Last Updated February 2021

The Multidisciplinary Response to Child Abuse and Exploitation

Suffolk County, MA

TABLE OF CONTENTS

The MDT Model....1
Our Shared Principles....2
Who is on the Team?....3
Presenting Concern....4-5
First Response....6
Reporting....7
DCF Screening & Response....8-9
Referrals to the MDT....10
MDT Coordination....11
Before the Interview....12
The Forensic Interview 13
After the Interview....14-15
Case Review....16
Your Role on the MDT Matters....17

Appendices

Appendix A. MDT Member Roles....18-20
Appendix B. Recognizing Abuse....21
Appendix C. Massachusetts Statutes....22
Appendix D. DCF Possible Response Outcomes....23
Appendix E. The MDT Referral Pathway....24
Appendix F. Support to End Exploitation Now (SEEN) Referral Pathway....25
Appendix G. Medical Referral Process, Children Age 11 and Younger....26
Appendix H. Medical Referral Process, Children Age 12 and Older....27

ACRONYMS

ACM	Area Clinical Manager at DCF
AD	Area Director at DCF
ADA	Assistant District Attorney
APM	Area Program Manager at DCF
BEST	Boston Emergency Services Team at Boston Medical Center, mental health emergency services provider
BOP	Board of Probation record (a.k.a. CORI)
BUILD	Being United In Leading our Destiny (life coach program @ Roxbury Youthworks)
C&P	Care and Protection
CAC	Children's Advocacy Center
CACU	Crimes Against Children Unit, Boston Police
CASA	Court Appointed Special Advocate
CFTSI	Child and Family Traumatic Stress Intervention
CORI	Criminal Offender Record Information (a.k.a. "background check")
CPT	Child Protection Team, often referring to the team in a hospital
CPU	Child Protection Unit, Suffolk County District Attorney's Office
CRA	Child Requiring Assistance, defined by M.G.L. c. 119, § 21 as "Runaway", "Stubborn Child", "Habitual School Offender", "Habitual Truant", or "Sexually Exploited Child"
CSAM	Child Sexual Abuse Material (formerly called "child pornography")
CSB	Children's Sexual Behaviors
CSEC	Commercial Sexual Exploitation of Children
DA/DAO	District Attorney/ District Attorney's Office
DCF	Department of Children and Families
DVU	Domestic Violence Unit, Boston Police
ED / EMS	Emergency Department / Emergency Medical Services
ER	Emergency
FFH	Fact Finding Hearing
FJC	Family Justice Center
FI/EFI/TFI	Forensic Interview/Extended Forensic Interview/Tele-Forensic Interview
GIFT	Gaining Independence for Tomorrow (life coach program @ Roxbury Youthworks)
HRVU	High Risk Victims Unit, Suffolk County District Attorney's Office
HTEU	Human Trafficking & Exploitation Unit, Suffolk County District Attorney's Office
HTU	Human Trafficking Unit, Boston Police
IA	Informal Assistance
ICAC	Internet Crimes Against Children Unit, Boston Police
JRI	Justice Resource Institute, a trauma treatment provider
LICSW & LMHC	Licensed Clinical Social Worker & Licensed Mental Health Clinician
MACA	Massachusetts Children's Alliance, umbrella organization for CACs in MA
MDT	Multidisciplinary Team
MGL	Massachusetts General Laws
MLMC	My Life My Choice
MOVA	Massachusetts Office for Victim Assistance
NCA	National Children's Alliance, accrediting organization for all CACs in the U.S.
NCAC & NRCAC	National Children's Advocacy Center & Northeast Regional Children's Advocacy Center
OMS	Outcomes Measurement System (survey for CAC clients to give feedback)
OVC	Office for Victims of Crime, a division of the U.S. Department of Justice
PAIN	Physical Abuse Investigative Network
Pedi-SANE/SANE	(Pediatric) Sexual Assault Nurse Examiner
PH	Preliminary Hearing
PSB-CBT	Problematic Sexual Behavior Cognitive Behavioral Therapy
SAU	Sexual Assault Unit, Boston Police
SAIN	Sexual Abuse Investigative Network
SEEN	Support to End Exploitation Now Program
SORB	Massachusetts Sex Offender Registry Board
SORI	Sexual Offender Registry Information
SRO	School Resource Officer
VIS	Victim Impact Statement
VOCA	Victims of Crime Act of 1984, established the OVC & Crime Victims Fund which funds victim's comp
VT	Victim
VWA	Victim Witness Advocate, District Attorney's Office
WT	Witness
YO	Youthful Offender
YPSB	Youth with Problematic Sexual Behavior

TO OUR MDT PARTNERS

To our Multidisciplinary Team Partners,

If you are reading this manual, it's likely that you are part of our incredibly important multidisciplinary child abuse response team. This guide is designed to orient you to the Team process and to help prepare you for the collaborative work ahead. Beyond that, we want to thank you: You are an irreplaceable component of our support system for children and families in Suffolk County.

Make no mistake, the Suffolk Children's Advocacy Center's Multidisciplinary Team is a lifeline for families facing the repercussions of abuse and exploitation.
Rather than confronting trauma in isolation, families have a Team in their corner: experts who understand the impact of abuse and who are committed to working together with children and the caregivers who love them, helping to navigate a path to healing. From the very first interaction, we can help families feel that they are safe and that they are not alone.

No one agency can tackle the challenges of this work by itself; no one agency can meet every need. Your role is instrumental as, together, we strive to put children and families first. Our trauma-informed investigations, evidence-based mental health services, and first-rate medical care are essential to helping families move forward - and wouldn't be possible without you.

Thank you for your commitment and welcome to the Team!

With gratitude,

All of us at the CAC

WHAT IS THE MDT MODEL? 1

When child abuse is reported, children become involved in several systems responsible for investigation, service provision, and protection. A Multidisciplinary Team (MDT) model refers to the coordinated efforts of professionals from many disciplines—child protection, law enforcement, prosecution, mental health, medical, and victim advocacy—to work together as a Team to make well-informed decisions about the investigation, treatment, case management, and prosecution of child abuse cases. MDTs conduct joint forensic interviews in order to minimize the number of times a child has to talk about what happened and provides services to children and families in a single, child-friendly setting.

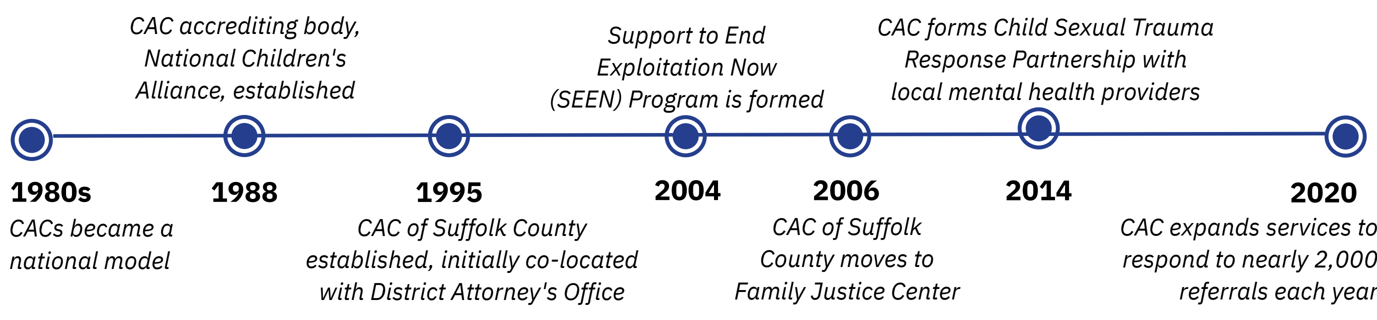
WHY IS THE MDT MODEL IMPORTANT?

Without specialized coordination, the investigation and assessment process can be fragmented, preventing children from receiving prompt and specialized services; increasing families' mistrust of the child protection, service delivery, and criminal justice systems; and hindering police and prosecution efforts to respond to and prevent violence. Children can be subjected to multiple, separate interviews by law enforcement, child protection, and mental health and medical professionals. Being made to talk over and over about the abuse can inadvertently re-traumatize children, and even confuse their memory of what happened.

Source: *National Children's Advocacy Center (2019). "Efficacy of the Child Advocacy Center Model."*

State law requires that law enforcement and child protection agencies notify one another of certain types of abuse because early notification enhances interagency coordination, evidence collection, and offender identification. More importantly, a coordinated response minimizes unnecessary repeat interviews, helps mitigate additional trauma to the child and family, streamlines services for families, and improves efficiency and effectiveness for investigating these difficult cases. The combined wisdom of various disciplines results in a more complete understanding of cases and the most effective, child- and family-focused system response.

Children's Advocacy Centers (CACs) are at the core of the MDT model. The CAC of Suffolk County was established in 1995 and is the center of Team coordination and service provision.



In Suffolk County, multidisciplinary investigative and response teams are at the core of the CAC and its services. The CAC and its partners have shared agreements defining their commitment, collaboration, and partnership. MDT members share a fundamental philosophy:

Child abuse is a multifaceted community problem and no single individual, agency or discipline has the necessary knowledge, skills, or resources to serve all the needs of children and their families and hold offenders accountable.

Our collective goal is to ensure that protective concerns are addressed quickly while minimizing stress to the child and family.

1 Child-Centered Investigations

Team members are committed to a child-centered approach to child abuse investigations. In planning and carrying out investigations, Team members make the needs and best interests of each child the highest priority.

2 Safety

The Team works together to identify whether a child has been abused and to identify the individual(s) who abused the child. The Team does everything possible to see that the abuse stops, the abuser(s) is (are) held accountable, and that non-offending family members and other witnesses are safe. Interagency notification should happen as early as possible to facilitate safety planning and service coordination.

3 Interviews

To lessen the impact that multiple interviews may have on the child, the Team strives to interview the child as few times as possible - preferably only once by a forensic interviewer. During that interview, all Team members should be present to observe and provide input to the interviewer.

4 Cooperation & Communication

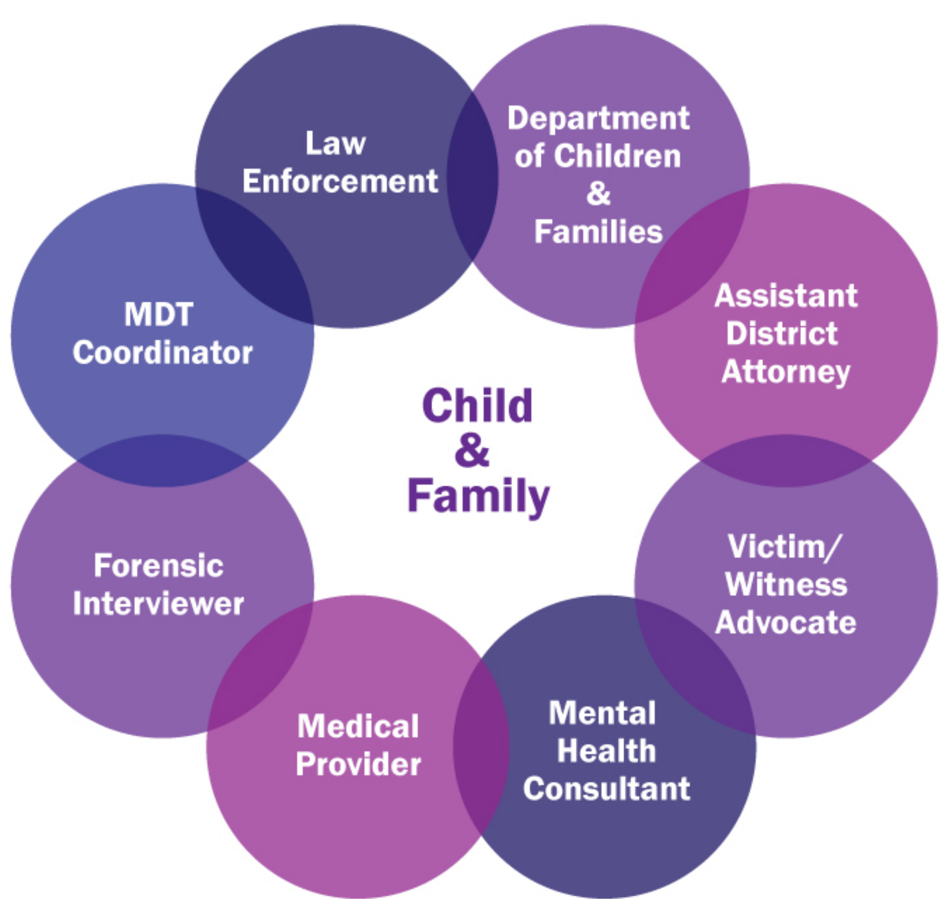
Within the limits of confidentiality, Team members work cooperatively to gather and share information and make decisions about the investigation and follow-up. Each Team member should understand and respect other members' roles and perspectives and take them into account during the investigation and subsequent decision-making and case management.

5 Documentation

Thorough and objective documentation is essential. Areas that should we well documented include, but are not limited to: interviews, descriptions of physical examination and injuries, and steps taken to respond to possible abuse.

Several agencies work together to provide a collaborative, comprehensive response that best fits the needs of each child and family. This may include the following:

- **MDT Coordinator:** Facilitates Team communication, schedules forensic interviews, and streamlines information sharing and Team planning.
- **Support to End Exploitation Now (SEEN) Coordinator:** Provides support, referrals, and case coordination for cases involving at-risk and commercially sexually exploited youth.
- **Detective:** Gathers evidence, interviews alleged perpetrators and witnesses, makes arrests when appropriate, and helps ensure the child's and family's safety.
- **Department of Children & Families (DCF):** Assesses child safety and whether abuse/neglect occurred by a caregiver. Their focus is child protection and strengthening families.
- **Assistant District Attorney (ADA):** Decides whether someone should be charged with a crime and which crimes to charge. Leads the criminal investigation and prosecution and presents evidence in court.
- **Forensic Interviewer:** Conducts a forensically sound, developmentally appropriate investigative interview. Provides a safe space for children to talk about anything.
- **Victim Witness Advocate (VWA):** Liaison between the Team and child/family. Provides support and advocacy, and helps the family understand and navigate the investigation and prosecution process.
- **Medical Provider:** Provides medial diagnosis and treatment and collects forensic evidence when needed. May provide expert testimony in court.
- **Mental Health Clinician:** Provides support, referrals, and counseling services for children and families and identifies services that would be helpful to the child and family.



How do children tell?

Nine in ten children who experience abuse or exploitation do not tell someone about it. Children may not tell because they are afraid of what will happen to them or their family, may not understand boundaries were crossed, or may be confused because the abuser is someone they know or trust. Children are often made to believe the abuse is their fault and may have been bribed, threatened, or forced to keep it a secret. Sometimes, children don't know how to tell you something is wrong because they either lack the language to describe the abuse or are nonverbal.

Concerns of child abuse may come to light in various ways:

- **Purposeful, direct disclosures:** Some children are ready and willing to tell a trusted adult or peer about the abuse. They may choose to tell a particular person in hopes of getting support.

  Example: A child tells their teacher they are being hurt at home by their uncle.

- **Purposeful, indirect disclosures:** Some children may tell someone about the abuse, but in a way that doesn't directly describe what happened.

  Example: A child says their babysitter makes them feel uncomfortable.

- **Concerning signs or behaviors**: Abuse may also be indicated when a child exhibits concerning behaviors or signs of abuse or exploitation.

  Example: Child has a history of running away and references frequent travel to other cities.

- **Accidental discovery**: Children may not tell anyone but abuse is indicated by physical evidence such as a photo, video, or post, or medical or forensic evidence. They may be a witness to abuse or they may be named by another victim or case.

  Example: Child indicates during case investigation that they saw their sibling being abused by the same perpetrator. This sibling had not previously disclosed abuse.

When a child discloses abuse...

A child may have disclosed abuse intentionally or accidentally, and may not be prepared for the consequences of telling. A child may have been bribed, threatened, or told not to tell, and may feel guilty or ashamed of the abuse. When a child visits the CAC, it is our job to make the environment as comfortable as possible. We must slow down and give kids the time and space they need to tell us what happened.

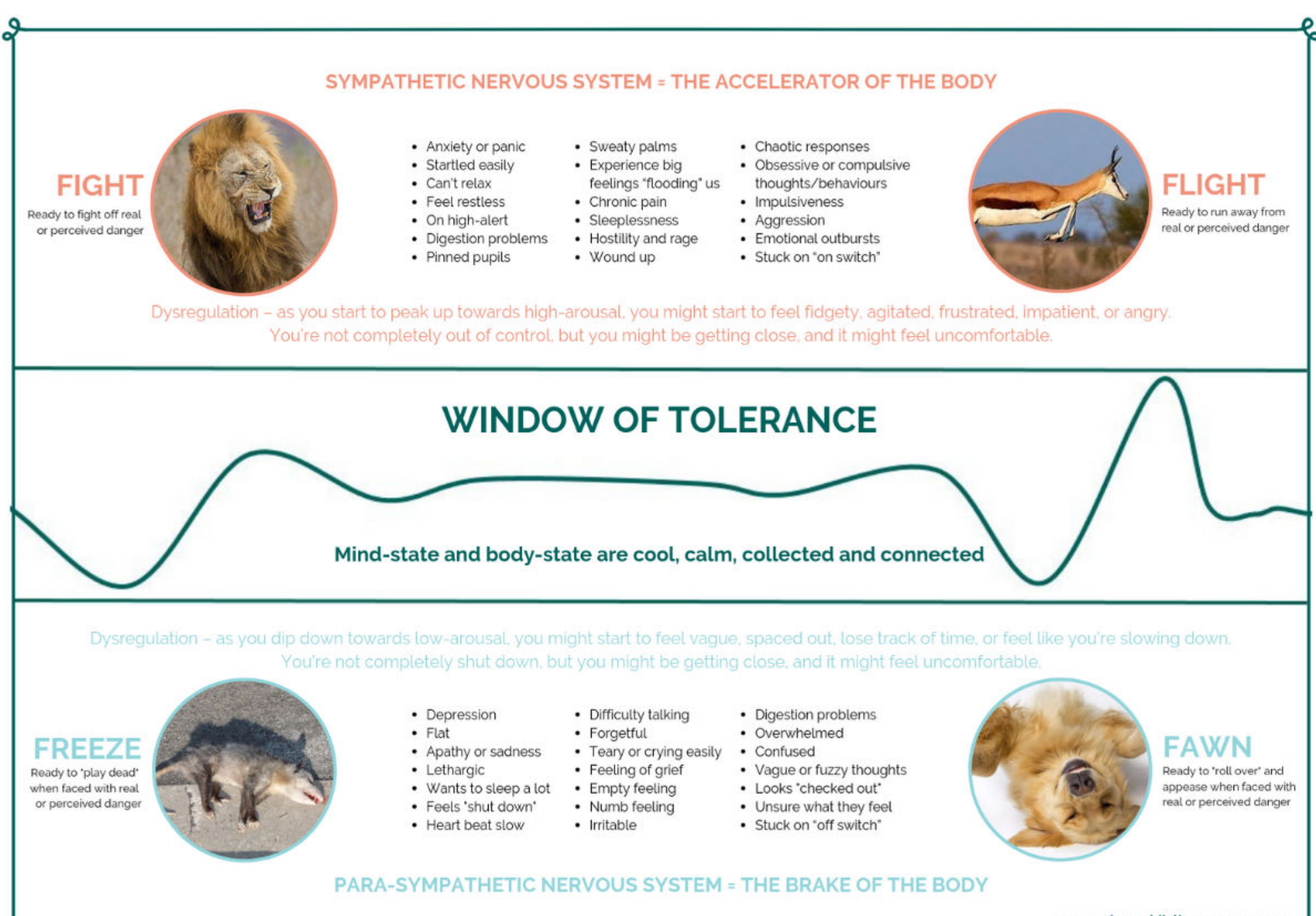
How do children present to the Team?

Every child is unique. How a child responds to trauma can vary and often depends on both the individual and their circumstances. Some children may seem catatonic, anxious, or overwhelmed and be in a state of hypo- or hyperarousal. Some children may seem extremely resilient; the Team may observe them happily playing in the CAC waiting room. Some children may refuse to participate in the investigation. Some children may recant their disclosure due to various reasons such as pressure from family or the abuser or exploiter. A child’s response can also change over time.

All children will be at various stages in their healing journey. There is no right or wrong way to process trauma, heal, and seek justice. It is important to remember that every child is different and has unique needs the Team must respond to.

Children who did not intentionally and purposefully disclose abuse or exploitation may not be willing or ready to participate in an investigation. They may decide to disclose what happened years from now. The goal is to support the child and family and meet them where they are.

Common Response to Traumatic Events or Trauma Reminders ("Triggers")



Ask Only Minimal Facts

When a child discloses abuse, you might feel inclined to ask lots of questions about what happened. However, knowing that this isn't the only time someone will ask the child what happened, best practice is to obtain only "minimal facts" to plan immediate next steps. "Minimal" means stopping short of asking for abuse details, recognizing this will occur during a forensic interview at the CAC.

Asking minimal facts helps prevent a child from being retraumatized by telling their story multiple times to multiple people. When asking minimal facts, it's best to speak with the child privately. Sometimes, talking only with the non-offending caregiver is sufficient. Explain to the family that a forensic interview at the CAC may follow.

When a child first discloses, only obtain facts needed to establish:

5W's What, Where, When, Who, Witness

Safety

Timely Evidence Collection

What are "minimal facts" (the 5W's)?

What
- **Type** and **nature** of incident
- **Injuries?**

Where
- **Jurisdiction**
- **Multiple locations?**

When
- **Last time** (How old were you?)
- **Frequency** ($\geq$ 1 time?)

Who
- ID and age of alleged offender
- **Relationship** to child
- **Access** to child

Witness
- Siblings, friends, etc.
- Their **risk**?

- **Ask neutral, open-ended questions**
- **Document** (child's words and what questions you asked)
- **Explain**: A forensic interview at the CAC may follow.
- Talking to the caregiver only may suffice

Who are mandated reporters?

Mandated reporters are professionals working in roles that interact with children and who are required by Massachusetts law to report any concerns of child abuse, neglect, or exploitation to DCF. Anyone can file a report, regardless of whether they are a mandated reporter. A person does not need to be certain or know all the facts about a situation to make a report. Anyone can (and should) file even if they believe someone else already made a report or the child already has an open case with DCF. Reports can also be made anonymously. Examples of mandated reporters include:

Medical Providers

Childcare Providers

Police, Advocates, First Responders, & Court Affiliates

School Staff

Behavioral Health Providers

Religious Leaders & Staff

Reporting Child Maltreatment

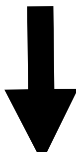
Massachusetts General Laws, Chapter 119, section 51A provides guidelines for the reporting of child abuse, neglect, and exploitation to the DCF Child-at-Risk Hotline. The law states that a report must be made if someone, in their professional capacity, has reasonable cause to believe that a child under 18 is experiencing physical or emotional injury from physical abuse, sexual abuse, neglect, or exploitation, which causes harm or substantial risk of harm to the child's health or wellbeing. DCF is mandated to screen in and investigate allegations of abuse by caretakers and allegations involving child trafficking.

What is asked on the call?

The DCF screener will ask you to provide:

- **Contact information, age, and language(s) spoken by:**
  - The child(ren) you're concerned about
  - Their parents/guardians
  - Other children in the family
- **Details about your concern and how you became aware of it**
  - Nature and extent of the suspected abuse or neglect
  - Any evidence or knowledge of prior injury, abuse, or neglect
  - When it may have occurred
  - Who may be responsible for the abuse/neglect (if known)
- **Action(s) taken thus far to treat, shelter, or otherwise assist the child(ren)**
- **Any other information you believe might be helpful to:**
  - Establish cause of injury and/or person responsible
  - Make safe contact with the family
  - Ensure the child's safety
  - Support the family to address the concerns

24/7 DCF Child-at-Risk Hotline
1-800-792-5200



Within 48 hours, you must follow up with a written report to the local DCF office.

DCF has a Protective Intake Policy that defines criteria for screening and responding to reports of child abuse, exploitation, and neglect. This policy establishes DCF requirements for performing responsibilities in accordance with MGL c. 119, §§ 51A-51B. Depending on the type of abuse allegation, the seriousness of the abuse, and DCF's role, referrals will be sent to the CAC and District Attorney's Office and may be coordinated by a designated MDT Coordinator, a SEEN Coordinator, or a Victim Witness Advocate.

Type of Abuse Allegation	DCF Screening Decision	Designated Coordinator
Sexual Abuse or Serious Physical Abuse or Neglect	Screened-In with DA Referral *(Active DCF Response)*	CAC MDT Coordinator
	Screened-Out with DA Referral *(No Active DCF Response)*	Victim Witness Advocate
Child Trafficking (Sexual Exploitation or Labor)	Screened-In with DA Referral	SEEN Coordinator

DCF Screening

When a 51A report is filed, a Screener at DCF reviews and assesses the presenting information, or "screens" the case. Based on the facts, and supported by daily DCF Screening Team meetings, DCF will decide how to screen the case. The purpose of screening is to gather information to determine whether a Response from DCF is necessary to ensure a child's safety and well-being (DCF Protective Intake Policy 2020, p. 2).

What does screening look like?

- The DCF Screener gathers information about the nature and extent of abuse allegation(s) which can include physical abuse, sexual abuse, neglect, emotional injury, sexual exploitation and/or human trafficking.
- The Screener assesses whether the abuse is a reportable condition under the law, meaning there is information that suggests a child may have been abused or neglected, may be at risk for being abused or neglected, or may have been sexually exploited or trafficked or at risk for exploitation or trafficking (DCF Protective Intake Policy 2020, p. 2).
- DCF Screeners assess whether there is an immediate concern regarding the child's safety (DCF Protective Intake Policy 2020, p. 2).

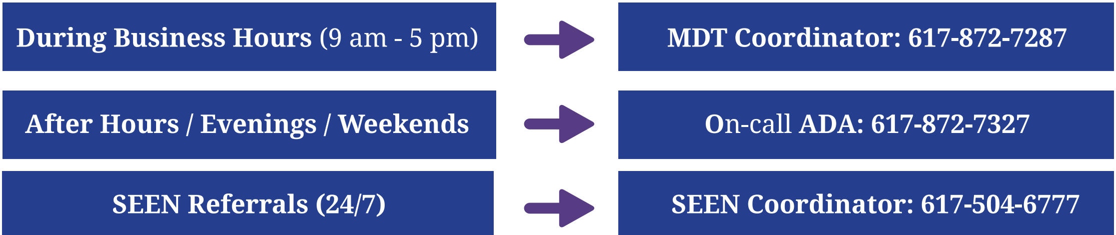
DCF Response

DCF Screening determines whether or not DCF will conduct a "response", and what that response looks like. The purpose of a DCF response is to determine whether, per MA statute, there is "reasonable cause to believe: that a child has been abused or neglected (DCF Protective Intake Policy 2020, p. 2). Response activities include completing the response within the required timeframe, assessing child safety and risk and parental protective factors, gathering information from the youth, family and other sources, visiting the home, interviewing alleged offenders, and documenting the response findings and decision (DCF Protective Intake Policy 2020, p. 6).

Screen-In Emergency Response

- Upon receiving a report, DCF immediately determines whether a failure to act immediately would pose a substantial risk of death, serious emotional or physical injury, or sexual abuse to a child (DCF Protective Intake Policy, p. 9).
- If so, the report is screened in for an Emergency Response that must be initiated within 2 hours. DCF must then make a determination about the child's safety within 24 hours.
- All response activities must be completed within 5 business days (DCF Protective Intake Policy 2020, p. 18).

Emergency Referrals from DCF to the CAC



Screen-In Non-Emergency Response

- DCF determines that, although the reported situation does not pose a substantial risk of death, serious emotional or physical injury, or sexual abuse, a child may have been abused or neglected by a caregiver, may be at risk for abuse or neglect by a caregiver, or has been or may be at risk for sexual exploitation or trafficking.
- Screening for a Non-Emergency Responses is completed in 1 business day (DCF Protective Intake Policy 2020, p. 9). The Non-Emergency Response must be initiated within 3 business days and all response activities and a formal report documenting the response must be completed within 15 working days (DCF Protective Intake Policy 2020, p. 18).
- Under some limited circumstances Non-Emergency Response deadlines can be extended for 5 business days (DCF Protective Intake Policy 2020, p. 18).

Screen-Out

DCF will screen out a case if they determine the following:

- The report does not pertain to a child
- There is no indication of abuse
- The alleged offender is not identified as a caregiver and the caregiver is safely protecting the child
- The specific situation reported is known to be old and has no bearing on the current risk for a child
- There are no protective concerns against a caregiver (DCF Protective Intake Policy 2020, p. 16).

The one exception to DCF's mandate to respond to protective concerns against caregivers is in regard to human trafficking and/or sexual exploitation. Cases with an allegation of sexual exploitation or human trafficking are screened in for a response, regardless of caregiver status.

After DCF competes their Response, it will determine a Response Outcome and whether any additional or ongoing DCF intervention is needed (Please refer to Appendix D).

Mandatory Referrals to DA's Office

Even if a case is screened out, it may still be referred to the District Attorney's Office (DCF Protective Intake Policy 2020, p. 13). Certain serious allegations warrant a mandatory referral to the DA's Office and include:

- Death of a child
- Sexual assault of a child
- Sexual exploitation of a child
- Human trafficking of a child
- Brain damage , loss, or substantial impairment of bodily functions or organs, substantial disfigurement of a child
- Serious physical abuse or injury of a child including a fracture, a severe burn, of an injuring necessitating life-support
- A child has experienced physical abuse or sexual abuse and there is a risk that evidence of the abuse may be destroyed if not investigated promptly

Discretionary Referrals to DA's Office

DCF can also send discretionary referrals to the DA's Office and the DA's Office can also request discretionary referrals. DCF can recommend a discretionary referral to the DA be made when information during screening identifies a serious threat to public safety or identifies serious criminal activity that may impact the safety or well-being of children (DCF Protective Intake Policy 2020, p. 13). These referrals must be approved by the DCF Area Director or designee and may involve consultation with DCF attorneys.

Referrals to the CAC

Who Refers Cases to the CAC?

Cases involving allegations of sexual abuse or exploitation, serious physical abuse, child witnesses to violence, and fatal child abuse can be referred to the CAC by DCF, the police, hospitals, mental health agencies, school departments, other organizations, and families. Any case with the possibility of multiple agency involvement should be considered for referral to the CAC. Most often, police reports and DCF 51a reports of suspected child abuse trigger the MDT Response.

Timely Notification

CAC partner agencies should notify members of the MDT about new case referrals *as early as possible*. Early CAC notification facilitates interagency communication and, in some cases, may result in an immediate emergency interagency response. The CAC is available to receive emergency referrals on a 24-hour basis. Timely notification to the occurs by making a phone call to the CAC MDT Program, the CAC SEEN Program, or the Suffolk DA's Office Child Protection Unit, accompanied by an email containing corresponding 51A reports and/or police reports.

Regardless of whether a case is considered a DCF emergency or not, it is important for the MDT to communicate as quickly as possible, in case there are any immediate needs related to evidence collection, medical evaluation, forensic interviewing, or mental health crisis and support.

Designated MDT Coordinators will assess referrals for immediate needs and determine whether a forensic interview is appropriate. When a referral is screened-in for a protective DCF Response, the assigned MDT Coordinator or SEEN Coordinator will coordinate forensic interviews within DCF's investigation period.

MDT Coordinators may:

- Contact DCF or PD to gather additional information.
- Contact the Chief of the Child Protection Unit or the Human Trafficking & Exploitation Unit to seek guidance.
- Send a SAIN or SEEN referral email to MDT partners. These emails explain the facts of the case and elevate pressing safety issues or outstanding questions. Upon receiving this information, PD will verify whether or not a detective is or will be assigned and the district attorney's office will indicate whether an ADA and VWA will be assigned (Specific ADA and VWA assignment for SAINs typically occurs after a SAIN is scheduled).
- Together, the MDT Coordinator and assigned MDT will assess the case information and make determinations related to gathering more information, conducting minimal facts in the field, scheduling forensic interviews onsite at the CAC or DA's Office, forensic evidence collection, medical evaluation, convening MDT conference calls for the development of collaborative response plans, and recommending supportive or therapeutic services.
- Follow-up with the MDT and individual partners by both phone and email to collect and share updates, confirm activities and next steps, and provide information about investigative developments.

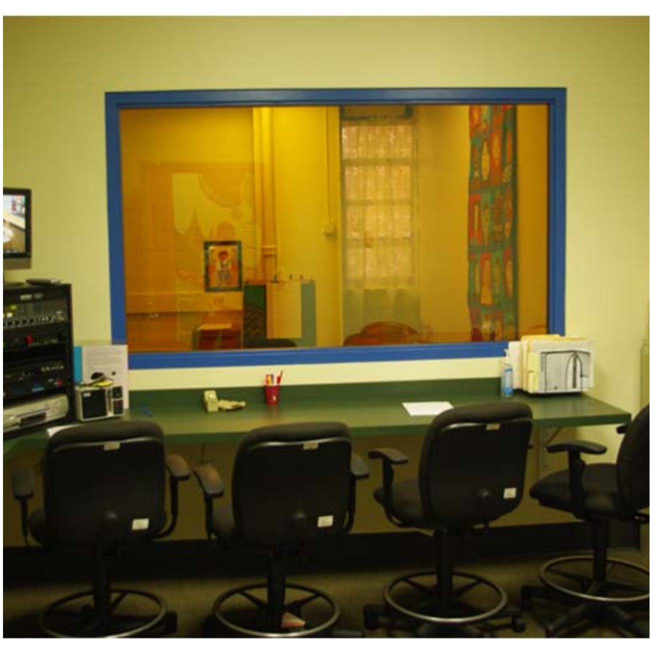
Outreach to Families

Most often, DCF or MDT Coordinators are in the best position to reach out to a child's non-offending caregiver, explain CAC services, provide them with information about the Team's process, and obtain consent for a child to participate in a forensic interview.

Scheduling the Forensic Interview

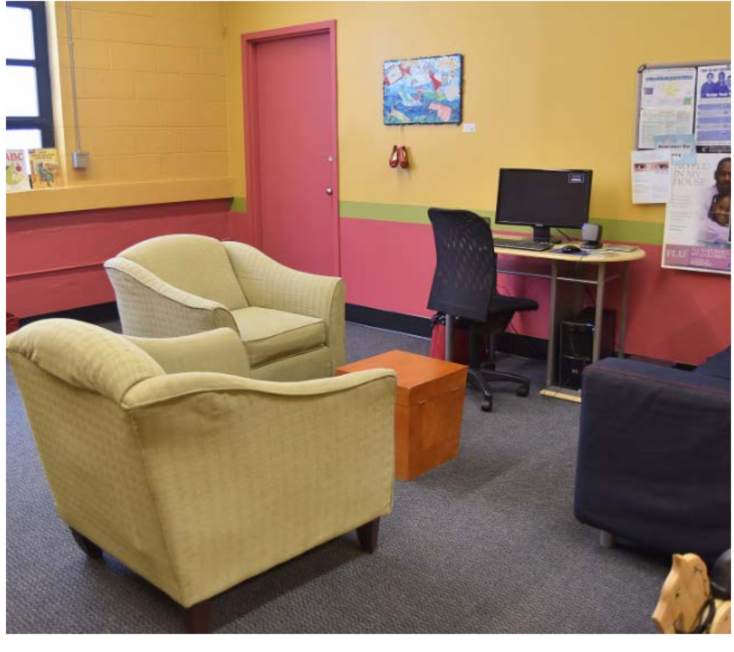
The MDT Coordinator schedules forensic interviews and manages the logistics, working with DCF to identify a timeframe that works for the family and MDT, determining the best location for the interview, assisting families with transportation, and obtaining interpreter services if necessary. If DCF is not involved, the VWA may help schedule the interview with the family.

Pre-Interview Team Meeting (VWA facilitates)



Multidisciplinary Team members arrive 30 minutes prior to the scheduled arrival of the child and caregiver to review information about the case, including:

- Relevant reports
- Whether the child was seen by a medical provider
- The family's response to the child's disclosure
- Knowledge of domestic violence in the home or concerns for the non-offending caregiver's safety
- Any action taken as a result of the allegations
- Information about the alleged perpetrator, including criminal history
- Case information and history
- Special developmental, educational, language, and/or clinical considerations
- Safety concerns
- Non-offending caregiver's support system
- Other issues and concerns specific to the individual case



Pre-Interview Meeting with Caregiver (as needed)

If appropriate, the VWA will meet with the caregiver and:

- Ask how the caregiver and child are doing
- Ask how the caregiver explained this appointment to their child
- Show the caregiver the interview room
- Explain Pedi-SANE services
- Inquire about any developmental issues that the interviewer should know about
- Ask how the child refers to their body parts and to the alleged offender
- Clarify the living situation, relationships, and names/ nicknames of family members

Interviews are conducted by one of the CAC's specially-trained Forensic Interviewers. Other members of the multidisciplinary Team observe the interview through a one-way mirror. The VWA and/or Interviewer greets the child in the waiting room, introduces themselves and their roles, and asks if there are any questions prior to the start of the interview. The VWA then returns to the Team and the interviewer accompanies the child to the interview room.

Interviews conducted at the CAC and Bulfinch site are electronically recorded. The recording begins when the child and Interviewer enter the interview room and ends when they leave the interview room (at the conclusion of the interview). Typically, the VWA turns the recording on and off.

Forensic interviewers follow the same general format:

1. **Introduction:** Interviewer introduces themselves and explains the interview process.
2. **Rapport Building/ Narrative Practice:** Interviewer asks questions to get to know the child. Child practices talking about an experience in narrative form.
3. **Substantive Phase:** Interviewer asks questions about the alleged abuse.
4. **Closing:** Interviewer thanks the child, addresses any questions the child has, and introduces a neutral topic to transition out of the interview.

Children are told, in an age-appropriate manner, that other Team members are observing the interview. In addition, children are oriented to the interview room, the mirror, and the equipment being used (camera, lapel microphone, Interviewer's earpiece). Team members communicate with the interviewer through the earpiece, as needed.

What kinds of questions does an interviewer ask?

Interviews are conducted in a non-leading, developmentally-appropriate, legally-sound manner. Forensic interviewers tailor their questions to the child using their expertise.

Open Ended →	**Focused** →	**Multiple Choice** →	**Yes/No**
"Tell me more about that."	*"How old were you when they started touching you?"*	*"Was it daytime, nighttime, or something else?"*	*"Did you see everything he did to her?"*

After the interview, off camera, outside of interview room, the interviewer asks the child if caregiver knows everything they talked about in the interview. The Team will confer about the most appropriate way to communicate with the caregiver, or support communication between the child and caregiver.

Post-Interview Team Meeting

Following the interview, the Team reconvenes to:

- Review results of the interview
- Identify concerns and needs of child and family
- Discuss agency decisions about child protection, arrest of alleged perpetrator, investigative activities (i.e. evidence collection, witness interviews, search warrants), prosecution, and mental health and medical needs
- Develop a coordinated plan of action, including steps to be taken by Team members jointly and individually

The Team decides what information to share with the caregiver/family about the child's interview and next steps. If there are new disclosures of abuse to share with caregiver **AND** the caregiver is the first complaint, the Team (Detective, ADA, VWA) will interview the caregiver before sharing this information.

If the Child Meets the Team

If the child wants to meet the Team after the interview, the forensic interviewer facilitates the meeting. *Interns and any additional observers exit the observation room.*

- The Forensic Interviewer facilitates Team introductions.
- The Forensic interviewer thanks the child for coming to the CAC.
- The Team reassures the child.
- The Team discusses next steps with the child, being sure not to place responsibility on the child to make charging decisions.

*If more investigative information is needed from the child, the Team makes a plan to address that before the family leaves.

Caregiver Meets with the Team (VWA facilitates)

During the post-interview Team meeting with family, children visiting the CAC or Bulfinch site remain in the waiting room/play room area. All children should be supervised by a family member, friend, or FJC/CAC/DA staff or intern. The MDT meets with non-offending family member(s) to discuss the interview, explain each agency's role, and respond to family members' questions and concerns. The MDT also provides follow-up recommendations and referrals for services, including:

Specialized Medical Exam/ Encounter	Pediatric Sexual Assault Nurse Examiner services are available on-site at the CAC. Children visiting the Bulfinch site are informed of the medical service at the CAC and can make an appointment for this service.
Referral for Mental Health Evaluation and/or Treatment	CAC staff provide families with mental health referral options, including on-site CFTSI and PSB-CBT services and referrals to participating member agencies and community-based providers.
Domestic Violence Screening and Referrals	CAC staff can provide domestic violence risk assessment, safety planning, restraining order assistance, support, and referral services following the Team meeting. Domestic violence services are also available from on-site agencies at the FJC.
Victim Advocacy	The Victim Witness Advocate or Mental Health Clinician provides ongoing information, support, and advocacy throughout the investigation. In charged cases, the VWA also provides trial preparation and court accompaniment.
Other Needed Services	The Victim Witness Advocate or Mental Health Clinician also provides assistance with other needed services (i.e. housing relocation, etc.).

All families are provided with a folder that includes contact information for participating multidisciplinary Team members, Pedi-SANE information, CAC Brochures, a Mental Health Resource list, and Victim Compensation application. Families are encouraged to call with any questions or concerns.

MDT Continues to Meet and Coordinate the Response

In addition to the post-interview Team meeting, the MDT will continue to provide a comprehensive response. The Victim Witness Advocate or Mental Health Clinician will remain in touch with the family as a main point of contact. The family may continue to receive mental health and family advocacy services at the CAC, and as cases progress through the investigative process, staff at the District Attorney's Office help families understand the court process and prepare them for trial while also providing emotional support and in-court advocacy.

When cases present complex issues, the MDT participates in case-specific reviews to comprehensively discuss the case, problem-solve, and ultimately improve effective system intervention.

Case Review is a meeting for the individuals assigned by their respective agencies to a particular case and/or the identified discipline liaisons to the CAC.

The purpose of the Case Review is to:

- maximize use of Team members' knowledge, experience, and expertise to enhance Team intervention;
- discuss, plan, and monitor progress of all agency investigations and follow-up services;
- strategize on protective, prosecution, and treatment needs for children and non-offending family members;
- promote communication among all involved agencies; and
- provide mutual support for professionals intervening in child abuse cases.

Cases referred for case review can include cases:

- with multiple agency involvement;
- with ongoing safety concerns;
- which would benefit from enhanced interagency communication about case status and service provision;
- which would benefit from expert consultation;
- approaching a critical decision or change in status (i.e. DCF case closing, child's return home following out-of-home placement, visitation with an alleged offender, criminal charges after a long investigation, etc.)

All MDT members can refer cases for review. The CAC Director of Mental Health & Advocacy facilitates case review meetings.

For cases involving the commercial sexual exploitation of children, the SEEN Program can similarly conduct a SEEN Case Conference to review complex cases.

Nine in ten children who experience abuse or exploitation do not tell someone about it. Knowing how difficult it is for children to disclose, when survivors do come forward, it is our duty to listen to them and provide a trauma-informed response that supports their healing. Receiving services at the CAC of Suffolk County may be the first step in the healing journey, and it is a very important one. The way we respond and interact with each child and family has tremendous power to help or hinder their healing.

"Everyone [on the Team] was very thorough and patient. I appreciate how my son was treated with respect and kindness."

-Caregiver of child survivor of abuse

"The staff made all the info available for me, so I knew what to expect. My children were interviewed respectfully and carefully."

-Caregiver of child survivor of abuse

"As a parent, you think your child's broken forever, she's just going to be messed up for the rest of her life. And it's not an easy story for her to tell. I mean, she doesn't feel comfortable telling family members. So I was really concerned, well, is she really going to want to talk to them [at the CAC]? And she felt so comfortable because they made her feel comfortable...I was so lost at first. I really felt like what do I do? What comes next? I really think that if I wouldn't have come here, I would have still been lost."

-Caregiver of child survivor of abuse

"Support of the CAC is very important to me because when I came forward, that was the Team that listened to me. They believed me. They supported me. They stood beside me. They're incredibly important and they have helped me release myself of that shame, that guilt, and everything else...If it wasn't for them, I wouldn't have been able to talk or come forward."

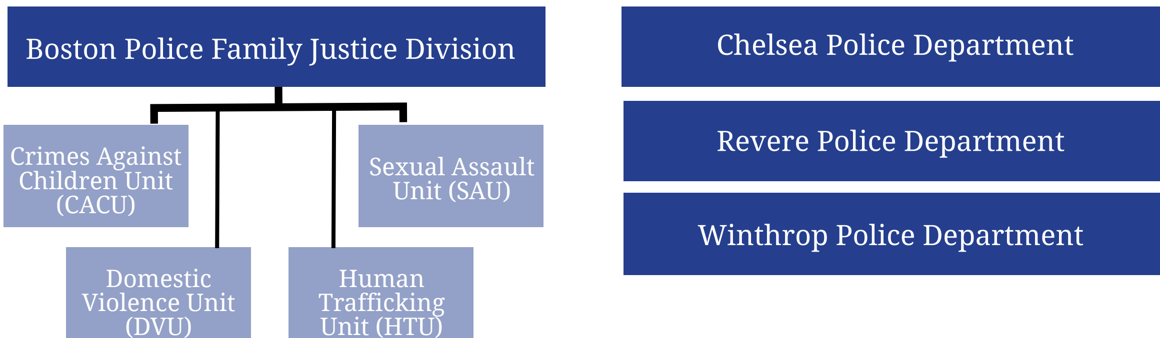
-Adult survivor of child abuse

Multidisciplinary Team (MDT) Coordinator

MDT Coordinators are the keystone of the multidisciplinary response. They receive MDT referrals, bring together Team members, and schedule forensic interviews when they are conducted as part of a DCF investigation concerning allegations of sexual abuse, physical abuse, or neglect. MDT Coordinators also assess referrals for other immediate needs (investigative, medical, mental health, etc.) and notify Team members in a timely manner.

Law Enforcement

Detectives are assigned to investigate child abuse reports. They are responsible for collecting evidence, executing search warrants, interviewing alleged perpetrators and witnesses, making arrests when appropriate, and helping to ensure the child and family's safety. When law enforcement is the first agency to come into contact with the child or family, they help explain the multidisciplinary response. Detectives also assist the Assistant District Attorney (ADA) in pre-trial and testify in court when appropriate.



Department of Children and Families (DCF)

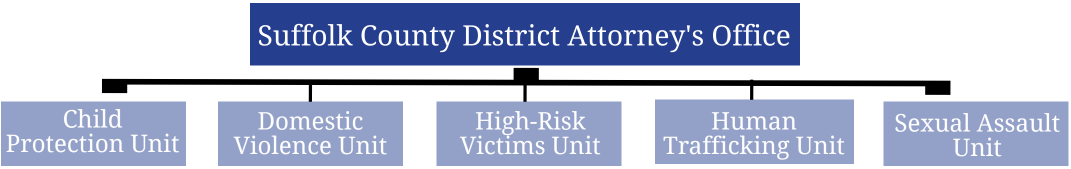
DCF has a primary mandate to ensure children's safety in an environment free from abuse and neglect, preserving family life when possible. Response workers are involved in the multidisciplinary investigation and assess protective issues in the home. Ongoing workers provide long-term support and connect families to critical services if the case remains open for protective or voluntary DCF services.

In conjunction with law enforcement, DCF may participate in joint interviews with alleged perpetrators, as determined by the Team. They also provide important contextual information to the Team, such as family demographics, circumstances of disclosure, prior DCF involvement, the child and family's response to allegations, information from collaterals, and any concerns about the safety and protection of the child.

Hyde Park | Dimock Street | Park Street | Harbor

Assistant District Attorney (ADA)

The prosecutor decides whether someone should be charged with a crime, which crimes to charge, and who should be charged, and then presents evidence in court to a judge and/or jury. They provide in-court advocacy during trial and sentencing. The prosecutor coordinates closely with law enforcement about investigative steps and evidence collection. They coordinate with other court personnel as needed. In conjunction with the Victim/Witness Advocate (VWA), the prosecutor may explain the court process and participate in pre-trial preparation with victims, witnesses, and family members.



Victim/Witness Advocate (VWA)

Advocates are the "link" between the child and family and the MDT. They are the main contact for the family throughout their case, providing information about victim rights, addressing safety concerns, providing referrals, and helping the family through the court process. When appropriate, VWAs coordinate with district courts on 209As (i.e. restraining orders), 258Es (i.e. harassment prevention orders), advocacy, and assistance, and can help apply for victim compensation or witness protection.

As cases progress through the investigative process, VWAs inform the child and family of the criminal case status and explain the court process, including the bail notification system. They participate in court orientation and trial preparation with victims, witnesses, and family members. During trial and sentencing, they also provide emotional support and in-court advocacy.

SEEN Coordinator

Support to End Exploitation Now (SEEN) Coordinators are responsible for coordinating referrals involving youth who have experienced child trafficking, commercial sexual exploitation, or who have been identified as high-risk. SEEN Coordinators assess referrals for immediate needs and convene MDT SEEN Case Conferences to address youth's specific needs, including:

- Placement/ Shelter
- Medical Care
- Psychological Treatment
- Investigative Interview
- Interpersonal Support
- Threats/Danger of Alleged Pimp/ Perp
- Youth Involvement

Forensic Interviewer

Forensic interviewers have specialized training to conduct interviews of children who may have been abused or witnessed serious crimes. They speak one-on-one with children about their experiences while the rest of the MDT observes from behind a one-way mirror. The interviewer's training and skills ensure that reliable information is elicited from the child in a legally, clinically, and culturally sound manner.

Mental Health Clinician

Mental health clinicians provide support and counseling services to children and families. They may observe forensic interviews, provide evidence-based treatment, or offer recommendations for follow-up evaluation and counseling. They also assist in identifying services that will be helpful for the child and family.

The CAC of Suffolk County offers two evidence-based treatments:

1. Child Family Traumatic Stress Intervention (CFTSI): a brief intervention for children ages 7-18 after exposure to a potentially traumatic event. Treatment focuses on:

- Increasing communication between the child and caregiver about the child's symptoms
- Developing and practicing coping skills to address those symptoms
- Addressing concrete stressors that may also be affecting the family (i.e., financial constraints, housing issues, school-related advocacy, etc.)

2. Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT): a brief intervention for children ages 7-12 who are exhibiting problematic sexual behaviors. The child and non-offending caregiver learn about:

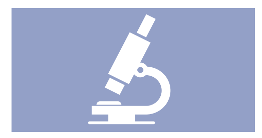
- Coping skills and self-control strategies
- Rules about sexual behavior and boundaries
- Social skills and empathy
- Sex education
- Parenting strategies, supervision, and safety

Medical Provider

A specially-trained Pediatric Sexual Assault Nurse Examiner (Pedi-SANE) at the CAC conducts medical evaluations, consults with families, and collects forensic evidence when needed. The CAC also works with medical professionals from area hospitals and health centers.

Rather than wait in a crowded emergency room following an abuse disclosure, children can be seen in a child-friendly setting at the CAC. The exam is an opportunity for the child and family to ask questions and begin emotional and physical healing. An exam at the CAC may:

Identify physical injuries and collect evidence


Reveal a sexual transmitted infection (STI)

Uncover other medical problems or injuries

Reassure the child and family of normalcy

Signs of Abuse and Exploitation

Physical Signs
- Bruises, cuts, welts, burns, broken bones, bald spots
- Pupils of unequal size/ signs of head trauma
- Frequent headaches, stomachaches, or soreness
- Difficulty urinating, walking, or sitting
- Sexually transmitted infections or pregnancy
- Recurring urinary or yeast infections
- Pain, itching, abnormal discharge, bruising, burning, or bleeding in the genital or rectal area
- Sudden change in appetite or weight
- Weather-inappropriate clothing
- Unattended medical, dental, or physical needs
- Poor hygiene
- Sleep disorders, nightmares, or difficulty sleeping
- Delayed physical, mental, or emotional development
- Speech delays or disorders
- Tattoos, especially ones the child is not eager to talk about
- Drastic change in appearance

Behavioral Signs
- Withdrawn or detached
- Can't recall how injuries occurred or offers inconsistent explanation
- Doesn't seek comfort when hurt
- Uncomfortable with physical contact
- Knowledge of sexual activity more extensive than what it should be for their developmental stage
- Overly compliant or eager to please
- Arrives early or stays late at school
- Self-injury
- Misuses drugs or alcohol
- Frequently tired or falls asleep during the day
- Begs, steals, or hoards food or money
- Consistently lacks adult supervision
- Has trouble forming peer relationships
- Shows insecure attachment to caregiver(s)
- Extremes in behavior
- Regresses to younger behaviors (e.g. bedwetting)
- Startles easily
- Sudden change in grades at school
- Overly protective of siblings
- Secretive or reluctant to communicate
- Thumbsucking, rocking, biting, or headbanging
- Restricts their own play or activities

Specific to commercial sexual exploitation:
- Uses slang like being in "the life," "turning tricks," going on "dates"
- Reports false name or age
- Spends time in areas known for prostitution (hotels, addresses, streets)
- Coached or rehearsed answers to questions
- History or running away and/or truancy
- References frequent travel to other cities
- Gang involvement

Emotional Signs
- Afraid of a certain place or person
- Afraid of being alone
- Afraid of going to bed
- Nervous when other children cry
- Protests or cries when it's time to go home
- Distrusting of adults/caregiver(s)
- Has mixed feelings about the abuser/exploiter
- Depression or anxiety
- Lonely or isolated
- Excessively or unusually clingy
- Low self-esteem
- Difficulty regulating emotions

MGL Part 1 Title XVII Chapter 119 Section 51A

Section 51A. (a) A mandated reporter who, in his professional capacity, has reasonable cause to believe that a child is suffering physical or emotional injury resulting from: (i) abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse; (ii) neglect, including malnutrition; (iii) physical dependence upon an addictive drug at birth, shall immediately communicate with the department orally and, within 48 hours, shall file a written report with the department detailing the suspected abuse or neglect; or (iv) being a sexually exploited child; or (v) being a human trafficking victim as defined by section 20M of chapter 233.

MGL Part 1 Title XVII Chapter 119 Section 51D

Section 51D. Each area director of the department shall be responsible for implementing subsection (k) of section 51B.

Each area director shall, in cooperation with the appropriate district attorney, establish 1 or more multi-disciplinary service Teams to review the provision of services to the children and families who are the subject of 51A reports that meet the conditions of subsection (k).

Each Team shall consist of the department's caseworker for the particular case, 1 representative of the appropriate district attorney, and at least 1 other member appointed by the area director who is not an employee of either office. The additional member shall have training and experience in the fields of child welfare or criminal justice and, as far as practicable, be involved with the provision of services to these families.

DCF Policy Regarding Referrals to District Attorneys

When DCF determines that a 51A report meets the conditions that require a district attorney (DA) referral,[2] it is required to report this to the DA's office that covers the geographic area where the incident took place and the DA's office for the area where the victim resides (if different), according to Section 51B of Chapter 119 of the General Laws.[3] According to DCF's District Attorney Referrals Policy, DCF's notification to the DA "may be by telephone and must be followed by a written referral." Additionally, within 30 working days, DCF meets with a social worker, a representative of the DA, and at least one other person outside DCF and the DA's office to discuss what actions have been and should be taken.

Possible Response Outcomes		
Support	**Substantiated Concern**	**Unsupport**
There is reasonable cause to believe that a child(ren) was, or is at substantial risk of being, abused and/or neglected; AND The actions or inactions by the parent(s)/caregiver(s) place the child(ren) in danger or present substantial risk to the child(ren)'s safety or well-being; OR A person was responsible for the child(ren) being a victim of sexual exploitation and/or human trafficking.	There is reasonable cause to believe that a child(ren) was neglected; AND The actions or inactions by the parent(s)/caregiver(s) create moderate risk and there is a presence of contributing factors that increase the likelihood of being neglected. In making a Substantiated Concern determination consider whether parental capacities need strengthening to avoid future abuse or neglect.	There is not reasonable cause to believe that a child(ren) was abused and/or neglected, or that the child(ren)'s safety or well-being is being compromised; OR The person believed to be responsible for the abuse or neglect was not a caregiver, unless the abuse or neglect involves sexual exploitation and/or human trafficking where the caregiver distinction is not applied.
Person Responsible/Central Registry Finding		
The person(s) responsible for the abuse and/or neglect, when known, is named to the Department's Central Registry. If there is substantial evidence that the person(s) named is responsible for the abuse or neglect and the report was referred to the District Attorney, the person responsible is also named to the Registry of Alleged Perpetrators.	No alleged perpetrator is named to the Department's Central Registry (or Registry of Alleged Perpetrators, even when the report was referred to the District Attorney).	No alleged perpetrator is named to the Department's Central Registry (or Registry of Alleged Perpetrators, even when the report was referred to the District Attorney).
Department Intervention		
Department intervention is needed to safeguard the child(ren)'s safety and well-being with one of the following results: ○ a new case is opened (see Family Assessment and Action Planning Policy); or ○ In limited circumstances, with approval from a manager, the Department may determine that intervention is not necessary.	Department intervention is needed to safeguard the child(ren)'s safety and well-being with one of the following results: ○ a new case is opened (see Family Assessment and Action Planning Policy); or ○ In limited circumstances, with approval from a manager, the Department may determine that intervention is not necessary.	Department intervention is not needed to safeguard the child(ren)'s safety and well-being, however: ○ the family may apply for voluntary services from the Department and/or ○ the Department may refer the family for services in the community if needed.

From DCF Protective Intake Policy 2020, page 26

Potential Responses to Child Abuse Referrals

Concern of child abuse

CAC contacted

51A filed with DCF

Report to police

Screened IN

Screened OUT

SAIN, PAIN, or SEEN referral to CAC

Referral to District Attorney's Office

Full MDT Assigned

CAC MDT Coordinator, SEEN FA, or VWA coordinates team

Team response may include:

forensic interview, case conference, child protection investigation, criminal investigation, medical visit, advocacy, trauma screening, mental health referral

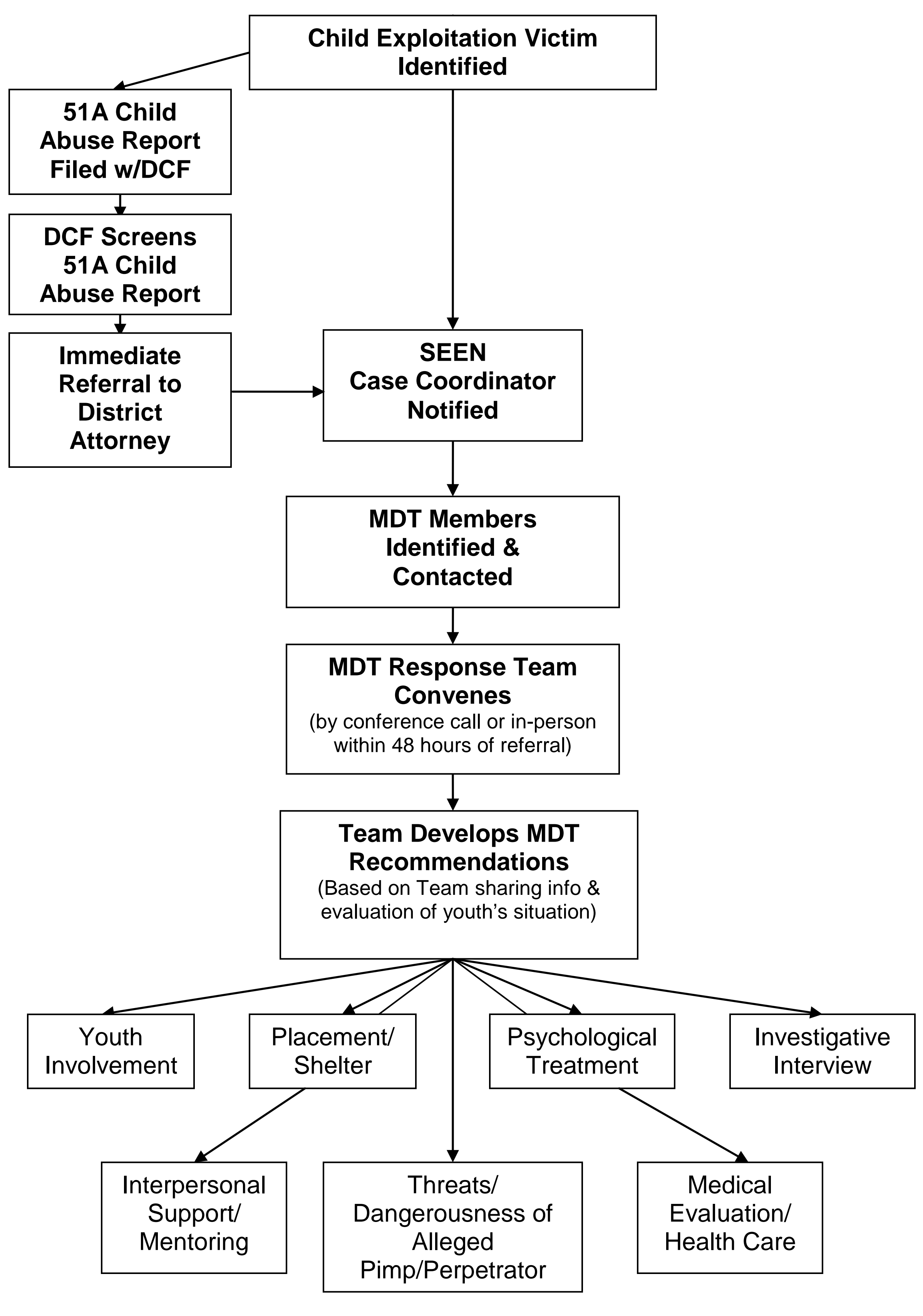
Criminal Investigation Unlikely

Assigned to CAC Team

FA or MH Director coordinates team, if needed

DA	District Attorney's Office
ADA	Assistant District Attorney
VWA	Victim Witness Advocate
DCF	Department of Children & Families
SAIN	Sexual Abuse Intervention Network
PAIN	Physical Abuse Intervention Network
SANE	Sexual Assault Nurse Examiner
Pedi-SANE	Pediatric Sexual Assault Nurse Examiner
CAC	Children's Advocacy Center
MDT	Multidisciplinary Team
CSEC	Commercial sexual exploitation of children
FA	CAC Family Advocate
MH	Mental Health
SEEN	Support to End Exploitation Now

SUPPORT TO END EXPLOITATION NOW (SEEN)
Child Exploitation – Multi Disciplinary Response Model



© Support to End Exploitation Now (SEEN) Children's Advocacy Center of Suffolk County Boston, MA www.suffolkcac.org

Attachment A

Suffolk County Medical Referral Process
Patients 11 Years and Younger Who Have Been Sexual Assaulted/Abused

Patient Presentation for Sexual Abuse or Assault

Is patient 11 years or younger?

Yes

Is there a report or concern of sexual abuse/assault that occurred within a 72 hour (3 days) period?

Yes

Are any of the following present?

- A clear disclosure of sexual abuse or abuse that was witnessed by another?
- Oral, vaginal or rectal penetration (however slight)?
- Possibility of ejaculate or saliva on child's body?
- Anogenital pain, bleeding or injury not consistent with reported mechanism of injury

Yes

Patient meets criteria for medical care and forensic evidence collection using the MA **Pediatric** Sexual Assault Evidence Collection Kit (MA PEDI KIT).

Is patient currently in ED?

Yes

- **ED Staff** to complete MA ***Pediatric*** Sexual Assault Evidence Collection Kit **(MA PEDI Kit).**
- File a 51A
- Consult social work or CPT per hospital protocol
- With guardian consent facilitate police notification
- **With patient/guardian consent:** Call Children's Advocacy Center (CAC) of Suffolk County (617) 779-2144 or (617) 779-2146 (M-F, 8:30 – 5:00) to link hospital intervention with CAC follow-up (Pedi SANE, forensic interview, advocacy, and other specialized resources).

No

Monday – Friday
9:00AM – 5:00 PM

- File a 51A report
- Call CAC to ascertain availability of Pedi SANE to complete acute evidence collection
- If Pedi SANE not available refer patient to emergency department

Evenings, Nights, Weekends and Holidays

- Refer patient to emergency department

No (to "Is patient 11 years or younger?")

Refer to Attachment B Algorithm for children 12 - 17 years

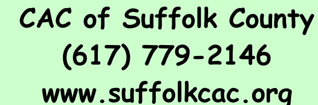
No (to 72 hour question / criteria)

Patient is outside of 72 hour window **or** does not meet criteria for forensic evidence collection.

- **File a 51A report**
- With guardian consent facilitate police notification

With guardian consent:

- Call Children's Advocacy Center of Suffolk County (617) 779-2144 or (617) 779-2102 (M-F, 9:00 – 5:00) to consult about appropriateness of patient referral for Pedi SANE and other services


CAC of Suffolk County
(617) 779-2146
www.suffolkcac.org

Attachment B

Suffolk County Medical Referral Process
Patients 12 – 17 Years of Age Who Have Been Sexually Assaulted