

Multidisciplinary Response to Child Maltreatment: International Implementation of the Children's Advocacy Center Model

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THE IMPORTANCE OF RESPONDING TO CHILD MALTREATMENT

The recognition of child maltreatment, especially child sexual abuse, has changed dramatically over the past 30 years as many courageous individuals, such as Dr. Henry Kempe, challenged professionals and the broader society to recognize an issue affecting so many children that had been widely ignored. Responding to child abuse is a human rights issue, as every child has the right to be protected from abuse and neglect and there should be social programs with highly qualified professionals available to provide the greatest quality care for those affected by abuse, as described in Article 19 of the United Nations Convention on the Rights of the Child (1989).

We know that some individuals may disagree with the notion of child maltreatment being an important human rights issue amidst all of the other issues facing our world. But we can also consider child abuse an issue that affects our world's health and economic productivity. Women who were sexually abused have 16 percent higher health care costs across their lifespan than their nonabused peers, and women who were both physically and sexually abused have 36 percent higher health care costs across their lifespan (Bonomi et al., 2009). Further, the Adverse Childhood Experience Study (Felitti et al., 1998) found countless alarming connections between child maltreatment/exposure to adverse childhood experiences and countless negative health outcomes, including a dramatically shorter lifespan for those exposed to multiple adverse childhood experiences. These studies are of concern for all. If the human rights perspective is not enough, the simple economics and long-term health impacts are immensely compelling reasons to improve the response to child abuse.

Because of both the human rights and health/economic considerations, the response to child abuse is in the best interest of all countries, and there have been efforts to respond to child sexual abuse for many decades, if not longer. However, the effectiveness of these efforts should always be enhanced by the newest research and practice considerations.

THE TRADITIONAL RESPONSE TO CHILD MALTREATMENT

The response to child maltreatment varies widely throughout the world, depending upon culture, the designated systems mandated to intervene, and the individuals within those systems. In some countries, there is a dramatic engagement of various government entities to address the issue of child abuse; in others, the child abuse response is a collaboration between government entities and nongovernmental organizations (NGOs); and in still others, there is very little—if any—attention to coordinating an effective response to child abuse, thus leaving children even more vulnerable. In countries where there is a response, the systems designated to respond often include law enforcement, child welfare (if present), and/or prosecutors or some similar type agencies established by the government to intervene in cases where children are being treated

outside the cultural norms of the society. Traditionally, these responses have been undertaken in isolation from one another, with each agency focusing on the work necessary to meet its own mandates for investigating child maltreatment. This approach prioritizes the needs of the investigating agencies rather than the needs of the child. The children's advocacy center (CAC) model dramatically modifies this approach, organizing the collaborative efforts of those mandated to assure the protection and safety of the child and assisting in the prosecution of the alleged offender.

While the responses by these agencies may be sufficient in achieving their particular objectives, from a larger community systems view, the overall response is traditionally disjointed, with little communication and no sharing of information gathered from the separate contacts with children, families, and alleged perpetrators. Each agency individually works to fulfill its mandates by interviewing the child, family, and collateral contacts, gathering other relevant information, assessing the credibility of the information, determining risk factors, and making a disposition of the case and then moving to the next actions required of them. The agencies often complete very similar tasks with the victim and others, but the tasks are undertaken in isolation and thus create a confusing, duplicative, and stressful environment for the child and caregivers. There are three primary negative impacts of this disjointed approach: the needs of the child/family are secondary to the needs of the responding agencies; the child/family are likely to demonstrate reduced engagement and compliance with these responding agencies over time; and the response and interventions are less effective, as evidenced by lower rates of prosecution of offenders and children/families receiving the services they need to heal.

Families are often put in positions of having to travel to or receive visits from many different agencies at different times and to recount the details of the abusive events over and over. Children are likely to be interviewed by professionals who may be very experienced in their own fields but who have received no specialized training in interviewing children in a developmentally appropriate and nonleading manner. In many situations, these interviews may take place in locations that are convenient for the professionals instead of in child-friendly environments. This traditional framework, based upon convenience for the professionals, results in a convoluted, confusing, and scary environment for families not familiar with the investigatory process, and may even deter them from reaching out for assistance when new instances of abuse arise.

HISTORY OF MULTIDISCIPLINARY RESPONSE AND CHILDREN'S ADVOCACY CENTERS IN THE UNITED STATES

Multidisciplinary teams (MDTs) have been used in various professional fields for many years. For example, the medical field has utilized multidisciplinary teams to staff complex medical issues of patients for over 50 years, and these efforts continue today based on their success. A wonderful example of this is found in the same community that spawned the first CAC. Dr. Wernher von Braun and his "Rocket Team" were relocated to Huntsville, Alabama, in the 1950s. Their ingenuity and extraordinary engineering skills, coupled with those of numerous other scientists and engineers, developed the Saturn 5 Rocket, which eventually took men to the moon. If we could land human beings on the moon and safely return them to Earth in the 1960s, surely

we could develop a multidisciplinary response to child abuse. However, until 1985, no such system existed.

In the early 1980s, a local prosecutor in Huntsville, Alabama, Robert E. “Bud” Cramer, became frustrated at the lack of coordination between the various agencies mandated to investigate and respond to child abuse and the additional trauma being inflicted upon children by the systems established to protect them. His office, along with the support of the local law enforcement agencies, child protective services, mental health professionals, and the health department, formed a multidisciplinary team to coordinate investigations and interventions for children who were sexually abused. The originating philosophy for this approach was founded on the following:

1. Child sexual abuse is a serious issue that must be addressed.
2. The system intended to protect children should help children, not further traumatize them or cause lack of trust.
3. The protection of children must bring all agencies involved in the investigation and intervention to work together.
4. This collaboration will include both government and NGOs.
5. Programs should be flexible based on the community’s strengths. Every community has developed capabilities and organizations that may be used to develop an effective multiagency collaborative response, but no two communities are exactly alike. Bringing together the unique expertise of and organizational support from those with a demonstrated effective track record of collaboration in the child abuse field enhances the CAC model to be most effective.

This team also determined a child-friendly environment would be essential to lessening the trauma to the child during the process of information gathering. The National Children’s Advocacy Center was established in 1985 to provide a coordinating point for the work of the team as well as a central location for the acquisition of services by the children and families affected by abuse. A child-friendly setting is defined as one that is both physically and psychologically safe—meaning that the CAC provides a private and dedicated place with its own entrance and a setting that is geared toward children, and does not allow alleged perpetrators to be present when any child services are being provided. Even in communities with limited resources, this can be accomplished by defining a dedicated space, often within a governmental building that can be modified to make children feel more comfortable.

As others became aware of the children’s advocacy center model, it spread quickly. Communities saw the value in providing a coordinated response to child sexual abuse. A networking organization, the National Network of CACs, was formed as a resource for

information and guidance for professionals working with a CAC or wishing to establish a CAC. This networking organization later changed its name to the National Children's Alliance and established itself as the membership organization for CACs in the United States, while the National Children's Advocacy Center and four regional children's advocacy centers established by the U.S. Department of Justice became the primary training and technical assistance resource centers for multidisciplinary teams and CACs. The United States continues to have the largest network of CACs, with over 850 spread across the nation. These served more than 286,000 children in 2012 alone.

MULTIDISCIPLINARY RESPONSE TO CHILD ABUSE CONSIDERATION

Multidisciplinary responses will necessarily look different throughout the world due to the structure of the agencies and organizations tasked with addressing child abuse and the cultural norms relating to the treatment of children. While there are accreditation standards for children's advocacy centers in the United States, these don't necessarily apply to other countries. For example, the implementation of the CAC model worldwide is most commonly accomplished using a government-based organizational capacity. Additionally, within the CAC model, the actual professional practices must consider cultural issues, as with the implementation of trauma-focused cognitive behavioral therapy (TF-CBT) in Greenland, where the use of animal imagery is widely integrated into this practice.

There are many ways in which teams vary. Teams may be located in extremely rural areas with low population bases or in highly concentrated urban areas. Team composition varies depending upon the specific target cases to be collaboratively worked on and the agencies mandated—or appropriate—to handle those cases. Teams vary significantly in their protocols for investigation and intervention depending upon the individual agency mandates and the cultures within which they work. The common element, however, is that the agencies responsible for investigation, intervention, and treatment should be core members of the multidisciplinary team, one of the founding philosophies of the CAC model. These agencies may be governmental or nongovernmental agencies, and should have well-defined roles in addressing child abuse. They likely include, but are not limited to, law enforcement, child protective services, prosecution, medical providers, mental health providers, and victim advocates. Other professional disciplines would be added to the team based on their role in the community in cases of child abuse. For example, in Turkey and some other countries, public and private universities are actively involved in these collaborative efforts, as they possess significant resources that are helping to create a community of care.

It is important for the agencies involved to be well informed regarding the rationale for using a coordinated multidisciplinary response to child maltreatment. Without a thorough understanding of the model and the benefits to both the children and the professionals involved, resistance is likely to be the initial response to any suggestion of fundamental change to the processing of these cases.

Foundational work must be done to gain the support of agency personnel, from top administrators to frontline workers, so that they are knowledgeable supporters of the MDT

model. Gaining this support is often a complex task due to the different mandates, histories, and cultures of each discipline. There are typically three levels of organization engagement for each of the disciplines involved: senior leaders, supervisors, and frontline professionals. Senior leaders are responsible for organizational leadership, and clearly without their support, the development of a CAC is dramatically challenged. Further, these individuals can play a significant role in engaging other senior leaders and creating a culture supportive of CAC implementation. At the other end of the employment chain, frontline professionals must be

supportive of the CAC model in order for it to be effectively implemented. In some cases, senior leaders have been supportive of the CAC model, but frontline professionals have been unwilling to comply and able to sabotage the CAC's implementation. Thus, the support of supervisors is essential—they are able to translate the senior leader's vision for improved response to child abuse to the work done on a daily basis by frontline professionals. Without the support of supervisors, frontline professionals will not be held accountable for not supporting the CAC model and responding to children in a more child-friendly manner. In addition to the initial challenge of getting all of these professionals across all of the involved disciplines together within the CAC model, an even greater challenge lies in the ongoing maintenance of the CAC and MDT over time, across all disciplines and levels of leadership and service within each discipline.

Obviously, the agencies have different mandates, policies, and procedures that they must follow in accomplishing the work they have been assigned to undertake in the case of child maltreatment, but the central organizing factor is the protection and well-being of children. Adherence to existing internal policies and procedures may be of primary importance to each entity and its employees, but the dramatic benefits of a collaborative response with regard to child well-being should challenge all agencies to creatively explore how to maximize their positive impact. Each discipline is tasked with specific responsibilities, and sometimes conflicting goals can be sources of potential conflict between professionals, creating barriers to collaborative investigations (Pence & Wilson, 1994). For instance, if Child Protective Services has a policy that requires the worker to interview the child within 24 hours of receiving a report, completing a joint interview with law enforcement may pose a challenge if law enforcement does not have the same policy and has other priorities for the day. According to Pence and Wilson (1994), team members must seek to understand the unique perspectives of the disciplines so that differences and potential sources of conflict may be openly discussed. The example above regarding response times is an example of conflicting policies that may lead to team conflict unless the policies are understood by all and discussed openly, and unless protocols are developed that respect these differing mandates. Similarly, conflict could arise if child protective service workers are required to notify an alleged perpetrator of the allegations made against him/her while law enforcement is trying to keep information from the perpetrator until the police have had a chance to gather evidence. These issues must be addressed and procedures established so that a coordinated response to a report is supported and individual team members are able to fulfill their obligations to their professions.

An additional barrier to effective teamwork may be the different cultures of the professional disciplines attempting to work together. Each discipline has a culture that has developed over time and is unique to those professionals in that particular field. Lederach (1995) defines culture

in this way: “Culture is the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them.” Hofstede (1984) writes, “Culture is the collective programming of the mind which distinguishes the members of one category of people from another.” The differing cultures of the disciplines bring varying views of the elements of cases and of how the team should operate. It may affect personal interactions of team members and fuel conflict on the team. An example of this may be conflict that arises because a mental health therapist may express her opinion that a child should not be interviewed by an officer with a gun, while the police officer may say that the gun will

make the child feel secure. Each of these professionals is expert in his or her own fields and has developed a viewpoint that may be in direct conflict with the others. Cultural differences must be explored, discussed, and respected in order for the team to reach some agreement on how its members will operate in a broad context and handle conflicts as they arise. It is important for all of the professionals to acknowledge that culture is neither right nor wrong and the best interest of the child should govern the decisions of the team. In the example of the gun above, it should be considered that not every child within the same geographical context would respond similarly. For example, a child who has always wanted to be a police officer, is regularly exposed to weapons in an appropriate manner (i.e., hunting with father), and often draws pictures of police officers with a weapon may respond positively to seeing a detective with a gun. However, a child of a similar age who has been exposed to violence within the home involving the use of a weapon, has witnessed gun violence within the community, and has also witnessed a police officer using his/her weapon leading to the arrest of a family member may respond very negatively to the presence of a weapon; it may make him/her more anxious and less willing to trust the responding professionals, and thus less likely to report possible abuse.

The mission of the multidisciplinary team must be jointly determined, clearly defined, and regularly reviewed by the team members in order for the team to be truly effective. Without a clear mission or purpose, individual team members may be inadvertently striving for outcomes that are different from one another. While the work of the multidisciplinary team is based on the core foundation of coordinated, collaborative investigations, interventions, and treatment in child abuse cases, the mission or purpose of the team should specifically define who makes up the team, as well as whom it serves, to what end, and how. By making the mission explicitly and clearly written, team members can be focused and efficient and new team members may be quickly oriented to their roles on the team.

The mission of the team and the ways in which it operates may vary widely depending on whether it is located in a rural or urban context. Rural teams often will try to provide services to extremely large geographic areas due to the lack of resources available to children, and due to the economic realities of supporting the work of the team, if associated with a CAC. Rural teams may be faced with long commutes for clients to come to scheduled interviews and other appointments. The lack of transportation in rural areas further complicates the long commute so that clients may not be able to keep appointments, even if they are willing to make the commute. Professionals are also impacted by the long commutes and may not be willing or able to take time away from their own positions, where they may be the only one on duty, to participate in collaborative interviews or to attend team meetings.

Alternatively, urban multidisciplinary teams usually do not have the same struggles as rural teams with geographic challenges but they often face barriers related to jurisdictions and the complexity of multiple organizations serving a densely populated area. In urban areas, the jurisdictions of the different agencies involved with child abuse cases do not cleanly align, so there may be various child protective service territories and numerous law enforcement jurisdictions. The bureaucracies of the involved agencies are often large and multilayered, and may experience high turnover rates as compared to smaller agencies. These urban complexities present challenges in scheduling interviews and team meetings, and in establishing strong team cohesion. Translating the MDT mission into specific actions that will be undertaken by each

MDT is critical for two primary reasons—for the specific identification of individual agency actions and collaborations, and also to ensure the entire MDT is fully engaged in this approach through working to create this operational protocol.

The initial leadership of a multidisciplinary team generally evolves naturally from the individuals who help establish the core team from its beginning. This initial leader often influences the priorities of the team and determines whether the team's focus leans more towards justice or more towards healing. Ideally, there would be a balance of these two ideations, but it is not unusual for a team to reflect more prominently the discipline of the initial leader. As the team develops, new members and new personalities mean that differing perspectives will be brought to the table and the mission and protocols of the team will need to be regularly reviewed and possibly revised to capture the evolution of the work of the team.

The multidisciplinary team is composed of those professionals directly involved with the investigation, intervention, and treatment of cases of child abuse. The team process requires the integration of the authority, resources, and expertise of each of the involved disciplines to successfully implement a coordinated and collaborative response. Each of the disciplines invited to participate on the team should have some authority, resource, or expertise relevant to most of the cases staffed by the team. Other disciplines that may have authority, resources, or expertise with only a few of the cases may best serve on the team on an "as needed" basis, so as not to overly burden them or dilute the team's mission.

The multidisciplinary team model also provides a platform for identifying and addressing larger systems issues that may impact the processing of cases. Policies and procedures of the different agencies may pose challenges for moving forward with cases, or may impede the timeliness of investigations or interventions. During team meetings, these may be identified and determinations made as to how these systems barriers may be brought to the attention of policymakers who may make the changes necessary to improve the work of the team. The team model also provides a venue for formal and informal cross-discipline training for its members. The professionals hear on a regular basis about the work of the other disciplines and gain an understanding of the challenges they face in completing their jobs. More formal cross training may also occur through scheduled training sessions and events. The multidisciplinary team also serves as a support system for the professionals on the team, particularly when the team is stable and has developed a strong level of trust among the members. The team members understand the stresses of the work and are able to identify with the struggles of others on the team.

As with any group, some knowledge of group dynamics is important for team members to have as they try to work together on these high-stress cases. Teams will often go through the stages described by Tuckman (1965, 1977) in his team development model: forming, storming, norming, and performing.

In the forming stage, each member will be covertly surveying the group, searching for commonalities, noting differences, and generally being present, getting along with others and not giving outlier opinions or thoughts. During the storming stage, the team members will have become more accustomed to each other and more willing to express their differing opinions. This is the sorting-out stage, where members are determining the level of trust within the group and

attempting to establish their position within the group. During the norming stage, members have come to know what to expect and fall into the roles defined by the group. This may be positive or negative, depending upon the ground rules established, whether formally or informally, in earlier stages. If a high level of trust has been established, the next stage—performing—may be reached.

It is important for teams to understand this cycle and to recognize that the cycle will begin again each time there is a major change in the configuration of the team, such as when a new member is introduced. For example, the world's first children's advocacy center (the National Children's Advocacy Center) has been in continuous operation since 1985 with an associated multidisciplinary team (the NCAC MDT). Over the course of these operations, there have been times of high functioning, in which the MDT was "performing." However, with staff turnover at partner agencies and a lack of full commitment from some MDT members, the NCAC MDT has struggled at times, and returned to a "forming" stage again. This cycle of operation, continual improvement, and maintenance is critical for the MDT to be successful over time, and a MDT should always seek to move forward, regardless of the current functioning. What is not acceptable is for the MDT to say, "This is too hard and we are just going to stop." The needs of the children served never stop, and neither should the MDT.

BENEFITS OF MULTIDISCIPLINARY RESPONSE

The development and implementation of the children's advocacy center model, which is wholly integrated within the multidisciplinary team approach to child abuse, has been anecdotally regarded as highly successful by both professionals and families served. In the 1990s, the U.S. Department of Justice commissioned a multisite evaluation of children's advocacy centers to determine if there was factual evidence of the positive impact of this model. Numerous articles have been published as a result of this comprehensive evaluation, in addition to other studies that have been subsequently conducted. However, before these studies were published, Jones et al. (2005) conducted a thorough review of the existing research to identify "best practices" in the criminal investigation of child abuse, and identified the following:

- • Multidisciplinary teams, providing coordinated investigations, following established protocols, conducting single forensic interviews;
- • Trained (and supportive) interviewers asking appropriate questions, after completion of nationally recognized training;

- • Videotaping of forensic interviews, to create a more accurate record than memory or written notes and also to capture all nonverbal communication;
- • Medical exams, bringing to bear specialized knowledge, expertise, and equipment utilized with a focus to treat and reassure the child;
- • Victim advocacy and support, including crisis counseling, support services, court school, and court accompaniment;
- • Access to mental health treatment, consisting of evidence-based practice and nonoffending caregiver support;
- • A dramatic increase in the number of children’s advocacy centers, utilizing their demonstrated ability to facilitate the other best practices.

These findings were further supported by the numerous articles published as a result of the multisite evaluation of CACs, and these are explored throughout the next few pages. If a multidisciplinary team is associated with a children’s advocacy center, it is likely that the child will be interviewed in a more child-friendly facility than he/she would be otherwise (Cross, 2007). The child may be more likely to have fewer interviews, and those interviews may be more likely to be conducted by trained forensic interviewers. All of these efforts seek to limit any additional trauma to the child while providing a more child-focused and child-friendly response. The intimidation that results from having to navigate many layers of bureaucracy may be reduced for a family when they experience the team as a single system. Jones et al. (2007) found that, when surveyed about their experiences at the CAC or within a comparison community without a CAC, children are less likely to be scared by the process, and caregivers are more likely to be satisfied with the interviews in cases where children’s advocacy centers were used for investigations. Additionally, children served by CACs were more than twice as likely to receive a medical evaluation/examination related to child sexual abuse allegations than children served by the traditional investigation methods (Walsh et al., 2007).

In addition to the benefits for children and families, the professionals also benefit from the collaborative work among the team members. Each discipline gains a fuller picture of the details of the child abuse event and the dynamics at work with the involved parties through sharing information and discussing the case. Those workers who are less experienced may gain the perspective of the more experienced members of the team instead of having to try to make decisions based upon their own minimal exposure to cases. The collaborative planning for investigations and interventions is based upon more complete data, and the duplication of efforts or working at cross purposes is likely to be reduced, resulting in a more efficient system. Cases may be less likely to be ignored or “fall through the cracks” since several professionals may be involved. Walsh et al. (2008) found that criminal- charging decisions in child sexual abuse cases were made significantly faster in communities utilizing the CAC (80 percent within 1–60 days) than communities utilizing the traditional investigation practices. In addition to the criminal investigation, consistent use of the CAC model has been found to dramatically increase the felony prosecution rates of child sexual abuse, almost 200 percent in one community (Miller & Rubin, 2009).

In addition to the overwhelmingly positive practice impacts of the CAC/MDT response, there are also dramatic financial savings when this approach is implemented. Formby et al. (2006) examined the economic and social resources invested in two different child sexual abuse

response protocols to identify the return on investment produced by these protocols. Their analysis included all costs associated with the reporting, investigation, intervention, multidisciplinary review, and prosecution of child abuse in a community with a CAC as compared to a similar community without a CAC. The study found traditional investigations were 36 percent more expensive than CAC investigations (those handled through a multidisciplinary response). The average per-case cost per case when using a CAC was \$2,902, while the cost of using the traditional investigative approach was \$3,949.

A comprehensive review of the available published literature, commissioned by the National Children's Alliance and prepared by the National Children's Advocacy Center, explores the research foundations for the 10 standards devised for accreditation of children's advocacy

centers throughout the United States by the National Children's Alliance. The goal was to identify and explicate the existing research, scholarship, empirical data, formal theory, management practice, complementary professional standards, or other evidence that provides the foundation of each of the standards. This compilation of 87 publications serves as a valuable resource for children's advocacy centers, providing a snapshot of the strengths and limits of research and scholarship for each of the 10 accreditation standards and demonstrating the children's advocacy center as an evidence-based model.

INTERNATIONAL DEVELOPMENT OF CHILDREN'S ADVOCACY CENTERS

Based on the success of the CAC model in the United States, many countries have begun to replicate and modify the model to fit within their unique structures. The first 25 years of the CAC model saw its expansion throughout the United States, becoming the standard of care in child sexual abuse cases, and it is anticipated that the next 25 years will see the CAC model spread internationally in a similar manner. At this time, CACs are currently operating in Australia (1), Belarus (1), Canada (5), Croatia (1), Cuba (3), Denmark (1), Estonia (1), Greenland (1), Iceland (1), Israel (3), Latvia (2), Mexico (1), New Zealand (2), Norway (8), Philippines (1), Poland (1), South Africa (1), Sweden (30), and Turkey (5). Additionally, efforts to develop CACs are actively underway in Brazil, Finland, Georgia, Greece, Guatemala, Hong Kong, India, Japan, Lithuania, Malawi, Malaysia, the Netherlands, New Zealand, Peru, Portugal, Russia, Rwanda, Tanzania, Taiwan, and Trinidad & Tobago.

One of the initial discussions related to the potential implementation of the CAC model in all countries is the identification of the most appropriate organizational structure to support these multidisciplinary efforts. CACs in the United States have a diversity of organizational structures, with a majority of these programs functioning as independent nongovernmental organizations (56 percent), but there are also many programs that are hospital-based (17 percent), government-based (16 percent), and organized as a program of a larger NGO (17 percent). This implementation may be specific to the United States, as most of the CACs being developed internationally operate as government-based entities, depending on the government for all or at least a majority of their financial support. However, the CACs in the United States often have diversified funding sources, including government and philanthropic support.

There are numerous significant policy and leadership efforts underway that support this international development of the CAC model, and the list by country is too exhaustive to mention. However, there are two significant initiatives that demonstrate creative efforts and leadership to serve as a sample of these efforts: the Council of Europe's Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (2007), and the development of the Nordic Network of Children's Houses (Barnahaus).

The Council of Europe's Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, published in 2007, includes numerous articles related to the coordinated multidisciplinary response to child sexual abuse involving professionals from the education sector, the health sector, social services, and the law-enforcement and judicial authorities; appropriate funding of these programs and the professionals working within them; specialized and developmentally appropriate settings for services to be provided; and the provision of victim advocacy services.

By August 2012, 21 member states of the Council of Europe had ratified the Lanzarote Convention, and many more of the remaining 26 member states are moving toward ratification. Additionally, the Council of Europe also published the Guidelines for Child Friendly Justice, and these will be translated into every language of the member states of the European Union. Both of these documents highlight the multidisciplinary and child-friendly response to child sexual abuse, suggesting the development of "child-friendly, multi-agency and interdisciplinary centres for child victims and witnesses where children could be interviewed and medically examined for forensic purposes, comprehensively assessed and receive all relevant therapeutic services from appropriate professionals" (Council of Europe Guidelines on Child Friendly Justice, 2010). The Council of Europe is currently producing a documentary film on children's houses for the purpose of distributing this among member states, and many other efforts are underway to identify mechanisms for financially supporting Barnahaus/children's houses throughout Europe.

In 2008, the Barnahaus Iceland celebrated its tenth year in operation, having been developed under the leadership of Bragi Guobrandsson, the general director of the government agency for child protection in Iceland. At this ceremony and the associated training session were representatives from Iceland, Norway, and Sweden, who were involved in the development of Barnahaus (children's houses/CACs), and a representative from the National Children's Advocacy Center in the United States. It is noteworthy that the Children's House Iceland was awarded the International Society for the Prevention of Child Abuse and Neglect's (ISPCAN) 2006 Multidisciplinary Team Award in recognition of their fantastic work. At this meeting, the concept of the Nordic Network of Children's Houses was conceived, and this group has developed significantly. The Nordic Network now facilitates the sharing of training resources and practice implementation experiences, regular sharing of country service data and program development, and the support of newly developing programs. As a result of these efforts, additional Barnahaus have been developed or are developing in several other Nordic countries. Additionally, the Nordic Network of Children's Houses has been supportive of the potential development of an International Association of Children's Advocacy Centers, which would further support the development of CACs throughout the world. It is believed that the founding philosophy of the CAC movement holds true for all countries, and additionally it is believed that

the application of the CAC model will look very different in countries throughout the world, and that while all countries have unique laws, structures, and cultures, the protection of children and their access to a child-friendly, multidisciplinary response to child abuse is not only possible, but essential. In some of these more challenging settings with limited resources, limited economic activity, and possibly minimal government capacity for responding to child abuse, there are some aspects of the CAC model that may be implemented. Communication, collaboration, and cooperation are all free, and these are essential for a coordinated and multidisciplinary response to child abuse, regardless of the other resources available. These communities can commit to identifying all of the local resources that can be used to respond to child abuse, convening these parties to develop a strategy for collaboration, and then actively supporting these organizations to continue their efforts with a long-term goal of developing a fully functioning children's advocacy center.

CONCLUSION

The children's advocacy center model began as an innovative strategy to address child sexual abuse in one community in the United States. This model of a coordinated and collaborative multidisciplinary team approach to child abuse achieved almost immediate success, serving as a model for the creation of additional CACs and recognized by the U.S. Departments of Justice and Health and Human Services as a promising practice. The next 25 years were highlighted by the dramatic expansion of the CACs throughout the United States, which has revolutionized the nation's response to child abuse allegations.

What will happen over the next 25 years? It is widely believed that the next 25 years will see the implementation of the Children's Advocacy Center model on an international scale. The CAC model, while specific in its mission and services, is also widely adaptable to all cultures, provided there is a commitment to most effectively, and efficiently, investigate and intervene on behalf of vulnerable children. Readers who may be interested in learning more about children's advocacy centers are encouraged to visit the National Children's Advocacy Center Web site (www.nationalcac.org) and to contact the NCAC directly for any additional assistance.

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