Children's Advocacy Centers (CACs) Engagement Illustrations
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On April 25th, individuals affiliated with Children’s Advocacy Centers (CACs) engaged in a virtual guided discussion. The discussion included individuals who previously completed a brief survey (see details of that below). The major themes and discussion points during the April 25th discussion are included below.

**Understanding importance of, deciding who needs a medical evaluation**

- Someone will go out and do a minimal fact-finding interview, but in the course of that process, law enforcement or child welfare decide there is no need for medical (i.e., this happened 5 days ago so don’t need medical)
- Law enforcement has “lost the sense of why this child needs a medical and that isn’t about the investigation, if there happens to be evidence that comes out of medical that is icing on the cake, but this is not about the investigation.”
- Medical evaluation is “just not as important overall, especially in sexual abuse cases.” The view (by both child welfare but largely law enforcement) is “if it can’t help them out, it doesn’t matter.”
- “Continual educating that has us feeling like we are on a hamster wheel.”
- Law enforcement often doesn’t think medical isn’t needed because it “wasn’t bad, it was just touching.”
- “Increasing trend”, given the availability of cell phones, that has child welfare workers “taking pictures and think that is it, no need for medical documentation.” Impacted by the quality of the device used to take pictures, but also “lighting, angle, etc.”
- Every child coming into the Philadelphia Children’s Alliance is “offered a medical” whether CPS or GPS or just for “safety because abuse of another child.” It is offered when come in for forensic interview or after and provide transportation if needed. Also have co-location of Children’s Hospital and St. Christopher. The challenge for PCA is when child is abused in home and the parent is the abuser and won’t give consent for the medical. PCA also can do “mobile forensic interview in the emergency department.”
- Leadership at Philadelphia Human Services “was huge” in helping alleviate caseworkers’ concerns and to help make the case “every child should be offered a medical.”
- Law enforcement and children and youth look at 104s and if they don’t see “where are we going to get evidence” and don’t see a medical exam as helpful then “not taking the time.” Often, we are told “we don’t need a medical, just the interview.”
- About 75% of our kids get a medical exam and it is an “expectation in our protocol” but even with that protocol decisions made by law enforcement (i.e., “it was just touching over clothes”) and children “taking pictures.” Still too few understand “the value” and it is a “leadership issue”
- Hospital-based and so we “just assume” that a medical “is part of the package.”
- Law enforcement “doesn’t need the medical so not thinking about what kid needs.”
- Disparate approach “kid in one zip code might get to the CAC but a child in the next zip code might not because of different police jurisdiction.” Need to address lack “of consistency, kids get services based on where they live and that’s not OK.”
- Having a “statute” driving when medical happen would “open a million other conversations, but it should not be up to a particular prosecution or police chief if a child gets the gold standard of treatment as a response to their victimization.”
- We see “not infrequently” are older youth interviewed by police (not a forensic interview) who are not getting medical exams and “those are the kids who need exams, might be sexually active or concerns about their bodies and need to talk with the doctor even if their parent or police don’t think so.”
94% of time not going to have any evidence so “not going to help them do their job and think it is traumatic for kid” and so overlook “benefit of the medical” for the child

**Screening and triaging of reports**

- “Things are not flowing as quickly as they should” and then when/if law enforcement is getting “definitely not reaching top of to dos when getting the reports”. Children and youth and district attorney get them “and share them” but it takes “weeks if not a solid month before law enforcement is even doing something with a report”
- Children and youth take their own pictures and then “feel a medical isn’t necessary” and where the child is then non-verbal even less likely to get to a CAC
- Not sure if Childline or CYS but the “code” put on seems to not match up with description (i.e., coded GPS but obvious sexual abuse or witness to violence) and that impacts if the CAC “gets it or not”
- Beginning in COVID and still continuing now is “an internal change in assessment of cases”. “Cases that should be coming to us are not.” Remains unclear why the change. It feels like it is “driven by total lack of staff, they are finding some way to triage but the triage doesn’t meet the law a lot of times, it is deeply concerning.”
- New child welfare staff are “not well trained” so that is a “huge gap”
- Philadelphia has a morning meeting with the various disciplines (i.e., police, Philadelphia DHS, nurses) to triage sexual and physical abuse cases. We do not struggle for “buy in”. This morning meeting “is key”
- Our CAC has wondered why we can’t get CY 104 ChildLine reports “so we can go through them as well and triage and then we can help to prioritize and work to avoid the delayed responses.”
- CACs are seen as a “provider” and CAC staff are not seen as able to “comb through 104s.” If CACs were “part of the triage process, then we could help advocate that the child needs full CAC services.”
- In one county, all calls go to an assistant district attorney and that person “makes the decision of whether kids come to the CAC or not.”

**Challenges, strengths in collaborating**

- Child welfare staff are making decisions in the emergency department they “are in no way equipped to make.”
- People say they need to go out and do a minimal fact-finding interview, but as doing that law enforcement or child welfare decide no medical needed
- Extensive training and messaging isn’t making enough of a difference. Need “more buy in or leadership” from other entities on MDIT to “see significant difference on access to medicals.”
- CACs are “a service, not always seen as the solution, we are not investigators, our opinion is valued by individual members but overall not really.”
- One county “votes” on whether a case should be indicated by police, community health nurse, child welfare. It is “troubling” and also see them “not believing the child abuse pediatricians”
- We can “train an entire staff” and months later have “all new people to train” because of “high turnover.”
Overcoming parental concerns
- Talking to a parent about how important it is for the child to have a medical and how it “is the beginning of the healing process for the child.” Sometimes the better communicator is someone from the medical team, but we “don’t force or push.” Important to explain what medical consists of
- “We act like the medical exam is a give in” when schedule just note it is part and then work with them to navigate the setting up and getting to the appointment
- In rural communities, even if we can navigate the transportation, you are still talking about a parent losing a day of wages so have to decide “do I lose my job” to take the child for the medical care. They will get “judged either way, not by us” so that “is really hard.”
- Did some research about why parent ‘not agreeing to a medical” and the “#1 driver of why parents were not agreeing to medical was because child welfare caseworker or law enforcement said it wasn’t necessary.” The next big “driver” was they had to come back for medical (because didn’t have full time medical staff at time). Worked to schedule that interview is at the same time as medical and that our registered nurse being the person to engage with the parent/family
- All a parent needs is “one person to say oh it was just touching or a finger, you don’t need a medical” that “reinforces beliefs the family might have and ignores the fact that sometimes kids don’t disclose anything who might have findings or STDs.”
- Parents who work can have a “trusted” person bring the child but parent needs to complete paperwork ahead of time
- Reframe to medical consult versus “examination.”

Rural communities
- Even with buy in from law enforcement on medical, the “closest option for a medical for a child is an hour and a half away.” Even if we could find the money for training and equipment, “the shortage of nurses” is a challenge. Children who need sexual assault exam, the choice is we have someone who “is not certified to do it” or you have to send them far away
- Need to be careful talking about Sexual Assault Nurse Examiners (SANEs) because while they can do medical care for sexual abuse, “it is outside their scope of practice to diagnose and treat children who are physically abused.”

Capacity, how can CACs be leveraged going forward
- We could see more kids and have the resources, “we feel the numbers are down and we are not brought the cases we should be getting.”
- In terms of sexual abuse, we do have the capacity
- We have medical in-house so no capacity issue, so we now say these are our services inclusive of medical. Those emergencies happening on weekend or evening it “is harder to find staff because we don’t have on-call staff.” We have a physician assistant and nurse practitioner who performs the services
- Concerned about number of child abuse pediatricians who are farther along in their career. We need to cultivate the next generation of specially trained physicians (notes fellowship in New Jersey if agree to a period of time of service in state)
- Shift to physical abuse we are hospital-based so we have “an advantage”, but in communities where there are “not a lot of providers and asking community-based provider to step in and do exams at CAC, there has to be money to pay for their time.” Physical abuse exams “take a long time” and may need to do case review or go to court “so there needs to be a way to pay the providers so it is not financially detrimental to them to do it.”
- Protocol does capture physical abuse, but also “we really only see the really significant, not the nuanced ones.” If you don’t have medical on-site it “doesn’t make sense to bring a child here that isn’t verbal.” We need some “mobile unit” (looking to New York and their practices)
• In Philadelphia, it was often the “more egregious cases where child was a witness in home” and those child witness statements “were critical”
• Idea of having practitioners in smaller areas might not work “for extreme cases” (i.e., bruise on face) don’t need to be seen at a CAC (unless hospital-based) because need skeletal survey and CT and “it is impossible to make that available everywhere.”
• At satellite CACs, we don’t have all day medical coverage so kids will have to travel or see own pediatrician
• Related to non-verbal children, when we did a case review of a near-fatality and fatality (in the same family), we “determined that lack of MDIT approach and information sharing” so now for non-verbal we have “staffing for those cases” even though no forensic interview. Feel like “information sharing” is “key to success.”
• We see “anything involving the child” (i.e., neglect, sexual, witness to violence) and the “directive has come from the DA that everyone comes to us and no where else.” The only “way something doesn’t come to us is if they go out and close it out.”

**Funding**

• For sexual assault we have “gotten better, but I think that is because there is a funding source” (i.e., VCAP)
• We are struggling with physical abuse medical evaluations, “because of medical insurance or lack thereof.” We need to explore something “easy for reimburse so kids can be seen for physical abuse.” Child welfare is taking pictures, but to ask for consult is “impossible if doctors are not seeing the kids” and that will continue until have an “easy structure for payment.”
• Physical abuse cases go directly to hospital because of “billing.”
• If we provide a forensic interview (physical abuse), we “can’t bill anyone for that and we have about $60,000 in uncovered forensic interviews.”