The Child Advocacy Center of Lapeer County

lighting the way for a child's future

MDT ORIENTATION MANUAL

A GUIDE FOR THE NEW MDT MEMBER

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PURPOSE OF THIS MANUAL

The Child Advocacy Center of Lapeer County
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The Multidisciplinary Team Orientation Manual is provided by The Child Advocacy Center of Lapeer County as a resource for new professionals joining the MDT. This manual serves as a guide for new members to become familiar with CAC Lapeer's processes, the purpose of the MDT, and responsibilities of MDT members. Additionally, this orientation manual provides several resources to promote a better understanding of each professional role within the Children's Advocacy Center model and foster collaboration among professionals that serve children and families.

Onboarding for new MDT members:

- Addresses FAQs
- Reviews processes and procedures
- Points to key documents
- Spells out acronyms
- Lists roles and responsibilities for each MDT member
- Sets a foundation for the culture and expectations of the MDT

2 THE CAC MODEL

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A Children's Advocacy Center (CAC) is a child-focused program in which representatives from core disciplines - law enforcement, child welfare professionals, prosecution, mental health, medical, and victim advocacy - collaborate to investigate child abuse reports, conduct forensic interviews, determine and provide evidence-based interventions, and assess cases for prosecution. As community-based programs, CACs are designed to meet the unique needs of the communities they serve and, as such, no two CACs look or operate exactly alike. They are founded on a shared belief that child abuse is a multifaceted community problem and no single agency, individual, or discipline has the necessary knowledge, skills, or resources to serve the needs of all children and their families. This unique model was established in 1985 in Huntsville, Alabama under the direction of District Attorney Bud Cramer. CACs offer a coordinated multidisciplinary response to child abuse cases with the goal to minimize trauma to child victims and their caregivers. The CAC model was initially created to address child sexual abuse cases; however, the model has also evolved to include severe physical abuse, neglect, witness to violence, commercially sexually exploited children, youth with problematic sexual behavior, etc.

The National Children's Alliance (NCA) is the national association and accrediting body for Children's Advocacy Centers (CACs). NCA opened in 1994 and has created standards for accreditation, with member CACs across the country and state chapter organizations in all 50 states.

Healing, Justice, & Trust

A National Report on Outcomes for Children's Advocacy Centers 2018

NATIONAL CHILDREN'S ALLIANCE®

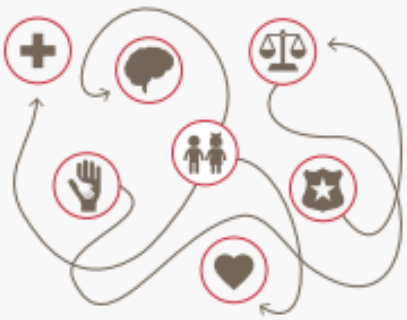
What is the National Children's Alliance?

NCA is the national association and accrediting body for a network of 854 Children's Advocacy Centers— CACs. We provide support, advocacy, quality assurance, and national leadership for CACs, all to help support the important work that CACs do in communities across the country. CACs provide a coordinated, evidence-based response to children who have been abused in all 50 states.

What are CACs and how do they help kids?

To understand what a CAC is, you must understand what children face without one. Without a CAC, the child may end up having to tell the worst story of his or her life over and over again, to doctors, police, lawyers, therapists, investigators, judges, and others. They may not get the help they need to heal once the investigation is over, either.

Without CACs



With CACs

When police or child protective services believe a child is being abused, the child is brought to the CAC—a safe, child-focused environment—by a caregiver or other "safe" adult. At the CAC, the child tells their story once to a trained interviewer who knows the right questions to ask. Then, based on the interview, a multidisciplinary team (MDT) that includes medical professionals, law enforcement, mental health, prosecution, child protective services, victim advocacy, and other professionals make decisions together about how to help the child. Finally, they offer a wide range of services like therapy, medical exams, courtroom preparation, victim advocacy, case management, and more.

CACs provide healing, justice, and trust for child victims of abuse

This past year, CACs demonstrated that their model works through the results of nearly 70,000 surveys from caregivers and MDT members. Here are some highlights that show our families and partners believe in the healing, justice, and trust we provide.

95% | Healing

95% of caregivers agree that CACs provide them with resources to support their children.

98% | Justice

98% of team members believe clients benefit from the collaborative approach of the MDT.

97% | Trust

If caregivers knew anyone else who was dealing with a situation like the one their family faced, 97% would tell that person about the center.

The CAC movement is growing and improving

With approximately **854 member CACs** serving **334,626 children** in 2017, NCA represents a growing movement providing more and better services to children and families nationwide.

In the last ten years, the number of NCA member centers serving kids has grown 25%

Since 2008, annually our member CACs have served...

- 70% more child victims of physical abuse
- 73% more child victims of neglect
- 126% more child witnesses to violence
- 55% more children endangered by drugs

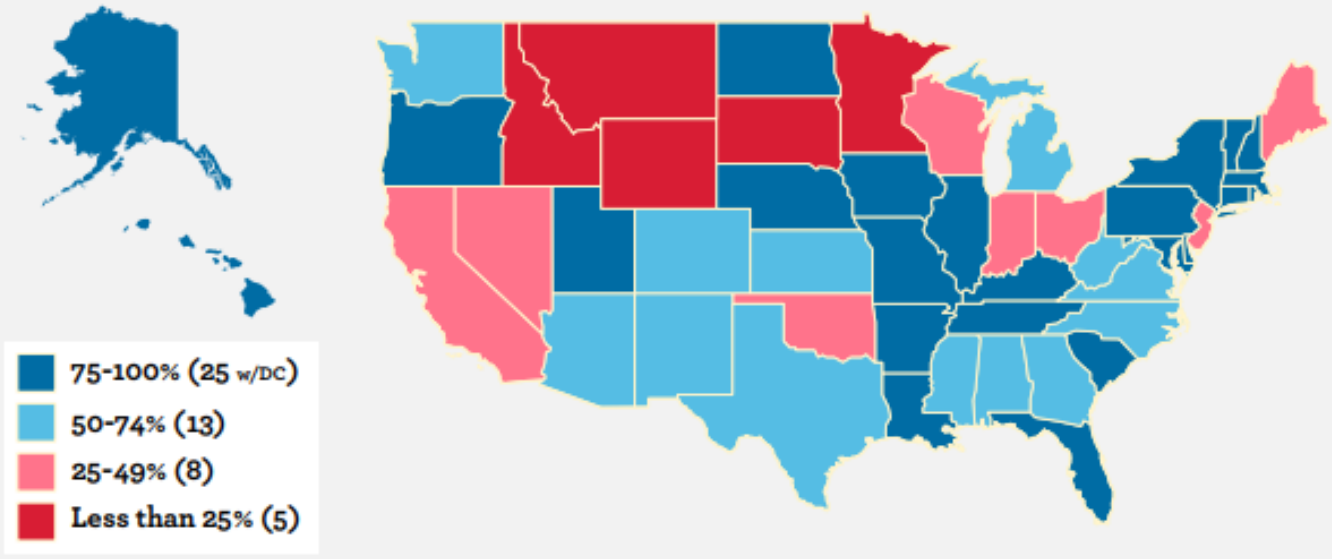
And provided...

- 36% more children with counseling and other mental health services
- 54% more children with onsite forensic interviews
- 716% more children and family members with case management services
- 202% more children, family members, and community members with prevention education

The need remains

Despite the success of the CAC model in helping children who have been victimized by abuse, there's still an outstanding need for more CAC coverage, and more support. States in red below have a lower proportion of counties covered by CACs, while states in blue have a higher proportion of CAC-served counties or have full coverage.

Proportion of Counties Covered by NCA Member CACs, by State



CAC services are available to approximately 5 out of every 6 U.S. children

But that still leaves 11,778,543 children living in areas without a CAC.

Funding and legislative support helps ensure children across the country have access to a CAC when they need it, and helps expand capacity and geographic coverage to reach more children and families with the services they need.
Thank you for your support of this crucial resource for children and families in communities across the country.

2 WHO WE ARE

The Child Advocacy Center of Lapeer County
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OUR HISTORY

The Child Advocacy Center of Lapeer County (CAC Lapeer) opened in 2008 and was the first organization in Lapeer County to create a non-threatening, child-friendly place for children to share their traumatic experiences. Law enforcement, child welfare professionals, prosecutors, and medical providers all came together to this single location to collaborate and ultimately reduce the number of times the child would have to share and relive their story. Since opening our doors, we have served more than 1400 children and their families free of charge.

Today, CAC Lapeer is Lapeer County's only non-profit organization that coordinates the efforts of law enforcement professionals, child protection staff, family advocates, medical experts, and mental health clinicians under one roof. Our staff:

- facilitates our partners' collaborative response
- arranges families' visits to the center, including provision of support services
- conducts forensic interviews
- provides family advocacy and crisis intervention services
- provides mental health therapy

OUR MISSION

The mission of the Child Advocacy Center of Lapeer County is to reduce the trauma to children during the investigation and intervention of alleged sexual or severe physical abuse through advocacy, education, intervention, and treatment.

OUR VISION

A community where all children are safe and free from abuse.

2 OUR SERVICES

Investigative Services

Our Intake Coordinator assists in a coordinated response for the investigative team by scheduling forensic interviews and medical exams for victims.

Forensic Interviewing

Forensic Interviewers provide objective, developmentally-appropriate and culturally-sensitive forensic interviews about abuse allegations that are legally defensible.

Medical Evaluations

Specially-trained Pediatric Sexual Assault Nurse Examiners (pedi-SANE) perform comprehensive forensic medical examinations and crisis intervention to male and female survivors of sexual assault up to 120 hours post-assault. Medical evaluations are available 24 hours a day, 7 days a week to both child and adult victims of sexual assault.

Family Advocacy

Our Family Advocate provides on-site advocacy to families of abuse victims, including education, emotional support, referrals, and follow-up. Advocates use a family screening tool to ensure that families are linked to appropriate, comprehensive services.

Mental Health Services

Child/Family Therapists provide crisis counseling, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), play therapy, and trauma-informed individual, family, and group therapy to victims and their non-offending caregivers.

Prevention Services

As part of our comprehensive approach, our Prevention Coordinator provides evidence-based child abuse prevention programs to elementary, middle, and high school students throughout Lapeer County. Additionally, Darkness to Light's Stewards of Children sexual abuse prevention training program is offered to community members on a regular basis.

3 BEING PART OF AN MDT

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The foundation of an effective CAC is the multidisciplinary team (MDT) and the relationships that develop among its members. The underlying premise of an MDT is that collaboration among individuals from diverse disciplines, and varied expertise will result in more informed decision making and ultimately better outcomes for children alleging victimization. A collaborative multidisciplinary response to child abuse cases effectively reduces trauma to children, promotes successful legal intervention, and ensures the availability of appropriate follow-up services for children and their families. A high-performing multidisciplinary team (MDT) is at the core of every Children's Advocacy Center that serves as the neutral, child-focused site within which coordinated investigation, intervention, and case management can be accomplished.

The power and challenge of an MDT are that each agency comes to the team with differing perspectives, mandates, obligations, training, supervision, evaluation, and resources. Part of the MDT function is helping agencies (and individual team members) see the bigger picture - that working together provides the best possible outcome for the children served. Effective teams occur when all team members' intentions and actions are consistent with a shared vision and a clear purpose.

3 OUR MDT MEMBERS

The multidisciplinary team members who respond to child abuse cases at CAC Lapeer are:

Law Enforcement

Michigan State Police | 810-664-2905

Lapeer County Sheriff Department | 810-664-1801

Lapeer City Police Department | 810-664-0833

Almont Village Police Department | 810-798-8300

Dryden Township Police Department | 810-796-2271

Imlay City Police Department | 810-724-2345

Metamora Police Department | 810-678-3657

Child Protective Services

Lapeer County DHHS - Child Protective Services | 810-667-0800

Prosecution

Lapeer County Prosecutor's Office | 810-667-0326

Victim Advocacy

Lapeer County Prosecutor's Office - Victim Services | 810-667-0326

Medical

LC SAFE (Lapeer County Sexual Assault Program) | 810-664-9990

Child Advocacy Center

The Child Advocacy Center of Lapeer County | 810-664-9990

- Intake Coordinator
- Forensic Interviewer
- Child/Family Therapist
- Family Advocate
- MDT Coordinator

3 PROTOCOLS & GUIDELINES

Protocols or operational guidelines are the mechanisms that prescribe the collaborative response among core members of the MDT, including law enforcement, child protection, prosecution, medical, mental health, victim advocacy, and Children's Advocacy Center professionals. Operational Agreements and Working Protocols are critical to ensuring a shared understanding and collective agreements about how the MDT will work together to ensure a collaborative approach throughout.

Memorandum of Understanding (MOU)

This document, required of all children's advocacy centers, represents the shared commitment to the mission, purpose, and intent of the CAC and the MDT approach for child abuse cases in our community. It is signed by the heads of the partner agencies and serves as formal documentation of the commitment made, on behalf of all MDT representatives from those respective agencies, to work these cases collaboratively and according to the agreed-upon and executed working protocols.

CAC Lapeer's Operational Agreement

This document, also required of all children's advocacy centers, represents a detailed guide on how the MDT has agreed to work together to ensure effective outcomes in child abuse cases. The Operational Agreement is developed and periodically reviewed and re-executed, with the vital input and involvement of all partner agencies - thus ensuring this agreement protects and respects the legal and ethical responsibilities and internal policies and procedures of all partner agencies and MDT disciplines. It is critically important that all team members have a comprehensive knowledge and understanding of the Operational Agreement. This ensures a consistent process for our shared work and helps us avoid undue confusion and conflict that might undermine our efforts on behalf of child abuse victims and their families.

If you have any questions regarding any of the information contained in this guide or within the MOU and Operational Agreement, please contact Heather Frayer, Executive Director of CAC Lapeer, at hfrayer@caclapeer.org or 810-664-9990.

4 ACCESSING CAC SERVICES

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The Child Advocacy Center

Upon receiving an initial report, review the information contained therein what services are needed for the child victim, as outlined in the CAC Lapeer Operational Agreement. This includes cases in which the victim and/or witness falls between the ages of 2 and 17 years and involves sexual abuse. CAC Lapeer also serves adults with disabilities who are alleged victims of sexual and/or physical abuse.

In addition, the MDT members may refer other alleged victims when the investigative agencies would benefit from the CAC/MDT's specialized, coordinated, child-focused approach, such as:

- Physical Abuse
- Child Fatality as a Result of Maltreatment
- Child Witness to Violent Crime
- Child at Risk of Sexual and/or Physical Abuse
- Commercial Sexual Exploitation of Children (CSEC)

LC SAFE (Lapeer County Sexual Assault Program)

CAC Lapeer is the umbrella agency for The Sexual Assault and Domestic Violence Coalition with SANE-SART Services of Lapeer County, which provides emergency scheduled forensic medical evaluations for adult and child victims of sexual assault. CAC Lapeer is the only Rape Crisis Center in Lapeer County that offers Sexual Assault Nurse Examiners/Sexual Assault Response Team (SANE/SART) services to victims and their families 24 hours a day, 7 days a week, 365 days a year.

4 SCHEDULING A FORENSIC INTERVIEW

1. Once you have made initial contact with the non-offending caregiver listed on the report, confirmed that the victim is safe, contact the Intake Coordinator to set up an appointment for a forensic interview and medical exam if necessary. Please be prepared to provide relevant information about the allegations as well as the alleged victim and their caregiver at that time, (i.e. demographics, contact information, special needs/disabilities, etc.).

2. Notify your investigative counterparts (CPS/Law Enforcement) about the report and plans for initiating the investigation, including but not limited to scheduling of the forensic interview and/or medical exam.

3. The Intake Coordinator will contact the non-offending caregiver to schedule the forensic interview/medical exam at the earliest time available that effectively addresses the unique needs of the child/family. You will receive a confirmation email from the Intake Coordinator once the appointment(s) have been scheduled.

4. If the child's legal guardian will not be present at the interview, it is the responsibility of the MDT to obtain the legal guardian's signature for consent PRIOR to the interview.

To schedule a forensic interview, please call: 810-664-9990

4 SCHEDULING A SANE/SART MEDICAL EXAM

1. If the assault occurred within 120 hours (5 days) of the report, call CAC Lapeer's 24-hour answering service at 810-664-9990 and request the SANE/SART Coordinator to contact you. If the incident occurred more than 120 hours ago, there is no evidence to collect. Refer the victim to the hospital for emergency trauma care and to follow up with their doctor.

2. The SANE/SART Coordinator will contact the referring agency and the Sexual Assault Nurse Examiner to coordinate an emergency medical examination time as soon as possible. At the request of the referring agency, the SANE/SART Coordinator may contact the victim or caregiver to confirm the appointment.

3. The SANE/SART Coordinator and a Sexual Assault Nurse Examiner will meet the victim at CAC Lapeer to complete the medical examination and provide the victim with comfort, support, and advocacy. After the exam, victims and families are referred to appropriate services, including but not limited to counseling, child protective services, and law enforcement.

4. Once the emergency forensic medical exam is complete, the SANE/SART Coordinator will enter the evidence kit information into the Track-Kit™ system. An email will notify the appropriate law enforcement agency that the evidence kit is ready to be picked up. Sexual Assault Evidence Kits must be retrieved at CAC Lapeer by Law Enforcement within 48 hours of the medical examination.

5 FORENSIC INTERVIEWING: BEST PRACTICES

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Forensic interviewers conduct legally-sound, developmentally appropriate, culturally-competent, neutral, fact-finding interviews of children (and adults with disabilities) in accordance with CAC Lapeer's referral policy. Forensic interviews are provided at CACs across the country as part of the multidisciplinary team response. Interviews are coordinated with the multidisciplinary team to avoid duplicative interviewing and minimize trauma to the child. At CAC Lapeer, Forensic Interviewers follow the Michigan Forensic Interviewing Protocol developed by the Governor's Task Force on Child Abuse and Neglect and Department of Health and Human Services. Our Forensic Interviewers also participate in monthly peer reviews to receive feedback on interviews conducted, share general practice with peers, and review relevant and updated research in forensic interviewing. There is research to support the specialized training and background of those professionals conducting forensic interviews. Resources detailing forensic interviewing best practices can be found in subsequent pages.

Children are referred to the CAC for forensic interviews by Child Protective Services and/or law enforcement. Interviews are coordinated with all parties involved to include child welfare professionals, law enforcement, prosecution, victim advocacy, and mental health. On the day of the interview, pre- and post-interview meetings will take place with the forensic interviewer and team members present to discuss case details. At the discretion of the MDT, the family may also have the opportunity to meet with the team after the interview to discuss the next steps in the investigation. All forensic interviews will be video, and audio recorded with the written consent by legal guardian of the child. Forensic interview recordings are property of law enforcement present for the interview.

5 FORENSIC INTERVIEW GUIDELINES

CAC Lapeer conducts forensic interviews of children referred to the center under guidelines outlined by the Operational Agreement between CAC Lapeer and its partners. The goal of the forensic interview is to obtain a statement from a child in a developmentally-sensitive, unbiased, and truth-seeking manner that will support accurate and fair decision-making in the criminal justice and child welfare systems. The following guidelines detail the forensic interview process at CAC Lapeer:

- All forensic interviews are scheduled through our Intake Coordinator at 810-664-9990. A confirmation will be emailed to all investigative agencies involved when the forensic interview date and time is confirmed with the family.
- If interview accommodations are needed due to disabilities or other special circumstances, arrangements will be made prior to the interview. Special accommodations such as diagrams, communication aids, or neutralizing the interview environment will be made upon consultation with the multidisciplinary team.
- If the child is reported to speak a language other than English, every attempt will be made to conduct the interview in the child's native language. If there is no Forensic Interviewer who speaks the child's language, CAC Lapeer Intake Coordinator will arrange for an interpreter to participate in the forensic interview.
- Any and all pertinent information obtained by law enforcement, Child Protective Services, CAC Lapeer Intake Coordinator and/or Family Advocate will be provided to the Forensic Interviewer prior to the interview.
- Forensic interviews will be conducted with a basic understanding of child development as well as understanding the nature and forms of abuse. Procedures used in interviews will be consistent with nationally recognized models of interviewing, such as the Michigan Forensic Interviewing Protocol. A link to the Michigan Forensic Interviewing Protocol can be found on the subsequent Forensic Interviewing Resources page.
- At CAC Lapeer, the following stages will occur during a forensic interview:

  Stage I Prepare for the Interview
  Stage II Introduce Yourself and Build Rapport
  Stage III Establish the Ground Rules
  Stage IV Conduct a Practice Narrative
  Stage V Introduce the Topic
  Stage VI Elicit a Free Narrative
  Stage VII Question, Clarify, and Test Hypotheses
  Stage VIII Close the Interview

  *Any variation in the above stages will be determined by the Forensic Interviewer in the best interest of the child.
- If the child discloses to new allegations of physical and/or sexual abuse, domestic violence, and/or neglect, it is the responsibility of the Child Protective Services or law enforcement investigator that is present for the Forensic Interview to follow-up with the family and subsequent reports (following CPS/Law Enforcement guidelines and procedures).
- Forensic Interviews will be recorded with the child's legal guardian's written consent and turned over to law enforcement involved in the investigation.

5 FORENSIC INTERVIEW PROCESS

BEFORE THE INTERVIEW

- The Alleged Perpetrator is NOT permitted to come to the Center with the child. If the Alleged Perpetrator is present, they will be asked to leave by either CPS or Law Enforcement.
- CAC Lapeer's Family Advocate will contact the non-offending caregiver to provide a brief explanation of the interview process, the CAC's role, and complete a pre-interview questionnaire to gather additional information about the child/family.
- The MDT will meet prior to the interview to discuss case information and any specific concerns or areas to be covered during the forensic interview. This meeting will take place outside the presence of the family.

DURING THE INTERVIEW

- The MDT observes the forensic interview at the Center via a closed-circuit video feed.
- The MDT is responsible for communicating any questions that have not yet been addressed. The Intake Coordinator, or another staff member running the recording equipment, will relay questions to the Forensic Interviewer at the appropriate time.
- The Family Advocate provides support for the non-offending family members, conducts a family needs screening to ensure adequate services are provided and provides education to parents regarding child sexual and physical abuse dynamics.
- A videorecording of the forensic interview is produced and is property of Law Enforcement involved in the investigation.

AFTER THE INTERVIEW

- The MDT will gather for a post-forensic interview meeting to discuss further collaboration efforts for the case. The CAC Lapeer Family Advocate will bring the caregiver to the post-interview meeting upon request to advise them of interview outcomes, next steps, and what to expect during their investigation. It is encouraged to discuss with team members how much information will be shared prior to meeting with the caregiver.
- The Child/Family Therapist present for the interview will meet with the non-offending caregiver to provide crisis counseling and make the necessary referrals for counseling services.
- The Family Advocate will follow up with the non-offending caregiver at 2 weeks, 6 weeks, 3 months, and 6 months post-interview to provide additional support, offer resources, and notify the family of case updates.

5 FORENSIC INTERVIEW RESOURCES

1. Michigan Forensic Interviewing Protocol, 4th Edition

https://www.michigan.gov/documents/dhs/dhs-pub-0779_211637_7.pdf

2. A Multidisciplinary Team Approach to the Investigation and Prosecution of Child Abuse Cases Involving Recantation

https://www.childabuseprosecution.apainc.org/monographs

3. Child Forensic Interviewing: Best Practices, OJJDP

https://ojjdp.ojp.gov/sites/g/files/xyckuh176/files/pubs/248749.pdf

4. Considerations for the MDT/CAC Approach to Recantation-Infographic

http://www.nrcac.org/wp-content/uploads/2020/04/recantation-infographic.pdf

5. Forensic Interviewing: What Every Prosecutor Needs to Know

https://www.childabuseprosecution.apainc.org/monographs

6. National Children's Advocacy Center's Child Abuse Library Online, Forensic Interviewing Bibliographies

https://calio.org/resources/bibliographies/

7. Position paper on the Introduction of Evidence in Forensic Interviews of Children

http://calio.org/images/position-paper-introduction-evidence-fi2.pdf

8. "How" and "Why" Prompts in Forensic Investigative Interviews with Preschool Children

https://www-tandfonline-com.proxy1.cl.msu.edu/doi/full/10.1080/10888691.2016.1158652

9. Children's Knowledge of Genital Anatomy and Its Relationship With Children's Use of the Word "Inside" During Questioning About Possible Sexual Abuse

https://www-tandfonline-com.proxy1.cl.msu.edu/doi/full/10.1080/10538712.2016.1269863

10. When Interviewing Children: A Review and Update

https://www.nationalcac.org/wp-content/uploads/2017/11/When-Interviewing-Children-A-Review-and-Update.pdf

11. Is Anybody Listening? The Literature on the Dialogical Process of Child Sexual Abuse Disclosure Reviewed

https://doi-org.proxy1.cl.msu.edu/10.1177/1524838015584368

12. Telling Interviewers About Sexual Abuse, Predictors of Child Disclosure at Forensic Interviews

http://www.unh.edu/ccrc/pdf/CV180.pdf

6 MEDICAL EXAMS: WHAT MDT PARTNERS NEED TO KNOW

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All children who are suspected victims of child sexual abuse are entitled to a medical exam conducted by a specialized medical provider. CACs/MDTs can share with families and partner agencies the reason a medical exam is important:

- To ensure the health and well-being of the child
- To reassure the child that everything is okay with their body
- To diagnose and treat medical conditions that may be related to sexual abuse
- To document any possible physical and forensic findings
- To allow for collection of evidence that may be present on the child's body or clothing (within 120 hours of abuse)

Emergency medical examinations are conducted at the CAC if the abuse occurred within 120 hours of the report (see page 13 to schedule an emergency medical exam). If the abuse occurred more than 120 hours prior to the report, all families are encouraged to follow up with their primary care provider to seek medical treatment for their child. It is also important for CACs/MDTs to share with families and partner agencies that most medical exams (over 90%) have normal findings, but that does not mean sexual abuse did not occur. Medical professionals can explain "why normal is normal" in court if needed. The medical exam is not painful and assures children and their caregivers that their body is okay in spite of what has happened to them.

The Role of Medical Provider:

The role of medical provider on the multidisciplinary team and at Case Review is to:

1. Explain the results of medical exams conducted;
2. Explain what happens during a medical exam and when it is recommended;
3. Discuss why a normal exam does not mean abuse did not happen;
4. Discuss who should conduct a medical exam and;
5. Answer any questions from the MDT.

Resources

NRCAC - Medical Exams in Child Abuse Cases: https://www.nrcac.org/resources/medical-resources/

7 MINIMAL FACTS GUIDELINES FOR LAW ENFORCEMENT & CPS

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Upon a report of child abuse allegations, both law enforcement and child protective services have initial responsibilities to ensure child safety and assess the situation before referring to the CAC for a forensic interview. Child Protective Services has a timeframe in which they need to see the child/family to assess safety and respond to family needs. The initial child contact must be completed within Child Protective Services policy timeframe but may not require a full interview of the child within this initial timeframe. In many cases, general information necessary to ensure child safety may be gathered from guardians/other referral sources, if they are protective of the child. In order to preserve the forensic interview, first responders should avoid interviewing the child and instead, interview the caregiver or complainant separate from the victim to gather basic information and assess the child's safety, emotional state, and physical condition.

It is understood that all investigations differ in some respect and the approach to the minimal fact's interviews must be flexible and permit the responding officer or child protection investigator to use their on-the-scene judgement. These guidelines do not supersede investigative needs if it is an emergency situation, safety is at risk, or an immediate arrest of the perpetrator is possible. In addition, if the child volunteers detailed information, that information should be documented, and a report should reflect the circumstances under which the child made the disclosure(s). If the child is not volunteering information, questioning - particularly leading questions - should be avoided and minimal facts should be developed from other sources whenever possible. If a caregiver or another adult can tell you what the child has disclosed, there should be no reason to question the child at this point.

Once minimal facts have been established and a decision has been made to make a referral for a forensic interview at the CAC, the caregiver should be advised that an in-depth interview will take place at CAC Lapeer, where all agencies will be represented and trauma to the child will be minimized. First responders should advise the caregiver or complainant NOT to question the child or contact the suspect and to document any statements made by the child.

7 MINIMAL FACTS GUIDELINES FOR LAW ENFORCEMENT & CPS

Minimal facts interview with caregivers include gathering basic information regarding:

1. The alleged perpetrators
2. Witnesses and/or additional victims
3. Where on the child's body did the abuse take place and what happened
4. When the abuse happened (last time, frequency)
5. Location where the abuse occurred (establish jurisdiction)
6. Necessary steps to assure the safety of the child and other potential victims (siblings or others to whom perpetrator has access)
7. Whether immediate medical attention is necessary - if abuse has taken place within 120 hours (5 days), a medical exam is necessary to gather evidence

Available Resources:

1. NRCAC Minimal Facts Guidelines, 2019

http://www.nrcac.org/wp-content/uploads/2020/05/MinimalFactsGuidelines_2020.pdf

2. NCAC's Online Training: Law Enforcement's Initial Response to Child Maltreatment

https://www.nationalcac.org/recorded_trainings/law-enforcements-initial-response-to-child-maltreatment/

8 CASE REVIEW

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MDT Case Review meetings are conducted on the third Tuesday of each month at Noon.

CAC Lapeer values and encourages collaboration and information-sharing among its partner agencies. The purpose of MDT Case Review meetings is to review cases that have received a forensic interview at CAC Lapeer. Monthly Case Review meetings improve communication and coordination of efforts between partner agencies and improve the overall system response to alleged cases of child abuse. MDT Case Review often reveals additional information affecting agency decisions and eventual outcomes for children and protective family members. Case Review is an important step in the multidisciplinary approach. It is not merely a meeting to 'report in.' Active participation and meaningful dialogue during case review are essential to effective problem solving and discovering the best possible approach to each child's case.

Generally, at Case Review, the team should:

- Discuss, plan, and monitor the progress of the investigation
- Review medical evaluations
- Discuss child protection and other safety issues
- Discuss emotional support and treatment needs of the child and family
- Assess the family's reactions and response to the child's disclosure and involvement in the civil/criminal justice system
- Discuss ongoing cultural and special needs issues relevant to the case
- Consider other factors as determined by the team

8 WHY SHOULD I ATTEND CASE REVIEW?

Regularly scheduled Case Review meetings are National Children's Alliance core standard for accredited CACs. Since all CACs are multidisciplinary by nature, Case Review becomes the formal process through which professionals share information that inform team decisions and assist participating agencies in making decisions about cases. Case Review allows the CAC to monitor cases and bring the MDT's knowledge, experience, and expertise together. Active participation by all involved agencies encourages mutual accountability and ensures that the children's needs are met sensitively, effectively, and in a timely manner.

1. Ensures proactive planning and case coordination in the best interest of the child and family
2. Enables team members to identify gaps in resources and conflicts in service provision
3. Helps prevent cases from "falling through the cracks" in the system
4. Provides an opportunity for new agency personnel to become acquainted with other team members and the case review process.
5. Allows each team member to retain their agency identity/mandate while becoming familiar with other systems involved with abused children and their families

8 CASE REVIEW GUIDELINES

The following lists are intended to outline some of the types of information shared by each of the MDT disciplines and the roles played by those disciplines at MDT Case Review meetings.

Law Enforcement:

- Brief summary of the general offense report and status of the investigation thus far
- Did the suspect give a voluntary statement?
- Were charges filed? If so, what were the charges?
- Does the alleged perpetrator have a previous criminal history?
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to the criminal investigation process and/or procedures

Child Protective Services:

- Brief summary of the intake/referral and status of the investigation thus far
- Any other alleged victims, siblings of victims, or alleged perpetrators not on CAC Intake
- Any corrections/additional information since initial report on names, ages, unknowns, etc.
- Information regarding whether the case will be opened for services by DHHS or closed, and/or if there is any pending or anticipating family court action
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to DHHS processes and/or procedures

Prosecution:

- Any information, ideas, or suggestions - from a prosecution perspective - on cases currently in investigative stages
- Updates on previous investigations being scheduled for upcoming court proceedings (grand jury, preliminary hearings, pleas, trials, etc.)
- Guidance regarding criminal court issues on cases being discussed
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to criminal court processes and/or procedure

8 CASE REVIEW GUIDELINES CONT.

Forensic Interviewer:

- Brief summary of forensic interview outcomes on cases being discussed
- Any unique or concerning behaviors observed during the forensic interview that may impact the investigation, safety decisions, referrals for medicals, mental health and/or family advocacy services and/or prosecution efforts
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to forensic interviewing processes and/or procedures

Victim Advocates:

- Updates or status reports on specific cases being staffed for clients who were provided advocacy support and services, social service referrals, etc.
- Any unique or concerning behaviors or dynamics observed during conversations with non-offending caregivers that might impact the investigation, safety decisions, referrals for medical and/or mental health services and/or prosecution efforts
- Guidance regarding family support services available and potential need for benefits of advocacy support services
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate

Medical Professional:

- Updates or status reports on specific cases being discussed for clients who have received a medical assessment
- Guidance regarding potential need for a medical assessment as well as its benefits
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to medical processes and/or procedures

Mental Health Professional:

- Updates or status reports on any clients involved in cases being discussed
- Any concerns or issues - from a therapeutic perspective - on cases being discussed
- Guidance regarding mental health considerations related to child victims and/or others involved in cases
- Any concerns, questions, or needs for which team members may be able to offer suggestions, ideas, or assistance, as appropriate
- Respond to team questions related to therapy processes and/or procedures

9 THE INVESTIGATIVE TEAM: CPS, LAW ENFORCEMENT, & PROSECUTION

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The role of child protection and law enforcement on the MDT is to provide referrals for child abuse cases that meet the community-specific case acceptance criteria (sexual abuse, physical abuse, neglect, commercial sexual exploitation of children, witness to violence, and youth with problematic sexual behavior, etc.) to the CAC for forensic interviews and/or medical examinations, observe the forensic interview, communicate with the MDT about the status of the case, and participate in case review.

The Role of Child Protective Services (CPS):

CPS investigates reports of child abuse and neglect and provides services to children who have been abused or neglected by a person responsible for a child's care, custody, or welfare. The focus of CPS is the protection of children and to act in the children's best interest. The decisions made concerning the protection of the child will be based upon the professional judgment of the CPS staff in compliance with CPS policy, statutory law and placement factors. Participation in the MDT does not take precedence over CPS policies and procedures.

The Role of Law Enforcement:

Law Enforcement coordinates with CPS to refer child abuse cases to the CAC for a forensic interview and medical examination (if the abuse occurred within 120 hours of the report). Law Enforcement attends the forensic interview at the CAC, investigates criminal activity, and files criminal charges when there is enough evidence. Participation in the MDT does not take precedence over law enforcement investigative policies.

The Role of Prosecution:

Prosecutors may attend the forensic interview at the CAC and provide recommendations to assist the investigation. Once law enforcement finishes their investigation and files criminal charges, prosecutors evaluate the forensic interview, review statements of any witnesses, suspects, and any other corroborative evidence to make decisions about criminal prosecution. Charging decisions shall be based upon the professional judgment of the prosecutor's office. If a case goes to criminal court, the prosecutor and victim advocate are responsible for maintaining contact with the family about the status of the case, providing information about victim rights, and preparing children and families for court.

10 VICTIM ADVOCACY THROUGH THE CAC PROCESS

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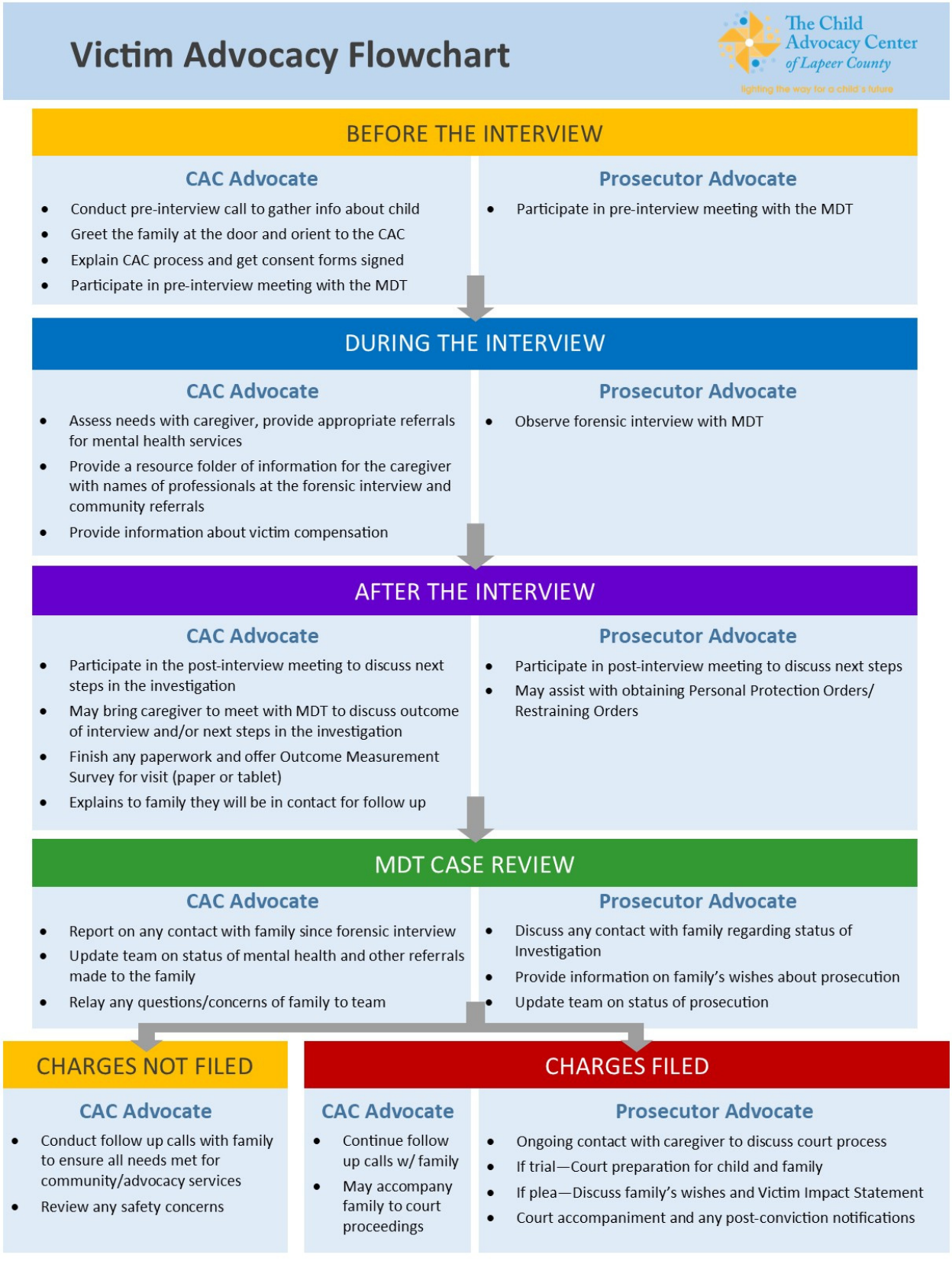
Victim advocacy services are essential to support the child victim and the non-offending caregiver(s) in the aftermath of allegations of abuse. Research shows that a supportive caregiver is a critical piece in the healing and recovery for children. CAC Lapeer's Family Advocate is present at the time of the forensic interview to meet with the MDT during the pre-meeting to discuss and share information with the MDT. The Family Advocate meets with the caregiver and other non-offending family members during the forensic interview to provide support and information about the CAC. The Family Advocate explains the forensic interview process, Victim Compensation information, and provides the names and contact information of the investigative team members. Referrals are made for mental health services, follow up services, and any other appropriate resources for the caregiver. The advocate will bring the caregiver to the post-forensic interview meeting with the MDT upon request to discuss the interview's outcome and the next steps in the investigation process. After the forensic interview, CAC Lapeer's Family Advocate continues to follow up with the caregiver periodically to offer support, receive updates about the child, encourage mental health services, and offer assistance with any additional referrals or resources.

Multiple Advocates (See Victim Advocacy Flow Chart)

More than one Victim/Family Advocate may perform these functions at different points throughout a case to ensure continuity and consistency in service delivery. Examples are:

- The CAC Family Advocate works with the child and family at the time of the forensic interview to provide information, support, crisis intervention, referrals, and follow up calls.
- The Prosecutor's Office Victim Advocate is responsible for provision of updates to the family on case status, continuances, disposition, sentencing, inmate status notification (including offender release from custody), provision of court education and courthouse/courtroom tours, support, and court accompaniment.
- Both the CAC Family Advocate and the Prosecutor's Office Victim Advocate participate in monthly Case Review meetings to discuss contact with family since the forensic interview, update the MDT on status of referrals made to the family, and relay any questions/concerns of family to the MDT.
- Both the CAC Family Advocate and the Prosecutor's Office Victim Advocate may accompany family to court proceedings.

10 VICTIM ADVOCACY FLOWCHART



11 EVIDENCE-BASED MENTAL HEALTH SERVICES

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CAC Lapeer provides trauma-informed, evidence-based mental health services on-site for children we serve and their non-offending family members at no cost. CAC Lapeer's Child and Family Therapists are trained in Trauma-Focused Cognitive Behavioral Therapy and provide other treatment options, such as play therapy and trauma-informed individual, family, and group therapy. Our Therapists can also provide referrals to community agencies that provide mental health services for child abuse victims and their families. Quality mental health services are critical for the long-term well-being and healing of children victimized by abuse. Trauma-informed mental health care is a specialized clinical process designed to assess and mitigate the long-term adverse impacts of trauma or other diagnosable mental health conditions. Research has shown that childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs); see resources below.

The Role of Mental Health Provider:

The role of mental health provider on the multidisciplinary team and at Case Review is to:

1. Provide clinical information regarding clients (if HIPPA release authorized);
2. Provide information about trauma-informed, evidence-based treatment modalities;
3. Discuss impact of trauma on child victims and their caregivers;
4. Answer any questions from the MDT.

11 MENTAL HEALTH SERVICES

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

The goal of TF-CBT is to help address the biopsychosocial needs of children with Posttraumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with Cognitive Behavioral Therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication. CAC Lapeer offers several other treatment options such as play therapy and trauma-informed individual, family, and group therapy to best meet the unique needs of each child and caregiver.

Crisis Counseling

Immediately after a forensic interview, a CAC Lapeer Therapist meets with the caregiver to offer support, provide brief psychoeducation on trauma-informed parenting, assess the family's physical needs and/or safety concerns, and encourage mental health services for their child. The caregiver is instructed on how to support their child after the forensic interview and how to respond should their child disclose additional information related to their abuse.

Available Resources:

1. **Adverse Childhood Experience(s), ACE Study**
   https://www.cdc.gov/violenceprevention/acestudy/about.html
2. **Adverse Childhood Experiences Study Video**
   https://youtu.be/IbsXh6wwc3Q
3. **CAC Directors' Guide to Mental health Services for Abused Children**
   http://www.westernregionalcac.org/wp-content/uploads/2018/04/CACDirectorsGuideforMentalHealthServices.pdf
4. **Thriving Kids 2019: A National Report on Mental Health Outcomes in Children's Advocacy Centers**
   https://www.nationalchildrensalliance.org/wp-content/uploads/2019/02/Thriving-Kids-2019-web.pdf
5. **NCA - Evidence-Based Mental Health Treatments for Child Abuse Victims**
   http://www.nrcac.org/wp-content/uploads/2018/01/nca_Guide-to-Evidence_Brochure_8.5x11_FINALweb-1.pdf
6. **NCA - Helping Your Child Heal From Abuse**
   http://www.nrcac.org/wp-content/uploads/2018/01/nca_Caregiver_booklet_8.5x11_FINALweb-1.pdf
7. **NCA - Ensuring the Well Being of Children, A Comprehensive Approach to Trauma-Informed Care for CACs**
   http://www.nrcac.org/wp-content/uploads/2018/01/nca_Trauma-informed-Care-Brochure_8.5x11_FINALweb-1.pdf

12 ACRONYMS

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CAC	Child Advocacy Center
CPS	Child Protective Services
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
DV	Domestic Violence
EBPs	Evidence Based Practices
FA	Family Advocate
FI	Forensic Interview
ICAC	Internet Crimes Against Children
LE	Law Enforcement
MDT	Multidisciplinary Team
MRCAC	Midwest Regional Children's Advocacy Center
MOU	Memorandum of Understanding
NCA	National Children's Alliance
NCAC	National Children's Advocacy Center
NCJTC	National Criminal Justice Training Center
NCMEC	National Center for Missing and Exploited Children
NCTSN	National Child Traumatic Stress Network
OJJDP	Office of Juvenile Justice and Delinquency
OMS	Prevention
PA	Prosecuting Attorney
SANE	Sexual Assault Nurse Examiner
SART	Sexual Assault Response Team
VA	Victim Advocate

13 ATTACHMENT 1: MDT ROLES & RESPONSIBILITIES

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MDT Roles & Responsibilities

I. REFERRAL PROCESS		
Discipline	Roles	Responsibilities
Law Enforcement	Refer cases where there are allegations of sexual abuse, physical abuse, witness to violence, or other forms of violence of anyone under 18 years old or adults with developmental disabilities	• Call the CAC • Provide case information and your availability • Confirm date/time of the forensic interview
Child Protective Services	Refer cases where there are allegations of sexual abuse, physical abuse, witness to violence, or other forms of violence of anyone under 18 years old or adults with developmental disabilities	• Call the CAC • Provide case information and your availability to the CAC • Confirm date/time of the forensic interview
Prosecutor's Office	Consult with CAC and law enforcement regarding referrals to the CAC if necessary	• Work with law enforcement and CAC regarding referrals • Confirm date/time of the forensic interview
All Other MDT Members	Make a Mandated Report to the Child Abuse Hotline	• Call the Child Abuse Hotline to report any suspicion or allegations of child abuse or neglect (1-855-444-3911)

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MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW		
Discipline	Roles	Responsibilities
Law Enforcement	Observe interview to gather information to investigate criminal acts	• Arrive on time for the forensic interview • Participate in pre-interview meeting with other MDT members • Share information about any prior knowledge of victim or family or suspect • Participate in the interview process and relay any specific questions to the Forensic Interviewer and/or Intake Coordinator • Participate in the post-interview meeting with the MDT and caregiver (if applicable)
Child Protective Services	Observe interview to gather information to investigate abuse and neglect	• Arrive on time for the forensic interview • Participate in pre-interview meeting with other MDT members • Share information about victim or family or suspect • Participate in the interview process and relay any specific questions to the Forensic Interviewer and/or Intake Coordinator • Participate in the post-interview meeting with the MDT and caregiver (if applicable)

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MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW		
Discipline	Roles	Responsibilities
Prosecutor's Office	Observe interview to gather information regarding prosecution of criminal acts	• Arrive on time for the forensic interview • Participate in pre-interview meeting with other MDT members • Share information about any prior knowledge of victim or family or suspect • Participate in the interview process and relay any specific questions to the Forensic Interviewer and/or Intake Coordinator • Provide feedback to the forensic interviewer regarding legal issues while observing the forensic interview • Participate in the post-interview meeting with the MDT
CAC Family Advocate	Provide support to the caregiver	• Attend pre– and post– interview meetings with the MDT • Provide support to the caregiver while child is interviewed • Provide information and referrals to community resources as needed • Offer OMS survey to caregivers at the end of the appointment

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MDT Roles & Responsibilities

II. ROLES AND RESPONSIBILITIES AT THE FORENSIC INTERVIEW		
Discipline	Roles	Responsibilities
Mental Health	Provide consultation to the team regarding mental health issues related to trauma and child development	• Participate in pre-interview meeting with other MDT members • Observe the forensic interview and provide expertise on mental health issues related to the child/family (if applicable) • Participate in the post-interview meeting with the MDT • Provide crisis counseling to the caregiver and provide referrals to trauma-informed mental health treatment
Medical Provider (if attending)	Provide information and consultation regarding medical care for child abuse victims	• Arrive on time for the forensic interview • Participate in pre-interview meeting with other MDT members • Share information about victim or family, including medical exam findings if already completed • Participate in the interview process and relay any specific questions to the Forensic Interviewer and/or Intake Coordinator • Participate in the post-interview meeting with the MDT

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MDT Roles & Responsibilities

III. ROLES AND RESPONSIBILITIES AFTER THE FORENSIC INTERVIEW		
Discipline	Roles	Responsibilities
Law Enforcement	Investigate criminal acts based on information obtained at forensic interview	• Interview witnesses & suspect(s) • File charges with prosecutor (if applicable) • Arrest or summons • Communicate with MDT Coordinator regarding status of investigation • Participate in Case Review
Child Protective Services	Determine outcome of child protection investigation	• Make investigation determination • Communicate with family and MDT Coordinator regarding decision to open/close case • Participate in Case Review
Prosecutor's Office	Make decisions regarding prosecution of criminal acts	• Communicate with law enforcement regarding investigation • Discuss charging options • Communicate with MDT Coordinator regarding decision to accept/deny case • Prosecute charged cases • Participate in Case Review

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MDT Roles & Responsibilities

III. ROLES AND RESPONSIBILITIES AFTER THE FORENSIC INTERVIEW

Discipline	Roles	Responsibilities
CAC Family Advocate	Support the caregiver through the investigation process and prosecution, if any	• Follow up with family on a regular basis post-interview to confirm resources secured • Provide support during ongoing investigation and prosecution • Provide case updates to caregiver • Participate in Case Review
Mental Health	Provide consultation regarding mental health treatment	• Provide specialized trauma-focused mental health care to victims and their non-offending caregivers • Update MDT members regarding child's mental health treatment progress, any issues and/or new information • Participate in Case Review
Medical Provider	Provide consultation regarding medical care	• Provide specialized medical exams • Provide medical information to MDT members • Participate in Case Review

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TRAUMA-INFORMED PRACTICE
BLUE KNOT FOUNDATION FACTSHEET FOR WORKERS IN DIVERSE SERVICE SETTINGS

1. The majority of people who access the community services and mental health sectors have trauma histories; i.e. have undergone many overwhelming life experiences, interpersonal violence and adversity.

2. Current organisation of service-delivery does not reflect the prevalence of trauma. This has led to calls for implementation of a new paradigm – *Trauma-Informed Care and Practice* (TICP) with change to existing ways of operating, and application *across the full spectrum of service-delivery*. See the Blue Knot Foundation Guidelines at **www.blueknot.org.au/guidelines** *(i.e. two sets of guidelines; second set is non-clinical for services, agencies and organisations to work in a `trauma-informed' way).*

3. Trauma-informed practice recognises that many problems, disorders and conditions are *trauma-related*. It rests on awareness of the impacts of trauma (as distinct from directly treating it) emphasises a `do no harm' approach and aims to avoid *re*-traumatisation.

4. Key principles of trauma-informed practice – ***safety, trustworthiness, choice, collaboration*** and ***empowerment*** – should be embedded *for all activities at all levels of service-delivery*. They enable positive relational experiences, established by research as necessary both for resolution of trauma and for general well-being. Trauma-informed practice is `win-win'!

5. Trauma is a state of high arousal in which coping mechanisms are overwhelmed in response to extreme stress. Our normal `survival' responses (`fight', `flight' and `freeze') activated by the perception/experience of threat are initially protective. They only *become* pathological if traumatic experience is not resolved after the precipitating event/s.

6. Unresolved trauma has pervasive effects, and impairs a wide range of functioning. Trauma radically restricts the capacity to respond flexibly to daily stress and life challenges. *If trauma is not resolved people cannot `move on'.*

7. `Complex' trauma is *cumulative, repetitive and interpersonally generated*. It differs from, and is more common than, `single-incident' trauma (i.e. post-traumatic stress disorder; PTSD). It includes *child abuse* in all its forms; sexual, physical, emotional and neglect.

8. Unresolved trauma has life-long impacts and affects the next generation. *Parents do not need to be actively abusive for their children to be adversely affected* (e.g. parents with unresolved trauma histories may be unable to connect with their children emotionally).

9. *It is possible to recover from trauma.* The resolution of trauma in adults has positive effects on their children and can avoid transmission of trauma to the next generation.

10. Research has established the relationship between overwhelming childhood experiences and emotional **and** physical health problems in adulthood. *Childhood coping mechanisms* become risk factors for adult ill health if overwhelming childhood stress is not resolved.

11. Many symptoms and challenging behaviours should be reappraised as responses to trauma, with focus not on what is *wrong* with a person but rather on what *has happened* to a person.

12. The structure of the brain changes in response to experience (*neuroplasticity*). Early interactions with caregivers `sculpt' the developing brain; experience of intimate relationships impacts our ability to cope with stress.

13. When a child is threatened, two brain circuits are activated simultaneously. Caught in the `biological paradox' between the `survival reflex' and the `attachment circuit', the child's internal world collapses (Siegel, 2012). The brain of the traumatised child reorientates from `*learning*' to `*survival*'.

blue knot foundation
National Centre of Excellence for Complex Trauma

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TRAUMA-INFORMED PRACTICE
BLUE KNOT FOUNDATION FACTSHEET FOR WORKERS IN DIVERSE SERVICE SETTINGS

14 Traumatised children often have problems with *emotional regulation, relationships, attention* and *reasoning under stress.* Such responses are frequently misinterpreted, evoking an ineffectual, punitive approach. While setting of boundaries is important, *consistent care,* rather than punishment, is required.

15 *Dissociative* responses to extreme stress (`spacing out') are common in infants and children, because under threat, young children are rarely able to `fight' or `flee'. *Both visible agitation (hyperarousal) and `emotional blunting' (hypoarousal) are trauma responses.*

16 Because recovery is relational, positive experiences need to occur *within services and organisational settings* accessed by people with trauma histories. Trauma-informed service-delivery requires sensitivity to diverse coping strategies, recognition that both agitation *and* withdrawal are signs of distress, and that challenging behaviour may be trauma-related.

17 Basic knowledge of the brain helps us understand the effects of negative experiences on our functioning. This understanding can increase empathy with clients, and *self*-compassion for our own compromised functioning when we are stressed and `not at our best'.

18 The brain comprises three regions from `top to bottom': **cortex** *(thinking)* **limbic area** *(emotions)* and **brain stem** *(controls states of arousal, including `survival' responses).* See Dan Siegel's `hand model of the brain at **http://www.youtube.com/watch?v=DD-lfP1FBFk** *Under stress, `lower' brain stem responses flow `bottom up' and limit our ability to be calm, reflect and respond flexibly.*

19 *Your own awareness, conduct and self-care affect your interactions with clients.* Personal well-being is a precondition for trauma-informed service-delivery. Staff well-being (which includes individual and organisational components) fosters empathy, reduces risk of vicarious trauma, and the likelihood of destabilising interactions with clients. Mutually rewarding, safe, courteous and respectful interactions *actively assist trauma recovery.*

20 In implementing the key principles of *safety, trustworthiness, choice, collaboration* and *empowerment,* trauma-informed practice focuses both on *what* the service offers, and on *the way in which it is provided. How* you provide services – not just *what* you do – is crucial to operating in a trauma-informed way.

21 You can learn more about trauma-informed practice by attending Blue Knot Foundation trauma-informed training. These programs can be tailor-delivered in-house on request. Alternatively you may attend one of the many training opportunities scheduled regularly around the country. To find out more, go to **www.blueknot.org.au/training**

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