IOWA CHAPTER OF CHILDREN'S ADVOCACY CENTERS GROWTH ASSESSMENT 2014

Prepared By

Censeo Solutions, Inc. and Mapping Strategies LLC

data analytics for practical policy solutions

ACKNOWLEDGEMENTS

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Steps in the Child Protective Process

1. Referrals, or allegations of abuse, are made to DHS as **intakes,** or incidents, and assigned a number.
2. **Intakes** are either **rejected** or **accepted** for an **assessment**, based on whether or not they meet criteria for **child abuse,** according to Iowa Code.
3. Those **intakes** accepted for an **assessment** then become abuse **reports.**
4. All **reports** of alleged child abuse (as defined by law) are responded to via an **assessment**.
5. Prior to January 1, 2014 all **assessments** were treated the same and resulted in an **outcome**. Beginning in 2014, **assessments** were done via one of two paths:
    a. **Child Abuse Assessment (CAA)** – same as previous assessment process.
    b. **Family Assessment (FA)** – a response to some cases of Denial of Critical Care that meet certain criteria and do not allege imminent danger or death or injury to a child. FAs differ from CAAs in that there is no outcome or substantiation and services are voluntary.
6. Those **assessment reports** from a traditional CAA (and all assessments conducted prior to 2014) result in an outcome of either "**Not confirmed**", "**Confirmed**", or "**Founded**".

Child Protective Process Key Terms

- ***"Report"*** means an accepted allegation of child abuse. The **report**, or incident, may cover one or multiple child **victims** in the same household. The **report**, or incident, may also allege one or multiple **types of abuse**. Therefore, the number of **reports** is NOT equivalent to the number of unique children, or the number of unique types of abuse alleged.*
- ***"Accepted"*** means intake information that, if true, would meet the criteria for child abuse.
- ***"Assessment"*** means the process by which DHS responds to all accepted reports of alleged child abuse. As of 2014 this could be either a Child Abuse Assessment or a Family Assessment.
- ***"Child Abuse"*** means an allegation which includes a "child", a "person responsible for the care of a child", AND a category of "child abuse" in accordance with Iowa Code Section 232.68.
- ***"Duplicate child victims"*** includes data counting each child who is a victim of child abuse and each time they are victimized.*
- ***"Intake"*** means alleged abuse reported to DHS.
- ***"Rejected"*** means intake information that, even if true, would not meet the criteria for child abuse.
- ***"Unique child victims"*** includes data counting each child who is a victim of child abuse once, in a calendar year, regardless of the number of incidents or the number of allegation types.*
- ***"Type of Abuse"*** includes data counting each substantiated allegation by type.*

**Note: These correspond with DHS data sets available to the public at:*
http://dhs.iowa.gov/reports/child-abuse-statistics

Outcomes of a Child Abuse Assessment

- ***"Not confirmed"*** means that there was not a preponderance of evidence to suggest abuse occurred and, therefore, the incident will not be placed on the Central Abuse Registry.
- ***"Confirmed"*** (not placed on registry) means there was a preponderance of evidence to suggest *Physical Abuse* or *Denial of Critical Care (lack of supervision or lack of adequate clothing)* occurred and ALL the following conditions were met:
  - The incident was minor.
  - The incident was isolated.
  - The incident was unlikely to reoccur.
- ***"Founded"*** (confirmed AND placed on registry) means there was a preponderance of evidence indicating the alleged abuse occurred, the victim was a child, and the perpetrator was a caretaker. In addition, if the allegations were Physical Abuse or Denial of Critical Care (lack of supervision and lack of adequate clothing), the criteria of minor, isolated, and unlikely to reoccur were not met.

*Note: Use of the term **"substantiated"** is sometimes used to mean all confirmed cases, to include those confirmed (not placed on the registry) and confirmed (and placed on the registry) or "founded".*

Executive Summary

A Child Protection Center (CPC) is a child-friendly facility where multidisciplinary teams, including representatives from child welfare and law enforcement, can collaborate on child abuse investigations and case planning. In effort to be good stewards of Iowa's resources, the Iowa Chapter of Children's Advocacy Centers (ICCAC) examined data and service provision across the state by way of a Growth Assessment. An ICCAC goal is to assist with the development of a CPC within a one hour distance of each child victim in the state. Standards for CPC Accreditation state that a CPC has to be readily accessible to CPC clients, so the one hour driving distance has become an industry standard of service. Censeo Solutions, Inc. and Mapping Strategies, LLC were selected by ICCAC to conduct research, map data, identify needs based on data and make recommendations for potential CPC growth in Iowa.

ICCAC collaborated with the Iowa Department of Human Services, the Iowa Department of Public Health, the five accredited Child Protection Centers of Iowa, Project Harmony CAC, the National Children's Alliance, and the Iowa Census. Censeo Solutions, Inc. gathered data from each of these entities. This data was analyzed using GIS Mapping, qualitative and quantitative analysis and agency surveys. Electronic surveys were administered to child advocates and community members in the following six counties with identified need based on the child abuse data: Carroll, Cerro Gordo, Davis, Wapello, Webster and Wright. The results of the analysis yielded the following trends and observations:

- A total of 60,229 children, under the age of 18, currently reside in counties which are underserved and outside of a one hour driving distance of any existing CPCs in Iowa and Project Harmony (Omaha, NE)
- Incidents of sexual abuse, physical abuse and denial of critical care, have an upward trend in the underserved areas in North Central Iowa
- Confirmed abuse reports in 2013 were at a high rate, noting that cases involving children five and under were also at an increased rate for 2013 in the underserved areas of North Central Iowa
- An area in South Central Iowa was also identified as underserved based on abuse rate increases and being outside of the one-hour driving distance for access to CPC services
- There is need and interest by communities in the underserved areas to further examine the potential for developing a CPC or Satellite Center

This assessment identified the scope of services provided by current CPCs in the state of Iowa, and identified unmet needs in rural areas of the state which fall outside of the parameters of the one hour access. Given this, the following recommendations for action are made:

- This report should be broadly disseminated to partners, state agencies and legislators. Provision of this report to interested stakeholders may increase understanding of both child abuse and CPC service provision in, and beyond, the state of Iowa.

- Establish a Child Protection Center in North Central Iowa. Consideration should be given to which CPC model will be the "best fit" for community needs and resources. Given this initial data analysis, it is recommended that strong consideration be given to establishing a satellite CPC which may then be expanded upon given demonstrated need and use. A satellite CPC is defined by NCA as a "child-friendly facility offering onsite forensic interviews and victim advocacy services under the sponsorship and oversight of an NCA Accredited Child Protection Center. Such satellites must also have the capacity for medical and mental health services either on-site or through linkage agreements."
- Establish a workgroup to further explore the needs and benefits of establishing a satellite CPC in the underserved counties of South Central Iowa. The workgroup will allow for more formal collaboration and collection of data from partner agencies and community members to drive planning. The workgroup, with guidance from the ICCAC Executive Director, should produce a comprehensive work plan, with associated timeline and identification of resources.

In summary, it is understood that community stakeholders have expert knowledge of their communities, and this report is a starting point so that communities may incorporate the data into their own planning.

INTRODUCTION

The Iowa Chapter of Children's Advocacy Centers (ICCAC) was formed in 2003 by a group of child abuse professionals in an effort to effectively address the problems associated with child abuse through utilization of the Children's Advocacy Center model. ICCAC is one of 49 Chapter affiliates of the National Children's Alliance.

Currently, the ICCAC supports five Child Advocacy Centers (CACs) located in the state of Iowa. These sites include the Mercy Child Advocacy Center in Sioux City, Regional Child Protection Center at Blank Children's Hospital in Des Moines, St. Luke's Child Protection Center in Cedar Rapids, the Mississippi Valley Child Protection Center in Muscatine, and the Allen Child Protection Center in Waterloo.[1] The Iowa Chapter, as the leading resource for these CAC's, provides targeted assistance with the development, continuation, and enhancement of the CAC model throughout the state.

An Accredited Child Advocacy Center, CAC, is a child-focused facility where representatives from many disciplines; law enforcement, child protection, prosecution, mental health, medical and victim advocacy, work together conducting forensic interviews and making joint decision about the investigations, treatment management and prosecution of child abuse cases. The combined wisdom and understanding of professionals from different disciplines results in a more complete understanding of case issues and the most effective child and family focused system response. NCA Accredited CACs must meet ten strict standards of competence which are re-evaluated every five years. Definitions of the ten standards listed below may be found in Appendix B.

The standards are broken down into ten categories:

1. Multidisciplinary Team (MDT)
2. Cultural Competency and Diversity
3. Forensic Interview
4. Victim Support and Advocacy
5. Medical Evaluation
6. Mental Health
7. Case Review
8. Case Tracking
9. Organizational Capacity
10. Child--Focused Setting

[1] Iowa refers to their centers as either a Child Advocacy Center (CAC) or Child Protection Center (CPC).

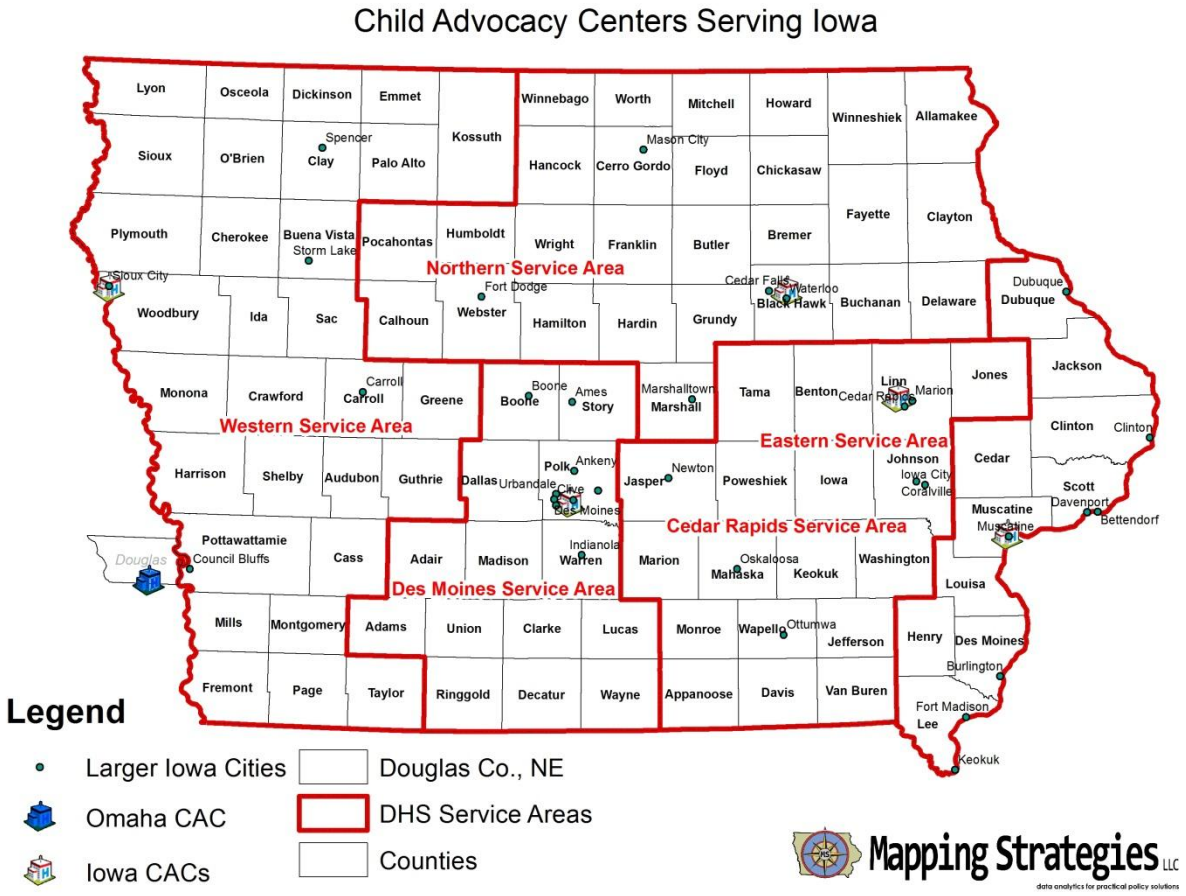


FIGURE 1: CHILD ADVOCACY CENTERS IN IOWA

ICCAC provides services to these local Child Advocacy Centers in order to support the development, continuation and enhancement of the Child Advocacy Center model in local communities. The organization is familiar with Iowa laws and strives in the continued engagement and education of legislative bodies on the subject of child abuse. Simultaneously, ICCAC compiles data from all Iowa Centers, much of which is collected through NCAtrak and the Outcome Measurement System (OMS), in order to determine services offered, clients served, satisfaction, and Center functioning.

PURPOSE

In this report ICCAC will assess Iowa's need for child advocacy centers and services. This includes the development of a comprehensive understanding of incidents of child abuse across Iowa and evidence of how current service providers, including the five CACs, provide services to meet these needs in communities throughout Iowa.

Data utilized in this assessment were collected from multiple sources. The Iowa Department of Human Services provided county-level child abuse data from 2009 to 2013, which included confirmed allegation rates by type of abuse. All of the five accredited Child Advocacy Centers across Iowa submitted data which allowed for mapping of services provided by county. Additionally, Project Harmony, a Child Advocacy Center located in Omaha NE, also provided data as the center is funded to serve a number of clients in western Iowa. Additionally, data were collected from other service providers. These providers include the University of Iowa Children's Hospital Child Protection Program (CPP) and Davenport's Child Protection Response Center (CPC).

METHODOLOGY

This Growth assessment is modeled after the "Child Advocacy Center Statewide Plan Development: Technical Assistance to the Commonwealth of Pennsylvania," authored by Richa Ranade, MPH; Debra Schilling Wolfe, MEd; and Jingru Hao, MSW. Particularly, this growth assessment adapted two key methods from Pennsylvania's Growth assessment. The first is the collection and analysis of data at a county level. The second is the measure of time between child advocacy centers and location of child abuse incidents. Specifically, analysis uses the standard of one hour travel time by car from an incident's location to a Center; and pays particular attention to those incidents occurring in counties located outside of these parameters.

Information obtained from ICCAC member centers across Iowa is paired with annual reports provided by the Department of Human Services (DHS). This is done to compare the number and characteristics of incidences reported across Iowa to those handled by ICCAC member centers. This information also allows for use of Geographic Information System (GIS) mapping of the location, frequency, type and confirmed rate of incidences. Overall, this assessment seeks to utilize multiple sources of data and visual mapping in order to identify underserved areas of the state. Ultimately, this will allow for further assessment to better understand both need for and interest in the establishment of additional Children's Advocacy Centers in Iowa.

RESULTS

TRENDS

In the state of Iowa, the number of child abuse reports were consistent between 2009 and 2013; ranging from a low of 25,814 in Iowa in 2009 and a high of 30,747 in 2011. Overall, the total number of reports increased by 315 during this time. Figure 2 details the trend in unconfirmed, confirmed and founded reports.

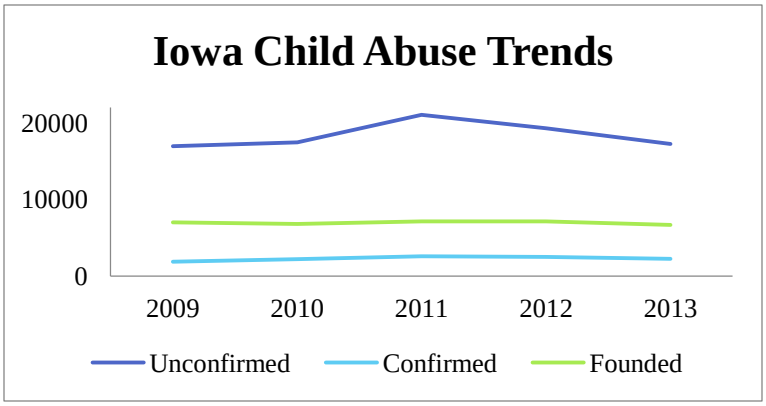


FIGURE 2: IOWA CHILD ABUSE TRENDS

Trends in confirmed and founded reports, by type of abuse, were also consistent between 2009 and 2013. The greatest difference in confirmed and founded reports was in denial of critical care, which decreased by 1,003 number of child victims. Figure 3 details trends in confirmed and founded reports, by type.

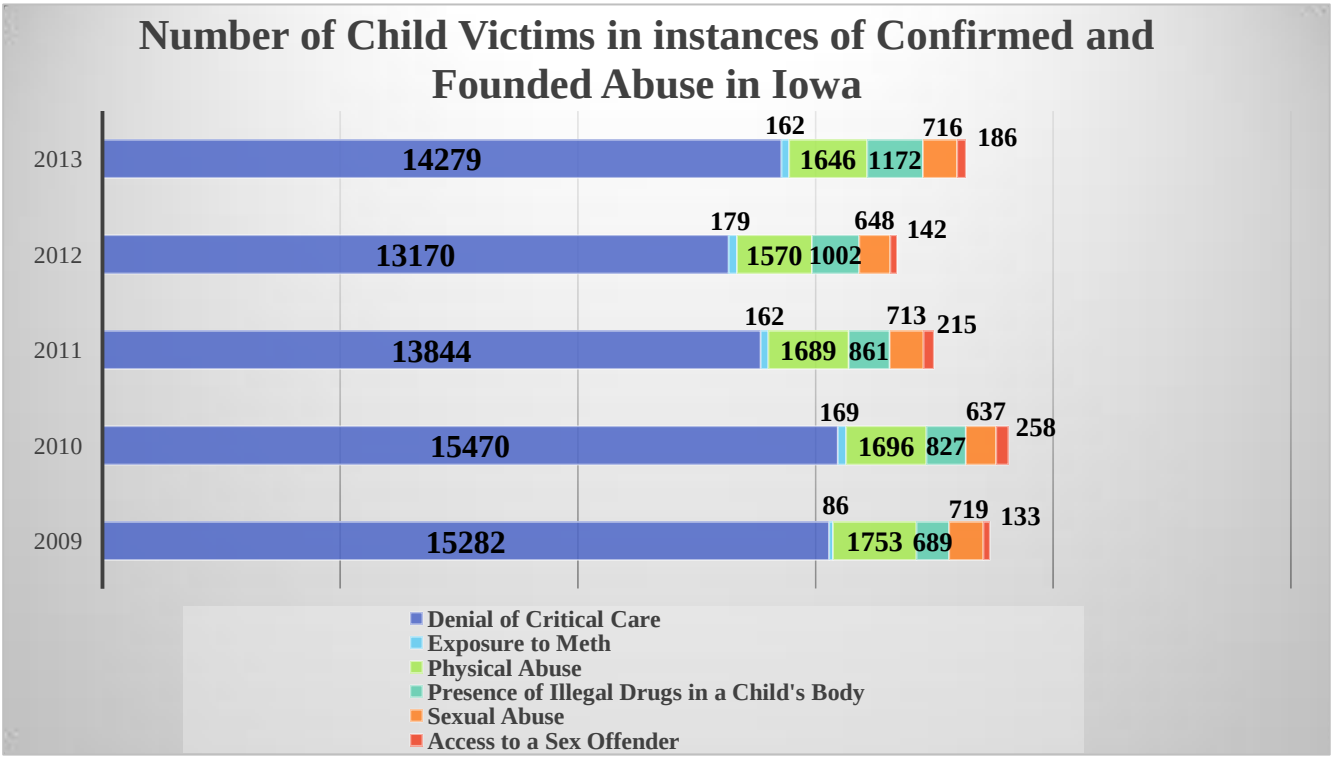


FIGURE 3: NUMBER OF CHILD VICTIMS IN INSTANCES OF CONFIRMED AND FOUNDED ABUSE IN IOWA

Between 2009 and 2013 confirmed and founded abuse varied slightly according to victim age. While the total number of confirmed and founded reports decreased (by 390) for children 5 and younger, reports increased by 251 for children ages 6 to 10. Figure 4 details overall trends.

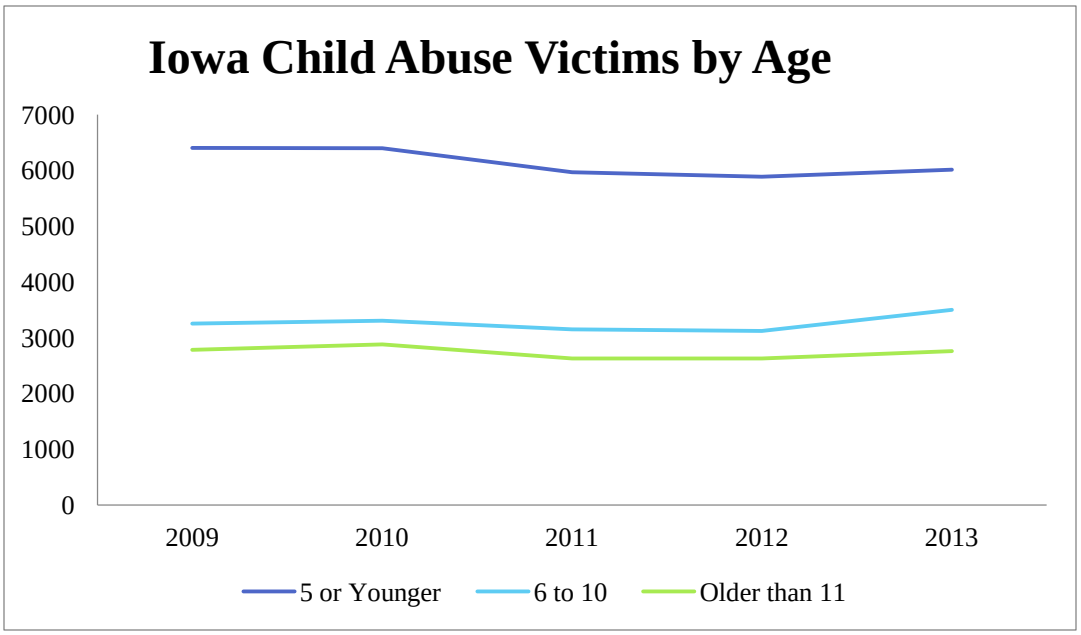


FIGURE 4: IOWA CHILD ABUSE VICTIMS BY AGE

2013 CAC DATA

When child abuse is reported, it may be referred to a Child Advocacy Center by DHS, Law Enforcement, and occasionally by a Medical Provider. In 2013, a total of 3,668[2] cases were referred to the six CACs studied in this report. Number of children served, number of reports and type of abuse varied according to each CAC.

Figures 5-10 detail the number, geographic location and type of abuse reported to CACs serving Iowa.

[2] This number includes all cases referred to the five Iowa CACs and Iowa cases referred to Project Harmony in Omaha

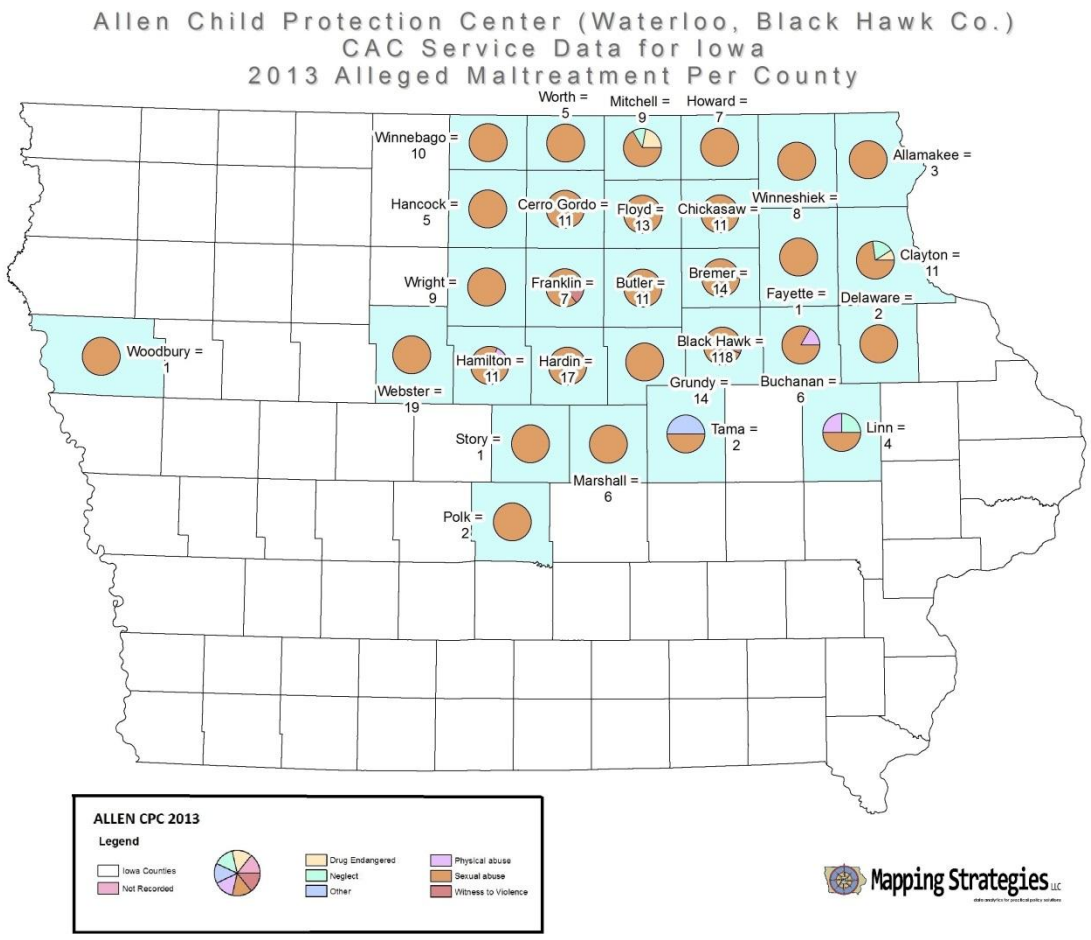


FIGURE 5: ALLEN CHILD PROTECTION CENTER ALLEGED MALTREATMENT PER COUNTY, 2013

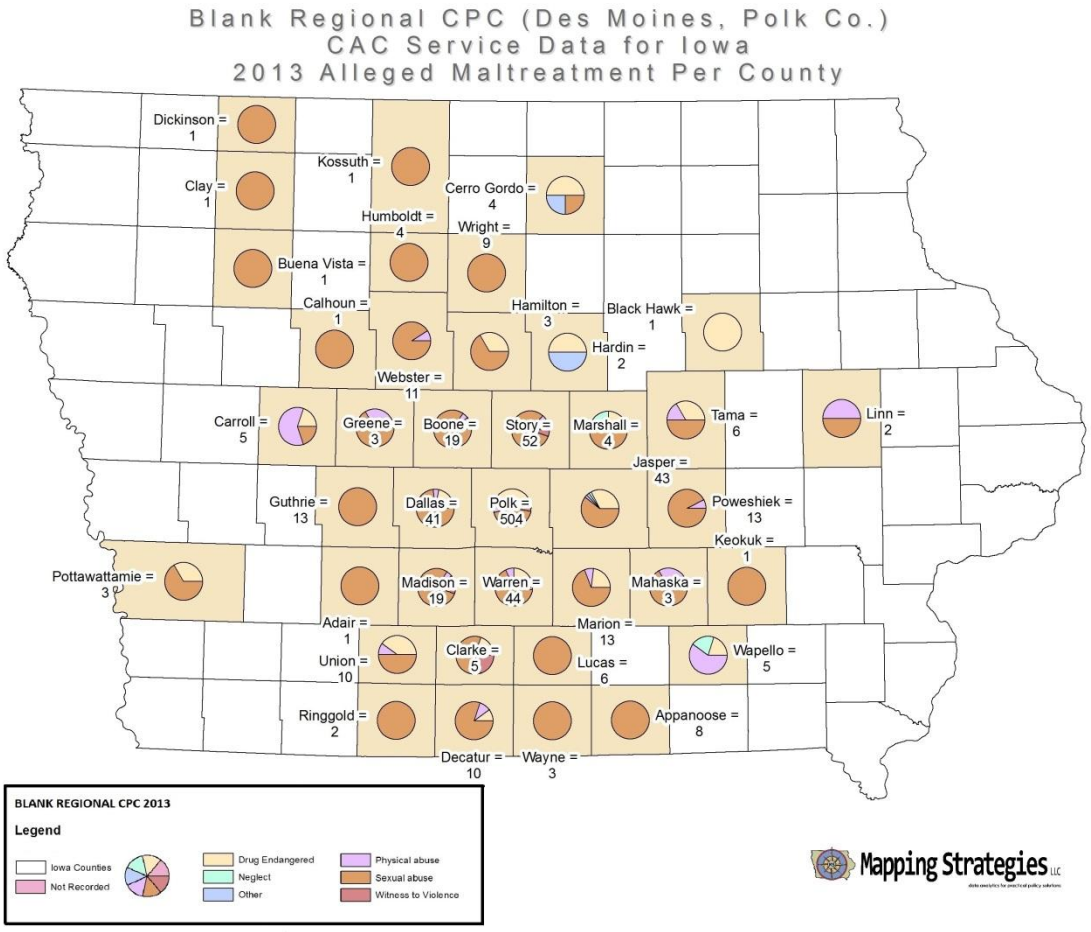


FIGURE 6: BLANK REGIONAL CPC ALLEGED MALTREATMENT PER COUNTY, 2013

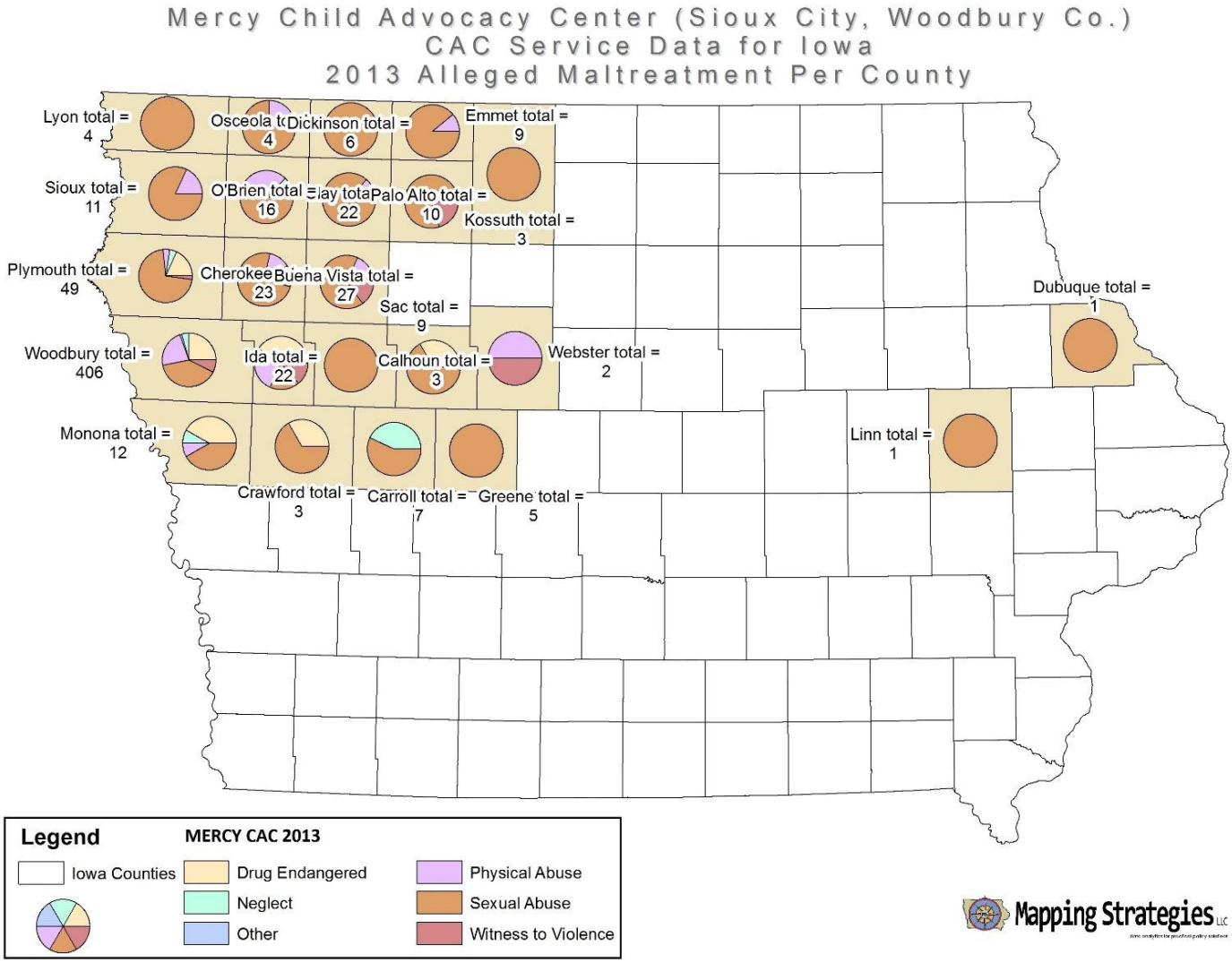


FIGURE 7: MERCY CHILD ADVOCACY CENTER ALLEGED MALTREATMENT PER COUNTY, 2013

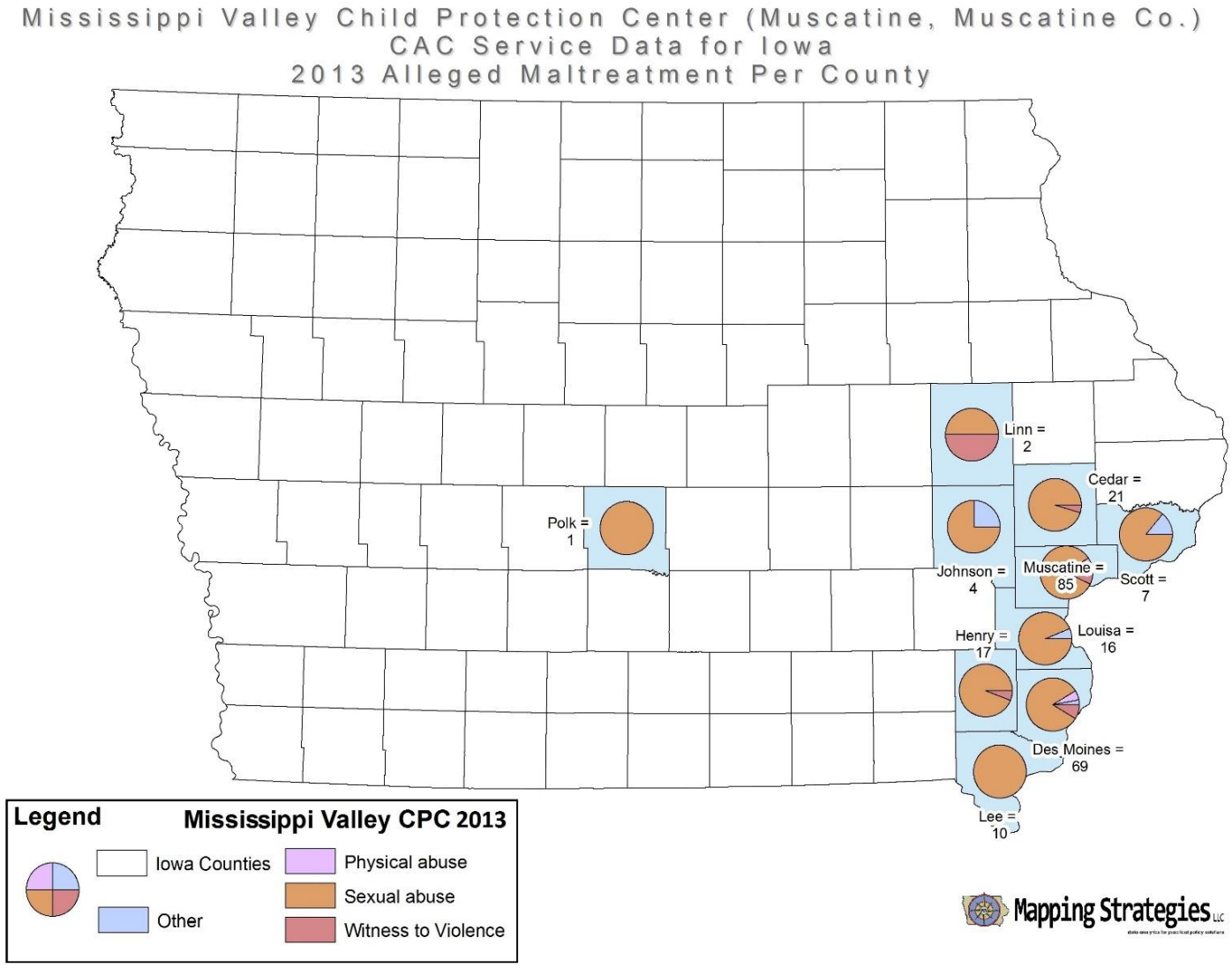


FIGURE 8: MISSISSIPPI VALLEY ALLEGED MALTREATMENT PER COUNTY, 2013

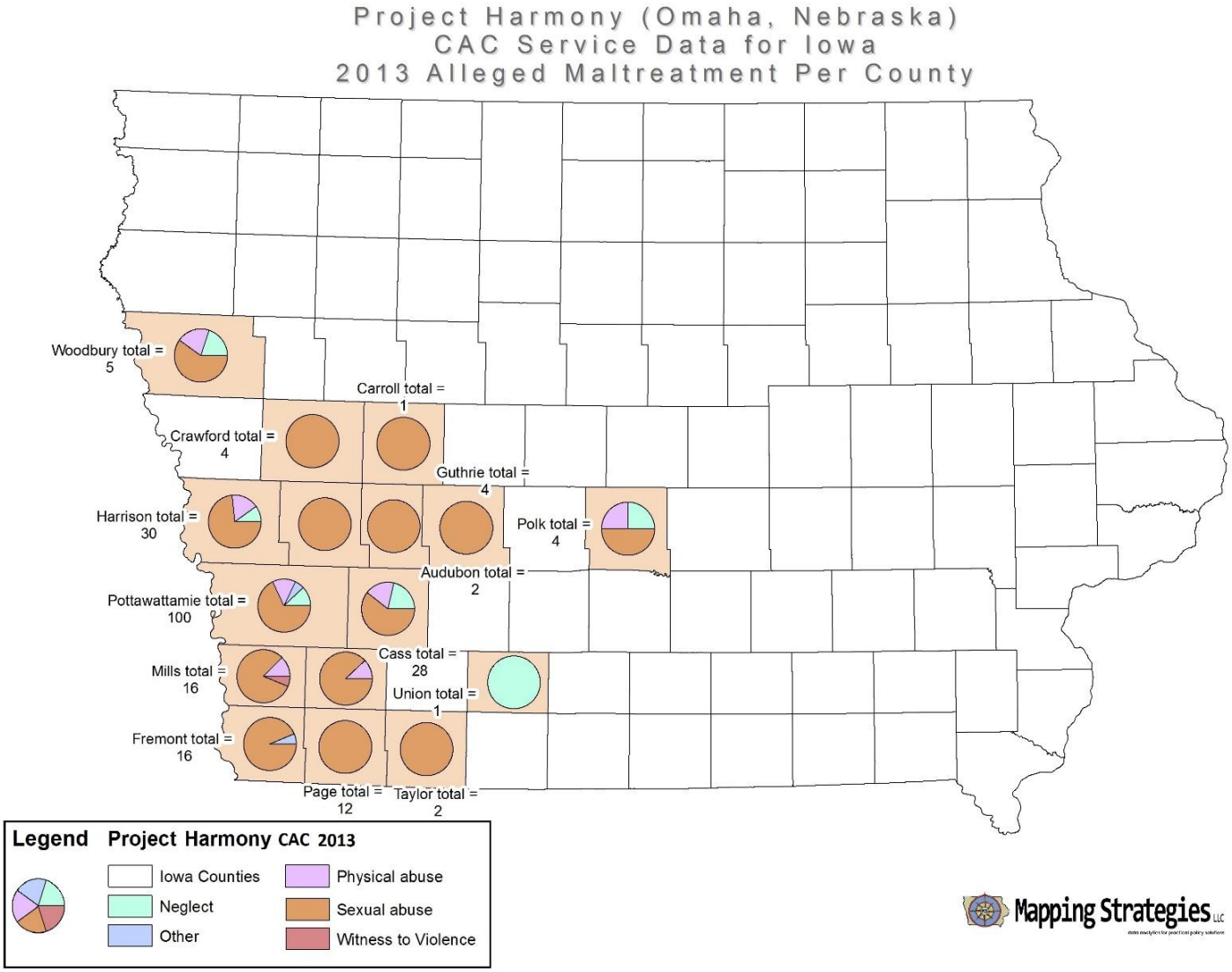


FIGURE 9: PROJECT HARMONY CENTER ALLEGED MALTREATMENT PER COUNTY, 2013

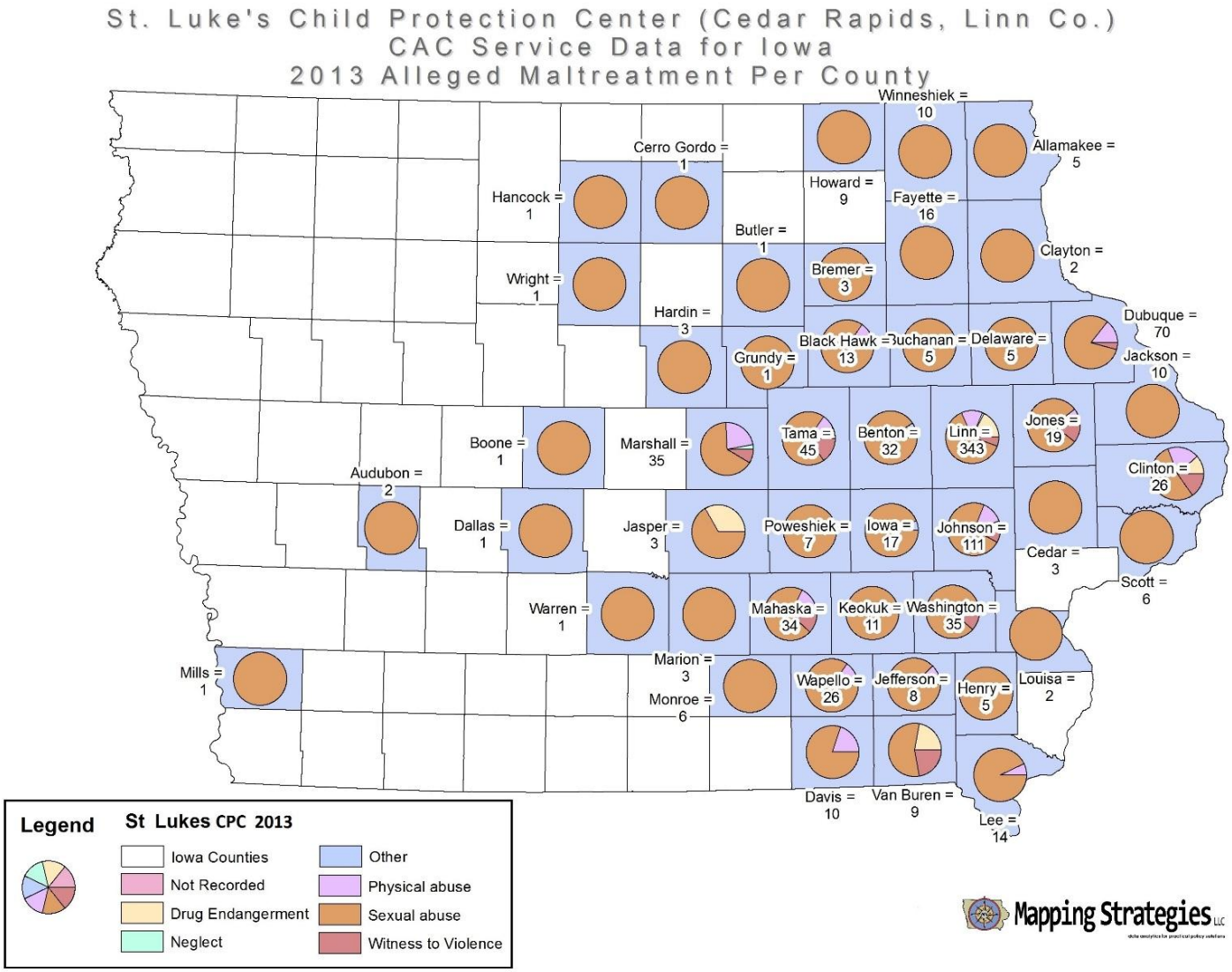


FIGURE 10: ST. LUKE'S CHILD PROTECTION CENTER ALLEGED MALTREATMENT PER COUNTY, 2013

"One Hour" Recommendation

The 99 counties of Iowa are separated into five DHS service areas; and each of Iowa's five CACs are located within one of these service areas. However, it should be noted that CACs are also located according to location in or near a hospital. Therefore, CACs are not centrally located within each of the following service areas: Western Service Area, Northern Service Area, Des Moines Service Area, Cedar Rapids Service Area, and Eastern Service Area. Furthermore, each of these areas serves between ten and thirty counties. Therefore, regions within each service area fall outside of the "one hour" recommendation; or a 60 miles radius which indicates that a center may be reached in a maximum of one hour's time. Figure 11 details how much of the state of Iowa is within one hour's drive of one of six CACs located in either Iowa or Omaha, NE, and Figure 12 details the counties which fall outside of these parameters.

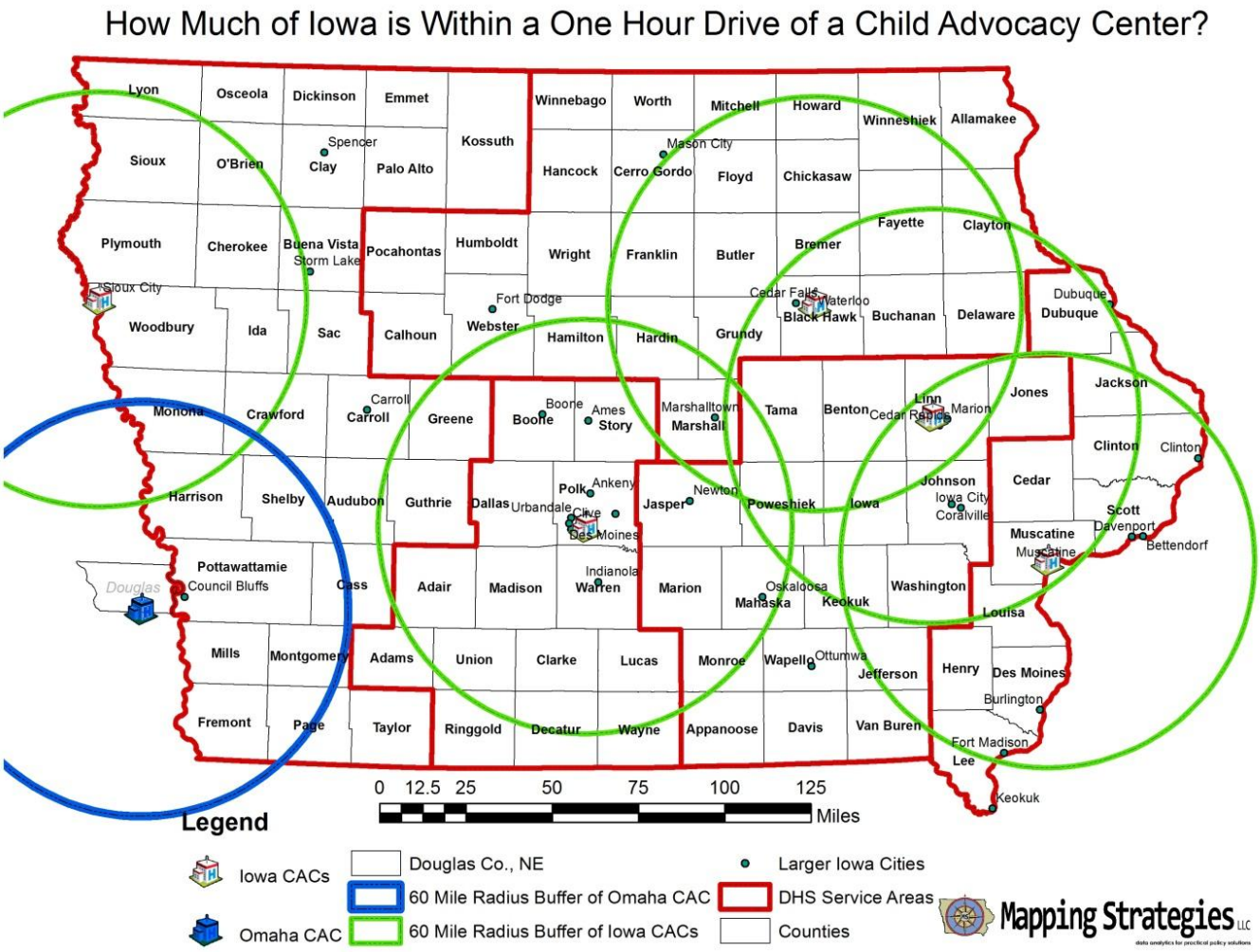


FIGURE 11: HOW MUCH OF IOWA IS WITHIN A ONE HOUR DRIVE OF A CHILD ADVOCACY CENTER?

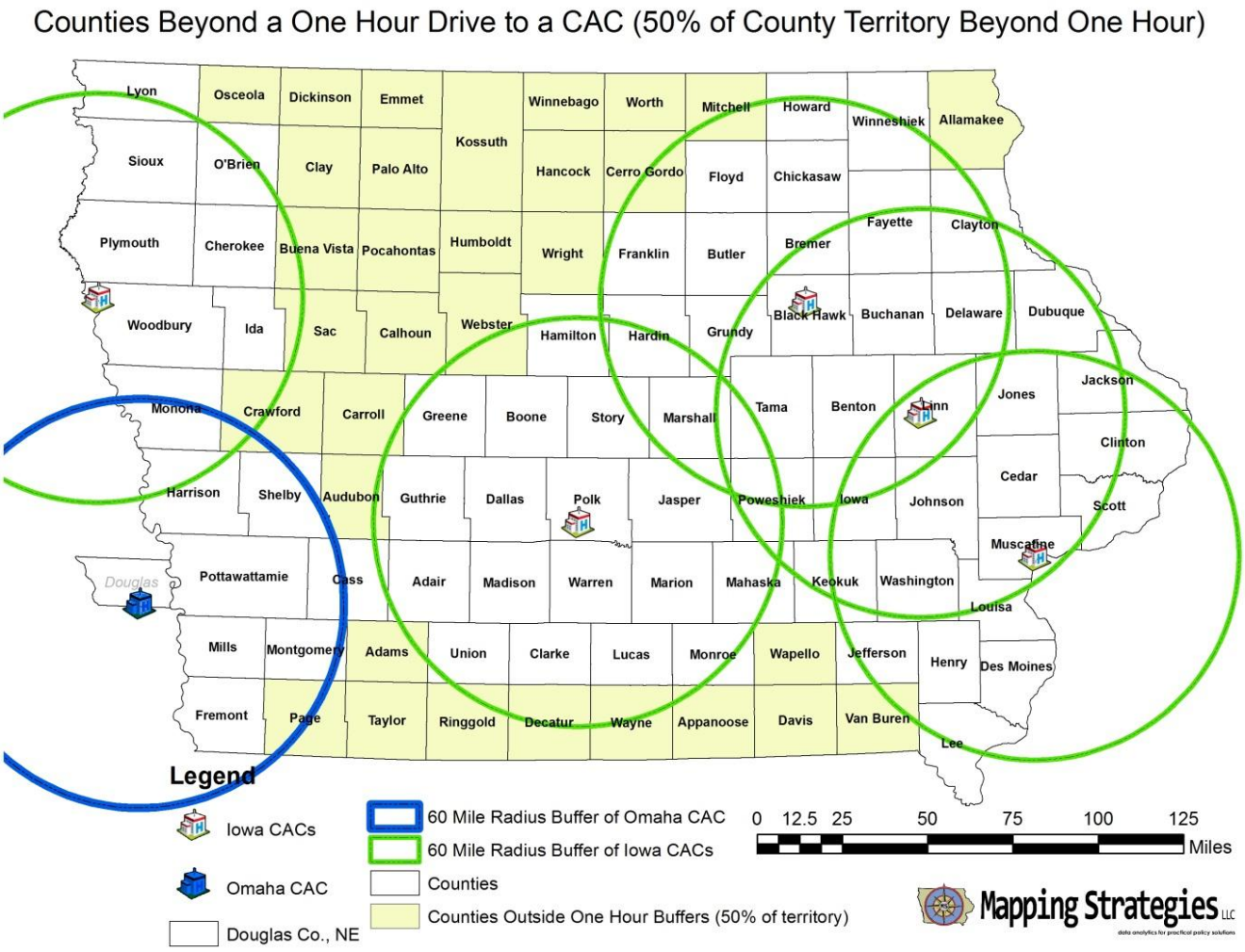


FIGURE 12: COUNTIES BEYOND A ONE HOUR DRIVE TO A CHILD ADVOCACY CENTER

In this diagram, it can also be assessed that 32 of Iowa's counties have at least 50% of their territory omitted from any of the one hour drive radiuses. The majority of these counties lie within the Western and Northern Service Areas; with a smaller portion of omitted counties being located in Southern Iowa, and Allamakee County in the North Eastern corner of Iowa. The North Western omitted counties alone have population of 60,229 children under the age of 18, according to the 2010 census.

In order to assess the size of the unserved area in Northern Iowa a radius was created specific to the "one hour" recommendation. Figure 13 illustrates these findings.

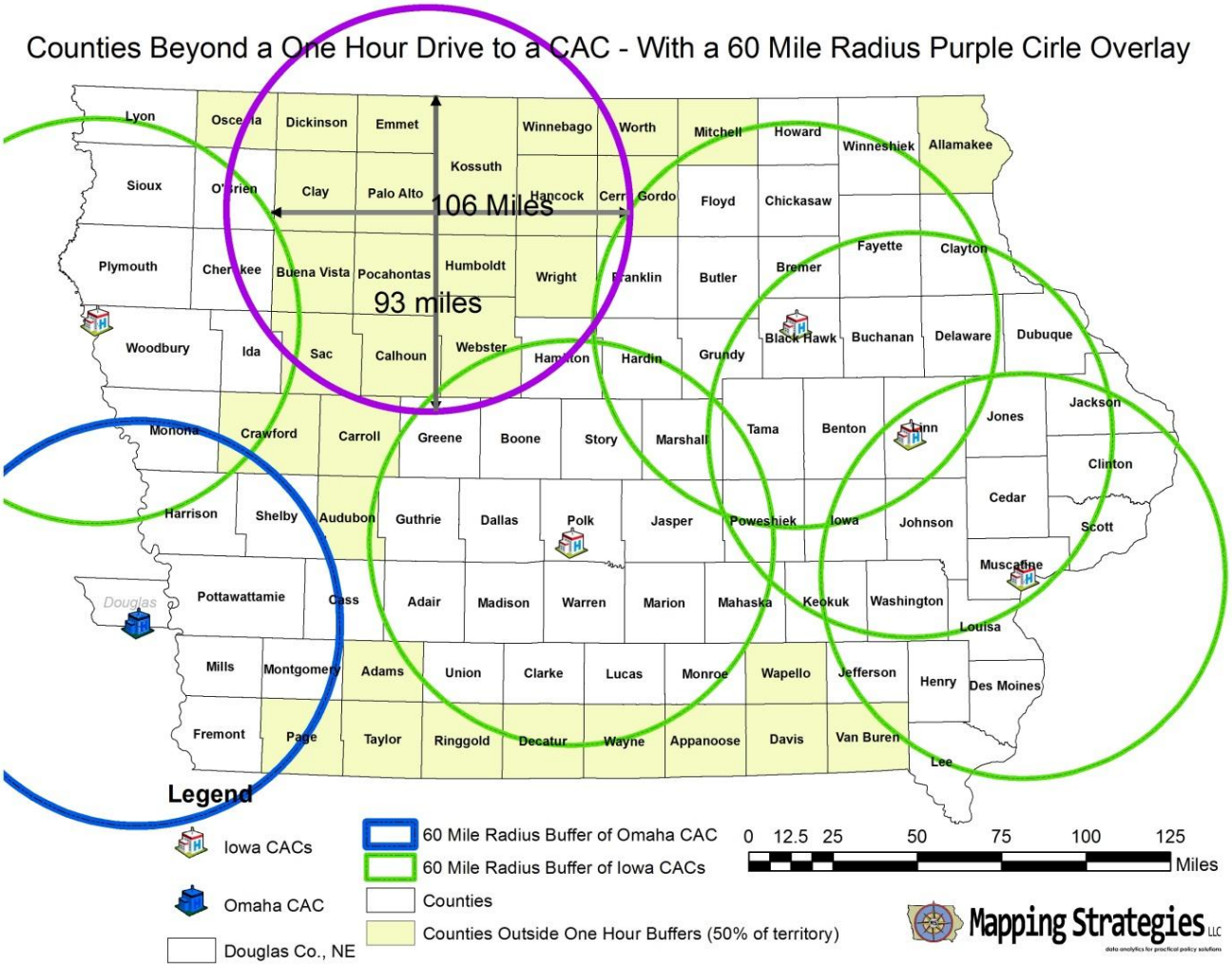


FIGURE 13: 60 MILE RADIUS OVERLAY OF COUNTIES BEYOND A ONE HOUR DRIVE TO A CAC

In order to best understand how the one hour recommendation applies, 2013 data from Iowa CACs was analyzed. Overall, CAC service data indicate counties falling within the "one hour recommendation" typically seek services at their nearest CAC. However, counties outside these parameters often sought services from multiple providers.

Table 1 details the number of total referrals made by underserved counties, and the CACs which provided services.

County	Number of Cases	CACs utilized
Appanoose	8	Blank
Audubon	4	Project Harmony, St. Luke's
Buena Vista	28	Mercy
Calhoun	4	Mercy, Blank
Carroll	13	Mercy, Blank, Project Harmony
Cerro Gordo	29	Allen, St. Luke's, Blank
Clay	23	Mercy, Blank
Crawford	7	Project Harmony, Mercy
Davis	11	St. Luke's
Decatur	10	Blank
Dickinson	7	Mercy, Blank
Emmet	9	Mercy
Hancock	6	Allen, St. Luke's
Humboldt	4	Blank
Kossuth	4	Mercy, Blank
Mitchell	9	Allen
Osceola	4	Mercy
Page	12	Project Harmony
Ringgold	2	Blank
Sac	9	Mercy
Taylor	2	Project Harmony
Van Buren	9	St. Luke's
Wapello	36	St. Luke's, Blank
Wayne	3	Blank
Webster	35	Allen, Mercy, Blank
Winnebago	10	Allen
Worth	5	Allen
Wright	19	Blank, Allen, St. Luke's

TABLE 1: CAC SERVICES IN UNDERSERVED COUNTIES, 2013

UNDERSERVED AREAS

Geographic analysis has established that underserved areas exist in both the North Central and Southern counties of Iowa. Given this, the needs of the underserved areas must be analyzed. This is done using the information derived from both the CACs themselves, and data acquired through DHS. Rates used for measurement in counties were also calculated using the 2010 Census count. For the purposes of this report, incidences of child abuse were measured in confirmed and founded cases.

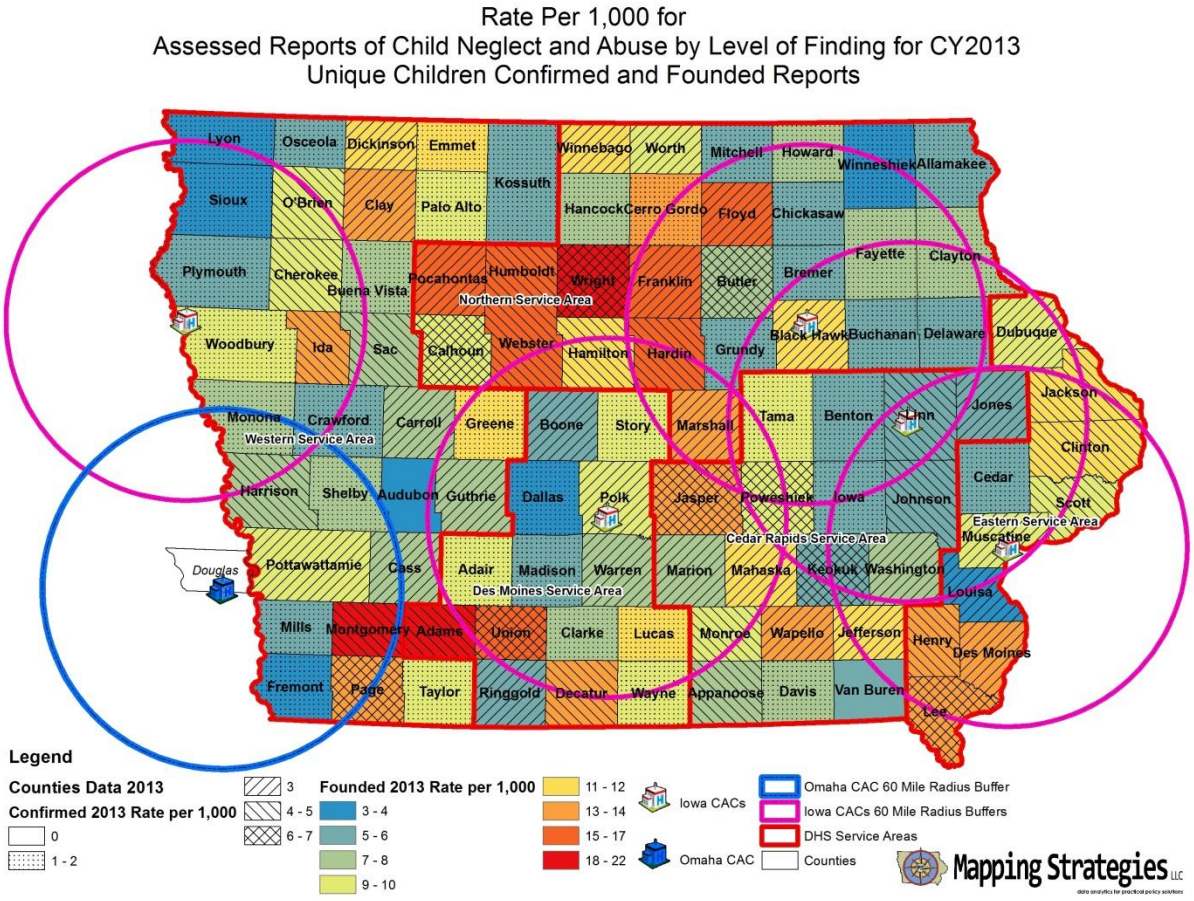


FIGURE 14: COMBINED TOTAL OF CONFIRMED AND FOUNDED REPORTS PER 1,000 CHILDREN, 2013

The underserved counties with the highest rate of confirmed and founded cases were Wright and Adams Counties. Although both counties hold the highest number of founded or confirmed cases, it does not necessarily mean they hold the highest rate for each type of child abuse.

Total, confirmed and founded reports were also trended between 2011 and 2013. There were 11 counties for which total reports of abuse increased during this time, including: Calhoun, Greene, Guthrie, Hamilton, Harrison, Henry, Ida, Monroe, Pocahontas, Sac and Worth. Four of these counties are located in the underserved area in North Central Iowa. Figure 15 illustrates the percent change in total reports. While total reports increased in these areas, trends differed for confirmed and founded, as illustrated by Figures 16 and 17. Data from Greene and Pocahontas counties also show an increase in confirmed reports. However, none of the counties in the underserved area, which experienced an increase in total reports, experienced an increased in founded reports. In both cases, other counties in the underserved areas experienced increases in the rate of confirmed and founded cases over the three years studied. This includes counties in both the North Central and Southern Iowa underserved areas.

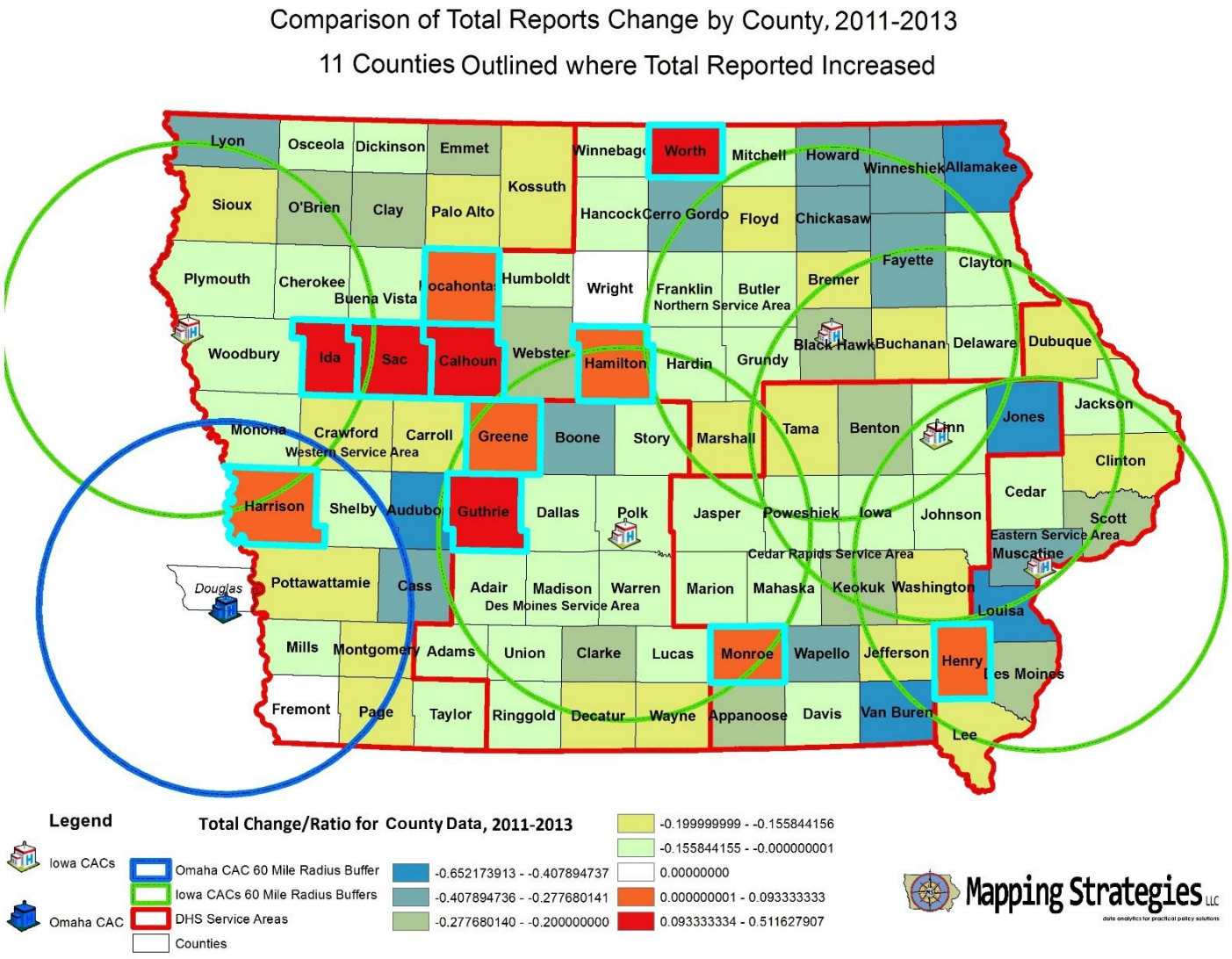


FIGURE 15: RATE OF CHANGE IN TOTAL REPORTS, 2011-2013[3]

[3] Calculated using DHS assessed reports of neglect and abuse by level for 2011 and 2013. Total reports change equals 2013 reports minus 2011 reports divide by 2013 reports.

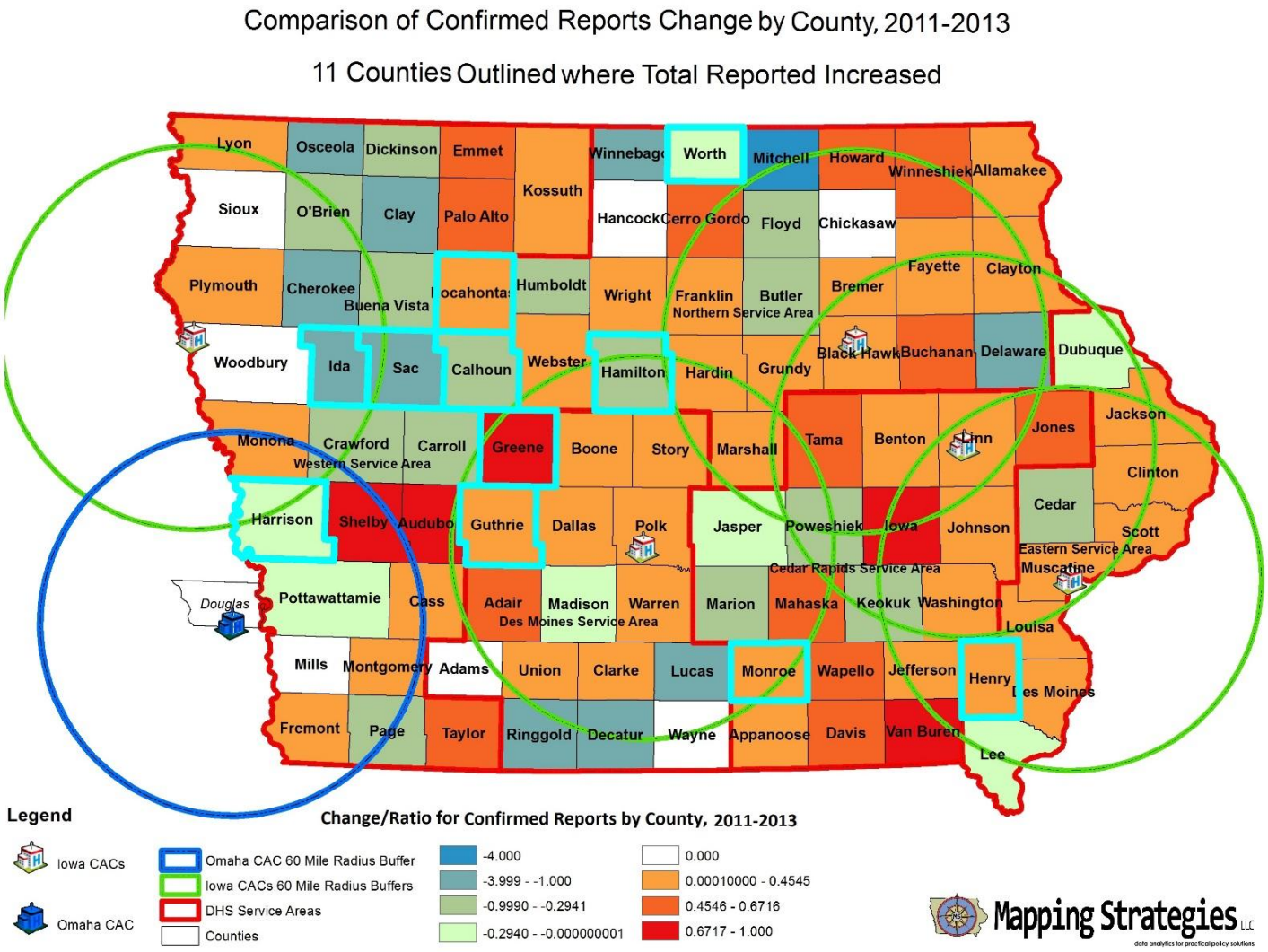


FIGURE 16: CHANGE IN CONFIRMED REPORTS, 2011-2013

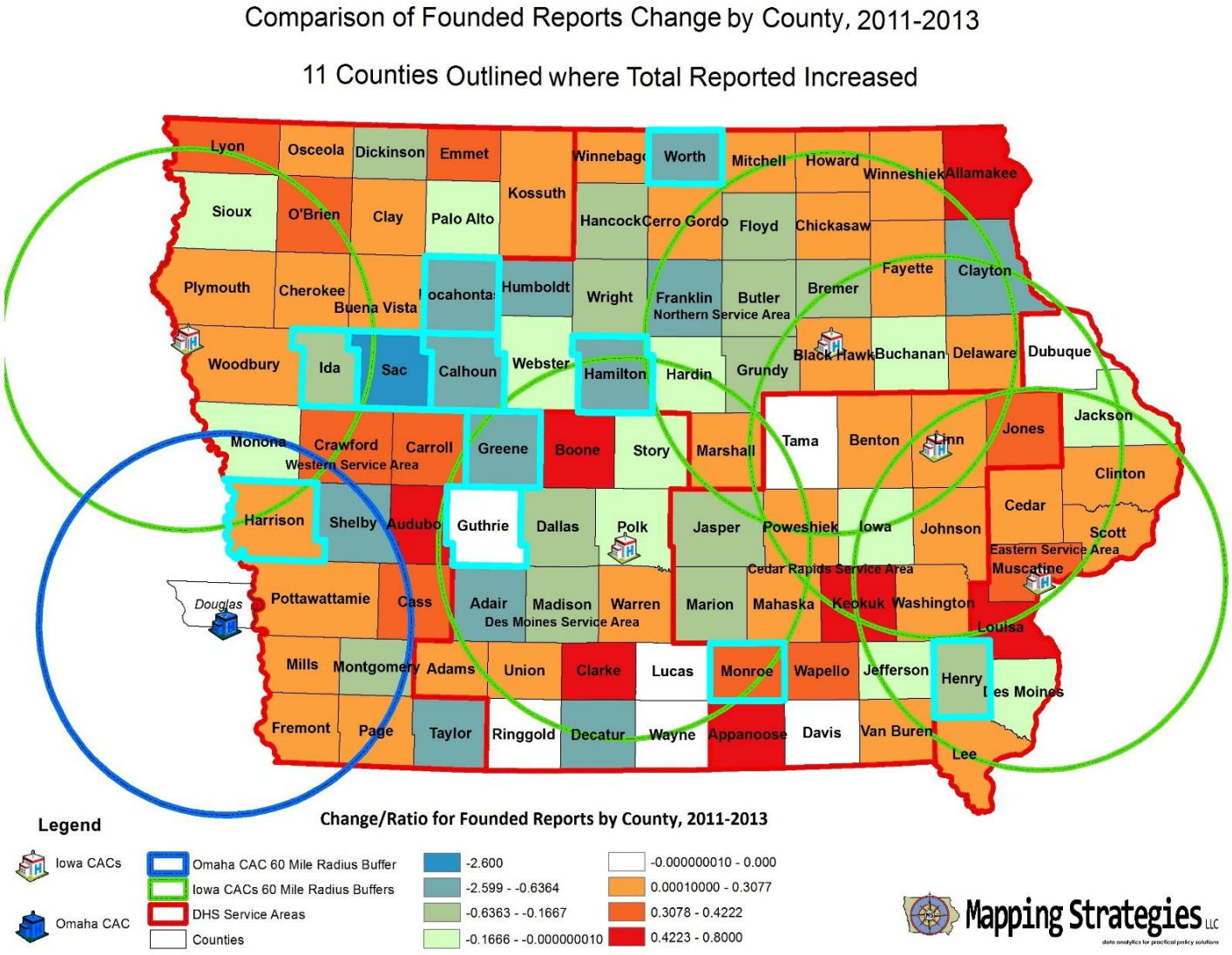


FIGURE 17: CHANGE IN FOUNDED REPORTS, 2011-2013

Allegations by Type

There are ten types of child abuse that were measured by DHS per county. For the purposes of this report, eight categories were analyzed: Denial of Critical Care, the Presence of Illegal Drugs, Sexual Abuse, Physical Abuse, providing Access to Registered Offenders, Mental Injury, Manufacture of Meth, and Allows access to a Registered Offender. Seven out of these eight categories of allegations had recorded and measured instances between 2009 and 2013. Only the allegation type of Allows Access to a Registered Offender was omitted from this Growth assessment because there were no recorded or measured instances. Additionally, types of allegation which fall into an "other" category were also omitted. These include: Bestiality in the Presence of a Minor, Child Prostitution, and Allows Access to Obscene Materials. For the purposes of this analysis, all of the counties were separated into two groups: counties with fewer than 20,000 children (Rural), and counties with more than 20,000 children (Urban). A longitudinal comparison of DHS county-level data was conducted, between 2009 and 2013, and trends were identified where present. Table 2 shows the allegation totals of all abuse types per year for both rural and urban counties.

County Type	2009	2010	2011	2012	2013	Total
Rural	10622	11007	10067	9436	10055	**51187**
Urban	8165	8093	7465	7322	8101	**39146**
Total	**18787**	**19100**	**17532**	**16758**	**18156**	**90333**

TABLE 2: TOTAL REPORTS OF ABUSE BY COUNTY TYPE, 2009-2013

Denial of Critical Care

First, confirmed and founded allegations of Denial of Critical Care were measured. It is worth noting that Denial of Critical Care is the largest category of allegations by far for both Rural and Urban counties, making up 75% of cases in most counties. Within the underserved areas with fewer than 20,000 children (rural counties), the most visible trends came from three counties: Webster, Cerro Gordo, and Wapello. Of these three counties, Webster had the highest count of 308 instances in 2013; Cerro Gordo followed with 306, and Wapello had 207. In counties served by a CAC, the most visible trend came from Clinton County, which had the highest frequencies of reported abuse of all the served counties; however, it was Jasper County that had the highest number of cases of denial of critical care with 332 in 2013. Figure 18 illustrates the five year frequencies and 2013 case counts per rural counties.

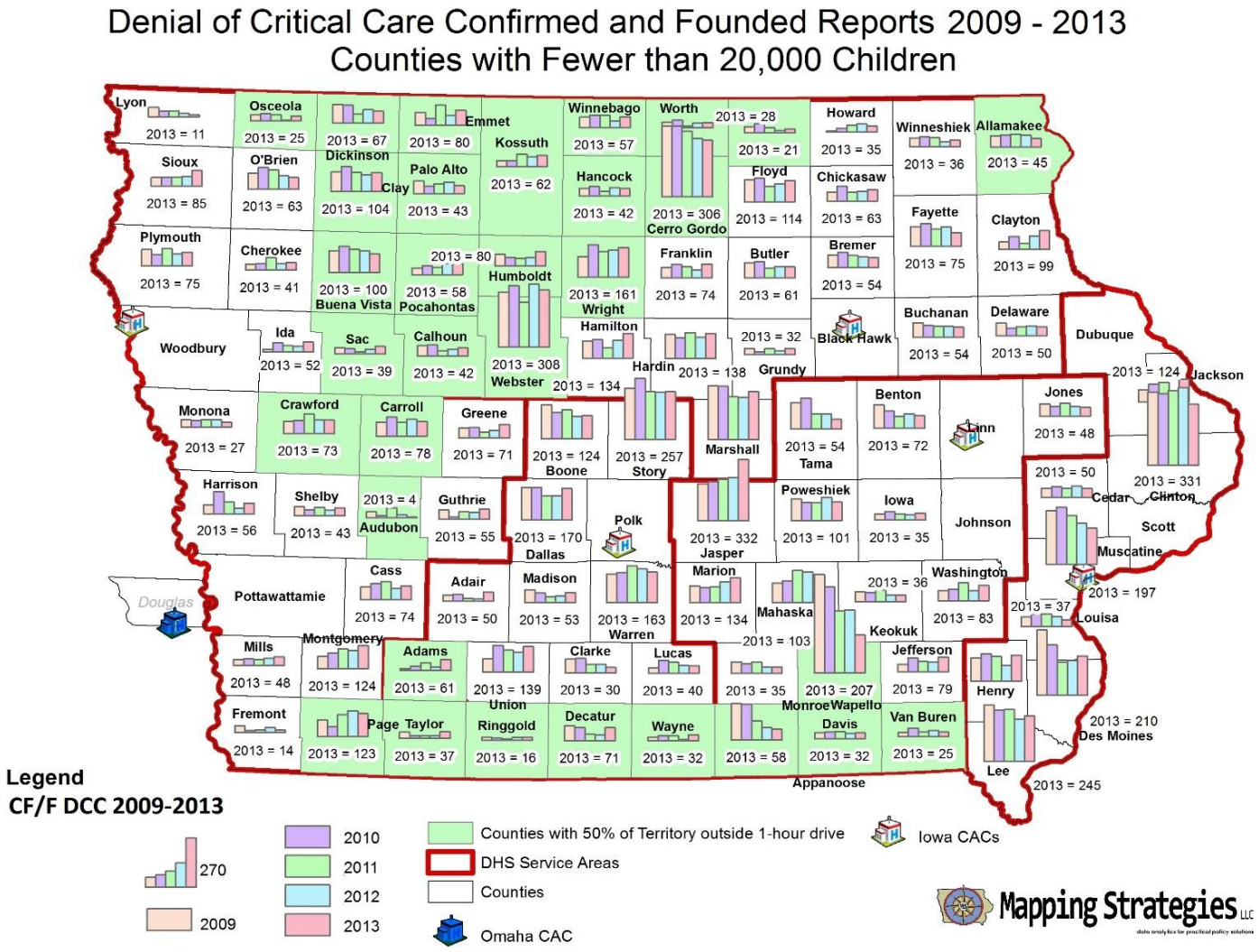


FIGURE 18: DENIAL OF CRITICAL CARE, 2009-2013

While Wright County does not have the highest number of cases of denial of critical care, trends identified within the data are of concern. Between 2009 and 2013, a slight increase in the number of founded and confirmed denial of critical care cases has emerged. Wright County is included in a group of North Central underserved counties with upward trends, including Humboldt County, Pocahontas County, Webster County, Kossuth County, and Emmett County. It should be noted that this trend is not observed in all rural counties. In Eastern Iowa, rural counties Lee, Des Moines, Muscatine, Clinton, Louisa, Cedar, and Jones Counties observed a downward trend over the five years.

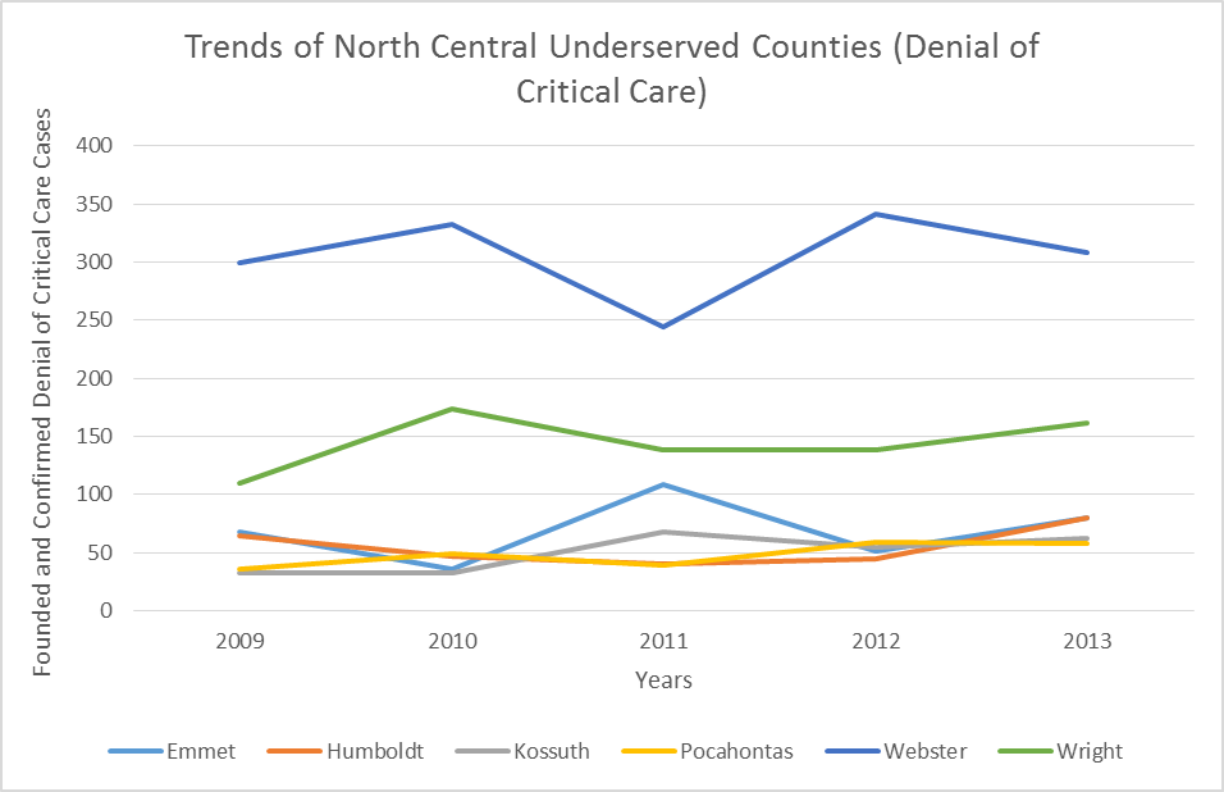


FIGURE 19: TRENDS IN DENIAL OF CRITICAL CARE REPORTS IN CENTRAL UNDERSERVED COUNTIES

It should be noted that none of the underserved counties identified in this assessment are urban, as defined by population of more than 20,000 children.

Presence of Illegal Drugs (PID)

The next case of abuse to be assessed was the Presence of Illegal Drugs in a Child's System (PID). Again, the number of allegations were analyzed according to rural and urban county categories. Of the underserved counties, Cerro Gordo County had both the highest trends over the five years and the highest count of founded reports in 2013, with 39 founded reports. It is followed closely by Webster County, which had 37 incidents in 2013. Nearly all the counties in the underserved North Central Area had an increase in reports over the five years, and for the last measured year of 2012-2013, as illustrated in Figure 20.

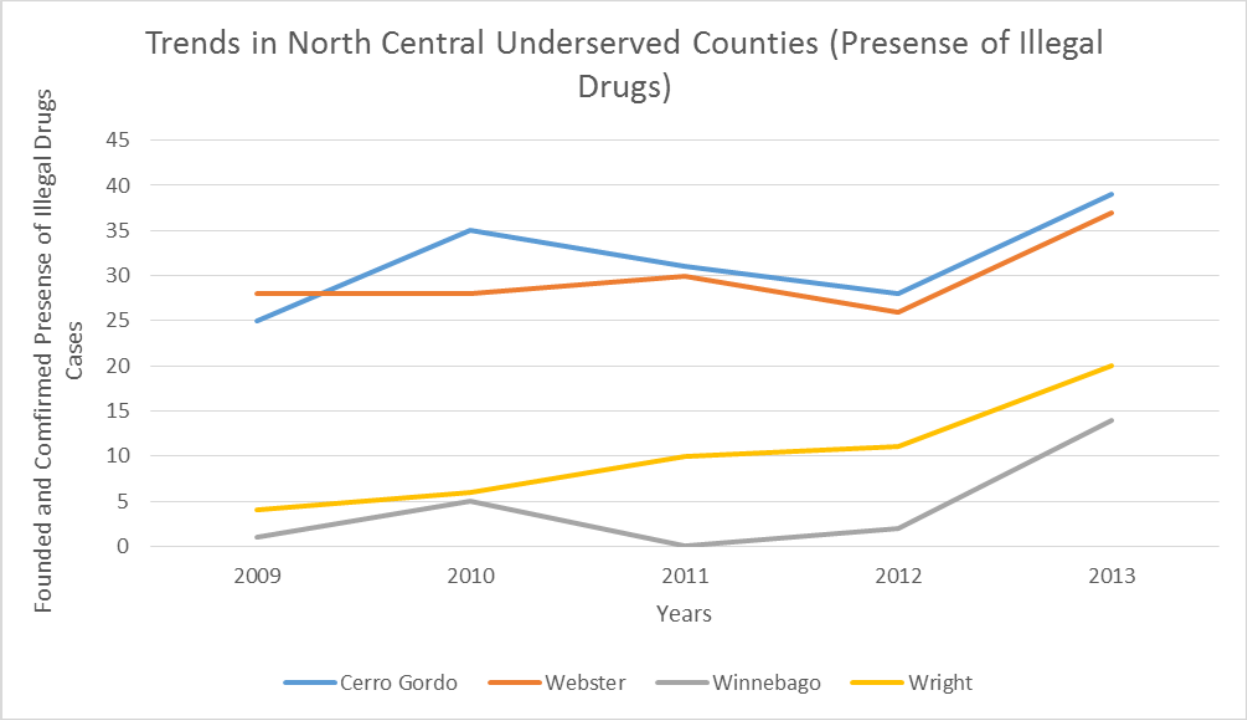


FIGURE 20: TRENDS IN PID REPORTS IN NORTH CENTRAL UNDERSERVED COUNTIES

The most notable increases for the 2012-2013 year were Wright, Cerro Gordo, Winnebago, and Webster Counties.

Figure 21 shows the distribution of cases per rural county over the five year period.

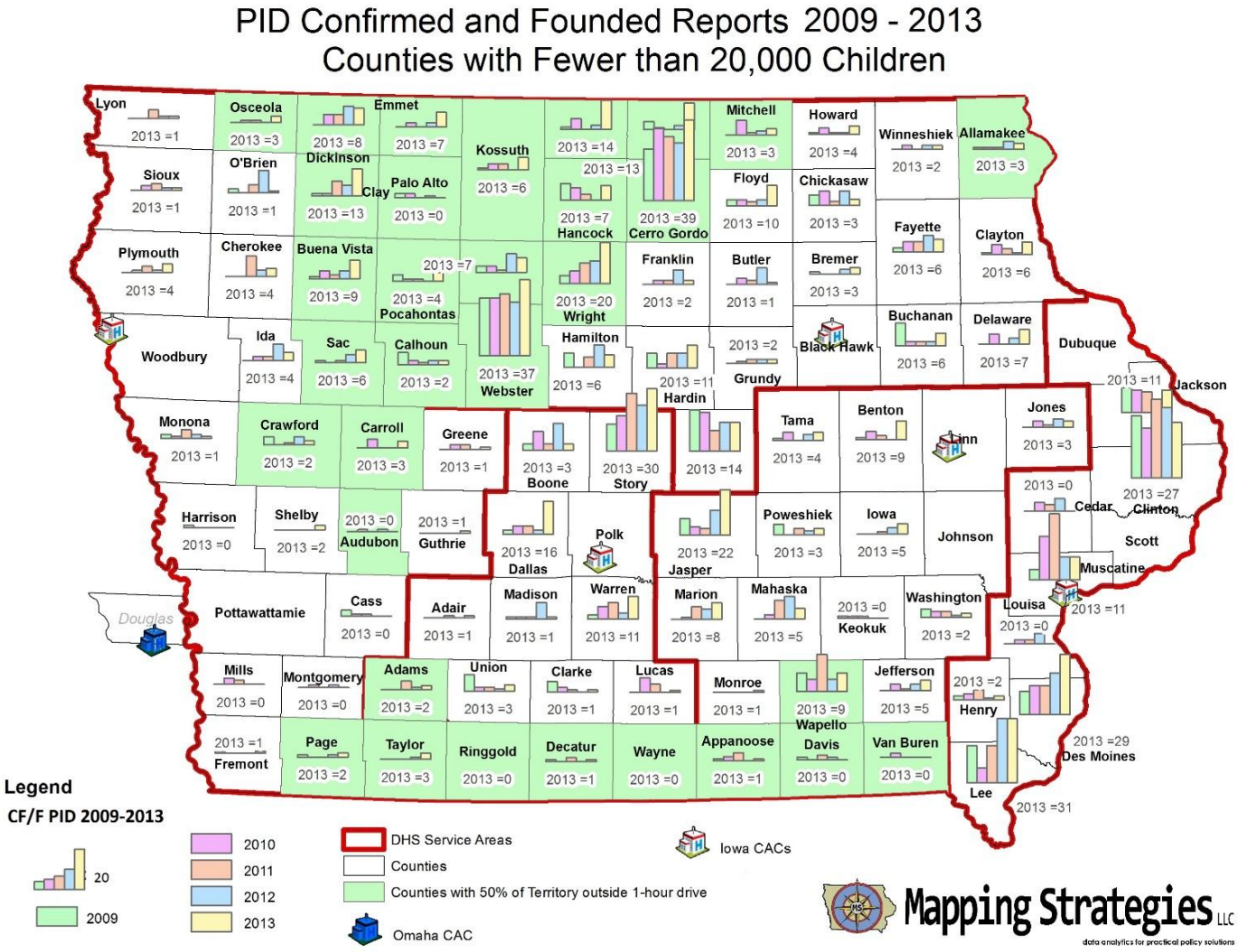


FIGURE 21: RURAL CONFIRMED AND FOUNDED PID REPORTS, 2009-2013

All urban counties reveal an upward trend over time, with the exception of Linn County.

Sexual Abuse

Allegations of sexual abuse were measured in rural and urban counties. Of the underserved counties, the most visible trends over the five years occurred in Webster, Wapello, and Wright Counties; Wright County had the most cases for the 2013 year, with 18 cases in that year. Over the course of the five years, the reports varied greatly over time, with no visible downward or upward trends. It should be noted that in 2012 Webster County reported 22 cases of sexual abuse and Crawford County reported 14 cases of sexual abuse in 2009. Figure 22 illustrates the rural distribution of founded and confirmed cases.

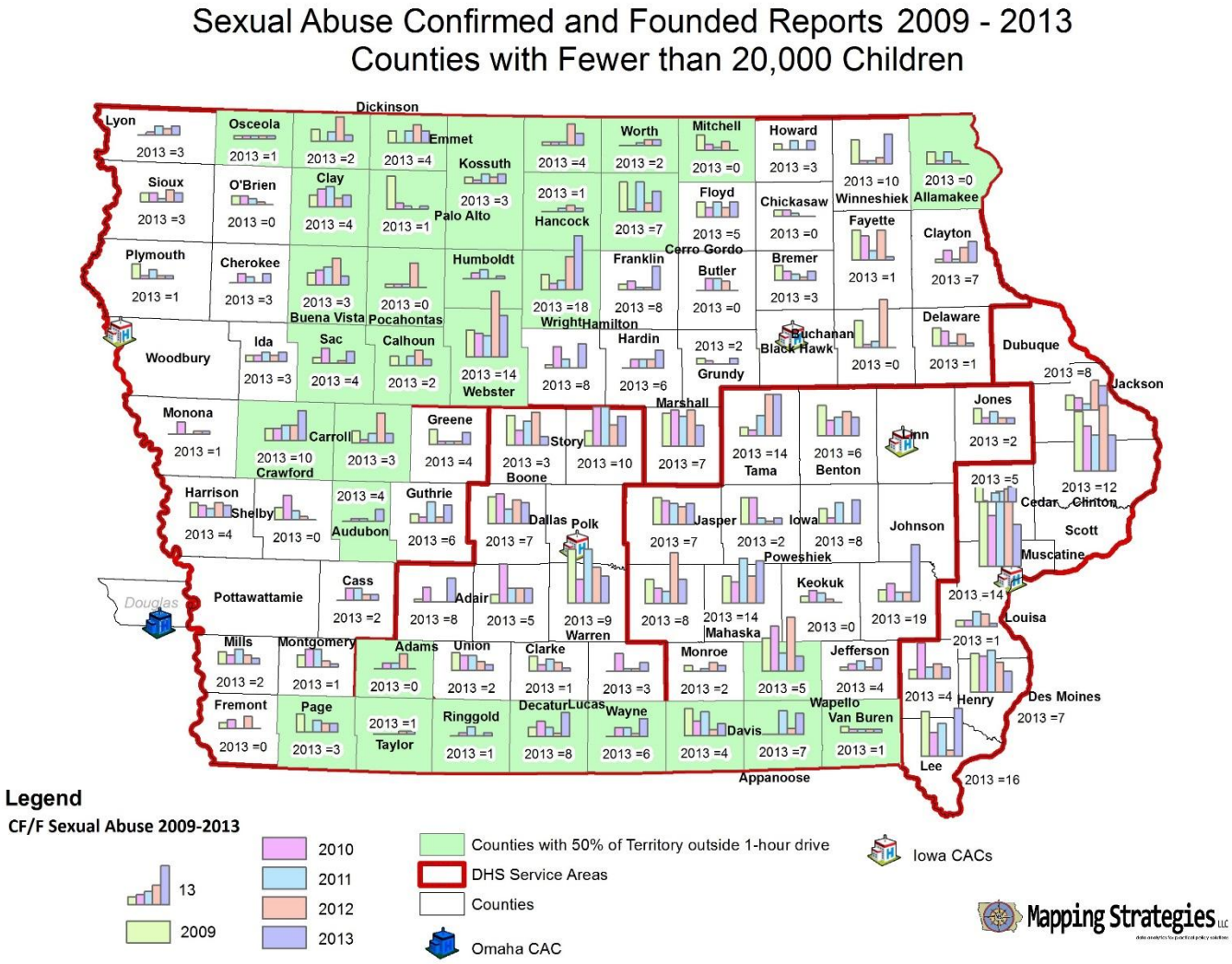


FIGURE 22: RURAL SEXUAL ABUSE CONFIRMED AND FOUNDED REPORTS, 2009-2013

The urban counties experienced a similar outcome with varied levels of cases over the five years. The most visible trend of the urban counties was Woodbury, which had an upward trend, from 16 incidents in 2009 to 38 incidents in 2013.

Physical Abuse

The number of physical abuse allegations in the rural counties seemed to show a spike in case numbers from 2009-2012, and then a gradual decline into 2013. The Eastern DHS Service Area contained the most counties experiencing high case numbers throughout the five years. In the underserved North Central and South Central counties, the highest levels of physical abuse cases occurred in Webster, Wapello, and Cerro Gordo; Cerro Gordo retaining the highest number of cases for 2013 in underserved counties. In regards to all counties, the most alarming statistics were shown in Central and Eastern Iowa, with high numbers indicated across the counties on Iowa's eastern border, and in Central Iowa's counties of Dallas, Story, and Marshall. However,

it can be noted that there is an apparent decline in numbers throughout the five years. Figure 23 illustrates the distribution of physical abuse confirmed and founded reports by county.

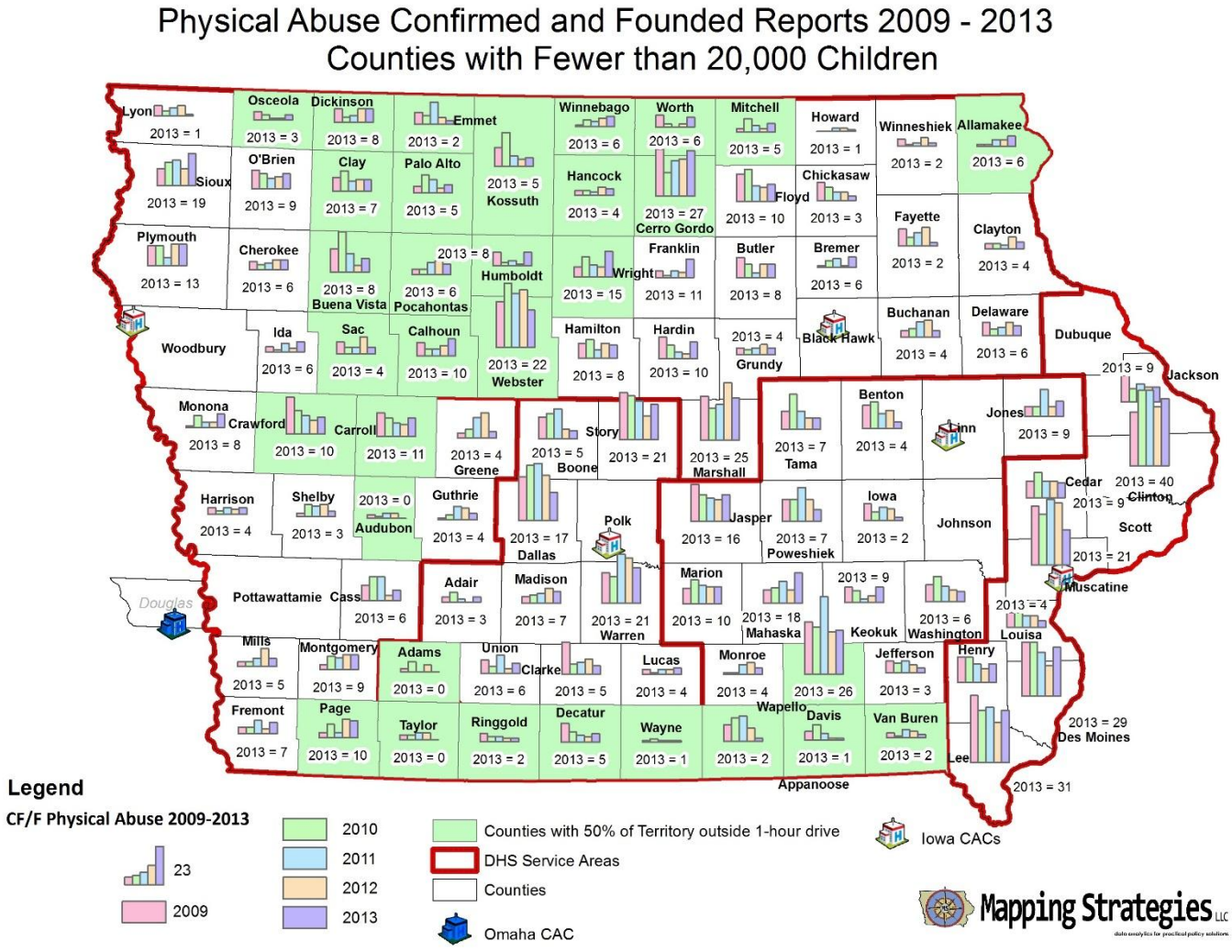


FIGURE 23: RURAL PHYSICAL ABUSE CONFIRMED AND FOUNDED REPORTS, 2009-2013

In the urban counties, Polk County had the highest count of cases for 2013, had a continued increase through four of the five years, and had the highest case numbers across the five years. Woodbury and Scott Counties also experienced an increase in case numbers throughout the five years; however, urban counties as a whole experienced trends closer to rural concentrations, with little change in the five year timeline.

Access to Registered Offenders, Mental Injury & Manufacture of Meth

The final three categories received the fewest confirmed and founded allegations per county. As a result, urban and rural counties were aggregated for analysis. The first type of abuse, allowing access to the child by someone on the sex offender registry, was recorded to have 258 confirmed

and founded cases in 2010 for the State of Iowa. Reported case numbers were lowest in the North Central underserved counties compared to the rest of the State; with the most active county being Webster, and only having a maximum of seven cases. Many counties in both the North Central and Southern underserved counties had few cases, and sometimes zero, reported throughout all five years.

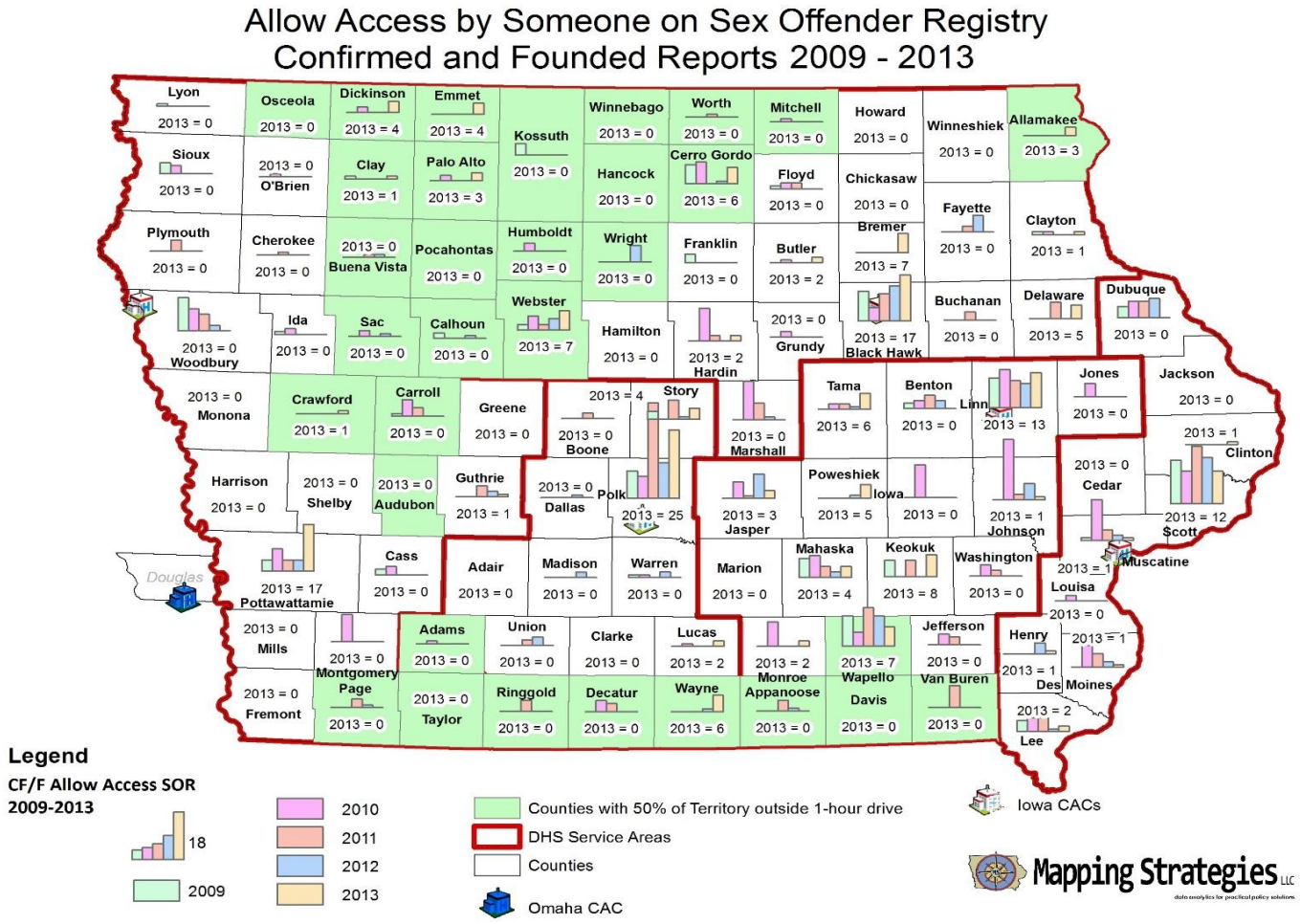


FIGURE 24: RURAL ACCESS BY SEX OFFENDER REGISTRY CONFIRMED AND FOUNDED, 2009-2013

Confirmed and founded allegations of mental injury were virtually nonexistent in all underserved counties, and having 165 recorded cases throughout the five years. The most active trend over the five year period in the underserved counties happened in Wapello County; with between two and three cases reported from 2009-2011, but zero reports occurring in 2012 and 2013. Polk County held the most reports for 2013, with 13 cases reported; however, the most active trend over the five year period in the served counties occurred in the Cedar Rapids and Eastern Service Areas. Johnson County was the only one to experience an upward trend in cases throughout the five year period. In the instances of mental injury, confirmed and founded reports on the abuse only happened in counties within one hour's travel time to CACs.

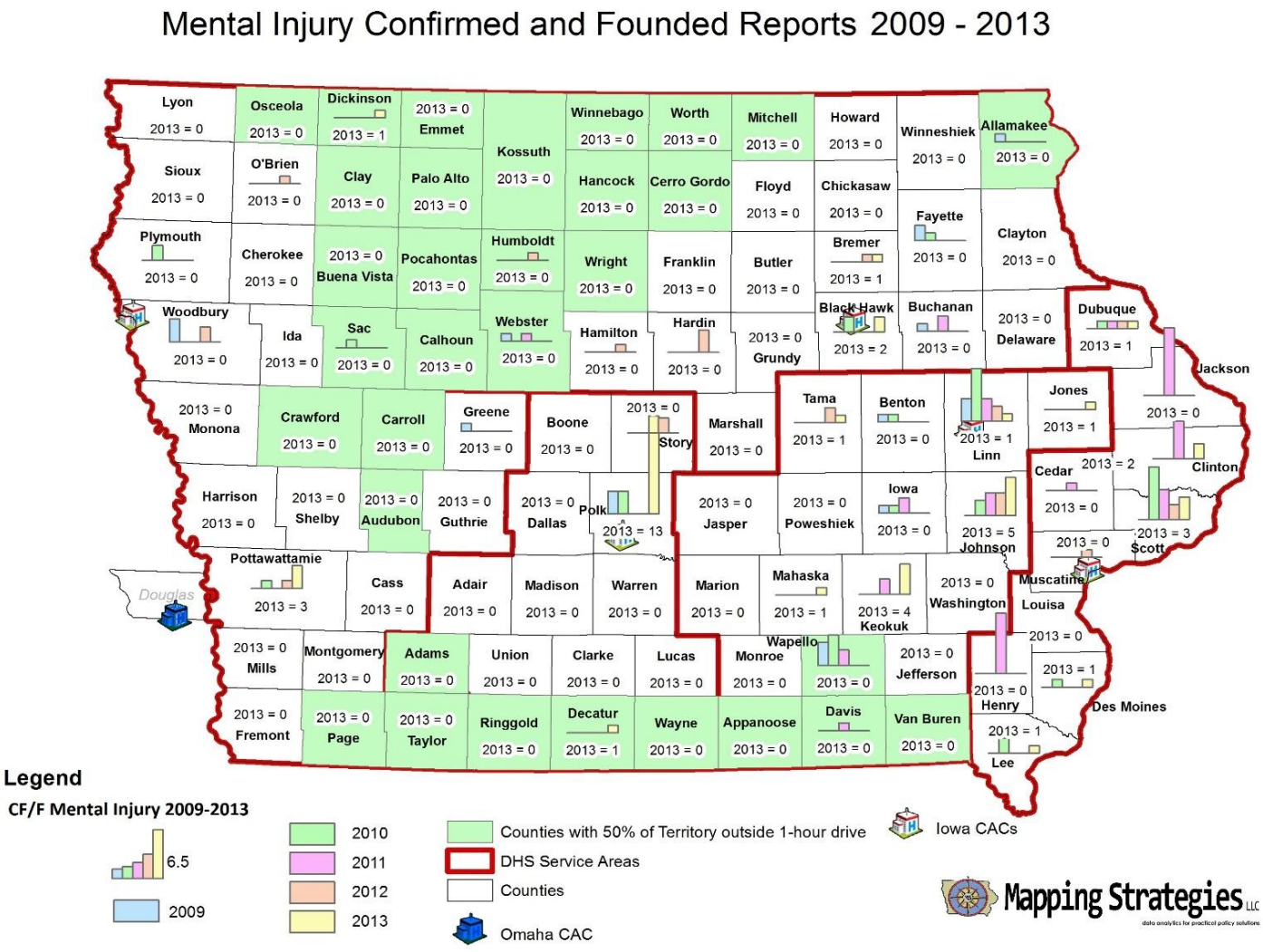


FIGURE 25: RURAL MENTAL INJURY CONFIRMED AND FOUNDED REPORTS, 2009-2013

Lastly, the manufacture of meth was measured across Iowa, with 758 confirmed and founded cases reported statewide from 2009-2013. Again, the count of confirmed and founded reports of this offense were relatively low compared to physical abuse, sexual abuse, and denial of critical care; but case numbers were visibly more prominent than mental injury and access by sexual offenders across all counties. Of all the underserved counties, Sac and Decatur Counties had the most cases for 2013, with six each. However, the most active across the five years was Webster County, seeing a fluctuation in the number of cases each year. Of all Iowa counties reporting cases of the manufacture of meth, Lee County experienced the highest fluctuating numbers in cases across the five years, but Scott County retained the highest number of cases in 2013 with 29 reports of the manufacture of meth. Linn County is also observed to have had a relatively steady amount of cases each year, seeing a drop and then increase of cases every other year.

Overall, confirmed and founded reports of the manufacture of meth seemed to cluster in different areas during different years.

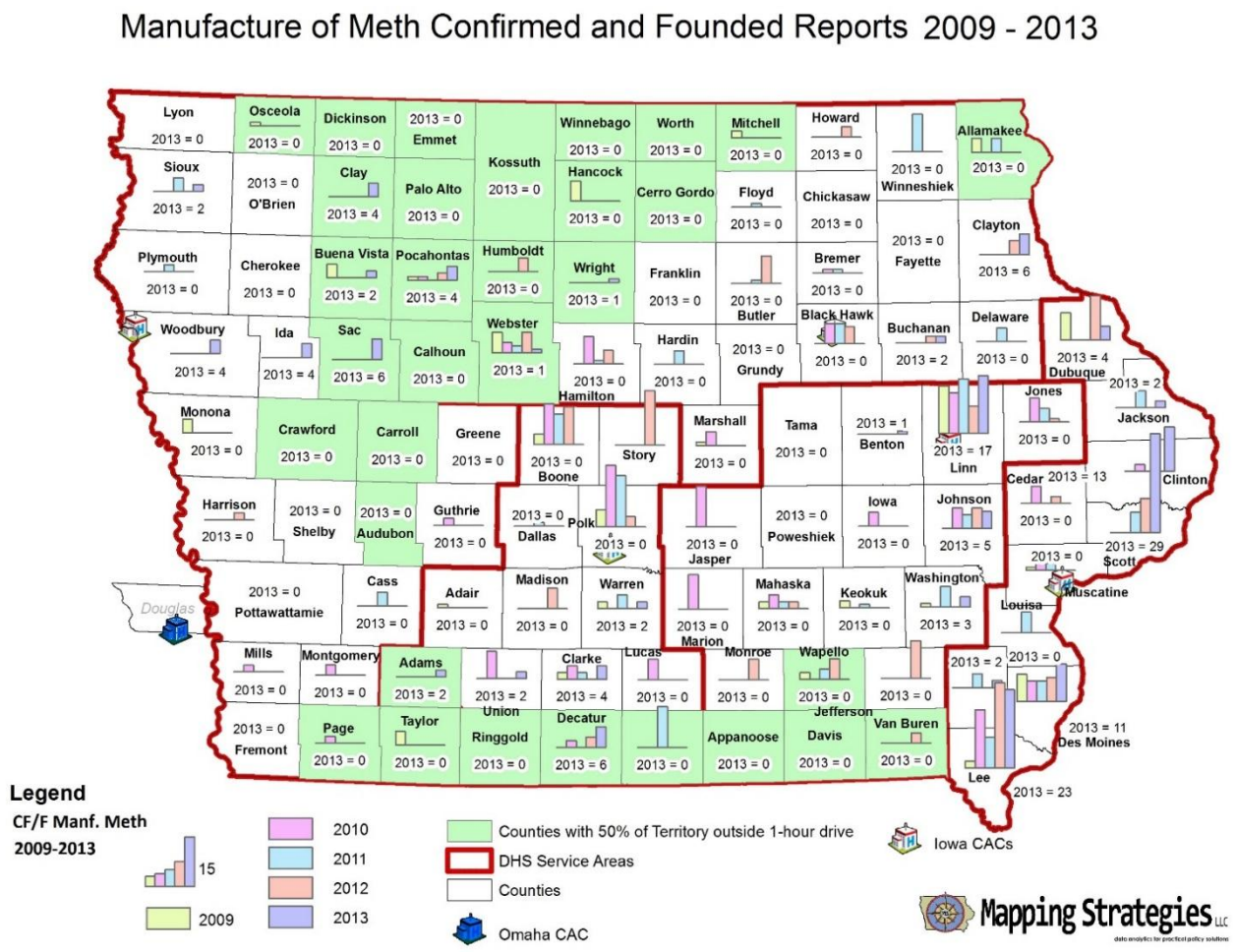


FIGURE 26: MANUFACTURING OF METH CONFIRMED AND FOUNDED REPORTS, 2009-2013

AGE

Abuse statistics may also be calculated according to rate of abuse according to the child population; defined as children age five and under. Rates were calculated according to the child population, age five or under, of the 2010 census. Several counties with high rates of abuse for children age five and under were located in areas identified as underserved by existing CACs. Figure 27 shows the rate of cases per 1000 children five and younger. Table 3 shows a list of counties with 30 confirmed and founded cases per 1,000 children five or younger, with underserved Northern Counties highlighted.

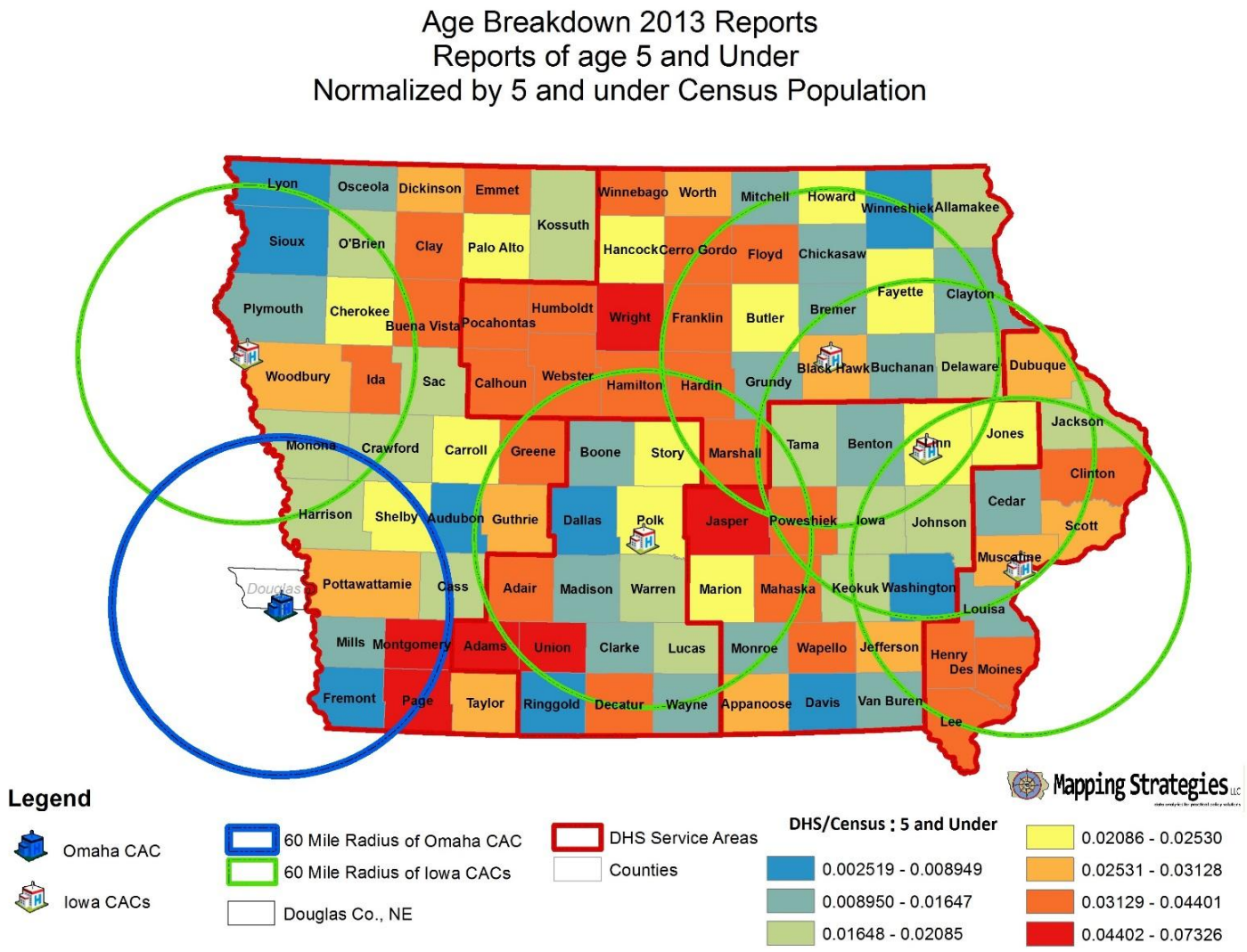


FIGURE 27: CONFIRMED AND FOUNDED REPORTS BY AGE, 2013

County	Confirmed and Founded Cases per 1,000 Children Age 5 and Under
Adams	73
Montgomery	55
Union	51
Wright	50
Jasper	46
Page	46
Ida	44
Floyd	42
Lee	42
Webster	41
Cerro Gordo	39
Hamilton	38
Emmet	38
Pochahontas	38
Decatur	37
Franklin	36
Calhoun	36
Clay	35
Clinton	35
Mahaska	35
Henry	35
Poweshiek	35
Marshall	34
Wapello	34
Buena Vista	33
Humboldt	33
Hardin	33
Adair	33
Des Moines	33
Winnebago	32
Greene	32
Jefferson	31

TABLE 3: COUNTIES WITH MORE THAN 30 CONFIRMED AND FOUNDED CASES PER 1,000 CHILDREN AGE 5 AND UNDER[4], 2013.

UNDERSERVED COUNTIES

[4] Calculated per 1,000 children under age five according to 2010 Census data

Community Needs

Using the rationale of the one-hour guidance, 60,229 children under the age of 18 currently reside in counties which are underserved by existing CACs in Iowa and Nebraska (Omaha). Analysis of abuse data indicate that the area most in need of services is North Central Iowa, containing the majority of underserved counties. While denial of care is the largest category of child abuse cases in Iowa, incidents of this type of child abuse form an upward trend in the underserved counties of North Central Iowa. PID cases are trending upward overall, including in underserved areas, while sexual abuse cases are concentrated in various spots in underserved areas. Lastly, underserved areas experienced an increase in physical abuse cases between 2009 and 2013. Confirmed reports in 2013 were at a high rate, and cases involving children five and under were also at a high rate for 2013. Additionally, it can be seen that the counties where cases involve children five and under are within underserved areas. Observing these reported facts, it can be rationalized that there is a need, specifically in the underserved areas of North Central Iowa.

In order to better understand community needs, an online survey instrument was created and administered in order to assess whether local community members and child advocates felt that child advocacy services were needed and if a child advocacy center would be supported.

Survey Results

The Iowa Department of Human Services identified SAMS (Service Area Managers) in the underserved areas to distribute surveys electronically to a variety of service providers and/or multi-disciplinary team members within their assigned counties. Service providers included representatives from Law Enforcement, Department of Human Services Personnel, Legal Service Providers, Medical Care Providers, Mental Health Personnel and other Community Agencies and Members. The survey was administered during December 2014 to child advocates and community members in the following six counties: Carroll, Cerro Gordo, Davis, Wapello, Webster, and Wright. A total of 36 surveys were collected. Results of these surveys are considered a preliminary exploration into community support for establishing a Children's Advocacy Center in underserved areas.

Survey results were aggregated into two main groups, or regions, according to the county location of each survey respondent. The *North Central Iowa* region had 83.3%, or thirty, of the total surveys completed from child advocates of four counties, including Carroll, Cerro Gordo, Webster and Wright. *Southern Iowa* results represented 16.7%, or six, of the total surveys completed from child advocates from two counties, including Davis and Wapello.

The growth assessment survey consisted of sixteen questions, including questions to assess level of agreement, rate of occurrence, type or category. Six of these survey questions offered the

option for additional open-ended responses, which were coded to summarize group themes. Survey items ranged from questions regarding the service provider's knowledge of the Child Advocacy Center (CAC) Model, to current utilization of CAC services, to potential benefits from more localized access.

Child Advocacy Center Current Knowledge and Processes

A total of seven survey items assessed the survey participants' role as a child advocate, their knowledge of the Child Advocacy Center (CAC) model, and current processes for child abuse investigations being utilized within their county or region.

A vast majority of survey respondents (90% in *North Central Iowa* and 100% in *Southern Iowa*) responded that they were familiar, or somewhat familiar, with the CAC services and model. The CAC model includes formation of a multidisciplinary team (MDT) of service providers. When asked whether their county has an active MDT, 66.6% of *North Central Iowa* respondents agreed or strongly agreed, while 50% of *Southern Iowa* respondents agreed or strongly agreed. In both groups, 16.7% responded (5 *North Central Iowa*, 1 *Southern Iowa*) that they were unaware of whether their county did or did not have an active MDT.

Survey respondents were asked what their primary role as a child advocate was. Table 4 illustrates the breakdown of provider roles for the *North Central Iowa* (NCI) respondents and *Southern Iowa* (SI) respondents.

	DHS	Law Enforcement	Legal Service Provider	Medical Care Provider	Mental Health Personnel	Other Community Agency	Other Community Member
NCI	33.3% (10)	6.7% (2)	10% (3)	0% (0)	10% (3)	30% (9)	10% (3)
SI	66.7% (4)	16.7% (1)	0% (0)	0% (0)	0% (0)	16.7% (1)	0% (0)

TABLE 4: SURVEY RESULTS, PRIMARY ROLE AS A CHILD ADVOCATE

In *North Central Iowa* 40% (12) of survey participants identified themselves as a Community Member or representative of a Community Agency. Descriptions for Community Members and/or Agencies included: Juvenile Court Services, Judge, Family Resource Centers, Social Service Agency, Local Advocate, FSRP Provider, Youth Employment Program, Child Care Resource and Referral.

Survey participants were asked regarding the current agencies providing services specific to interviewing and performing exams in possible child abuse cases. Providers of this service were

listed by role and/or location. Individual survey responses varied greatly, with the majority of survey participants providing multiple examples (2 or more) of service providers. While local providers included the Department of Human Services, Child Protective Workers, and Law Enforcement., Child Advocacy Centers (CACs) were most often referenced, and with particular emphasis on being utilized as a resource for interviews and exams associated with certain types of abuse, including sexual abuse or physical abuse. Table 5 gives an overview of service providers utilized according to *North Central Iowa* survey results and *Southern Iowa* survey results.

North Central Iowa Service Providers		Southern Iowa Service Providers	
Regional/Blank CPC-DSM	10	St. Luke's CPC-CR	4
DHS-general	8	Regional/Blank CPC- DSM	3
Allen CPC-Waterloo	7	DHS-general	3
Project Harmony-CB	7	Other: "CACs out of county"	3
Mercy CAC-SC	7	Law Enforcement-general	1
Other:	6	Iowa City (Dr. Oral)	1
Unknown	5	Local Medical Professional	1
Law Enforcement-general	3		
St. Luke's CPC- CR	2		
Iowa City	1		
Local Doctor	1		
"Dr. Behr"	1		

TABLE 5: SERVICE PROVIDERS UTILIZED FOR CHILD ABUSE INTERVIEWS AND EXAMS

Survey participants were asked to describe the level of efficiency of the current process used in their county to investigate child abuse cases. Almost 67% (4 out of 6) of *Southern Iowa* survey participants responded with Very Efficient or Mostly Efficient compared to 57% (17 out of 30) from *North Central Iowa*. Three *North Central Iowa* survey participants felt the process was Not Efficient while one participant was unsure. Additionally, when asked "How successful is the current process utilized in your county to investigate child abuse cases," both regions provided positive results with *Southern Iowa* showing 100% positive response compared to *North Central Iowa's* 83.3% positive response.

Current Utilization of Child Advocacy Centers

Two survey items measured the use of Child Advocacy Centers in relation to how often they are accessed in the investigative process for child abuse and for what particular types of abuse referrals are made to CACs.

Survey participants were asked, "What rate of child abuse cases in your county are referred to a CAC?" Answers were provided on a five-point Likert scale which ranged from "All of them" to "None of them". While there were no responses which indicated "All of them" nor "None of them" in either region, over 50% of responses for both the *North Central Iowa* and *Southern Iowa* groups included "Some of them" or "Few of them."

For survey participants who answered "Some, Few, or None" regarding the number of child abuse cases referred to a CAC an open-ended follow up question provided an opportunity to further explain their answer. *Southern Iowa* survey respondents provided two open-ended responses which stated that all sex abuse cases were referred to CAC's, and that on occasion, physical abuse assessments were referred. It was also referenced that a lack of referrals made to CAC's was *"due to the travel distance of two hours to the nearest CAC".*

Seventeen survey participants in *North Central Iowa* provided comments which were coded to identify three themes, including: Referral of Sexual or Physical Abuse Cases, Travel Barriers and Unknown/Speculative reasons. Almost 60% of *North Central Iowa* survey respondents gave explanations of how the severity and type of case made a difference in whether a referral was made to a CAC.

"Many allegations that are not physical or sexual abuse are handled locally."

Respondents stated that a majority of cases are neglect or denial of critical care which do not require a forensic interview, but "*virtually all sex abuse cases go to a CAC*," and many CACs are consulted for physical abuse cases. Various members of multi-disciplinary teams, such as Law Enforcement or Child Protective Workers, were named as the person(s) responsible to make official referrals to CACs. Table 6 details the types of abuse referred to CAC, by region.

TYPES OF CHILD ABUSE	North Central Iowa (n=30)	Southern Iowa (n=6)
Denial of Critical Care	20%	0%
Presence of Illegal Drugs in the Child's System (PID)	13.3%	16.7%
Sexual Abuse	93.3%	100%
Physical Abuse	53.3%	16.7%
Mental Injury	16.7%	16.7%
Manufacture of Meth	13.3%	0%
Other	1	0

TABLE 6: CAC REFERRALS BY TYPE OF ABUSE

Further responses for survey participants, who answered "Some, Few, or None" in regards to the rate of referrals made to a CAC mentioned Travel as a significant deterrent. Comments included:

- *"They are a long distance away."*
- *"There is a lack of desire by law enforcement to travel to another location."*
- *"It is not feasible to go for every case due to travel time. I have to travel several hours to get to any CAC."*
- *"Due to distance and availability of scheduling."*
- *"Only refer sex abuse cases at this time. If a CAC were closer it may be increased to other cases such as physical abuse."*

Finally, several *North Central Iowa* respondents stated they were unsure why referrals were not made to CACs, and made speculative statements as to why. Two responses stated that 'differential response' has made an impact on child abuse while one response stated that "*reports are rejected when they should be looked into."*

Needs and Benefits for County-Level Child Advocacy Centers.

Survey participants were asked to rank their level of agreement with the statement, "Our county would benefit from a Children's Advocacy Center" on a four point Likert Scale of agreement. All six, or 100%, of *Southern Iowa* survey participants "Agreed" or "Strongly Agreed" their county would benefit from having a local CAC while 28, or 93.3%, of *North Central Iowa* responses Agreed or Strongly Agreed.

Similar results were produced when survey participants were asked if they would like to see a CAC located in their county. 100% (6) of *Southern Iowa* survey participants and 86.6% (26/30) of *North Central Iowa* participants "Agreed" or "Strongly Agreed" they would like to see a CAC located in their county. The remaining 4 (13.3%) Northwest Iowa participants answered that they were not sure at this time.

Survey participants from both the *North Central Iowa* region and the *Southern Iowa* region shared numerous responses regarding the advantages, and some disadvantages, of locating a Child Advocacy Center in their county. Comments were coded to identify themes, which were consistent among both regions. These themes included: Travel, Services and Access, and Money.

North Central Iowa had 30 survey participants provide 50 comments on the advantages and disadvantages of having a local CAC in their county. The majority, or 48% (23), of their responses referred to the topic of Travel. Travel was mentioned most frequently as a barrier for utilizing CACs due to the time, cost and distance from the child advocates county. The far distance and/or amount of time to travel to and from a CAC was mentioned within all 23 comments on travel. Respondents shared that a local CAC would be advantageous not only for the child/family involved but also for law enforcement and DHS personnel. Statements included

- *"It would reduce travel time for law enforcement for the transport of victims."*
- *"It would prevent barriers for families that do not have transportation or have to take extra time off work for the travel to another county."*
- *"Currently our children and families have to travel quite a distance and this can also lead to additional trauma for the child."*
- *"Right now, children and families have to travel a considerable distance to access the CAC. Due to transportation issues, many never make it there."*

Related advantages that were given included community agencies and families saving money by traveling less, and having quicker, more efficient access to services. As one person, whose county is a two hour drive (one-way) to the nearest CAC, stated *"Interviews and evaluations that are completed are very valuable in determining what type of trauma a client has experienced,*

and what services will best meet the needs to become healthy and sustainable." Further comments stated that in addition to increased access to local services, necessary interviews and exams could occur "sooner," and community partnerships would be strengthened through the participation in professional working relationships between law enforcement, DHS and collaboration with local providers. Two disadvantages mentioned pertained to concerns in the region maintaining a consistent level of use to support a local CAC, and maintaining fidelity, or the level of professional skills for both medical exams and forensic interviews by staff. Overall, North Central Iowa survey responses were positive in response to listing advantages in locating a CAC in their county. As one response read, *"It would be a resource to advocate for abused children and help give them a voice."*

Southern Iowa had six survey participants provide eight comments on the advantages of having a local CAC in their county. Four responses referred to the topic of Travel, again, as a barrier for utilizing CAC's due to the time, cost and distance from the child advocate's county. One respondent stated that the two nearest CACs both required 2 hours of travel for families to reach. Three responses detailed the improvement of services and access to services through having a local CAC, resulting in more children being seen to help ensure their health, safety and welfare. Funding limitations of families, specifically around transportation costs, was also mentioned as a limitation that could be addressed by having a CAC closer to those families in need. No disadvantages were given.

When asked how often a CAC would be utilized for investigation into cases of child abuse, if a CAC were put into their county, 60% (18/30) of *North Central Iowa* responses were "All of the time" or "Most of the time" and 23.3% (7/30) were "Unsure." Half of *Southern Iowa* results were "All of the time" or "Most of the time." See Table 7 for details.

	All of the time	Most of the time	Some of the time	Not at all	Unsure
NWI	16.7% (5)	43.3% (13)	16.7% (5)	0% (0)	23.3% (7)
SI	16.7% (1)	33.3% (2)	50% (3)	0% (0)	0% (0)

TABLE 7: SURVEY RESULTS POTENTIAL CAC USE

Survey participants were asked to determine how supportive area service providers would be of establishing a CAC in their county. Table 8 shows 100% of *Southern Iowa* service providers ranked as "Supportive" or "Highly Supportive" while *North Central Iowa* rankings showing more variance.

	Region	DHS Personnel	Law Enforcement	Legal Service Provider	Mental Health Personnel	Other Community Agencies	Other Community Member
# Responses		*30/6*	*30/6*	*29/6*	*29/6*	*29/6*	*29/6*
Highly Supportive	NWI	46.7% (14)	63.3% (19)	48.3% (14)	41.4% (12)	34.5% (10)	31% (9)
	SI	100% (6)	83.3% (5)	100% (6)	100% (6)	100% (6)	100% (6)
Supportive	NWI	36.7% (11)	26.7% (8)	34.5% (10)	41.4% (12)	41.4% (12)	6.9% (2)
	SI	0% (0)	16.7% (1)	0% (0)	0% (0)	0% (0)	0% (0)
Unsupportive	NWI	3.3% (1)	0% (0)	0% (0)	3.4% (1)	0% (0)	0% (0)
	SI	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Highly Unsupportive	NWI	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
	SI	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
Unsure	NWI	13.3% (4)	10% (3)	17.2% (5)	13.8% (4)	24.1% (7)	27.6% (8)
	SI	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)

TABLE 8: SURVEY RESULTS LEVEL OF LOCAL SERVICE PROVIDER SUPPORT

Survey participants were asked to list any possible resources (human or fiscal), in their county that would support the establishment of a CAC. The *North Central Iowa* region had 30 responses with just under half responding they were unsure, or did not know, of specific resources. DHS and/or Decat was listed 9 times, FSRP Providers twice, and Medical Staff and the United Way mentioned once. Southern Iowa had six responses, all of whom listed Local Agencies as a resource. Specific agencies or description of agencies included Children & Families of Iowa, Child Alliance, and several different services that are part of the Davis County prevention against child abuse organization. In addition, Child Health Specialty Clinics were listed three times, DHS twice, and one reference to Law Enforcement. Two responses included Financial Support as an available resource as well.

Child advocates were provided the opportunity to share any additional comments in their survey responses. Nine responses were given with the majority reiterating that there was a need for a CAC, or CAC type services, in their local or nearby county. One response stated, *"The counties I serve would certainly benefit from a CAC. I would like children to be seen at a CAC as soon as determined necessary so that the trauma/fear can be addressed as soon as possible. This will allow the child to commence "healing" as soon as possible and law enforcement (if involved) to keep its investigation running smooth."* Specific needs mentioned included having a high volume of CINA cases. Specific counties listed included, Carroll County, Cerro Gordo, Wapello and Webster. Lastly, one comment was a request for an in-service on CAC's which they felt would be beneficial to community agencies as laws and regulations change often.

Overall, CACs receive referrals from underserved areas primarily for sex abuse cases and severe physical abuse cases. Survey respondents identified travel as a predominant deterrent in utilizing a CAC for both service providers (i.e. law enforcement, medical staff) and clients. The majority of survey respondents in *North Central Iowa* and *Southern Iowa* stated they like the idea of having a CAC located closer to them and/or would utilize a CAC located in their county. Finally,

over 90% of respondents could identify two or more resources within their community that would support the existence of a CAC.

RECOMMENDATIONS

The Iowa Chapter of Children's Advocacy Centers will utilize the results of this growth assessment to inform and guide its support of efficient growth for any additional CPC's and/or satellites in Iowa, taking into account the need for services in the state and the most efficient use of state and local dollars in providing those services. This assessment clearly identified the scope of existing services provided by current CACs in the state of Iowa. It also identified unmet needs for CAC services in rural areas of the state which fall outside of the parameters of the "one hour recommendation." The national standards for accreditation say that the CAC has to be readily accessible to CPC clients and MDT members so the one hour driving distance has become an industry standard and common practice. The results of the underserved area surveys, used as a component of this assessment, indicate that respondents in these areas are supportive of a CAC, would utilize a CAC, and can identify community resources and partnerships which may support establishment of a CAC. Given this, the following recommendations for action are made:

- This report should be broadly disseminated to partners, state agencies and legislators. Provision of this report to interested stakeholders may increase understanding of both child abuse and CAC service provision in, and beyond, the state of Iowa.
- Through partnership with a local community, the state, and the ICCAC and individual CAC's, establish a Children's Advocacy Center in North Central Iowa. Consideration should be given to which CAC model will be the "best fit" for community needs and resources. Given this initial data analysis, it is recommended that strong consideration be given to establishing a satellite CAC which may then be expanded upon given demonstrated need and use. A satellite CAC is defined by NCA as a "child-friendly facility offering onsite forensic interviews and victim advocacy services under the sponsorship and oversight of an NCA Accredited Children's Advocacy Center. Such satellites must also have the capacity for medical and mental health services either on-site or through linkage agreements."
- ICCAC should establish a workgroup to further explore the needs and benefits of establishing a satellite CAC in Southern Iowa. The workgroup will allow for more formal collaboration and collection of data from partner agencies and community members to drive planning. The workgroup, with guidance from the ICCAC Executive Director, should produce a comprehensive work plan, with associated timeline and identification of resources.

Appendix A: Other Service Providers

Other Service Providers

In order to understand service provision in the state of Iowa, data were collection was not limited to current Iowa CACs and state departments. Data were also collected from other non-accredited providers. In these instances, it must be noted that these service providers do not investigate all types of abuse. Therefore, while these data sources don't allow for a fully comprehensive analysis of abuse, they do allow for insight into how counties receive additional child advocacy services through third parties. Information collected was specific to how these child care providers operated compared to CAC providers; in regards to agency cooperation, current operations, the presence of MDTs, the number of cases reviewed and services provided.

Two practitioners not accredited by NCA also provided data for this assessment. These practitioners take referrals from multiple sources, not limited to DHS and Law Enforcement; standards which apply to Iowa accredited CACs. The first is located at the University of Iowa Children's Hospital Child Protection Program (CPP). The comprehensive assessment provided from CPP revealed that they provide services to all incidences regardless of a perpetrator's caretaker status. CPP collaborates with these and multiple governmental and non-governmental agencies in the implementation of service projects. The CPP provided services to 158 children, the majority of whom were ages six and under, through the past year. Cases ranged from Physical Abuse to Drug Endangerment.

The second practitioner not accredited by NCA is located at Davenport's Child Protection Response Center (CPC). The CPC's assessment indicated the CPC provides an array of services; including new patient exams, forensic interviews, emergency room and inpatient hospital visits, expert witness, and more. Over the last year, the CPC served 257 total abuse cases, including emotional abuse, mental health, and physical and sexual abuse. These cases mainly stemmed from the CPC's home in Scott County, but others came from outside counties including: Clinton (IA), Rock Island (IL), Mercer (IL), Henry (IA), and Knox (IL).

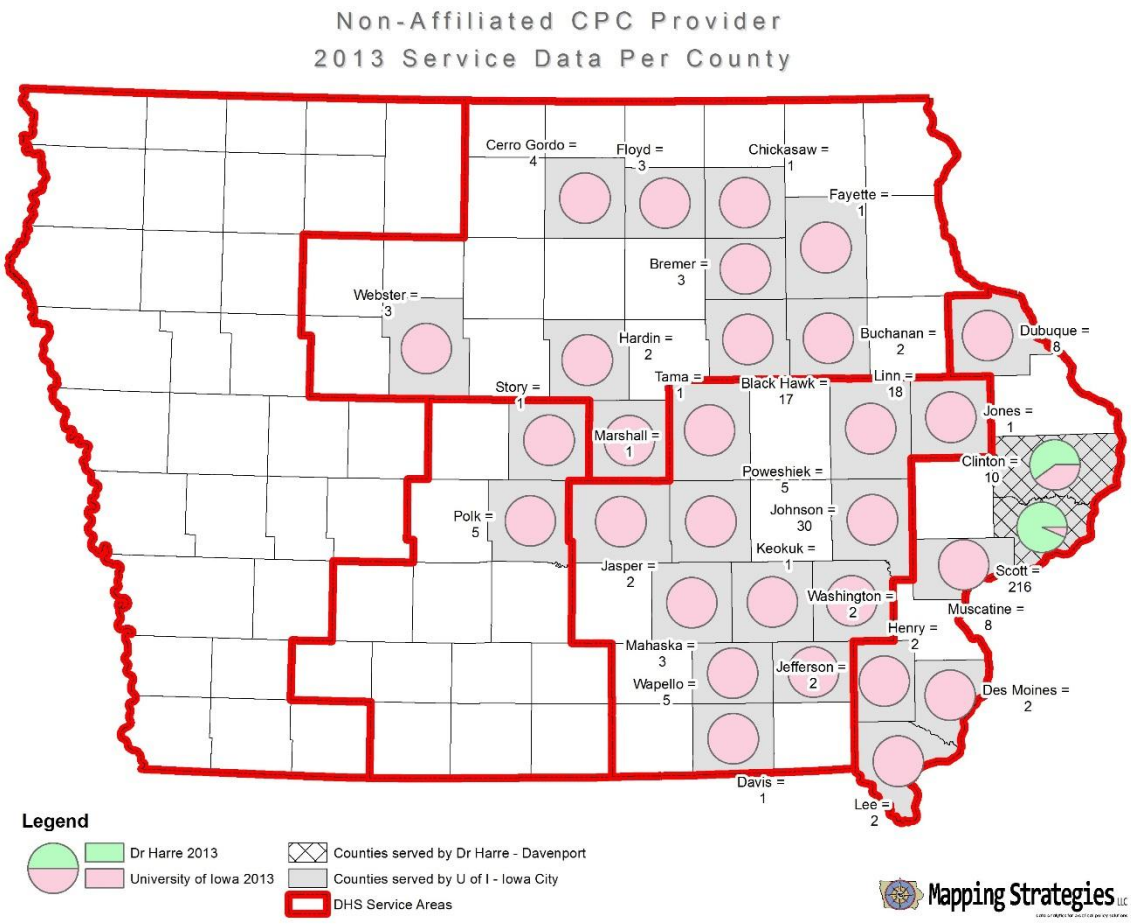


Figure 28: Non-Affiliated CPC Provider 2013 Service Data Per County

APPENDIX B: CAC STANDARDS FOR ACCREDITATION

MULTIDISCIPLINARY TEAM: FOR RESPONSE TO CHILD ABUSE ALLEGATIONS

Together with CAC staff, the core MDT includes representation from the following six disciplines; law enforcement, child protective services, prosecution, medical, mental health, and victim advocacy. A functioning and effective multidisciplinary team approach (MDT) is the foundation of a CAC. An MDT is a group of professionals who represent various disciplines and work collaboratively, from the point of report, to assure the most effective and coordinated response possible for every child. The purpose of interagency collaboration is to coordinate intervention so as to reduce potential trauma to children and families and improve services, while preserving and respecting the rights and obligations of each agency to pursue their respective mandates.

CULTURALLY COMPETENT SERVICES: ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND COORDINATED WITH THE MULTIDISCIPLINARY TEAM RESPONSE.

Cultural competency 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 competency is as basic to the CAC philosophy as developmentally appropriate, child-friendly practice.

FORENSIC INTERVIEWS: CONDUCTED IN A MANNER THAT IS LEGALLY SOUND, OF A NEUTRAL, FACT FINDING NATURE, AND ARE COORDINATED TO AVOID DUPLICATIVE INTERVIEWING.

Forensic interviews create an environment that provides the child an opportunity to talk to a trained professional regarding what they have experienced or know that resulted in a concern about abuse. Forensic interviews are typically the cornerstone of a child abuse investigation, resulting in effective child protection and subsequent prosecution. They are often the beginning of the road toward healing for many children and families.

VICTIM SUPPORT AND ADVOCACY: SERVICES ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND THEIR NONOFFENDING FAMILY MEMBERS AS PART OF THE MULTIDISCIPLINARY TEAM RESPONSE.

The focus of victim support and advocacy is to help reduce trauma for the child and non-offending family members and to improve outcomes. Coordinated victim advocacy services are a necessary component in the MDT's response, as they encourage access to and participation in Investigation, Prosecution, Treatment and Support Services. Up-to-date information and ongoing support is critical to a child and family's comfort and ability to participate in intervention and treatment.

MEDICAL EVALUATION: TREATMENT SERVICES ARE ROUTINELY MADE AVAILABLE TO ALL CAC CLIENTS AND COORDINATED WITH THE MULTIDISCIPLINARY TEAM RESPONSE.

All children who are suspected victims of child abuse should be assessed to determine the need for a medical evaluation. Medical evaluations should be required based on specific screening criteria developed by skilled medical providers or by local multidisciplinary teams which include qualified medical representation.

MENTAL HEALTH: SPECIALIZED TRAUMA-FOCUSED SERVICES, DESIGNED TO MEET THE UNIQUE NEEDS OF THE CHILDREN AND NON-OFFENDING FAMILY MEMBERS

Children's Advocacy Centers have as their missions: protection of the child, justice and healing. Healing may begin with the first contact with the MDT, whose common focus is on minimizing potential trauma to children. Without effective therapeutic intervention, many traumatized children will suffer ongoing or long term adverse social, emotional, and developmental outcomes that may impact them throughout their lifetimes. Today we have evidence-based treatments and other practices with strong empirical support that will both reduce the impacts of trauma and the risk of future abuse. For these reasons, an MDT response must include trauma assessment and specialized trauma-focused mental health services for child victims and non-offending family members.

CASE REVIEW: FORMAL PROCESS IN WHICH MULTIDISCIPLINARY TEAM DISCUSSION AND INFORMATION SHARING REGARDING THE INVESTIGATION, CASE STATUS AND SERVICES NEEDED BY THE CHILD AND FAMILY OCCURS ON A ROUTINE BASIS.

Case review is the formal process which enables the MDT to monitor and assess its effectiveness - independently and collectively - ensuring the safety and wellbeing of children and families. It is intended to monitor current cases and is not meant as a retrospective case study. This is a formal process by which knowledge, experience and expertise of MDT members is shared so that informed decisions can be made, collaborative efforts are nurtured, formal and informal communication is promoted, mutual support is provided, and protocols/procedures are reviewed.

CASE TRACKING: CAC'S MUST DEVELOP AND IMPLEMENT A SYSTEM FOR MONITORING CASE PROGRESS AND TRACKING CASE OUTCOMES FOR ALL MDT COMPONENTS.

Case tracking is an important component of a CAC. "Case tracking" refers to a systematic method in which specific data is routinely collected on each case served by the CAC. Case tracking systems provide essential demographic information, case information and investigation/intervention outcomes.

ORGANIZATIONAL CAPACITY: DESIGNATED LEGAL ENTITY RESPONSIBLE FOR PROGRAM AND FISCAL OPERATIONS HAS BEEN ESTABLISHED AND IMPLEMENTS BASIC SOUND ADMINISTRATIVE POLICIES AND PROCEDURES.

Every CAC must have a designated legal entity responsible for the governance of its' operations. The role of this entity is to oversee ongoing business practices of the CAC, including setting and

implementing administrative policies, hiring and managing personnel, obtaining funding, supervising program and fiscal operations, and long term planning.

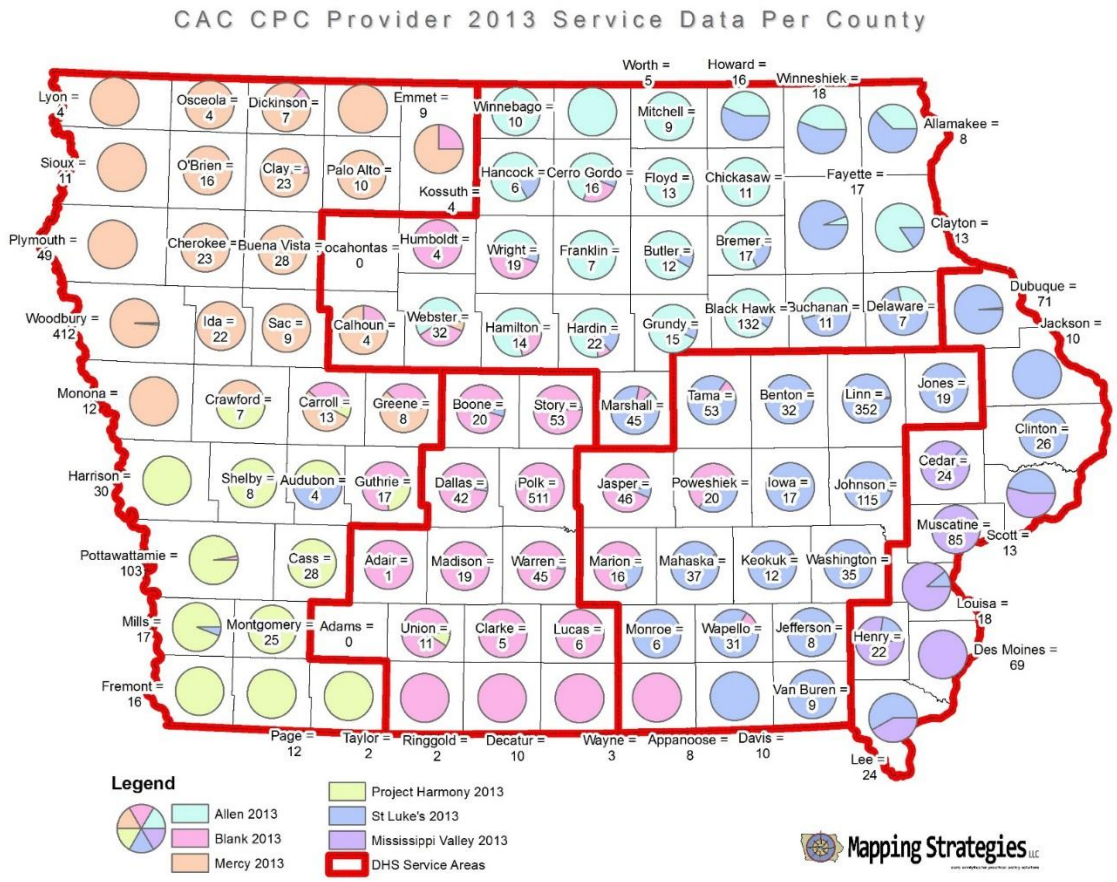
CHILD-FOCUSED SETTING: COMFORTABLE, PRIVATE, AND BOTH PHYSICALLY AND PSYCHOLOGICALLY SAFE FOR DIVERSE POPULATIONS OF CHILDREN AND THEIR NON-OFFENDING FAMILY MEMBERS.

A Children's Advocacy Center (CAC) requires a separate, child-focused setting designed to provide a safe, comfortable and neutral place where forensic interviews can be conducted and other CAC services can be provided for children and families. While every center may look different, the criteria below help to define some specific ways that the environment can help children and families feel physically and psychologically safe and comfortable. These 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.

APPENDIX C: BRIEF SUPPORT DOCUMENT

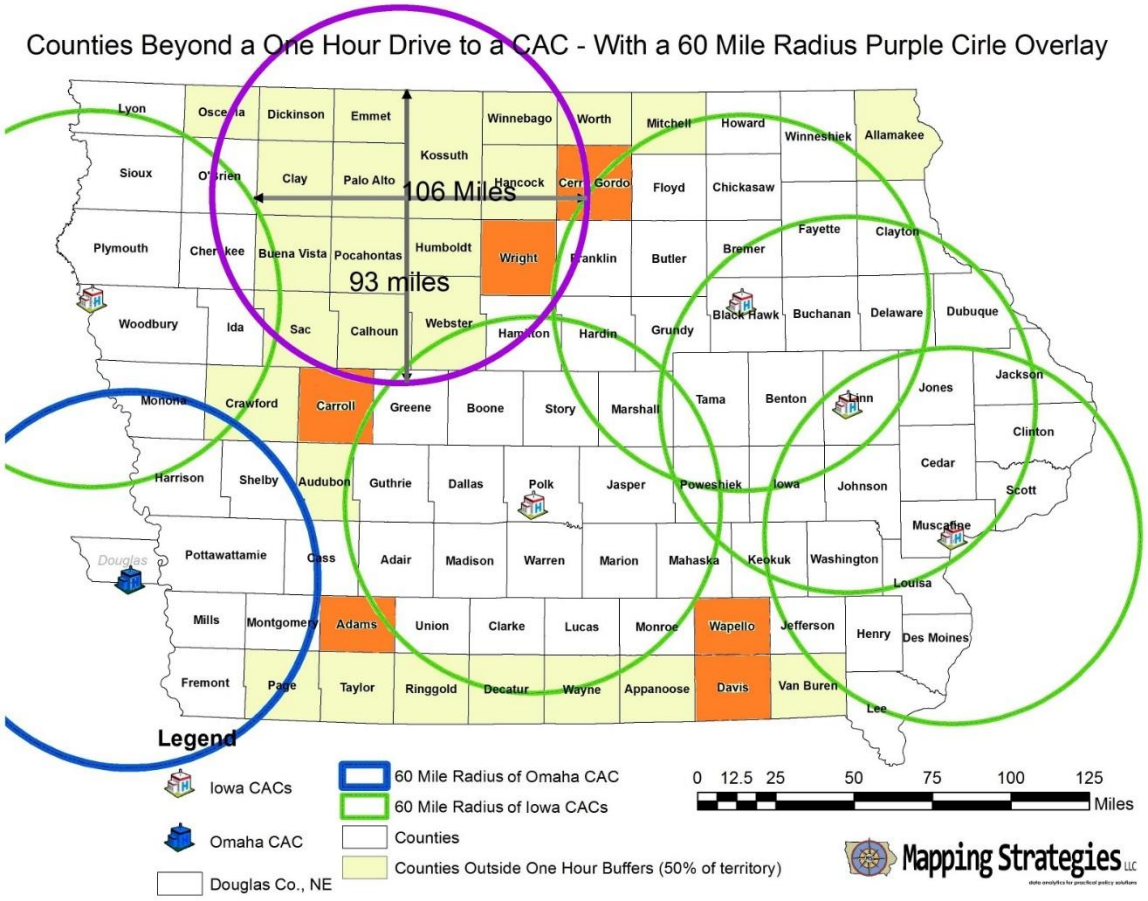
Iowa Child Protection Centers – Current Outlook

Iowa has five CPC's Accredited by the National Children's Alliance. Children under the age of 18, for whom there are concerns of abuse, are served. Family support services are provided to non-offending parents or caregivers. These services are provided in a neutral, child focused environment and may include: recorded forensic interviews, medical evaluations, mental health treatment and/or referrals, provision or coordination of advocacy services, case review and case tracking. In 2014, the five Iowa CPC's reported serving 2,887 children. Project Harmony, Omaha, NE contracts with Iowa to serve the southwest corner of Iowa and served 264 children. All Iowa CPC's participate in the Outcomes Measurement System which collects client satisfaction surveys. The CPC's consistently score above 95% satisfaction rate on questions asked of clients and 100% of MDT members believed the clients served by the CPC's benefit from the collaborative approach of their multidisciplinary teams. Multidisciplinary members include; law enforcement, child protective services, prosecution, medical, mental health, victim advocacy, together with CPC staff. 2013 Service Data by county for the CAC's is shown on the map below.



Iowa Child Protection Centers – Future Outlook

The Iowa Chapter of Children's Advocacy Centers in partnership with Iowa Department of Human Services and Iowa Department of Public Health recently completed a Growth Assessment. This project involved gathering statistical data from a variety of sources to determine the rates and trends of child abuse over a five year period and the availability of CPC services for those alleged victims and their families. There were six counties identified with an upward trend in child abuse reports and areas within the state that are outside a one hour radius of travel to obtain services from an existing CPC. Counties of concern include: Carroll, Cerro Gordo, Davis, Wapello, Webster and Wright, highlighted orange. The complete Growth Assessment provides information and data to help key stakeholders in the state look at where potential growth in the CPC movement is most needed. It can be utilized in those communities to help secure support and funding should the community decide that developing a CPC center or Satellite Center is necessary and feasible.



[i] For more information, please contact Nancy Wells, Executive Director, Iowa Chapter of Children's Advocacy Centers at nwells@iowacacs.org or 515-401-9897.