"Co-location of health-care providers and investigators to enhance support and justice for crimes committed against children and adolescents- A national model."

Amount requested over two year period: $541,190

Attachment 1: Program Abstract

This application addresses the Byrne Memorial Competitive Grant Program Category VI: Improving Resources and Services for Victims of Crime for child sexual abuse and domestic violence using an enhanced child advocacy center model. Child advocacy centers provide a multidisciplinary approach to child abuse based upon the The success of treatment, investigation and prosecution, in large part, rests upon a coordinated service system; however, few child advocacy centers have been successful in their mission to provide this level of coordination. Barriers include lack of: integrated services; resources for treatment; and, training of professionals (social work, medical, law enforcement, child protection and prosecution). In addition, the co-occurrence of domestic violence is one of the strongest risk factors for child abuse. Yet, inter-disciplinary coordination of domestic violence services with child abuse services is nearly non-existent for most regions. To effectively ensure justice for crimes against children, a coordinated, integrated system is essential.

is a state-of-the-art, evidence-based and progressive approach to support abused children through one-stop, comprehensive services for victims and their non-offending family members with co-located law enforcement presence (detectives and prosecutors). A recent (1/09) expansion of our prosecutors' participation with weekly rotations for our county prosecutors, is enhancing their expertise in the prosecutorial matters of child abuse. also provides support to victims of domestic violence, and these services are coordinated at treatment for both child and mother. Assessment, treatment, case preparation, and follow-up care are made available to families. While served the more victims in 2008 than in prior years, it has also experienced the highest reduction in force, and cut back on positions out of budget necessities due to the economic decline in Ohio. This project would help to avoid a significant reduction in the number of child victims from receiving the needed services for successful treatment, and prepare for the prosecution phase of their experience.

Goals for this project are: 1. support and integration of child abuse and domestic violence assessments, treatment and investigation, using an enhanced model of child advocacy centers; 2. greater presence of prosecutors within the multidisciplinary team during the initial investigations to improve prosecution rates; 3. consistent and effective, outcomes-focused case tracking across agencies. Key deliverables include: 1. the re-creation of an intake and tracking position lost last year; 2. retention of mental health advocates who initiate treatment at assessment and provide an individualized treatment plan for child and non-offending parent; 3. support to collaborative partnerships and improvements of victim services by a coordinated intake process (avoiding duplication of efforts), and longitudinal tracking by the intake coordinator role. Our overarching goal is to ensure child and/or adult victim are provided access to the necessary resources for success to accomplish the important outcomes of treatment, protection and prosecution for these child victims. Forecasting into 2010, this project will prevent any further reduction in force and services to be able to continue to serve child victims and support a regional, multidisciplinary system of child protection and prosecution, and treatment.

"Co-location of health-care providers and investigators to enhance support and justice for crimes committed against children and adolescents- A national model."

Category VI: Improving Resources and Services for Victims of Crime

Attachment 2: Program Narrative

Statement of the Problem

In 2006 in the United States, approximately three million referrals were made to child protective services; nearly 900,000 children were victims of child abuse or neglect (12.1/1000) (U.S. D.H.H.S., 2008); over 80,000 were sexual abuse victims. Direct costs for child abuse exceed $90 billion each year- an annual toll of $1,500 for every American family. In Ohio, the rate of child maltreatment (15.0/ 1000) is higher than the national average, and in more densely populated regions of the state, like Franklin County, over 100,000 new reports of child abuse or neglect were reported with 13,000 new allegations of sexual abuse (PCSAO Factbook, 9th Edition, 2009). Therefore, the impetus to have a coordinated, collaborative regional response to the problem of child abuse is paramount. The economy can have a detrimental effect on the burden of child abuse cases as was noted in 2001-02 (U.S. D.H.H.S., 2003) with an increased incidence of child maltreatment during a significant economic downturn. A 20% increased volume of child victims served in 2008 (CCFACTS, 2008) likely reflects the current economic crisis and need for additional assistance to serve child victims.

The is an accredited member of the National Children's Alliance (NCA) as a child advocacy center (CAC). There is ample evidence demonstrating improved investigations with law enforcement, increased use of child forensic interviewing, and increased likelihood of having a medical examination, an important goal to ensuring access to care for child victims of sexual abuse (Cross, 2007; Walsh, 2007). Additionally, use of CACs improves the victims' and families' experiences which can lead to greater cooperation for successful mental health and

prosecution outcomes (Jones, 2007). Evidence of felony prosecutions of child sexual abuse doubled in a district where the use of a CAC tripled compared to another district with no change in CAC use (Miller, 2009). In a two year period (2005-07), the . demonstrated a 13% increase in successful prosecutions by virtue of the continued efforts to improve the quality of investigation, support to victims and their families, and multidisciplinary team participation (Forgach MA, 2007). Given the risks of delinquency and other risk behaviors observed in crime victims (OJJDP, 2009), having a coordinated response to the child abuse crimes which is directly tied to treatment services is paramount to foster resiliency and future well-being.

The purpose of this request is to support the clinical and forensic activities of the ( ) to provide comprehensive, coordinated and integrated services to victims of family violence in a 35 county Ohio region. Specifically, integration of service delivery to the child sexual abuse victim and his/her non-offending parent requires: 1. excellent quality diagnostic interviewing skills; 2. inclusion of mental health advocates to ensure that families have access to high quality assessment and treatment; and, 3. follow up and case tracking within the complex, multidisciplinary systems, especially during the follow-up phases of an investigation. The critical linkage of identification/ assessment, protection/ treatment, and investigation/ prosecution requires an organized approach for success at all of these important levels. Given our existing program and efforts, this project can begin quickly to retain jobs and to add vital jobs lost last year. The economic impact of this project is described in Attachment 4.

Program Design and Implementation

First, access to services must be timely, and without barriers for child victims and their families. Our Intake and Tracking department includes a trained staff (MSW social work) as the first contact with families, physicians, detectives and child protection service caseworkers in

making a referral of a child to the Child Assessment Center. Notification and coordination of team members is completed with a goal of patients being seen within 3 days of referral for non-urgent referrals and within the same day for urgent referrals. The family is informed about what to expect during the assessment i.e. interview, medical evaluation, mental health family assessment, and the participants of the multidisciplinary team.

Second, medical and forensically trained social work (MSW) staff conducts medical forensic interviews to elicit information in a child sensitive, developmentally appropriate fashion. The quality and benefits of such a child advocacy center employee to conduct these interviews is substantial in the context of integrating wellness and prosecution. These interviews (in accordance with NCA guidelines) are monitored by child protective services, law enforcement agency staff, and prosecutors, to reduce the need for subsequent interviewing of the child victim during an investigation. A video recording of the interview is provided to law enforcement agency staff as evidence in their ongoing criminal investigation. Reducing the need for multiple interviews is cost-effective, and provides an opportunity for the entire team to develop agency plans for protection, law enforcement, prosecution and treatment domains.

Third, a medical examination is conducted by pediatric sub-specialists and nurse practitioners specializing in the field of child abuse pediatrics. While this is a separate service for many , the ability to successfully complete a forensic medical examination immediately following the interview provides many advantages to the child, family and law enforcement investigators. Nationally, the coordination of medical care within the multi-disciplinary approach to child sexual abuse is often limited without efforts like These medical evaluations include use of colposcopy with photo-documentation, evaluations for sexually transmitted diseases, and treatment. Since our program also provides care for acute sexual

assault victims with completion of evidence collection kits, we are able to offer a complete systems-integrated approach to care.

Fourth, mental health assessments are provided by mental health advocates (MSW therapists) who begin the process of providing "treatment at assessment", and offer initial crisis counseling and family support. This unique service in child advocacy centers provides a family assessment to best inform the multidisciplinary team of the needs, and potential barriers to successful outcomes (treatment, protection and prosecution). This face to face interview with the non-offending parent has identified over 63% of our client families having a history of domestic violence, 40% with their own prior sexual abuse experience, and 70% with a history of mental health concerns in the family (CCFACTS, 2008). Services including the co-located domestic violence services may be offered to address these parent experiences. Approximately, 20% of families will exhibit some level of crisis reaction during the assessment, and the mental health advocate provides support during this crisis and enables the rest of the staff to continue to work through the child sexual abuse assessment in an efficient, yet family-sensitive fashion. An individualized treatment recommendation is provided for child and non-offending family members, and often includes linkage of patients and families to our co-located Family Support Program (child victim trauma treatment program) and/or domestic violence treatment services.

Fifth, ongoing surveillance of child protective services, law enforcement, mental health and prosecution outcomes are tracked by the Intake Coordinator to assess the effectiveness of the Center in achieving its goals. An electronic case tracking system has been developed and is utilized to track cases weekly in a team meeting forum. Specifically, the supervisors for child protection, law enforcement, prosecution, medical and mental health treatment meet weekly to report and update the tracking system to ensure that all activities relevant to the child and family

needs are completed. This system of transparency and accountability provides supervisors the ability to know cases that are not completed, and identify possible trends that can be corrected to improve the delivery of services in each respective discipline. This process also enables the Center administration to evaluate the intervention effectiveness and determine how to improve the quality of those services. A critical surveillance system offers the best outcomes for victims; however, the 2008 reduction in force has recently decreased the consistency of these efforts.

Capabilities/ Competencies

y ( ) is a joint partnership between

, and the

. This unprecedented relationship between providers of child abuse and adults experiencing domestic violence developed in 2002 and was the first center in the U.S. with co-located child abuse and domestic violence programs under one roof. mission is "to foster a safe community by breaking the cycle of violence through coordinated, comprehensive services in the treatment and prevention of child abuse and domestic violence." In 2004, highlighted by the National Association of Children's Hospitals and Related Institutions as one of four programs described in the U.S. programmatically addressing child abuse and domestic violence as an essential part of family- centered, collaborative, systems care. One of strengths is its inter-agency collaboration, critical to success in addressing crimes committed against children.

The itself is a public/ private partnership, with a combined staff of over 120 professionals, who are dedicated to addressing the complex issues of family violence. These partners include:

(child protective services),

(domestic violence service agency), and

, and the). These agency partners have realigned resources to the Center in order to facilitate greater communication, collaboration and effectiveness in service delivery. A President (

JD), Medical Director (Dr.), and Operations Director ( ) comprise the leadership team to support the healthcare staff. The Operations Director also chairs the Partners Council, a committee of multi-agency supervisors to address cross-agency communications and collaborative problem-solving. will be the Project Director and also lead the evaluation of this effort. His extensive experience in program and research federal grant awards (i.e. Administration on Children and Families, Centers for Disease Control, Agency for Healthcare Research and Quality) will provide the pre-requisite leadership for this project. All grant activities will be served by a

project officer to ensure clear reporting and management of grant expenditures.

In 2008, the treated more than 1,400 abused children from 37 Ohio counties. Using the child advocacy center model, the maintains a rigorous case tracking and review process to ensure high quality and accountability in the investigative and ongoing treatment processes for child victims of abuse. Case tracking enables law enforcement, child protective services and prosecution to meet regularly and continue to provide input into a case investigation to ensure optimal success once a case is brought to trial for prosecution. From 2005-07, an increase of 11% more convictions was noted through increased coordinated, multidisciplinary efforts. Having a coordinated, trauma focused treatment program as part of this team effort further assists children and families in the healing of that trauma, but also provides support during the judicial proceedings of their case. Each year approximately 700 children engage in

our treatment program to receive evidence-based models of treatment which are coordinated with the rest of the team.

Impact/ Outcomes Sustainment, Data Collection for Performance Measures

There are eight areas that will be evaluated to assess the program success: Coordination, Diagnosis, Treatment, Job preservation, Job creation, Promotion of economic recovery, Promotion of collaborative partnership, and Tracking and accountability to improve victim services (see Attachment 4: Project Timeline and Position Description, and Evaluation Certification). Under Coordination, prompt intake of child victims will be evaluated by units of service delivered (access to care, MDT coordination, special needs i.e. interpreter services). Under Diagnosis, evaluation of quality of diagnostic forensic interviews resulting in high victim disclosure will be performed. Under Treatment, evaluation of the assessment and support for child victim and non-offending parent the specific services received (i.e. individual, group or family therapy, community based service), duration of treatment and referrals made to other agencies (i.e. substance abuse treatment, domestic violence victim services, psychiatry services, and general counseling for adult, child) will be conducted. Job preservation will be accomplished by maintaining of current staff and stabilization of vulnerable positions (mental health advocate) and will be assessed by monthly staffing FTE reports. Job creation will be assessed by successful recruitment of an intake coordinator position and will be monitored by FTE addition to the current staff. Promotion of economic recovery will be tracked by ensuring the capacity to serve child victims and measured by the essential services delivered (intake, interview, mental health, child protective services, law enforcement, and treatment dispositions). Promotion of collaborative partnerships will address the goal of avoiding service reductions and/or duplication of service by measuring the Ohio counties served, victims served, and

whether there was a prior, comprehensive, child interview. Lastly, Tracking and accountability to improve services to victims will include: child protective services (disposition decisions of the sexual abuse investigation, secondary findings identified during the investigation, whether the case was filed in juvenile court, and the outcome of the filing); and law enforcement activities (whether charges were filed, listing of those charges, reason why charges may not have been filed, and whether a confession was obtained by the alleged perpetrator in the course of the investigation). Ongoing evaluation of the juvenile court and criminal court dispositions will be undertaken and entry of the status of the alleged perpetrator as a registered sex offender is included. The inclusion of our rotation of prosecutors, as described previously, will maximize the successful prosecution outcomes and offer significant impact to the program.

We are confident that the funding from this project will bridge a critical gap to being able to secure future sustainable funding for these personnel with other clinical initiatives that will enhance revenues by 2010. Ongoing private foundation fundraising efforts by the leadership team will continue to ensure sustainability to these and other essential staff positions.

Budget Worksheet

Complete the budget worksheet, with computations.
(Note: Fields expand in size as data and text is entered.)

A. Personnel **$291,203**

Name	Computation	Cost
	$196,700 x 5% WOC/ (Year 1)	0
	$202,601 x 5% WOC/ (Year 2)	
	$62,729 x 85% (Year 1)	$53,320
	$64,611 x 85% (Year 2)	$54,919
	$61,233 x 62% (Year 1)	$37,964
	$63,070 x 62% (Year 2)	$39,103
TBN-Intake Coord.	$44,000 x 100% (Year 1)	$44,000
	$45,320 x 100% (Year 2)	$45,320
	$81,659 x 10% (Year 1)	$8,166
	$84,109 x 10% (Year 2)	$8,411

B. Fringe Benefits **$75,713**

Name	Computation (Rate)	Cost
	WOC- 29.8% (Year 1 & 2)	0
	26% (Year 1)	$13,863
	(Year 2)	$14,279
	26% (Year 1)	$9,871
	(Year 2)	$10,167
TBN-Intake Coord.	26% (Year 1)	$11,440
	(Year 2)	$11,783
	26% (Year 1)	$2,123
	(Year 2)	$2,187

C. Travel **$4,910**

Purpose	Location	Item	Computation	Cost

Travel for the local OCFO training (Columbus, OH- airfare, hotel and meal allowances - $55 (each year)
Travel for the OCFO training in Washington, D.C.- airfare, hotel and meal allowances – $1,200 (2 staff – each year) = $2,400 per year

D. Equipment _____

Item	Computation	Cost

E. Supplies **$4,000**

Supply Item	Computation	Cost
MH Advocate Supplies - $1,000 per year	(total cost $2,000)	
Coordinator/Tracking Supplies - $1,000 per year	(total cost $2,000)	

F. Construction

Description	Computation	Cost

G. Consultants/Contracts _____

Consultant Fees

Name	Service	Computation	Cost

Contracts

Item	Cost

H. Other

Description	Computation	Cost

Total Direct Costs **$375,826**

I. Indirect Costs

Indirect costs for this project is 44%. This is our institution's federally approved indirect rate. The total indirects for this project is $165,364.

Budget Summary Page

A. Personnel/Salary Costs	$ 291,203
B. Fringe Benefits	$ 75,713
C. Travel	$ 4,910
D. Equipment	$ 0
E. Supplies	$ 4,000
F. Construction	Unallowable
G. Consultants/Contracts	$ 0 -
H. Other	$ 0
I. Indirect Costs	$ 165,364
TOTAL PROJECT COSTS	$541,190
Federal Request	$541,190
Applicant Funds, if any, to be applied to this project	$ 0

Budget Narrative:

A. Personnel

will serve as the Project Director for this project and will provide the general oversight and direction for the evaluation of the performance measures for this grant. His effort on this project is 5% WOC.

will serve as the Clinical Manager for this project and will provide the clinical supervision for the mental health advocates and intake and tracking coordinator. Her effort on this project is 10%.

will serve as the mental health advocate and will conduct the psycho-social risk assessments, and provide support to the child victim and non-offending parent and family. She will participate in the MDT meetings. Her effort on the project is 85%. The remainder of her salary support is covered through another source.

will serve as the mental health advocate and will conduct the psycho-social risk assessments, and provide support to the child victim and non-offending parent and family. She will participate in the MDT meetings. Her effort on the project is 62%. The remainder of her salary support is covered through another source.

To Be Named will serve as the intake and tracking coordinator. She will provide the coordination for access to care, as well as tracking of case dispositions following the initial assessment. Her effort on the project will be 100%.

B. Fringe Benefits
All personnel fringe is calculated at 26%

C. Travel
Travel for the local OCFO training is for mileage reimbursement given the training within our city (Columbus, OH).
Travel for the OCFO training in Washington, D.C. for two staff to attend a two day training is calculated based upon average airfare, hotel and meal allowances.

D. Equipment
None

E. Supplies
Supplies (copyright materials) for the mental health advocate: educational materials for victims of sexual abuse/assault, women experiencing domestic violence are included. Intake and tracking coordinator supplies for case tracking and communications with law enforcement and child protection are included.

F. Construction
None

G. Consultants/Contracts
None

H. Other
None

I. Indirect Costs
An indirect rate of 44% is included.