clients. It also serves as an external statement of the CAC/MDT's commitment to its core values and principles for interdisciplinary, cross-agency work. In addition, a code of conduct helps provide for a healthy work environment for staff and MDT members, and thereby helps ensure the delivery of high-quality, relevant, and accessible child- and family-centered services. In the event of any violations of stated codes of conduct, it also provides an understanding of how to report and/or address them.

Essential Component F

A child safety assessment must be conducted annually to ensure that the building and CAC space is a safe and child-focused setting for children and their families.

STATEMENT OF INTENT:

Core to CACs is their ability to provide a setting that underscores the critical importance of providing and/or restoring a sense of safety, both physically and psychologically, for children and families in crisis. Safety must be assured if children and families are able to participate in forensic interviews, investigations, evaluations and identified services. As such needs and safety measures change or are updated, assessments must be conducted at least annually.

Essential Component G

CAC staff are mandatory reporters. CACs are required to ensure that mandated reporter training is provided to all staff and volunteers. Updates to state statutes and mandated reporter laws must be provided to staff and volunteers annually, if applicable.

STATEMENT OF INTENT:

Given the nature of the work of CACs/MDTs, all those involved in the delivery of services to children and families must be trained and understand the requirements of mandated reporter laws and the procedures for reporting known or suspected instances of child abuse and neglect. Annual training is important to ensure that changes in the law and/or agency reporting procedures can be understood and observed.



Medical Evaluation Standard Appendices



Appendix 1

Medical History for Child Sexual Abuse

COMMON COMPONENTS OF MEDICAL HISTORY FOR POSSIBLE SEXUAL ABUSE

(Needed to guide testing, treatment and make diagnosis)

Sources: Child, Parent/caregiver, Investigator/FI, social work/advocate, medical records. Coordination and collaboration should occur to avoid duplication in the child being asked to recount details of the abuse event.

History of Present Illness (HPI):

- History of the event:
 - What happened, when, where, who was involved
- History of the contact:
 - Body sites involved, actions involved, associated symptoms
- What has happened since the event?
 - Physical/emotional symptoms/behavioral response
 - Safety threats, bullying, school performance
 - Family relationships
- What response has already occurred?
 - Prior medical exam and treatment
 - Interview by investigators or CAC staff
 - Counseling/mental health screening

Past Medical History (PMH):

- Significant Illnesses/Surgeries/Hospitalizations
- Development (including sexual development and menstrual history in girls)
- Behavioral, educational or mental health issues
- Prior abuse and sexual history including consensual partners
- Medications, allergies and vaccination history (esp. HPV and Hep B)

Family History (FH):

- Significant health problems in parents, siblings and close relatives.

Social History (SH):

- Home composition, violence in the home, substance abuse by patient or those in the home.
- Does the patient feel safe and supported by current caretakers?
- Prior child welfare involvement in the family.

Review of Body Systems (ROS): Ongoing or current problems/concerns (usually 10 systems)

- HEENT - Head, Eyes, Ears, Nose, Throat
- Respiratory-breathing
- Cardiac- heart
- Hematology- bruising or bleeding
- Endocrine - glands, weight gain/loss
- Neurology-headaches, seizures, balance
- Gastrointestinal-nausea, vomiting, constipation, diarrhea, rectal pain/bleeding/DC
- Genitourinary-discharge, burning, dysuria, bleeding, pain, lesions
- Musculoskeletal-(muscles, bones and joints)
- Skin- rashes, lesions, tattoos, bruises

Appendix 2

IMPORTANT DEFINITIONS

Didactic Training

Didactic training for CAC medical providers should cover examination positions (supine, lateral, knee chest), examination techniques (gathering of forensic evidence, samples for STI testing, labial traction, use of cotton swab with pubertal females to demonstrate edges of hymen, foley catheter, etc), and the review of multiple examples of:

- A. anatomical variants
- B. acquired or developmental conditions that mimic abuse
- C. accidental trauma and sexual abuse trauma
- D. STIs and forensic evidence

Competency Based Clinical Preceptorship

A preceptorship has a clinical training component that provides observation and training with an experienced examiner. The length of the preceptorship is determined by the time it takes the trainee to demonstrate competency in obtaining medical history, using appropriate exam techniques, obtaining diagnostic quality photodocumentation, and applying strategies for testing and prophylaxis for STIs and pregnancy.

TABLE 1: MEDICAL DISCIPLINES, NCA TRAINING REQUIREMENTS AND CREDENTIALING ENTITY

		Foundational Training Requirements	NCA Training Requirements	Licensing Entity
Physician (MD or DO)		Undergraduate Degree 4 years of Medical School 3 years of Residency 1-3 years of Fellowship (optional)	 16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse	State Medical Board
	Pediatrics, Family Medicine, or other physician,	Undergraduate Degree 4 years of Medical School 3 years of Residency		State Medical Board
	Child Abuse Pediatrician	Undergraduate Degree 4 years of Medical School 3 years of Residency 3 years of Child Abuse Fellowship Board certification in Child Abuse Pediatrics	No additional training requirements	State Medical Board

	Foundational Training Requirements	NCA Training Requirements	Licensing Entity
Advance Practice Nurse (APRN), Nurse Practitioner (NP), Pediatric Nurse Practitioner (PNP)	Undergraduate Degree 2 years of Graduate School Certification Exam	 16 hours of formal didactic training in the medical evaluation of Child Sexual Abuse	State Nursing Board
Physician's Assistant (PA)	Undergraduate Degree 2 years of Graduate School Certification Exam		State Licensing Board
Sexual Assault Nurse Examiner (SANE)- Adult and Pediatric	Nursing Degree (RN or BSN) Licensure Exam Adult and/or pediatric and adolescent SANE training consistent with IAFN guidelines Competency Based Clinical Preceptorship Providers who have completed SANE training and preceptorship may also choose to apply for SANE-A and/or SANE-P certification by IAFN.	 40 hours of formal didactic training in the medical evaluation of Child Sexual Abuse  Competency Based Clinical Preceptorship	State Nursing Board Some states have state-specific forensic nursing requirements.

Appendix 3

Continuous Quality Improvement

IMPORTANT DEFINITIONS

Continuous Quality Improvement

is the process-based, data-driven approach to improving the quality of a product or service. It operates under the belief that there is always room for improving operations, processes, and activities to increase quality.

Advanced Medical Consultant

A Child Abuse Pediatrician, Physician or Advanced Practice Nurse who:

1. Has met the minimum training outlined for a CAC provider (see above)
2. Has performed at least 100 child sexual abuse examinations
3. Current in CQI requirements (continuing education and participation in expert review on their own cases)

Expert Review

Expert review of examination findings is a de-identified continuous quality improvement (CQI) activity and is NOT a consultation/second opinion.

1. The CAC should include in their policies and procedures the documentation procedure for continuous quality improvement.
2. The CAC should track examinations determined to be abnormal, using either a patient log kept in a secured location or through the MDT case review process. The

number of abnormal exams and percent of exams reviewed by an expert provider should be available if requested for site review purposes/practice audits.

3. The medical provider or organization who provides the expert review should maintain a de-identified log noting how many times they have provided examination review for a specific provider. Notation of whether consensus was reached is also recommended.
4. A MOU to delineate roles and expectations between the CAC/medical provider and the person serving as the expert reviewer outlining the roles and responsibilities should be considered.

EXPERT REVIEW

NCA Medical Standard for Accreditation states that “all medical professionals providing services to CAC clients must demonstrate that 100% of all findings deemed abnormal or “diagnostic” of trauma from sexual abuse have undergone expert review by an advanced medical consultant”.

- A. Advanced Medical Consultants as defined above should also have abnormal exams reviewed by another expert.
- B. An abnormal exam is one that has acute or healed physical findings in the anogenital area indicating that abuse/assault has occurred. Laboratory testing for STIs or pregnancy and DNA evidence collection are NOT included in the definition of an abnormal exam.

SAMPLE EXPERT REVIEW LOG

Below is a sample table that can be created in an Excel document or preferred database to track the review of abnormal exams by an advanced medical consultant. It is recommended that every CAC Medical provider keep such a log on file for review by NCA Site Reviewers.

Date	Site/examiner	Pre/post puberty	Examiner findings/concerns	Reviewer findings

SAMPLE LANGUAGE FOR MEMORANDUM OF UNDERSTANDING WITH ADVANCED MEDICAL CONSULTANT

MOU for Expert Review of Examinations with Abnormal Findings

It is understood that the examination review services represent a continuous quality improvement (CQI) activity and are not intended to serve as medical consultation or provision of direct patient care so results of CQI activity should not be documented in the patient’s medical record. It is the responsibility of the medical provider of the CAC to document the findings of the examination in the patient’s medical record, establish referral protocols with the CAC’s medical director, communicate the findings with the appropriate MDT members and be available for case review and court testimony if needed. This MOU for examination review services does not act as or substitute for the role of the local medical director of the CAC.

A process for tracking information from the examination review process is needed for both CQI as well as for application for accreditation/re-accreditation with the National Children’s Alliance.

The CAC and/or the medical provider will maintain a de-identified log of the number of cases in which the medical examination was deemed to represent an abnormal examination. An abnormal exam is defined as an exam in which acute or healed genital or anal injuries are identified as consistent with sexual abuse . Abnormal laboratory tests (sexually transmitted infections and pregnancy) and results of biologic evidence collections are not included in the definition of abnormal exams for the purpose of this examination review activity.

The medical provider of the CAC will maintain a log documenting the number of cases with abnormal findings submitted for expert review. Patient information on the log will either be de-identified or maintained in a secure, locked location to protect sensitive health information.

The medical provider serving as the expert reviewer will maintain a de-identified case log listing the date, examiner and whether the reviewer agreed with the examiner’s conclusion of abnormal findings on the examination.

Logs should be maintained for a minimum of 5-years to coincide with the cycle for re-accreditation.

CAC Director	Date
CAC Medical Provider	Date
Expert Reviewer	Date

Appendix 4

Examination Referral and Timing

IMPORTANT DEFINITIONS

Suspected victim of sexual abuse

A suspected victim of sexual abuse may be identified by the following criteria:

1. Disclosure of abuse
2. Witness of abuse by an adult or child
3. Exposure to high-risk offender (i.e. adult in possession of child pornography, sibling/household contact of a child victim)

TABLE 2: TIMING OF MEDICAL EXAMINATIONS¹

	Timing of Exam	Medical Indications
Indications for emergency evaluation	Exam scheduled without delay	• Medical, psychological or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking • Alleged assault that may have occurred within the previous 72 hours (or other state-mandated time interval) necessitating collection of trace evidence for later forensic analysis • Need for emergency contraception • Need for post-exposure prophylaxis (PEP) for STIs including Human Immunodeficiency Virus (HIV)
Indications for urgent evaluation	Exam scheduled as soon as possible with qualified provider	• Suspected or reported sexual contact occurring within the previous 2 weeks, without emergency medical, psychological or safety needs identified
Indications for non-urgent evaluation	Exam scheduled at convenience of family and provider but ideally within 1-2 weeks	• Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by MDT, or family concern for sexual abuse, but contact occurred more than 2 weeks prior without emergency medical, psychological or safety needs identified

1 Adams JA, Kellogg ND, Farst KJ, Harper NS, Palusci VJ, Frasier LD, Levitt CJ, Shapiro RA, Moles RL, Starling SP, Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused, *Journal of Pediatric and Adolescent Gynecology* (2015), doi: 10.1016/j.jpag.2015.01.007.

	Timing of Exam	Medical Indications
Indications for follow-up evaluation	As determined by qualified provider	- Findings on the initial examination are unclear or questionable necessitating reevaluation - Documentation of healing/resolution of acute findings - Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations - Further testing or treatment for STIs

THE 5 P'S

Other indications for medical evaluation even if outside of the DNA collection window

1. Pain/bleeding with/after contact
2. Potential for STI's due to nature of contact
 - A. Many STI's do not cause symptoms
3. Perpetrator exposed
 - A. Sibling/household contacts of the alleged offender
4. Pornography (child) use by caregiver/household contact
5. Patient/parent concern
 - A. Patients often have distorted thoughts of body due to perpetrator manipulation
 - B. Initial partial disclosures are common

Appendix 5

Disclosure Log for Protected Health Information (PHI)

Maintain in patient’s chart

Date	Type of PHI disclosed	Entity receiving PHI	Purpose of Disclosure (Investigation, billing, continuity of care...)	Person making disclosure

