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Understanding the Development and Impact of Child Advocacy Centres (CACs)

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Research and Statistics Division,
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Executive summary

Child Advocacy Centres (CACs) and Child and Youth Advocacy Centres (CYACs)[1] arose out of a need to reduce stress placed on child/youth victims during sexual abuse investigations. Previously, a lack of coordination between social services and the criminal justice system meant victims were interviewed multiple times by different agencies, often by people untrained in child development.

CACs have been developed to create a safe place for child victims and their non-offending caregivers. They feature child friendly spaces, a multidisciplinary team approach with police, social services, victim advocates, and medical personnel working together as well as victim advocacy and support. As of 2016, 22 CACs are operating in Canada, and at least seven other sites are currently developing or exploring the model.

This study was commissioned by the Department of Justice (Department) to better understand how Canadian CACs are developing and operating; measure client satisfaction with CACs; measure client satisfaction with the criminal justice system's process and outcomes; and measure how CACs meet the following Federal Victims Strategy (FVS) objectives: increasing access to victim services, enhancing capacity to deliver appropriate and responsive services to victims, and reducing financial and non-financial hardships for victims.

Three main data sources informed this report: (1) case file data from the CACs, (2) client interviews (child/youth victims and non-offending caregivers), and (3) Multi-Disciplinary Team (MDT) interviews. Researchers also interviewed CAC stakeholders, including members of boards of directors and local politicians, and conducted a criminal justice system satisfaction survey.

Researchers conducted 109 MDT interviews (with 125 individuals) and 123 in-person interviews with 26 child victims (aged five to 11), 17 youth victims (aged 12 to 19), five adults who had been victims as children (i.e., deemed historical cases), and 75 non-offending caregivers.

Operation of the CACs

The six CACs featured diverse governance structures, which did not appear to influence service delivery as long as communication was open and the management board was knowledgeable and supportive. These findings highlight the CAC model's flexibility.

There were four types of delivery models for the CACs in the study. One site was located in a hospital which helped clients gain access to specialized medical personnel; two CACs shared their location with other agencies; two were not co-located; and one was a virtual site. A dedicated physical, child-friendly space is a core component of the CAC model.

The study found that there is a need for a physical space for the CACs to operate effectively. Although the "virtual" site that was in development over the course of the study had a strong victim advocate and a robust MDT response, clients and MDT members expressed a preference for a physical, child-friendly location to increase convenience and reduce stress. It is currently developing a child and youth-friendly

[1] This report will use the term CAC to refer to both CACs and CYACs. In the United States, where the term CAC was first used, the term refers to Children's Advocacy Centers.

'soft room' at a location that provides integrated services for youth. These findings are consistent with national practice guidelines for CACs regarding the critical importance of having a comfortable, safe, private designated space that is child-focused and neutral where forensic interviews can be conducted and other CAC services can be provided.[2]

The co-location of MDT members is also important. When law enforcement, child protection, and victim services and other partners, where feasible, were housed at the same site with CAC staff such as the victim advocate, it facilitated quick responses, information sharing, regular case meetings, and coordinated support for clients. While MDTs that are not co-located can still perform well, they must develop trusting relationships, well-negotiated and understood protocols, and conduct regular case review meetings.

The study also found that the role of the victim advocate was a significant strength of the CAC model. It was seen as providing the glue to hold the MDT together and supporting clients throughout the process. Caregivers identified the victim advocate as the most important service received by them and their child(ren). The victim advocate's impact on clients was evident:

> "The victim [advocate] is our rock through the whole process. I don't know what we would do without her" (caregiver).

While the victim advocate's role varied by site, his/her presence at the CAC is what mattered most. The advocates worked closely with victim services and the courts, supported other MDT members, communicated with clients, undertook community outreach, and maintained contact with families after file closure.

The study also highlighted the following as lessons learned: access to mental health services for clients and MDT members is essential; providing case updates and sharing information with clients, especially youth, is important; clients benefit from having both female and male staff in the CACs; and access to private spaces within CACs enhances the experience for clients.

Clients and Cases

- Researchers studied **1,804 case files**.
- Victims were primarily **female** (67%).
- Almost half of **victims were 8 years or younger**. The average age was 9.4 years.
- Over half of victims were **Caucasian** (56%). The second largest group was **Indigenous** (17%).
- Offences were **primarily sexual** in nature (72%). Physical assault cases made up the remainder (28% of offences).
- The accused were **primarily family relatives** (64%). They were also mostly adult males.
- Police and child protection were the two most common referral sources (together comprising 94%).
- The average elapsed time between first contact at the CAC and file closure was **187.7 days**, and the median was **126.5 days**.

[2] National Children's Alliance, "Standards for Accredited Members, 2017," online: http://www.nationalchildrensalliance.org/sites/default/files/downloads/NCA-Standards-for-Accredited-Members-2017.pdf; Bertrand, Lorne D. Ph.D., et al. 2015. "Evidence Supporting National Guidelines for Canada's Child Advocacy Centres." [J4-80-2015-eng.pdf (publications.gc.ca)]

Effect of CACs on clients

Overall, the CACs reduced both non-financial and financial hardship for clients. They reduced stress and re-victimization by providing a single, safe, and child-friendly place for victims and their families to obtain interviews, information, and support (for five of the six locations); reducing the number of victim interviews (e.g., by videotaping); providing a single point of contact through the victim advocate who provided emotional support, information, referrals to services, and/or assistance navigating intimidating systems; and in some sites providing emergency cell phones, bus tickets, taxi slips, and/or food vouchers.

The CACs have also worked to address gaps in the system which affect their particular clients, including access to medical examinations, availability of prosecutors with expertise to work with child victims, use of testimonial aids (e.g., screens and closed-circuit TV), and access to child-friendly environments for forensic interviews and court appearances.

1. Child Advocacy Centre Model (CAC)

Child Advocacy Centres (CACs) and Child and Youth Advocacy Centres (CYACs)[3] arose out of a need to reduce stress placed on child/youth victims during sexual abuse investigations.

Approximately one in three Canadians experience abuse before age 15. While the accused are often strangers or acquaintances (e.g., a teacher, neighbour, or priest), a large portion are family relatives. For instance, in 2014, approximately 53,600 children and youth were victims of violent crime.[4] Approximately 16,300 (31%) of these young victims experienced family violence.[5]

Canada's former Chief Public Health Officer, Dr. Gregory Taylor, explained in 2016 that "family violence … takes many forms, ranges in severity, and includes neglect as well as physical, sexual, emotional, and financial abuse."[6] Youth (between the ages of 12 and 17), females, Canadians living in the territories and Saskatchewan, and rural residents are more likely to experience family violence. Perpetrators tend to be parents (61%), as opposed to siblings or extended family members.[7] The most common type of family violence against children and youth is physical assault.

CACs also aim to address a lack of coordination between social services and the criminal justice system which resulted in victims being interviewed multiple times by different agencies, often by professionals

[3] This report will use the term CAC to refer to both CACs and CYACs. In the United States, where the term CAC was first used, the term refers to Children's Advocacy Centers.
[4] Canadian Centre for Justice Statistics. 2016. "Family violence in Canada: A statistical profile, 2014." http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14303-eng.pdf
[5] *Ibid*.
[6] Public Health Agency of Canada. 2016. "A Focus on family violence in Canada: The Chief Public Health Officer's Report on the State of Public Health in Canada 2016." http://healthycanadians.gc.ca/publications/department-ministere/state-public-health-family-violence-2016-etat-sante-publique-violence-familiale/alt/pdf-eng.pdf
[7] Canadian Centre for Justice Statistics. 2016. "Family violence in Canada: A statistical profile, 2014." http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14303-eng.pdf

untrained in child development. Moreover, locations of investigations, such as police stations, were not child-friendly. To prevent system-induced trauma which many consider another form of child abuse,[8] CACs coordinate services by bringing together professionals into a multi-disciplinary team (MDT) ideally, located in a single, child-friendly location. Today, police and child protection agencies may refer both victims and witnesses of various types of abuse and other offences to CACs.

> "They just want to help regardless of the outcome. Their main goal is to help children. Every place needs a place like [a CAC]" (caregiver).

United States leadership

The United States is an international leader in the development, implementation, and research of CACs. The first CAC was developed in Alabama in 1985 and today, over 800 CACs operate in the United States.[9] The National Children's Alliance offers a system of accreditation in the United States,[10] which identifies the following key elements of the CAC model:

- **MDT**: CACs bring together law enforcement, child protection, prosecution, victim advocacy, medical, and mental health professionals into one team with CAC staff.
- **Cultural competency and diversity**: CACs provide culturally sensitive services to all clients.
- **Forensic interviews**: CACs conduct child-friendly, neutral, and legally sound forensic interviews, and avoid duplicative interviews (e.g., by videotaping).
- **Victim support and advocacy**: Victim advocates provide ongoing, comprehensive support to victims and non-offending caregivers.[11]
- **Medical evaluation:** Medical examinations and treatment are provided on-site or at an affiliated medical facility by staff trained in child sexual abuse.
- **Mental health**: CACs offer trauma-focused mental health services to victims and non-offending caregivers to prevent long-term adverse social, emotional, and health outcomes.
- **Case review:** CACs provide a formal process for information sharing and case review among MDT members.
- **Case tracking:** CACs provide a system for monitoring case progress and tracking outcomes.
- **Organizational capacity:** A governing entity oversees the CAC's business aspects, implements policies, seeks funding, hires staff, promotes employee well-being, and plans.
- **Child-focused setting**: Rooms are private, safe, and comfortable for all clients.[12]

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[8] Jackson, Shelly L., "A USA National Survey of Program Services Provided by Child Advocacy Centers" (2004) 28 Child Abuse & Neglect 411 at 412.
[9] National Children's Alliance, "How does the Children's Advocacy Center Model Work?" Online: http://www.nationalchildrensalliance.org/sites/default/files/download-files/NCA_CACmodel.pdf
[10] One Canadian CAC in this study, Sophie's Place CYAC, is an Affiliate Member of the National Children's Alliance.
[11] A non-offending caregiver is a parent or legal guardian of the child victim who is not the alleged perpetrator of the offence against the child.
[12] National Children's Alliance. 2017. "Standards for Accredited Members." Online: http://www.nationalchildrensalliance.org/sites/default/files/downloads/NCA-Standards-for-Accredited-Members-2017.pdf

However, the CAC model varies in practice. For instance, some sites offer only certain services, while others deliver services differently (e.g., on-site or off-site). As a result, different levels of accreditation exist to recognize the diversity of American CACs. In fact, the model is designed to be flexible, so CACs can meet the unique needs of communities and victims.

The United States also leads in research on CACs. The most prominent study was conducted in 2008 by Dr. Theodore Cross and colleagues from the University of New Hampshire's Crimes Against Children Research Centre. The Cross Survey evaluated four American CACs in relation to nearby non-CAC communities.[13] This research found that, although CACs and comparison communities feature similar rates of prosecution and conviction, CACs offer more coordinated investigations, better access to medical exams, more referrals for mental health services, and higher levels of caregiver satisfaction with investigations. While children's satisfaction did not differ between CAC and non-CAC communities, evidence suggested that CACs might reduce children's fears during interviews. However, CACs did not reduce the number of interviews per child victim. This research, as well as a subsequent meta-study of the effectiveness of CACs by James Herbert and Leah Bromfield in 2015, has identified the MDT approach as the bedrock of the CAC model.[14] However, few studies have addressed whether CACs reduce trauma, which is the model's goal.[15]

Canadian model and history

The model's development in Canada has been more recent, with the first Canadian CAC opening in Regina in 1997. As late as 2009, the former Federal Ombudsman for Victims of Crime, Steve Sullivan, voiced concern that "professionals were often working in isolation and do not communicate efficiently or effectively with the child and family, or with each other. The result is a fragmented, confusing, inefficient and expensive process."[16] In response, the 2010 federal budget announced support for the creation and development of CACs through the Victims Fund under the Federal Victims Strategy (FVS). Further funding in the 2012 federal budget aimed to build the capacity of service providers who work with child and youth victims.

Interest in the CAC model has grown in Canada among all sectors.[17] As of 2016, the following CACs are operating in Canada, and at least seven other sites are currently developing or exploring the model:

- Alisa's Wish CYAC, Maple Ridge, British Columbia;
- Sophie's Place CYAC, Surrey, British Columbia;
- Victoria CYAC, Victoria, British Columbia;

[13] Cross, Theodore et al, "Evaluating Children's Advocacy Centers' Response to Child Sexual Abuse" (2008) Juvenile Justice Bulletin 1 at 2-3, online: https://www.ncjrs.gov/pdffiles1/ojjdp/218530.pdf.
[14] Crimes Against Children Research Centre, "Child Advocacy Centers: Papers" *CCRC*, online: http://www.unh.edu/ccrc/centers/papers.html. (A list of articles by Cross and others about CACs can be found at this website).
[15] Bertrand, Lorne D. Ph.D. et al. 2015. "Evidence Supporting National Guidelines for Canada's Child Advocacy Centres." [J4-80-2015-eng.pdf (publications.gc.ca)] at 12.
[16] Federal Ombudsman for Victims of Crime, *Every Image, Every Child: Internet-Facilitated Child Sexual Abuse* (Ottawa: OFOVC, 2009) at 30, online: http://www.victimsfirst.gc.ca/pdf/childp-pjuvenile.pdf.
[17] Justice Canada, "Building Our Capacity: Children's Advocacy Centres in Canada," by Susan McDonald, Katie Scrim & Lara Rooney, in *Victims of Crime Research Digest*, Issue No 6 (Ottawa: Justice Canada, 2013), online: http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd6-rr6/p2.html#sec2.

- Vancouver CYAC, Vancouver, British Columbia;
- Oak CYAC, Vernon, British Columbia;
- Willow CYAC, Kelowna, British Columbia;
- Sheldon Kennedy CAC, Calgary, Alberta;
- Zebra Child Protection Centre, Edmonton, Alberta;
- Caribou CYAC, Grande Prairie, Alberta;
- Regina Children's Justice Centre, Regina, Saskatchewan;
- Saskatoon Centre for Children's Justice, Saskatoon, Saskatchewan;
- Snowflake Place for Children and Youth, Winnipeg, Manitoba;
- Koala Place CYAC, Cornwall, Ontario;
- Kristen French CAC Niagara, St. Catharine's, Ontario;
- CAC of Simcoe/Muskoka, Orillia, Ontario;
- Boost CYAC, Toronto, Ontario;
- Waterloo Region CYAC, Waterloo, Ontario;
- Centre d'expertise Marie-Vincent, Montréal, Québec; and,
- SeaStar CYAC, Halifax, Nova Scotia.

Three sites consider themselves to be virtual models:

- Project Lynx, Whitehorse, Yukon;
- SKY (Safe Kids and Youth) Coordinated Response, Nelson, British Columbia; and
- the Ottawa CYAC pilot project.

Research on Canadian CACs is limited. The Department of Justice Canada (the Department) worked with two organizations, Boost CYAC (Toronto) and Zebra Child Protection Centre (Edmonton), to explore the impact of amendments to the testimonial aids provisions of the *Criminal Code* passed in 2005.[18] Academics such as Mireille Cyr, Kim Roberts, Nick Bala, and Alison Cunningham have also examined interview techniques, testimony, and other issues related to children in the criminal justice system.[19] However, research on services is limited to organizations' internal program evaluations which are not always readily available to the public.

To support the development of Canadian CACs, the Department created a national database of CACs, which led to the first national CAC Knowledge Exchange in 2011 in Ottawa. This event brought together

[18] Canada, Bill C-2, *An Act to amend the Criminal Code (protection of children and other vulnerable persons) and the Canada Evidence Act,* 1st Sess, 38th Parl, 2004 (SC 2005, c 32).

[19] In for example: Lafontaine, Jonathan and Mireille Cyr. "The Relation between Interviewers' Personal Characteristics and Investigative Interview Performance in a Child Sexual Abuse Context." Police Practice and Research 18, no. 2 (2017): 106-118; Evans, Angela D., Kim P. Roberts, Heather L. Price, and Candyce P. Stefek. "The use of Paraphrasing in Investigative Interviews." Child Abuse & Neglect 34, no. 8 (2010): 585-592; Price, Heather L. and Kim P. Roberts. "The Effects of an Intensive Training and Feedback Program on Police and Social Workers' Investigative Interviews of Children." Canadian Journal of Behavioural Science/Revue Canadienne Des Sciences Du Comportement 43, no. 3 (2011): 235-244; Bala, Towards a National Strategy for Combatting Child Sexual Abuse, for Special Advisor to the Minister of Health & Welfare Canada, 1989 (44 pages); Cunningham, Alison J., Judy van Leeuwen, Centre for Children and Families in the Justice System (London, Ont.), and Canadian Electronic Library (Firm). Finding a Third Option: The Experience of the London Child Protection Mediation Project. London, Ont: Centre for Children and Families in the Justice System, 2005.

MDT partners from across the country to share knowledge of the CAC model, develop a common understanding of services provided, and discuss successes and challenges. A follow up meeting occurred in 2012 and a second knowledge exchange was held in 2013. These events sparked research on developing national guidelines for Canadian CACs, which included input from CAC stakeholders through a national network of CACs led by the Department of Justice, and work being undertaken in Ontario to support the development of CACs in that province.[20] Partners agree that guidelines should promote consistency across the country, reflect how child abuse cases are handled in Canada as opposed to the United States, assist new organizations to establish CACs, and retain the integrity of the CAC model.[21] A report by Lorne Bertrand and colleagues offers evidence to support the recommended guidelines,[22] which include, a child-focused setting, MDT, cultural sensitivity, forensic interviews, advocacy and support services, medical evaluation and treatment, mental health evaluation and treatment, case review, case tracking, and organizational capacity. These guidelines reflect the National Children's Alliance standards in the United States.

Today, CACs also exist in Australia, Croatia, Cuba, Finland, Israel, Moldova, New Zealand, Norway, South Africa, Sweden, and the United Kingdom.[23]

2. The Objectives of the FVS

The FVS involves several federal departments and agencies and is coordinated by the Department's Policy Centre for Victim Issues. The FVS seeks to improve victims' experiences in the criminal justice system by:

- enhancing victim participation in the criminal justice system;
- ensuring that victims and their families are aware of their role in the criminal justice system and the services available to support them;
- developing policy, legislation, and other initiatives which consider victims' perspectives;
- increasing awareness of victims' needs, legislation designed to protect them, and services available to support them among criminal justice system personnel, allied professionals, and the public; and
- creating and disseminating information about effective approaches in Canada and abroad to respond to victims' needs.

Since the six CACs included in this study received financial support through the FVS, achievement of key FVS objectives were also examined. More specifically, the study assessed the extent to which the CACs (1) increased access to victim services, (2) enhanced capacity to deliver appropriate and responsive victim services, and (3) reduced financial and non-financial hardships for victims.

[20] A set of draft guidelines was developed by the Ontario CYAC network. The national guidelines will build on this foundation.
[21] Bertrand et al, *supra* nota 9 at 1.
[22] *Ibid.*
[23] *Ibid* at 4.

3. CAC Study—Methodology

Objectives

The Department identified the research objectives and questions, and contracted Proactive Information Services Inc. to conduct the study. The project's goals were as follows:

(1) better understand how Canadian CACs are developing and operating;
(2) measure client satisfaction with CACs;
(3) measure client satisfaction with the criminal justice system's process and outcomes; and
(4) measure how CACs meet the following FVS objectives:
    (a) increasing access to victim services;
    (b) enhancing capacity to deliver appropriate and responsive services to victims; and
    (c) reducing financial and non-financial hardships for victims.

Research questions

Objective #1: Better understand how Canadian CACs are developing and operating

Research Question: What services are provided by the CAC and how does it operate?

(1) How long has the CAC been operating? At what stage is it in its strategic plan? What elements are left to be realized? What is the timeline for completion?

(2) What are the CAC's objectives?

(3) How does the CAC operationalize its objectives?

(4) Where is the CAC located (e.g., neutral facility, court house, hospital)?

(5) What services are available on site?

(6) What are the CAC's policies and procedures on the following:
    (a) multi-disciplinary team response;
    (b) child and family-friendly facilities;
    (c) forensic interviewing;
    (d) victim advocacy and support;
    (e) specialized medical treatment and evaluation;
    (f) specialized mental health treatment;
    (g) training, education, and support for workers;
    (h) community education;
    (i) case training and review; and
    (j) cultural competency and diversity?

(7) How do clients come into contact with the CAC (e.g., referrals)?

(8) How does the CAC's internal referral process function (e.g., are referrals for medical examinations standardized/automatic or made on the judgment of other staff members)?

(9) What lessons learned and/or best practices can be shared with other CACs?

Research Question: What are the characteristics of cases at the CAC?

The information collected should include, but not be limited to, the following:

(a) incident characteristics and allegations;
(b) victim and family characteristics;
(c) characteristics of the accused;
(d) services referred by staff and accessed by victim and non-offending caregivers;
(e) investigation details (e.g., what examinations were performed and where? How was the forensic interview conducted and who was involved? How many times was the child interviewed?);
(f) charges laid (recommended);
(g) court outcomes;
(h) sentencing; and
(i) elapsed time.

Objective #2: Measure client satisfaction with CACs

Research Question: How satisfied were the child and his/her non-offending caregiver(s) with the services received through the CAC and the techniques/procedures that were used to deliver these services (e.g., forensic interviewing, referrals, locations of services, access to/availability of services, culturally sensitive services, and services available in language of choice)?

Objective #3: Measure client satisfaction with the criminal justice system's process and outcomes

Research Question: How satisfied were the child and his/her non-offending caregiver(s) with the criminal justice system (e.g., the length of time it took to lay charge(s), the charge(s) laid, the court process, the length of the trial, the court decision, and sentencing)?

Objective #4: Measure how CACs meet the FVS objectives

Research Questions:

(1) How does the CAC attempt to mitigate financial and non-financial hardships for the victim and his/her non-offending caregiver(s)?

(2) In the caregiver's opinion, were the hardships reduced by the CAC? In what ways? What else could reduce hardships (e.g., enhanced capacity for the delivery of appropriate and responsive victim services)?

(3) To what extent has the funding received through the FVS enabled CAC capacity enhancements (e.g., additional staff, tools, knowledge and training, and access to information/resources)?

(4) How has the CAC increased access to services in response to victims' needs and gaps in services (e.g., hours, location, types of services provided, culturally sensitive services, and translation/language of choice)?

How the study's scope changed

The Department originally selected the following five sites to participate in the study:

- Caribou Child and Youth Centre, Grande Prairie, Alberta;
- Regina Children's Justice Centre, Regina, Saskatchewan;
- Koala Place CYAC, Cornwall, Ontario;
- SeaStar CYAC in the IWK (Izaak Walton Killam) Health Centre, Halifax, Nova Scotia; and
- Project Lynx, Whitehorse, Yukon.

CACs were selected to reflect a variety of governance structures and were chosen from different regions of the country. Originally, the Department proposed 600 interviews with child/youth victims and non-offending caregivers over a three year period as well as approximately 60 interviews with MDTs to understand how the CACs are operating.

However, recognizing that four of the five CACs were still in the development phase, it was not feasible to have the number of client interviews projected. Therefore, the study period was extended to five years to allow for the CACs to establish and be able to have a sufficient number of interviews to be conducted (approximately 200, 1/3 less than the originally 600 targeted). Also, in response, the researchers focused on documenting the development of CACs to meet clients' needs. Consequently, researchers conducted 109 MDT interviews (including 125 individuals) rather than 60.

A sixth CAC, Sophie's Place in Surrey, British Columbia, was also brought into the study in year three when it became evident that one of the five CACs would not be able to include interviews with victims and non-offending caregivers.

Data sources

Three main data sources informed this report: (1) case file data from the CACs, (2) client interviews (child/youth victims and non-offending caregivers), and (3) MDT interviews. Researchers also interviewed CAC stakeholders, including members of boards of directors and local politicians, and conducted a criminal justice system satisfaction survey. These tools formed the basis of a research and evaluation resource that the Department of Justice created for CACs in 2015.[24]

[24] Justice Canada. 2015. *Resources for Conducting Research and Evaluation of Child Advocacy Centres & Child and Youth Advocacy Centres* by Katie Scrim. [Available upon request from the Department of Justice at rsd.drs@justice.gc.ca]

(1) Case file data

Caribou Child and Youth Centre collected data from 320 anonymized case files between January 1, 2014 and September 30, 2016 using an online Fluid Survey instrument developed by the Department. It reported data in Excel and SPSS formats. Data featured distinct files for victims, witnesses, and family members; and variables in the following domains: alleged offences, characteristics of victims and family, characteristics of the accused, services provided by the CAC, and number of forensic interviews.

SeaStar CYAC collected data from 511 case files between January 1, 2014 and September 30, 2016. It reported data in Excel format. It was limited to reporting aggregate data, as opposed to distinct files for victims, witnesses, and family members. Data featured variables in the following domains: case information, demographics, CAC participation, types of abuse, services, and outcomes.

Koala Place CYAC collected data from 319 anonymized case files between January 1, 2014 and September 30, 2016 using Fluid Survey. It reported data in Excel and SPSS formats. Data featured distinct files for victims, witnesses, and family members; and variables in the following domains: screening information, client information, incident information, case information, trial information, forensic interview, forensic medical exam, mental health clinical assessment, multi-disciplinary team case review, information provided to client/caregiver, court accompaniment, services provided to family members, closing file, and follow-up.

Project Lynx collected data from 82 anonymized case files between January 1, 2014 and September 30, 2016 using an Excel template. It reported data in Excel format. Data featured variables in the following domains: client information, services, case information, testimonials aids and other measures, and services provided to family members.

Regina Children's Justice Centre collected data from 107 anonymized case files between January 1, 2014 and September 30, 2016 using Fluid Survey. It reported data in Excel and SPSS formats. Data featured approximately 79 variables in the following domains: screening information, client information, incident information, case information, trial information, forensic interview, forensic medical exam, mental health clinical assessment, MDT case review, and information provided to client/caregiver, court accompaniment, services provided to family members, closing file, and follow-up.

Sophie's Place CAC collected data from 470 anonymized case files between April 1, 2014 and September 30, 2016 using an Excel template developed by Sophie's Place. It reported data in Excel format. Data included approximately 28 variables.

From all six sites, the researchers were able to identify 15 key variables to aggregate for the national report (Table 1).

Table 1:
Case File Variables for National Reporting

Domain	Variable	# of CACs reporting
Client	Type	5
	Gender	6
	Age	6
	Ethnicity	6
Services	Referral source	4
	Joint investigation and forensic interview	6
	Location of forensic interview	6
	Interpretation required	5
	Advocate support	5
	Forensic medical exam	5
	Other referrals offered/accepted	4
Alleged offence/offender	Alleged offence	6
	Relationship to offender	6
	Age of alleged offender	5
	Outcome of police investigation	3

(2) Client interviews

Researchers conducted 123 in-person interviews with 26 child victims (aged five to 11), 17 youth victims (aged 12 to 19), five adults who had been victims as children (i.e., deemed historical cases), and 75 non-offending caregivers (Table 2).

Table 2:
Child/Youth and Non-Offending Caregiver Interviews by Site and Year

Year/ Respondent	Caribou	SeaStar	Koala	Lynx	RCJC	Sophie's Place	Total
2013/14							
Child	--	--	--	--	8 (5F/3M)	--	**8** (5F/3M)
Youth	--	--	--	--	3 (3F)	--	**3** (3F)
Caregiver	--	--	--	--	10 (10P)	--	**10** (10P)
2014/15							
Child	--	2 (1F/1M)	--	2 (1F/1M)	--	--	**4** (2F/2M)
Youth	--	2 (1F/1M)	--	3 (3F)	--	--	**5** (4F/1M)
Caregiver	--	3 (3P)	--	8 (5P/2G/1C)	7 (7P)	--	**18** (15P/2G/1C)
2015/16							
Child	4 (3F/1M)	--	--	--	3 (3F)	--	**7** (6F/1M)
Youth	--	--	--	2 (2F)	3 (3F*)	1 (1F)	**6** **(6F)**
Historical					2 (2M)		**2** (2M)
Caregiver	3 (3P)	2 (2P)	--	5 (4P/1G)	8 (8P)	1 (1P)	**19** (18P/1G)
2016/17							
Child	5 (5F)	--	--	1 (1M)	--	--	**6** (5F/1M)
Youth	1 (1F)	--	--	2 (2F)	1 (1F)	--	**4** **(4F)**
Historical					3 (3F)		**3** (3F)
Caregiver	4 (4P)	6 (6P)	--	3 (3P)	8 (7P/1G)	7 (5P/2O)	**28** (25P/1G/2O)
Total	**17**	**15**	**--**	**26**	**56**	**9**	**123**

F= female, M= male, P= parent, G= guardian, C= caregiver, and O= other relative
*Developmentally delayed

Proactive Information Services Inc. drafted the interview instruments, which were reviewed by the Department and CAC sites. Interview instruments were standardized (i.e., they included questions that were asked at all sites) and separate guides were developed for each of the respondent groups: child victims, youth victims, adult historical cases, and non-offending caregivers.

In addition, while the interviewers asked questions, children were invited to draw something that they liked about the CAC. At the end, the interviewer transcribed the child's description of his/her drawing to ensure an accurate interpretation. Five drawings were relevant to the child's CAC experience. While other children drew unrelated drawings (e.g., a family friend or family dog), the activity nevertheless encouraged

the child to relax. To reimburse expenses associated with participating in this study (e.g., child care and parking), each family received $30.

(3) MDT interviews

Researchers conducted interviews with 125 MDT members (Table 3). Although most MDT interviews were in-person, some were conducted by phone. Proactive Information Services Inc. drafted the interview instrument, which was reviewed by the Department and CAC sites. While the interview instrument was standardized, only questions relevant to each member's role were asked. Executive directors, program coordinators, and/or victim advocates were interviewed multiple times at all sites.

Table 3:
MDT Member Interviews by Site (2013 - 2017)

Site	Number of Interviews	Number of Individuals Interviewed
Caribou	20	25
SeaStar	23	25
Koala	10	12
Lynx	15	19
RCJC	19	20
Sophie's Place	22	24
Total	**109**	**125**

Researchers interviewed 9 executive directors, 18 program coordinators, 26 police officers, 17 child protection workers, 11 Crown prosecutors, two family support advocates, 16 victim services workers, five victim/witness coordinators, one Crown witness coordinator, four doctors, three therapists, two clinical supervisors, one mental health worker, two dog handlers, one court worker, one domestic violence coordinator, one board chair, three board members, one CEO foundation, and one executive assistant to a mayor.

Criminal justice system satisfaction survey

Proactive Information Services Inc. also developed a survey, which was reviewed by the Department and CAC sites to measure client satisfaction with the criminal justice system. One questionnaire was for children (aged five to 11) and their non-offending caregiver to complete together, while another was for youth victims (aged 12 to 19). CAC staff mailed surveys to clients following a justice system outcome, accompanied by a letter explaining the survey's purpose and assuring anonymity. Respondents also received a postage-paid, addressed return envelope. However, only one survey was returned. This was in part due to the length of time in which it takes for a case to move through the criminal justice process and have an outcome. Given that there was only one survey returned, researchers evaluated clients' satisfaction with the criminal justice system during interviews, wherever possible.

Limitations of the study

A number of limitations of the study are identified below along with their mitigation strategy.

Although the purpose of the research was to provide an overview of CACs operating in Canada, it is important to note that the results are not generalizable to other CACs outside the six sites included in the study. However, the results of the study provide valuable lessons learned and best practices that can be adopted by other CACs in Canada and in other countries.

A second limitation concerns the reporting of case file data. Since each of the CACs collected and reported their case file data differently it was not possible to analyze all of the data across CACs. To mitigate the variability, the researchers and the Department identified 15 variables to be analyzed across the different sites. Even for the 15 variables identified, some sites were not able to provide a complete accounting. Also, since aggregate case file data was only available for one CAC, researchers could not distinguish victim only data from this site. Finally, inconsistencies were apparent in the different Fluid Surveys tools (e.g., different response categories to the same question). Although case file data that can be reported on a national level is limited, it provides a picture of the types of cases that are referred to and dealt with by the six CACs.

A third limitation was that the youth interview instrument proved too lengthy and difficult to answer. As a result, the child and youth interview instruments were merged early in the study, which led to some missing data on youth victims. However, the integrated instrument produced more consistent and comparable data between children and youth.

A fourth limitation was the recruitment of client interviewees. One CAC declined to participate in client interviews but shared the results of a client satisfaction questionnaire developed by the CAC.[25] Additionally, participation rates of victims and non-offending caregivers were low. Some families were automatically excluded because the victim advocate felt they were too vulnerable to participate, while other families simply declined to participate. Other factors included one CAC's lengthy protocol to contact families, and delays in receiving a research ethics board's approval to conduct interviews. As a result, a sixth CAC was brought into the study and the length of the study was extended from three to five years. So although the study did not achieve the 600 client interviews originally projected, the 123 interviews with victims and non-offending caregivers over the five years provide a valuable insight into the experiences of CAC clients.

A final limitation of the study was in assessing client satisfaction with the criminal justice system. Although a client satisfaction survey was developed and sent to clients once their case received an outcome in the criminal justice process, only one survey was returned and included in the study. To address this limitation, the researchers asked questions about satisfaction with the process in the interviews. However, it must be noted that this only included satisfaction at the beginning of their experience with the system and did not include any information on their participation post involvement with the CAC.

[25] A total of 11 questionnaires were received and analyzed for this report.

Research lessons learned

Relationships are important in multi-year projects: One member of the research team liaised with CACs throughout the project, which built and maintained trust and collaborative relationships. As a result, site visits went smoothly and information flowed easily in both directions.

Research involving child/youth victims and their families is challenging: Researchers were not able to interview as many victims or caregivers as first intended or even as revised during the study. Many families and one CAC declined to participate. Families coping with trauma may not want to be interviewed again. Researchers were most successful in obtaining participation in the interviews when the victim advocate explained the purpose of the research to the caregiver and accompanied families to interviews (e.g., entertaining the child while the caregiver was interviewed).

4. Operation of CACs

Governance Structures

The six CACs featured diverse governance structures, reflecting the flexibility of the CAC model. The most important elements identified to support service delivery were the need for open communication and a management board that was knowledgeable and supportive. The following outlines the different governance models among the six sites.

Caribou Child and Youth Centre is governed by the board of the Providing Assistance, Counseling & Education (PACE) Sexual Assault Centre. The Caribou Centre's MDT is the main decision-making body for day-to-day operations.

SeaStar CYAC is governed by the IWK Health Centre. The steering committee is comprised of 22 partners from within and outside the health centre, while the MDT deals with day-to-day operations.

Koala Place CYAC is an independent, incorporated CAC with charitable status. It is governed by a 17-member board that includes partner agencies, three non-voting members, and an executive of three people.

Project Lynx identifies itself as a "virtual" CAC that operates out of the victim services office and RCMP detachment. Its governance structure features three levels: the directors group, the working group, and the coordination team.

Regina Children's Justice Centre operates as a long-term partnership between the Regina Police Service and the Ministry of Social Services. Each partner contributes to the rent of the space, has their own supervisor and clerical staff and follows their own policies.

Sophie's Place CAC operates out of the Centre for Child Development (CCD), a registered charitable society that provides general administrative, fiscal, and program oversight for Sophie's Place. A steering committee develops confidentiality agreements, fundraising, and risk management, while the MDT supervises day-to-day services.

Since the CAC model relies on information sharing between partners, signed consent forms and memoranda of understanding (MOU) among partners are important. Three sites used signed consent forms to acquire caregivers' consent to information sharing between MDT partners (although only 32% of cases at one site featured consent forms). Additionally, many sites developed MOUs among directors and partners. Such agreements fostered a better understanding of roles at the CAC, instructed how to collaborate and share information appropriately, and established a firm commitment among partners. Upper-level management committees that met frequently also encouraged information sharing.

Location and facilities

All six CACs are located in urban centres, although many serve rural residents, and the one virtual site serves the entire territory. There are four types of delivery models in the study. The following describes their location and the benefits and limitations of each model as described through the interviews.

The **hospital-based** CAC benefits from being able to offer on-site medical examinations. This is seen as increasing convenience and reducing hardship for clients who require a medical examination. This site also enjoys access to medical specialists at the health centre, such as pediatricians trained in child maltreatment. In comparison, victims at non-hospital-based CACs are referred to off-site health centres where they sometimes wait hours to be seen and often receive treatment from non-specialists or staff untrained in collecting legal evidence. Overall, researchers found that while on-site medical examinations are very convenient for clients, access to available and trained medical staff is more important regardless of location.

Two **CACs are housed with other non-governmental organizations** (i.e., a sexual assault centre and a child development centre) and benefit from a pre-existing infrastructure. Parent agencies have provided funding (e.g., paying for telephones, office supplies, and interview training) and programs, such as school workshops on sexual abuse (e.g., K-6 'Who Do You Tell? Program) and access to services for disabled children. Additionally, since a client may visit the site for several reasons, such co-location offers greater privacy.

Two CACs are **not co-located** with other agencies. The sites are located centrally to ensure convenience for clients. For one of the CACs, the cost for the facility is shared between two partner agencies, while the other CAC is working independently. This provides more flexibility in how the CACs operates, however, it also offers less privacy to clients since the reason for their visit is more pronounced.

A **virtual** model was chosen for one of the sites to accommodate the jurisdiction's dispersed population and to serve as many clients as possible. The coordinator meets with clients at a government victim's services unit and forensic interviews are conducted in a former cell at the RCMP detachment. Although the CAC has a strong victim advocate and a robust MDT response, clients and MDT members expressed a

preference for a physical, child-friendly location to increase convenience and reduce stress. Since the study concluded, Project Lynx has made child friendly enhancements in some communities, identifying appropriate spaces for interviews, and adding comfortable furniture and décor. Improvements have also been made with technology and infrastructure in partnership with Court Services to enable out of courtroom testimony in all communities.

Some challenges the CACs faced at start-up included delays in locating and acquiring a location as well as issues with the set-up of equipment required for forensic interviewing. Challenges with the physical space also continue to exist for some CACs as they are taking on more cases and need to expand their space. While another CAC, currently housed within a parent organization, is considering creating its own board now that it has matured.

Overall, the research has found that a dedicated physical, child-friendly space is a core component of the CAC model. This is consistent with previous research and best practices of the National Children's Alliance.[26] Caregivers and clients commented on the impact of the physical space on their experience with the CAC:

> "It would be nice to have a dedicated space and it would help parents to have a visual of it all . . . [that] people are there for them . . . [It] would make a huge difference" (caregiver from the virtual model).

> "It helps the way it's decorated. I don't want to be walking into a dark place . . . This is definitely better than going to the RCMP" (youth).

"I love coming to this place because I love playing with the toys. I got a stuffie. And we needed help with [what happened]" (child).

[26] National Children's Alliance. 2017. "Standards for Accredited Members." Online: http://www.nationalchildrensalliance.org/sites/default/files/downloads/NCA-Standards-for-Accredited-Members-2017.pdf; Theodore Cross et al., 2008. "Evaluating Children's Advocacy Centers' Response to Child Sexual Abuse." Juvenile Justice Bulletin 1 at 2-3, online: https://www.ncjrs.gov/pdffiles1/ojjdp/218530.pdf

Child-friendly rooms at Caribou CYAC, Sophie's Place CYAC, and Regina Children's Justice Centre.

The MDT model

The MDT brings together law enforcement, child protection, prosecution (Crown), victim support and advocacy, medical, and mental health professionals, and the CAC staff into one team to coordinate investigation and intervention. Although the composition and approach to working as MDTs varies among the six CACs in this study, they all offered joint investigations between at least police officer and child protection worker.

Table 5 provides an overview of MDT membership by site. It also outlines the frequency of case review meetings, which vary from four times per year to twice a week. The frequency of meetings depends on protocols and the co-location of MDT members (although case review meetings can still occur if MDT members are not co-located). Regular meetings were important. One CAC that increased its frequency of meetings to monthly cited better follow-up with clients as a positive consequence. Examples of questions asked at meetings include: What was the outcome? What worked and why? What did not work and what could have been done differently?

Table 4:
MDT Membership and Case Review Information

MDT Member	Caribou	SeaStar	Koala	Lynx	RCJC	Sophie's Place
CAC coordinator/ victim advocate/ responder	★	★	★	★	★	★
Law enforcement	✓	✓	★	✓	★	★
Victim services	✓	✓	✓	✓	★	★
Child protection	✓	✓	★	✓	★	★
Crown	✓	✓	✓	✓	✓	X
Medical	X	★	✓	✓	✓	X
Mental health (counselling)	★	★	✓	✓	X	X
Other	X	X	X	✓	X	X
Frequency of Case Coordination/ Review Meetings	Once a Month	Quarterly	Once a month	Every 2 weeks	Twice a week	Once a month

★ means they are part of the MDT and housed on site, at least for a portion of their time.
✓ means they are part of the MDT, but not on site.
X means they are not part of the MDT.

The best situation for MDTs is co-location, with law enforcement, child protection, and victim services housed at the same site with CAC staff such as the victim advocate. Co-location facilitates quick responses, information sharing, and coordinated support for clients. However, MDTs that are not co-located can still function well if they build trusting relationships, have well-negotiated and understood protocols, and hold regular case review meetings.

Building a MDT and developing MOUs often took longer than expected. For instance, where nurses were trained to provide specialized medical treatment, many were still concerned about being able to practise in the hospital and testify in court. Protocols for information sharing at all sites required negotiation and trust building. However, over the course of the study, communication between MDT members improved and responses were better coordinated, thus improving service to clients. Some CACs now provide mandatory training on collaboration to new MDT members.

CAC services

Many CACs added or expanded services, largely thanks to FVS funding throughout the five years of the study. New services included psychoeducational workshops on trauma for caregivers, therapy dogs, and a committee on vicarious trauma. New MDT members included a First Nations representative, and a victim advocate at the longest-standing CAC in the study. Therefore, despite different levels of development, all sites were continuously evolving to meet clients' needs.

The one service that was offered across all six sites was victim advocacy (Table 5).

Table 5:
On-Site Services by CAC

Service	Caribou	SeaStar	Koala	Lynx	RCJC	Sophie's Place
Advocacy through a victim advocate	✓	✓	✓	✓	✓	✓
Forensic interviewing	✓	✓	✓	X	✓	✓
Child-friendly meeting places for information provision	✓	✓	✓	X	✓	✓
Law enforcement support	X	X	X	X	✓	✓
Social worker support	X	✓	✓	X	✓	✓
Forensic medical examinations	X	✓	X	X	X	X

✓ means available on site (including full-time and part-time positions)
X means not available on site

The victim advocate is the centre of each CAC and the glue that holds the MDTs together. They are involved throughout the entire process, ensuring a welcoming atmosphere; acting as the central point of contact for victims and their families; answering questions; providing referrals, updates (e.g., about the court case), and information (e.g., about testimonial aids and victim impact statements); and/or liaising with other MDT members. The victim advocate's impact on clients is evident:

> "The victim [advocate] is our rock through the whole process. I don't know what we would do without her" (caregiver).

Another caregiver described the victim advocate as "calming and re-assuring," since they were with the CAC, their role was to support the family. While the victim advocate's role varied by site (Table 6), their presence at the CAC is what mattered most. Advocates worked closely with victim services and court supports. They reached out to small and First Nations communities and maintained communication with clients throughout the process and even after file closure.

Table 6: Roles of the Victim Advocate

Roles	Caribou	SeaStar	Koala	Lynx	RCJC	Sophie's Place
CAC administration	★	X	★	★	X	★
Support for child/youth victims and families during forensic interviews	★	★	✓	X	★	X
Ongoing support for child/youth victims and families ('listening ear')	✓	★	★	★	★	★
Follow-up and ongoing provision of information to child/youth victims and families	✓	★	★	★	★	★
Court preparation and support	✓	X	✓	✓	✓	✓
System navigator (e.g., providing referrals to other agencies)	✓	★	★	✓	★	★

★ means this is a key role
✓ means this is a function sometimes undertaken
X means this is not part of the role

The second most common service available on site is forensic interviewing. A forensic interview is a structured conversation with a child/youth to gather detailed information about possible event(s) that they may have experienced or witnessed. It seeks information for criminal investigations, to assess the safety of the child's living arrangements, and to determine the need for medical or psychological treatment. Most CACs used the Step-Wise Interview Technique,[27] while one site preferred Rapport, Anatomy Identification, Touch Inquiry, Abuse Scenario, and Closure (RATAC).[28] In some instances, forensic interviews were performed at a child's school with mobile video/audio equipment.

Access to mental health services is also described as "limited". Although one CAC had two part-time therapist positions, one spot was vacant during the study because the CAC could not afford to offer an attractive salary. Another site had a clinical social worker and psychologist. Four CACs refer clients to off-site mental health services, described as a 'patchwork' of programs with long wait lists (e.g., up to one year) and gaps in services for children/youth and specialized adult counselling. In some locations, victim services offer mental health treatment, but access sometimes depended on criminal charges and police reports. As a result, some caregivers access mental health services through private insurance or work.

Although it is not part of the CAC model, two sites offer therapy dogs as an additional service. These dogs calmed young victims before forensic interviews, during court preparation, and in at least one instance, a therapy dog provided support at the courthouse while a young CAC client awaited legal proceedings and testimony. One site has begun a seven-year commitment to working with a therapy dog. Another site is currently waitlisted for a Pacific Assistance Dogs Society (PADS) trauma dog. One MDT member described a dog's impact as follows:

> **"**There was a child that was so stressed there was no way that he/she was going to be interviewed. The child just sat and rubbed [the support dog's] belly for a long time in the waiting room. To see if the child would be comfortable going into the interview room, we suggested that [the support dog] could help him/her choose a chair. Once the victim got in the room and sat in the chair that [the dog] chose, he/she seemed to settle. We said that [the dog] would be waiting just outside the door. The child had the interview… [which] would not have happened without the dog's help."

The flexibility of the CAC model has allowed for a number of innovative services. Some that were highlighted include:

- **Workshops/ community education:** To reach more people with limited funding, several sites have created workshops for families and professionals in the community. Classes taught caregivers about the

[27] Yuille, John C., Barry S Cooper & Hugues HF Hervé, "The Step-Wise Guidelines for Child Interviews: The New Generation" in M. Casonato & F. Pfafflin, eds, *Handbook of Pedosexuality and Forensic Science* (Italy: Franco Angeli, 2009) at 11. (The Step-Wise Interview Technique is widely used in Canada, the US, and the UK to interview young victims and witnesses of sexual abuse, physical abuse, and neglect. Interviewers follow steps, including building rapport, establishing the need for truth, allowing a free narrative, asking general questions, and proceeding to more specific questions if required).

[28] Anderson, Jennifer et al., "The CornerHouse Forensic Interview Protocol: RATAC®" (2010) 12 TM Cooley J Prac & Clinical L 193 at 195. (RATAC is based on the idea that every child is unique. Accordingly, interviews are tailored to each child's age and cognitive, social, and emotional levels. Interviews are also semi-structured to allow the child's spontaneity.)

importance of self-care, how to support children coping with trauma and how to navigate the legal system. Over 800 people have attended one site's classes. Other CACs also hosted conferences, one of which was live-streamed and attracted 180 participants; and created caregiver handbooks, which had a "huge" impact.

- **Therapy dogs:** Two sites introduced therapy dogs to calm young victims before forensic interviews and during court preparation and court appearances. Both victims and caregivers reported reduced anxiety and stress as a result.

- **Girls' groups:** One site offered workshops for girls on self-care, self-esteem, and healthy relationships (e.g., not putting yourself down). One participant explained that the group had helped her, and she remains in contact with two of the other girls.

- **Support for MDT members coping with vicarious trauma, PTSD, and/or burnout:** One victim advocate received training in compassion fatigue and most police partners were required by their home organizations to de-brief with a psychologist annually, quarterly, or following major disturbing cases. One site is also developing a committee on vicarious trauma. However, support remains limited.

- **Training:** Several MDTs received training in collaboration (mandatory), forensic interviewing, and child abuse and maltreatment. Partners could also attend conferences and visit other CACs to observe best practices.

- **Cultural competency:** Three sites added First Nations representatives to their MDTs to increase cultural competency, and one site offered smudging and case planning with Elders in a circle. Another CAC that served a large immigrant and Sikh community required MDT members to attend yearly cultural relations courses, and employed a South Asian victim advocate. While the CACs in this study served diverse populations, the need for culturally sensitive services at other CACs could vary.

Staff training

Access to training varies among the CACs. Two CACs provide mandatory initial training to MDT members on how to collaborate and work as a team, while another site uses roundtables to understand each member's roles. All members can attend conferences or visit other CACs. Many MDT members have received training in forensic interviewing and/or child abuse and maltreatment. Some have been trained in cultural competency and diversity through their school or home organization (e.g. RCMP). Three sites that serve Indigenous communities have worked closely with First Nations (e.g. First Nations policing and child protection agencies) to improve cultural competency, including case planning with Elders. One site that serves a large immigrant population requires its MDT members to attend yearly cultural relations courses.

However, very little formal training and support is available to help MDT members cope with vicarious trauma, post-traumatic stress disorder (PTSD) and/or burnout, which was described by an interviewee as something that can "eat you alive." Most police partners are required by their home organizations to de-brief with a psychologist annually, quarterly, or after major disturbing cases. One victim advocate has also been trained in compassion fatigue to support MDT members. Another site is currently creating a

committee on vicarious trauma, while other partners explained that "if we need a day off or time for self, we are encouraged to do it." However, support remains informal and most members rely on their home organizations for mental health services.

Outreach

CACs also educate local communities. Three sites hosted conferences, including one titled "Building Resiliency through Collaboration" in 2016 that was live-streamed and attracted 180 participants. Some CACs have also offered workshops for caregivers on coping with trauma. For instance, a series of trauma-informed workshops included Trauma and the Importance of Self Care, How to Support Your Child's Healing: Becoming Your Child's Emotion Coach, and More Emotion Coaching. This CAC also offers classes in meditation, trauma-informed yoga, mindful parenting, and strategies to navigate the legal system.

5. Clients and cases

Researchers studied 1,804 case files. The following tables report results by two categories: (1) victims, and (2) all clients (including victims, witnesses, and family members) because one site was only able to provide aggregate data on all clients.

Demographic information

Victims were primarily female (67%) (Table 7).

Table 7:
Gender of Clients

Gender	Victims** (n=978)*		All Clients (n=1782)*	
	n	%	n	%
Female	651	67%	1137	64%
Male	327	33%	645	36%

**** Data are missing for 8 victims and 22 cases overall.***
*****Data for victims are only available from 5 sites and therefore, do not include data for 511 cases. These data are included in the overall.***

Almost half of victims were 8 years or younger. The average age was 9.4 years (Table 8).

Table 8:
Age of Clients

Age	Victims** (n=957)*		All Clients (n=1715)*	
	n	% ***	n	%
Under 6 years	233	24%	382	22%
6 to 8 years	230	24%	428	25%
9 to 11 years	195	20%	354	21%
12 to 14 years	185	19%	359	21%
Over 14 years	114	12%	192	11%

**** Data are missing for 29 victims, and 89 cases overall.***
***** Data for victims are only available from 5 sites and therefore, do not include data for 511 cases. These data are included in the overall.***
******Percentages may not add up to 100 due to rounding.***

Over half of victims were Caucasian (56%) (Table 9). The second largest group was Indigenous (17%).

While data regarding the provision of language interpretation are missing for 348 cases, interpretation services were provided for 14 clients. At one site, Immigration Services provided interpreters, although it is not part of the MDT.

Table 9:
Ethnicity of Clients

Ethnicity	Victims** (n=928)*		All Clients (n=1227)***	
	n	%	n	%
Caucasian/white	518	56%	715	58%
Indigenous	162	17%	202	16%
Other (i.e. South Asian, Black)	136	15%	183	15%
Unknown	112	12%	127	10%

**** Data are missing for 58 victims.***
***** Data for victims are only available from 5 sites and therefore do not include data for 511 cases. These data are included in the overall.***
******One site provided only approximate numbers for some response categories.***

Offences were primarily sexual in nature (72%) (Table 10). Physical assault was the second most common alleged offence (28% of offences).

Table 10:
Types of Alleged Offences

Alleged offence	Victims** (n=1189)*		All Clients (n=2036)*	
	n	%	n	%
Sexual assault	378	32%	691	34%
Physical assault	329	28%	617	30%
Other (i.e., sexual interference, luring a child via a computer, invitation to sexual touching, sexual exploitation)	478	40%	683	34%
Unknown	4	0.3%	4	0.1%
Not applicable	0	0%	41	2%

**** This question can have multiple responses, so the total response is higher than the number of victims/cases.***
*****Data for victims are only available from 5 sites and therefore, do not include data for 511 cases. These data are included in the overall.***

The accused were primarily family relatives (64%) (Table 11). They were also mostly adult males.

Table 11:
Relationship of the Accused to Clients

Relationship of Accused	Victims** (n=966)*		All Clients (n=1717)*	
	n	%	n	%
Family member (i.e., parent, step-parent, uncle/aunt, sibling)	615	64%	1090	64%
Known to individual/victim, but not a family member (i.e. friend, acquaintance)	161	17%	365	21%
Unknown to individual/victim	109	11%	144	8%
Other (e.g., a friend's older sibling)	81	8%	118	7%

**** Data are missing for 20 victims, and 87 cases overall.***
***** Data for victims are only available from 5 sites and therefore, do not include data for 511 cases. These data are included in the overall.***

Police services and child protection agencies were the two most common referral sources (together comprising 94%) (Table 12). These data correspond with the fact that most investigations (71%) were jointly conducted by police and child protection.

Table 12: Referral Source for Clients*

Referral Source	Victims (n=645)		All Clients (n=824)	
	n	%	n	%
Police	396	61%	520	63%
Child Protection	209	32%	257	31%
Victim Services	9	1%	9	1%
Other (varies by site)	26	4%	31	4%
Unknown	5	1%	7	1%

**Data for victims and overall clients are only available from 4 sites and therefore, do not include data for 981 cases.*

The most common type of information provided to clients was general information about the justice system (37%), which highlights the importance of the victim advocate in helping clients navigate the criminal justice system. Indeed, case file data revealed that 79% of victims had received advocate support.

Table 13:
Type of Information Provided (n= 614)*

Type	n	%**
General information about the justice system	229	37%
Counselling services	223	36%
Case specific	133	22%
Court preparation	21	3%
Testimonial aids	8	1%

*Data were only available from two sites.
**Percentages may not add up to 100 due to rounding.

Over the course of the study, the most common service provided was forensic interviewing (received by 96% of victims). In comparison, only 11% of victims received forensic medical examinations. These numbers reflect the availability of on-site services, since five CACs offered on-site forensic interviews whereas only one offered on-site medical examinations.

Clients were most frequently referred to the following off-site services: counselling/therapy/mental health services (n=67), police/crown/courts (n=51), and victim services/victim witness coordinators/victim compensation (n=33). Therefore, CACs seeking to expand their on-site capacity may want to consider these services, particularly mental health services.

Police laid charges in 16% of cases involving victims (n=160). At one site, outcomes of sexual assault charges were: found guilty (n=4), guilty pleas (n=11, including 10 before the preliminary trial), and stays (n=7). Outcomes of sexual interference charges were: stays (n=15). Outcomes of common assault charges were: guilty pleas (n=2, including one before the preliminary trial) and stays (n=3).

The average elapsed time between first contact at the CAC and file closure was 187.7 days, and the median was 126.5 days. Since clients spent over half a year in contact with a CAC, the retention of staff, particularly the victim advocate who is the family's main contact, was critical to maintaining trust and relationships.

Interview and survey results

Overall client satisfaction with CAC services

> "They [CAC staff] are a godsend. I'm so glad they're here . . . it's a must that these services remain available. They are phenomenal. It feels like a whole team is behind you, even when you just met these people" (caregiver).

Almost all victims and non-offending caregivers appreciated the services received; they reported that they felt welcome and were treated fairly and non-judgmentally (Table 14). The child-friendly rooms were very popular, as was the fact that police officers at four sites wore street clothes instead of uniforms. As a result, victims did not feel pressured: "the kids loved her [RCMP officer]. She was very friendly" (caregiver).

Table 14:
CAC Experiences by Child/Youth Victim and Non-Offending Caregiver

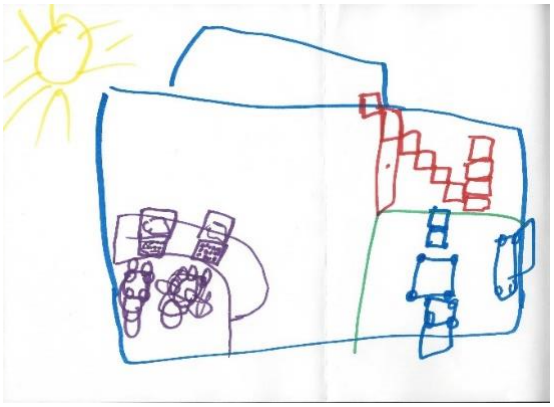
CAC experience	Yes			
	Victim		Non-offending caregiver	
	n	%	n	%
Felt safe during the interview(s) (n=26)	22	85%	--*	--*
Child felt safe during the interview(s) (n=64)	--*	--*	54	84%
CAC staff made you feel welcome (victim n=24) (caregiver n=70)	24	100%	66	94%
CAC staff made your child feel welcome (n=68)	--*	--*	57	84%
CAC staff were fair (non-judgmental/open minded) when they talked to you (victim n=23) (caregiver n=73)	22	96%	69	95%

Indicates this question was not asked of these interviewees.

Table 15:
Caregiver Satisfaction with CAC Services/Support

Question: Were/are you satisfied with the following supports you received at/through the CAC?	Yes	
	n	%
Support for themselves (non-offending caregivers) (n=65)	65	100%
Support received by their child (n=60)	60	100%
Information provided (n=62)	56	90%
Wait times for services (n=57)	52	91%

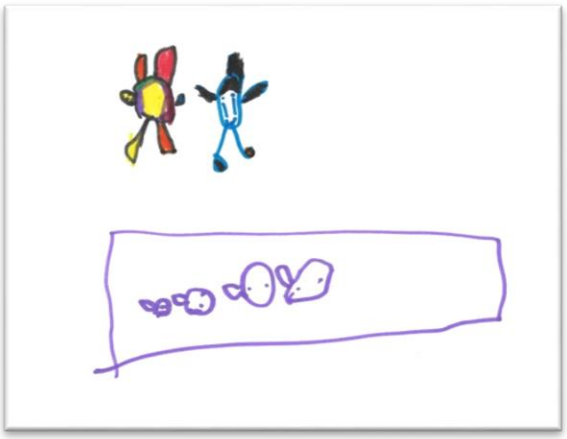
Among the 36 victims who provided an overall rating of the CAC, 83% rated their experience as either "good" or "great." The two victims who rated their experience as "not good" were from the same site. One did not want to be videotaped during the forensic interview, and the other was concerned that the offender would be present. No victim gave a rating of "terrible."



This drawing (left) shows the CAC's entrance, the family room with couches and a TV, and the play area with computers. The child liked coming to the CAC. The sun shining suggests a warm place.

This drawing (right) shows the pictures on the ceiling of the play room, the stuffed animals, and the Wii. "There was a bin of stuffed animals and they told me I could take one home with me – a little pink stuffed bear."

One child drew the CAC's victim advocate (above). "I like her, so I used lots of colours."



A six-year-old child explained the best part about the CAC in her drawing (above): "a bumblebee stuffed toy, a person smiling, and the fish tank."

Another child drew a Wii (left). "I was happy I could talk to someone who wasn't my mom. And they gave me a book so if I ever needed someone to call, I could call them."

Forensic Interviews

Of the 75 caregivers who were asked about their child's experience, 91% (68 caregivers) said that their child underwent a forensic interview. Of the 45 caregivers whose child had a forensic interview in a child-friendly room, 76% (34 caregivers) reported that their child was comfortable in the room.

The victim advocate also supports caregivers during their child's forensic interview. Parents are usually not allowed to monitor the interview to reduce possible stress on the child and provide a neutral setting. Since this can be stressful for caregivers, the victim advocate often meets with caregivers before, during, and after the interview to explain the interview's purpose and rules, and to discuss questions and concerns.

Victims had conflicting feelings about the forensic interview. While many felt uncomfortable at the beginning, they often felt relieved afterwards as if "a weight was taken off my shoulders." Others were "upset because of what happened, but relieved they [CAC workers] would take it seriously." While most victims reported that people were nice to them during the interview (85%), only some were told what was going to happen afterwards (27%) (Table 16). Caregivers were more likely than youth victims to receive updates on their case and to know who to contact at the CAC. Child/youth victims reported wanting more details and explanations.

Caregiver satisfaction with the forensic interview was also mixed. A few parents were dissatisfied that they could not monitor their child's interview:

> "I don't think it's fair that parents aren't in the room. I didn't know anything. I didn't know how or what to deal with after the fact...They should involve parents to determine what is truth and what is not" (caregiver).

Most frequent and important services

Caregivers and youth victims most frequently received support from the victim advocate. Ninety-three percent of respondents indicated that the support they received from all professionals was helpful. Caregivers also identified the victim advocate as the most important service received by them (46%), while counselling/therapy was the most important service received by their child(ren) (33%).

> "[The counsellor] was great – awesome. She was someone I could open up to, a shoulder to cry on. . . she understood and was easy to talk to" (youth).

Location and accessibility of services

Most caregivers found the CAC's location convenient (84%), that services for themselves were easy to access (86%), and that services for their children were easy to access (79%).

Cultural sensitivity and language of services

Most youth victims (79%) and caregivers (91%) received services that were culturally sensitive. As one caregiver explained, the CAC director "understood our culture and religion and acted as a go-between [between the family and the Crown]." Another CAC that served a large Sikh population employed a South Asian victim advocate, which an MDT member cited as "important." All youth victims and most caregivers (98%) received services in the language of their choice, although one caregiver felt that services should have been offered in French. While the need for culturally sensitive services was high among CACs in this study because they served diverse populations (including Indigenous and immigrant communities), this need could vary by CAC.

Satisfaction with the criminal justice system

The survey developed by Proactive and reviewed by the Department to measure client satisfaction with the criminal justice system was not widely utilized. Although respondents received a postage-paid, addressed return envelope, only one survey was returned. This may be because cases take so long to be completed that only a few people were able to offer their opinions during the timeframe of the study. The sole respondent was a caregiver of a seven-year-old child. They were satisfied with the information provided and court accompaniment. The Crown was available and explained the caregiver and child's roles in the court process. The child did not have to testify in court, and neither the parent nor the child submitted a victim impact statement. While the parent was satisfied with the length of the trial and the CAC's support, he/she was dissatisfied with the plea bargain, court decision, and sentence. The respondent rated his/her experience at the CAC as "great" and the court process as "good." The child reported that she felt scared before she went to court, but was happy afterwards.

Client interviews provided further information. Both caregivers and youth victims were frustrated with the system, particularly lengthy investigations and trial delays which increased their stress.

The system was similarly stressful for caregivers, many of whom were "exhausted" because "it drags on forever":

> "No one told me the investigation would take six months. No one talks to you during that time. Every week feels like a month."
>
> "The CAC is helping me with going to court, but the date keeps changing. I think it is taking too long" (victim).
>
> "The biggest problem is the Canadian justice system, it took so long!" (caregiver).

Although CACs alleviate many problems, they are not designed to fix clients' biggest complaint: the criminal justice system, including frequent court adjournments. Many clients feel that speedier resolutions would reduce hardship: "finally getting a conviction would be a start to the long journey of healing" (caregiver). However, while CACs assist investigations and court preparation, they cannot control court delays or outcomes. Aside from perhaps collecting better evidence, CACs cannot produce more convictions or

tougher sentences, even though some researchers have examined whether CACs lead to such outcomes.[29] As one caregiver observed, "[the CAC] is excellent, but in the end, it is not a people issue, it's a systems issue. The system does not protect children." CAC staff, such as the victim advocate, should inform clients upfront that, although they can help in many ways (e.g., providing a therapy dog for court accompaniment), they cannot control the criminal justice system.

6. Effect of CACs on clients

> "Before I came here I was stressed out. I didn't know how to handle it. Here I can talk about it. I don't keep it inside and walk around with it every day." (victim)
>
> "When I didn't feel capable of telling someone, they helped me feel capable of talking." (victim)

Reduced non-financial hardship

CACs reduce stress and re-victimization. Five sites provide a single, safe, and child-friendly place for victims and their families to obtain information and support, and a location for interivews. CACs also reduced the number of victim interviews (e.g., by videotaping), which was important since having to tell their stories was the most difficult part of the process for victims. The average number of interviews per victim was 1.3, as reported by caregivers. Nine of the 10 victims who remembered their number of interviews reported being interviewed once. In one instance where a child was re-interviewed, a child psychologist accompanied interviewers to prevent re-traumatization. These findings contrast with the Cross study, which found that American CACs do not reduce the number of victim interviews. However, since this study did not examine comparison communities unlike the Cross study, a definitive answer awaits future research.

Sites also reduced non-financial hardship by providing a single point of contact—the victim advocate—to offer emotional support, information, referrals to services, and/or assistance navigating intimidating systems. This reduced stress and saved time since families did not have to deal with multiple people. As one caregiver explained, "it was a life saver. I would have lost my mind without them."

Reduced financial hardship

CACs alleviated some financial hardship either by themselves or through their partners. Having services at one location also reduced financial stress for clients. Some sites provided emergency cell phones, bus tickets, taxi slips, and/or food vouchers. Some staff also assisted clients with filling out applications for government support (e.g., victim compensation applications to help pay for counselling and applications for housing).

[29] Justice Canada, *supra* note 8 at 7.

Increased access to victim services

CACs have addressed many gaps in the system, including access to medical examinations, access to child-friendly environments for forensic interviews, support for court appearances,and more coordinated responses to child abuse cases. CACs also provided assistance to families in making linkages with MDT partners and for ongoing information and supported them throughout the criminal justice process, through the role of the victim advocate.

Enhanced capacity to deliver appropriate and responsive victim services

FVS funding was crucial. Some sites would not have existed without the funding, which "fully enabled us to develop everything," including establishing the victim advocate and coordinator positions, providing training and knowledge exchanges for MDT members developing protocols and MOUs, and purchasing and installing forensic interviewing equipment. Some sites also used funding to purchase computers, TVs, video game systems, toys, and movies for the child-friendly rooms, which the children and youth really appreciated.

7. Conclusion

The objectives of this study were to better understand how Canadian CACs are developing and operating; measure client satisfaction with CACs; measure client satisfaction with the criminal justice system's process and outcomes; and measure how CACs were meeting Federal Victims Strategy objectives related to increasing access to victim services, enhancing capacity to deliver appropriate, responsive victim services, and, reducing financial and non-financial hardship for victims of crime.

The centres that were part of the study were at various stages of development at the outset of the study and some are continuing their development toward a the ideal model, while others are continuing to grow and develop or expand their services.

Results of the study found that each CAC model has its strengths and limitations that need to be weighed according to the best fit for the community and developing CAC. It was found that the hospital-based CAC increased access to medical examinations and health specialists. However, while on-site medical examinations increase convenience for clients, having available and trained medical staff was seen as more important. CACs located within other agencies benefit from a pre-existing infrastructure, funding, and program support. However, parent agencies like police or government services can carry negative connotations for clients. The stand-alone CACs have more flexibility in their operations, however, there were challenges around acquiring space and there is a risk that clients would have less privacy because the purpose of their visit was clear.

The flexibility of the CAC model enables the organizations to respond to the unique needs of the community. Diverse governance structures do not appear to affect service delivery as long as communication is open and the management board is knowledgeable and supportive.

The co-location of MDT members is an important strength of the CAC model. When partners were housed at the same site with CAC staff, such as the CAC coordinator and/or victim advocate, it facilitates quick responses, information sharing, regular case meetings, and coordinated support for clients. While MDTs that are not co-located can still perform well, they must develop trusting relationships, well-negotiated and understood protocols, and regular case review meetings.

The location and physical setting of the CAC was also important. The study found that there is a need for a physical space for the CAC to operate effectively. Although the one CAC that was using a virtual model had a strong victim advocate and a robust MDT response, clients and MDT members expressed a preference for a physical, child-friendly location to increase convenience and reduce stress. Since the study concluded, this site has made efforts to be more child-friendly in as many communities as possible, identifying appropriate spaces for interviews, and adding comfortable furniture and décor.

The study found that the role of the victim advocate was a key strength of the CAC model. It was seen as providing the glue to hold the MDT together and supporting clients throughout the process. Caregivers identified the victim advocate as the most important service received by them and their child(ren). Despite variations in the victim advocate's role, their presence at the CAC is what mattered most.

These findings are in line with best practices identified in the National Children's Alliance Standards for Accreditation[30] and the draft national guidelines for CACs in Canada.[31] The following were also identified as lessons learned:

- **Access to mental health services for clients and MDT members is important**. Only two CACs provide on-site mental health services. Both on-site and off-site services were described as a 'patchwork' of programs, with long wait lists (e.g., up to one year) and gaps in services for children/youth and specialized adult counselling. Additionally, support for MDT members coping with vicarious trauma, PTSD, and/or burnout, which can "eat you alive," is limited.

- **Child/youth clients want more information**. During the investigative process, while most child/youth victims reported that people were nice to them during the interview, three quarters indicated that they were not told what was going to happen afterwards. Compared to caregivers, young victims were also less likely to receive updates and to know who to contact at the CAC. Clients expressed interest in learning more about the process in general and in the progress of their case in particular.

- **CACs need diverse staff and MDT members.** CACs benefit from having diverse staff and partners – both male and female, and members of local communities, including those who share similar religious and cultural backgrounds as clients. Clients mentioned that young girl victims appreciated being able to work with female staff, while one caregiver lamented the difficulty of finding a male counsellor for her son.

[30] National Children's Alliance. 2017. "Standards for Accredited Members." Online: http://www.nationalchildrensalliance.org/sites/default/files/downloads/NCA-Standards-for-Accredited-Members-2017.pdf
[31] Bertrand, Lorne D. Ph.D., et al. 2015. Evidence Supporting National Guidelines for Canada's Child Advocacy Centres. [J4-80-2015-eng.pdf (publications.gc.ca)]

- **Privacy.** Private spaces within CACs enhance the experience for clients: At one site, the victim advocate often has to speak to families in front of other people due to limited space, reducing clients' privacy. Clients at other sites also suggested adding sound-proof walls, opaque doors, and/or drop-down shades to increase privacy.

Overall, the CACs reduce both non-financial and financial hardship for clients. They reduced stress and re-victimization by providing a single, safe, and child-friendly place for victims and their families to receive information and support (for five of the six locations); reducing the number of victim interviews (e.g., by videotaping); providing a single point of contact through the victim advocate who provided emotional support, information, referrals to services, and/or assistance navigating intimidating systems; and in some sites providing emergency cell phones, bus tickets, taxi slips, and/or food vouchers.

The CACs have also addressed many gaps in the system, including access to medical examinations, access to child-friendly environments for forensic interviews and court appearances; the need for increased collaboration between partners that respond to child abuse cases; and provided victims and their families with a single point of contact—the victim advocate—to offer emotional support, information, referrals to services, and/or assistance navigating intimidating systems.

The study was the first of its kind on CACs in Canada and contributes to what we know and understand about the development and growth of these organizations. As the number of CACs continues to grow in Canada, further research is recommended. Future research could examine Canadian CACs in comparison to non-CAC communities to assess whether CACs lead to faster investigations, fewer interviews, and better client satisfaction, for example. As noted earlier in this report, few studies have assessed whether or not CACs reduce trauma, which is one of the main goals of the model. Future Canadian research could address this research question. Other research could evaluate the effectiveness of different trauma-reducing strategies at CACs, such as the use of therapy dogs and their impact both on MDT partners and on CAC clients.

Appendix: Site Reports

Sophie's Place CAC
(Surrey, British Columbia)

Opened in 2012, Sophie's Place is housed with and governed by the Child Development Centre (CDC), a registered charity that helps developmentally challenged children. Since children with disabilities are vulnerable to abuse, the partnership between Sophie's Place and the CDC is beneficial. Also when a child and their caregiver enter the building, they are not identifiable as victims, because they could be there for a diversity of reasons. It protects anonymity of victims.

Multi-disciplinary team

The MDT consists of 15 people: a director, a coordinator, seven RCMP officers, a child protection worker, a part-time Aboriginal stream social worker, and four victim services workers. Partners signed a Letter of Understanding to confirm their commitment. Case review meetings occur monthly, and partners follow a procedures manual developed by Sophie's Place (e.g. how to conduct interviews and how to store videotapes). Since the team members started working under one roof, "barriers have been broken down [and] there are no longer silos" (MDT member).

RCMP officers conduct forensic interviews using the StepWise technique[32] (98 percent of interviews occur on site). Social workers observe from a monitoring room, and interviews are videotaped for further review and court proceedings. Medical evaluations occur off site at the nearby Health Evaluation Assessment and Liaison Clinic (HEAL) or at the BC Children's Hospital in Vancouver. Mental health services are provided off site by Child and Youth Mental Health, Options Community Services (which specializes in counselling for children with special needs), and Surrey Women's Centre (which provides services in multiple languages). Victim advocacy includes court preparation, helping caregivers find housing and income support, and developing strategies for the child's/youth's safety.

Facilities

The child-friendly rooms and hallway (left) feature bright colours, comfortable furniture, snacks, art activities, and an Xbox. Additionally, police wear street clothes instead of uniforms. As a result, "there is a light and airy feeling to the

[32] Yuille, John C., Barry S Cooper & Hugues HF Hervé, "The Step-Wise Guidelines for Child Interviews: The New Generation" in M. Casonato & F. Pfafflin, eds, *Handbook of Pedosexuality and Forensic Science* (Italy: Franco Angeli, 2009) at 11.
(The Step-Wise Interview Technique is widely used in Canada, the US, and the UK to interview young victims and witnesses of sexual abuse, physical abuse, and neglect. Interviewers follow steps, including building rapport, establishing the need for truth, allowing a free narrative, asking general questions, and proceeding to more specific questions if required).

place," which feels more like a daycare than an investigation hub.

Clients

Sophie's Place works with victims of sexual, physical, and mental abuse. The CAC serves a diverse community, to which it has been able to adapt. Surrey, British Columbia is home to 517,887 people.[33] Visible minorities comprise 53 percent of the city's population, with a large group (23 percent) identifying as Sikh[34] and 10,995 people (2 percent) identifying as Indigenous.[35] During the study, 15 percent of clients were South Asian and 14 percent were Indigenous. Sophie's Place has hired a South Asian victim services worker, a decision which one MDT member described as "important." Further, one MDT member was an Aboriginal social worker, who offered cultural teachings, visits with Elders, and smudging for clients.

Results

All clients interviewed for this study expressed satisfaction with the services received. Support was available 24/7 and services were well coordinated. The number of forensic interviews per victim was reduced, which is a key goal of CACs. A community member believed that "from a societal perspective, the [criminal investigation] process has become more empowering because of Sophie's Place."

Innovations and next steps

Sophie's Place offers their own staff de-briefs with police, child protection, and victim services within one week of a triggering incident. The CAC has also developed a committee on vicarious trauma to support MDT members, and organized several provincial conferences, notably "Building Resiliency Through Collaboration" in 2016 which was live-streamed and attracted 180 participants. In 2015, Sophie's Place became an Affiliate Member of the National Children's Alliance in the United States, only the second CAC thus distinguished in Canada.

Since opening, Sophie's Place has renovated and expanded to better serve clients. The City of Surrey has provided access to child-friendly waiting rooms in the old city hall across from the courthouse, where victims can avoid the offender and will soon be able to testify in court using CCTV. Next steps for the CAC include hiring a full-time director since the number of cases and requests for advice from other communities have grown.

[33] Statistics Canada. 2017. "Census Profile, 2016 Census." Online: http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E.
[34] Statistics Canada. 2011b. "National Household Survey Focus on Geography Series: Surrey, City." Online: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-spg/Pages/Fog.cfm?lang=E&level=4&GeoCode=5915004.
[35] *Ibid.*

Caribou Child and Youth Centre
(Grande Prairie, Alberta)

Opened in 2012, Caribou Centre is housed with and governed by Providing Assistance, Counselling, & Education (PACE) Sexual Assault Centre. Since most CAC clients are victims of sexual assault, the partnership between Caribou Centre and PACE is beneficial. For instance, PACE provides training and school workshops on sexual abuse, like the K-6 'Who Do You Tell?' program.

Multi-disciplinary team

The MDT consists of more than 12 people: a coordinator, a family support advocate, three RCMP officers, several victim services workers, two Northwest Alberta Children's Services workers, a Crown prosecutor, PACE employees, and two part-time therapists. Case review meetings occur monthly. Since the team started working under one roof, "we have a much better environment… [and] now there is an element of coordination" (MDT member). Another partner explained: "build it and they will come."

RCMP and Children's Services jointly conduct forensic interviews using the StepWise technique (99 percent of interviews occurred on site). MDT members could observe from a separate monitoring room, and interviews are recorded for further review and court proceedings. Medical evaluations occur off site at Grande Prairie's hospital. No protocols exist for child examinations and victims are seen in the emergency room by any doctor. Mental health services are provided on site, although one therapist position was vacant during the study because the CAC could not offer a competitive salary. Consequently, qualified therapists in the community have pursued other employment opportunities. Victim advocacy expanded over the study, from providing initial information upon first contact at the CAC to assisting with court preparation.

Facilities

The child-friendly rooms (left) are bright and private, featuring snacks and games. Children can select a toy to take home with them. Police wear street clothes instead of uniforms. One child was quoted as saying that they were "not scared of cops anymore." The parents surveyed appreciated the facilities, especially in comparison to the RCMP detachment.

Clients

Caribou Centre provides services to children and youth (under 18) who have experienced sexual, physical, or psychological abuse, exploitation, and/or neglect. The CAC serves a large Indigenous community, which influenced its choice of name. Grande Prairie is home to 63,166 people.[36] Indigenous peoples comprise 9 percent (10, 200 people) of the Grande Prairie and Spirit River area.[37] During the study, 18 percent of clients to the CAC were Indigenous. Staff thus selected the caribou as the CAC's name and mascot, an important animal in Dene culture. Symbolizing strength and perseverance, Caribou travel in herds and they keep each other together where the young ones are in the centre (with) the elderly and then the warriors and the bulls are on the outside.

Results

All clients interviewed for this study were satisfied with services received. Children felt safe and comfortable at the CAC and caregivers felt that staff were understanding and supportive. The number of forensic interviews per victim was reduced, thus limiting stress. A caregiver indicated that the CAC "felt like a cocoon of safety."

Innovations

Caribou Centre hosted the 2016 Peace Country Child Abuse Conference, followed by a workshop on child forensic interviewing. CAC and PACE staff also developed a *Parent and Caregiver Handbook on Sexual Abuse*, which has had a "huge" impact according to a parent since it explained what to expect during the process. Additionally, the site has offered girls' groups on self-care, self-esteem, and healthy relationships, where girls acquire support and new friends.

Challenges and next steps

A lengthy intake process at Children's Services has caused delays, and one caregiver reported being misinformed about the Caribou Centre by Victim Services. Caribou Centre also noted that to improve access to mental health support, it is important to fill the vacant therapist position. One MDT member also cited a need for a sexual response unit (i.e., a health care worker trained in administering a sexual kit) to reduce wait times for clients. Next steps for the CAC include the co-location of RCMP officers on site since the number of cases has increased.

[36] Statistics Canada. 2017. "Population and Dwelling Count Highlight Tables, 2016 Census." Online: http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/pd-pl/Table.cfm?Lang=Eng&T=302&SR=1&S=86&O=A&RPP=9999&PR=48.

[37] Statistics Canada. 2011. "National Household Survey Profile, Division No. 19, CDR, Alberta, 2011." Online: http://www12.statcan.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=4819&Data=Count&SearchText=grande%20prairie&SearchType=Begins&SearchPR=01&TABID=1&A1=All&B1=All&Custom=#tabs1.

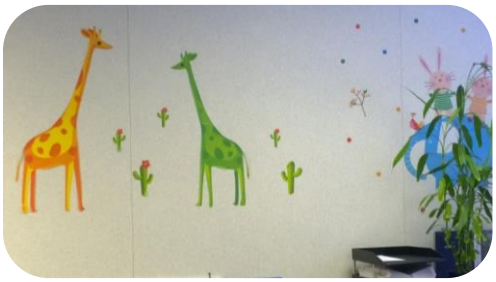
Regina Children's Justice Centre
(Regina, Saskatchewan)

Established in 1997, Regina Children's Justice Centre is the longest-standing CAC in Canada. Although located in an independent facility, the CAC is a partnership between the Regina Police Service and the Ministry of Social Services. It was developed using the National Children's Alliance standards from the United States as a guide.

Multi-disciplinary team

The MDT consists of more than 23 people: 12 police officers including a victim services responder, eight social services workers, a Crown prosecutor, Child Abuse Team members, and a handler with a therapy dog. Not all MDT members are located on-site. Partners signed a Memorandum of Understanding and followed the *Saskatchewan Child Abuse Protocol*.[38] Case review meetings occur twice weekly. According to members, working as part of a team requires partners to "look at things with several different pairs of glasses," but is "rewarding [since] I feel like we are making a difference."

Police and child protection jointly conduct forensic interviews using the RATAC technique[39] (94 percent of interviews occurred on site). Interviews are videotaped for further review and court proceedings. Medical examinations occur off site at the Regina General Hospital's Pediatric Outpatient Unit with the Child Abuse Team. Mental health services are provided off site by Wascana Rehabilitation Centre and Community Health Services; however, wait lists are very long (up to one year). Supports provided by the victim services responder include home visits, assistance completing compensation applications, and continuing support even after file closure if the child or caregiver remains fragile. Clients can also phone the victim advocate on weekends.



Facilities

The child-friendly rooms (left) include toys, couches, and a PlayStation. The ceiling tiles are decorated with cartoon characters, which one child incorporated into his/her drawing during the study. Since police wear street clothes instead of uniforms, children are not afraid, with one client observing that "everybody just looks like people."

[38] Saskatchewan, "Saskatchewan Child Abuse Protocol 2014," (Regina: Government of Saskatchewan, 2014), online: http://publications.gov.sk.ca/documents/17/18812-Saskatchewan-Child-Abuse-Protocol-2014.pdf.

[39] Anderson, Jennifer et al., "The CornerHouse Forensic Interview Protocol: RATAC®" (2010) 12 TM Cooley J Prac & Clinical L 193 at 195. (RATAC is based on the idea that every child is unique. Accordingly, interviews are tailored to each child's age and cognitive, social, and emotional levels. Interviews are also semi-structured to allow the child's spontaneity.)

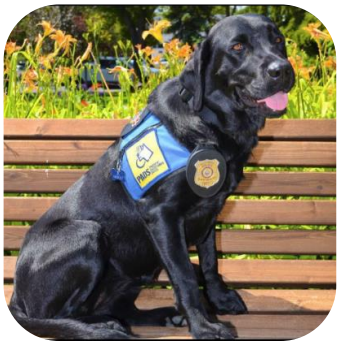
Clients

Regina Children's Justice Centre provides services to victims of various kinds of abuse, including child exploitation and child pornography. The CAC serves a large Indigenous community. Regina's population is 210,556 people.[40] Approximately nine percent of Regina's population is Indigenous, which is more than double the national percentage,[41] and 24 percent of clients during the study were Indigenous. The city also features a growing immigrant community. The CAC has developed case plans with Elders and required MDT members to participate in yearly cultural relations courses offered through the police service, which involved The Open Door Society.[42]

Results

Virtually all clients surveyed for this study were satisfied with services received, and many commented on how quickly they were seen. Almost all victims experienced only one forensic interview. One parent explained that the CAC "was relief from a very heavy burden … now justice will be done … Now I can deal with other things, like a mortgage and make plans I couldn't before."

Changes and Innovations



Thanks to FVS funding, Regina Children's Justice Centre hired a victim services responder and purchased new interview software which has since been adopted by police and public prosecutions. The CAC also added Merlot, a therapy dog (right), to its MDT in 2015 to reduce clients' stress. The Internet Child Exploitation Unit is also now housed within the CAC, providing support and resources. A Domestic Violence Worker is housed at the CAC to ensure that linkages are made for children who witness violence against their parent.

Challenges and next steps

One MDT member suggested that the interviewing technique, RATAC, was outdated. Partners also cited a need for more child development training and annual psychological assessments for MDT members. Meanwhile, caregivers would like to see increased awareness of the CAC through pamphlets at grocery stores, since many clients did not know where to go for help. One caregiver also suggested 'after programs' to help parents tackle remaining questions (e.g. how do you love your child after he/she has been abused?).

[40] Statistics Canada. 2011. "Focus on Geography Series, 2011 Census: Census Metropolitan Area of Regina, Saskatchewan." Online: http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma-eng.cfm?Lang=Eng&TAB=1&GK=CMA&GC=705.
[41] *Ibid.*
[42] The Regina Open Door Society, "About Us," online: http://rods.sk.ca/pages/about-us-regina-open-door-society.
(The Open Door Society is a non-profit organization that provides settlement and integration services to refugees and immigrants in Regina).

Koala Place CYAC
(Cornwall, Ontario)

Opened in 2014, Koala Place (previously called PrévAction) is the youngest CAC in this study. While independent, it is located close to a police station, courthouse, and public transit, thus increasing convenience for clients.

Multi-disciplinary team

The MDT consists of the CAC executive director and representatives from the Cornwall Police Service (including its Sexual Assault and Child Abuse Unit), Ontario Provincial Police (OPP), Children's Aid Society, Akwesasne Mohawk Police Service, Victim Services, Victim/Witness Assistance Program, Cornwall Community Hospital's Assault and Sexual Abuse Program, Children's Treatment Centre, and Cornwall Crown Attorney's Office. Partners signed a Memorandum of Understanding and followed the *2014 Standards and Guidelines for CYACs in Ontario*. Case review meetings occur quarterly for complex cases.

Police and child protection jointly conduct forensic interviews (97 percent of interviews occur on site). MDT members could observe from a monitoring room. Medical examinations occur off site at the Cornwall Community Hospital's Assault and Sexual Abuse Program. Mental health support is similarly located off site at the Children's Treatment Centre or Child and Youth Counselling Services. French language counselling is available through *L'Équipe psycho-sociale* or the *Centre de santé*. Additionally, if there is a wait for public mental health services, the Victim Quick Response Program could provide up to 10 private counselling sessions. Victim advocacy includes on-going information and updates and the Victim/Witness Assistance Program provides court support.[43]

Facilities

The child-friendly rooms are colourful, featuring teddy bears, iPads, a Wii, and snacks. One MDT member believed he/she was "yielding more information in my interviews because the kids are more relaxed," while another partner noticed that "kids say they don't want to leave. They are at ease here." Police also use the rooms to interview adult victims of domestic violence, pointing to the "softer, more comfortable, and victim-friendly environment" at Koala Place.

[43] Ontario, Ministry of the Attorney General, "What's My Job in Court?" (Toronto: MAG, 2014), online: https://www.attorneygeneral.jus.gov.on.ca/english/ovss/whats_my_job_in_court-EN.pdf.
(Clients were encouraged to consult Ontario's "What's My Job in Court?" book).

Clients

Koala Place serves children and youth who have experienced sexual abuse, physical abuse, domestic violence and maltreatment. The CAC has been able to meet the specific needs of Cornwall, which is home to 45,723 people.[44] The region is bilingual (English and French), and includes both urban and rural communities, such as the counties of Stormont, Dundas, and Glengarry. The region is also home to a large First Nations population. During this study, five percent of clients were Indigenous. Koala Place has invited Akwesasne Mohawk police to join the MDT. Services are also offered in both French and English, while Immigration Services provides interpreters for other languages.

Results

Koala Place developed its own Client Satisfaction Survey and MDT Partner Satisfaction Survey and then agreed to forward the results to Proactive for inclusion in this research. Almost all clients surveyed in the Koala-specific survey indicated that Koala Place had made a positive difference in their lives. Clients were satisfied with services received and almost all victims were interviewed only once during the investigation, thus reducing stress and re-victimization.

Innovations

Koala Place has demonstrated several innovative practices. For instance, it organized a full-day workshop on child abuse in 2014, entitled "Making A Difference," which attracted 80 participants. It also designed a one-day MDT workshop on collaboration with 50 participants in 2016. Furthermore, the CAC developed a *Guide for Caregivers Booklet and a Network of Support Services Booklet* in partnership with Victim Services, which is provided to caregivers upon their first visit. It includes information about the CAC and referral services, and answers to frequently asked questions.

Challenges and next steps

Sustainable funding remains a challenge for Koala Place. FVS funding cuts in 2015 led to reduced hours for the CAC's executive director. Staff have struggled to find financial support beyond the Department of Justice. The amount of time required to seek funding is onerous. Next steps for the CAC include developing protocols and securing the co-location of all partners at the CAC on a full-time basis. Clients also suggested enhancing the privacy of rooms by adding soundproof and opaque doors.

[44] Statistics Canada, "Census Profile, 2016 Census" (2017), online: http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=POPC&Code1=0205&Geo2=PR&Code2=35&Data=Count&SearchText=Cornwall&SearchType=Begins&SearchPR=01&B1=All.

SeaStar CYAC

IWK Health Centre[45]

(Halifax, Nova Scotia)

Begun in 2012, SeaStar grew out of the IWK Health Centre's pre-existing child protection team, called Suspected Trauma and Abuse Response Team (START). Governed by and located in the health centre, SeaStar increases victims' access to medical services, including Child Life Services. While currently a pilot project, SeaStar is seeking to establish itself as a full-scale CAC, although location and implementation remain to be determined.

Multi-disciplinary team

The MDT consists of more than 60 people: the SeaStar project coordinator, members of START (including three pediatricians who specialized in child maltreatment, a clinical nurse specialist, a clinical social worker, and two child/youth advocates), 10-12 police officers, 40 child protection workers, and Mi'kmaq Family and Child Services workers. Case review meetings occur quarterly for more complex cases and for cases in court. While SeaStar follows the hospital's protocols, it has developed a *Reference Guide* for MDT members which outlines a typical case and procedures.

Police and the Department of Community Services jointly conduct forensic interviews using the StepWise technique (almost all interviews referred to SeaStar occur on site). Other MDT members could observe from a monitoring room, and interviews are video recorded. Unique to this CAC, most medical examinations are conducted onsite, while some take place elsewhere either within the hospital (i.e. Emergency Department) or at other centres (i.e. family doctor). Mental health treatment is also available onsite, although wait times are long. Some victims have been referred to the Criminal Injuries Counselling Program (Victim Services), although only if charges were laid, or to the Avalon Sexual Assault Centre. Victim advocacy expanded over the study, including support for caregivers during forensic interviews and help to navigate the criminal justice system.

Facilities

The child-friendly rooms (left) feature colourful murals, toys, and a fish tank which one child incorporated into his/her drawing during the study. However, limited space (SeaStar only occupied 900 square feet) and a lack of private rooms reduced victims' privacy.

[45] The IWK Health Centre provides both tertiary and primary care to women, children, youth, and families. The centre's START is the only team east of Montréal with a physician who is Board Certified in Child Abuse Pediatrics.

Clients

Located in Halifax, SeaStar provides services to children and youth who have experienced abuse. The population of Halifax is 390,096 people.[46]

Results

Victims and caregivers felt safe and welcome at SeaStar, although young victims reported mixed ratings of the CAC (e.g. one did not want to be videotaped during the forensic interview). Caregivers identified victim advocacy as the most important support received. One parent revealed that "[without the SeaStar Centre,] I would have walked away."

Innovations

Despite limited space and resources, SeaStar has demonstrated several innovative practices. For instance, one child/youth advocate has received training in compassion fatigue to support MDT members. Further, two therapy dogs, Munich and Rocsie, and a therapeutic clown served as icebreakers with children. One child kept a picture of Rocsie (right) at his bedside, which helped him to fall asleep. Additionally, the CAC has organized 32 psycho-educational workshops for caregivers, which trained over 800 people (including children/youth and professionals). Classes included self-care, trauma-informed yoga, and navigating the legal system. SeaStar also organized a one-day conference in 2014 entitled "Responding to Child and Youth Maltreatment: Collaboration, Coordination, Compassion," which attracted 115 participants.

Challenges and next steps

Like most sites, SeaStar requires more mental health workers, who can provide trauma-informed support with a focus on post-traumatic stress disorder (PTSD) for victims, families, and MDT members. Again, similar to almost all CACs in the study, SeaStar requires greater funding. Although staff successfully secured funds from a private foundation to expand their mental health support, greater financial support is required to re-locate and expand the centre. Next steps for SeaStar, which hopes to become a full-scale CAC, include securing stable operational funding, finding a suitable location, and determining governance and operations models.

[46] Statistics Canada, "Focus on Geography Series, 2011 Census," online: http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma-eng.cfm?LANG=Eng&GK=CMA&GC=205.

Project Lynx
(Whitehorse, Yukon)

Project Lynx began in 2012 as a virtual MDT to accommodate Yukon's dispersed population and to serve as many clients as possible. It meets clients at two different locations: the Yukon government's Victim Services offices and the RCMP detachment.

Multi-disciplinary team

The MDT consists of the Project Lynx coordinator, who is the CAC's only dedicated staff member; representatives from Victim Services, RCMP, Family and Childrens Services, Regional Services, Public Prosecution Service of Canada, Child and Adolescent Therapeutic Services, Court Services, and Council of Yukon First Nations. Case review meetings occur bi-weekly facilitated by the Project Lynx Coordinator with participation from RCMP, Family and Childrens Services, Regional Services, Public Prosecution Service of Canada and Child and Adolescent Therapeutic Services. Key documents include Terms of Reference, consent forms, information sharing guidelines, and Case Review processes although the CAC still lacks a Memorandum of Understanding. The Yukon government has also developed a *Resource Guide for Justice Professionals* which assists partners.

Police conduct forensic interviews at the RCMP detachment using the StepWise technique, although some interviews are jointly conducted with Family and Childrens Services and Regional Services. Clients almost universally disliked the interview facility, citing it as cold, intimidating, and isolated. Medical examinations occur at the Whitehorse General Hospital. However, while 14 nurses had received specialized training (before Lynx existed), they still needed permission to practise at the hospital. Mental health support is provided by Child and Adolescent Therapeutic Services. However, access to specialized adult counselling remains poor. Options for counselling and for adults can be accessed by referral to any community agency of the client's choosing. Victim advocacy is offered by the coordinator through the Victim Services office or via phone, email, and text messaging. She provides case tracking, updates, and information, and also sits on the community's Sexual Assault Response Committee.

Facilities

Project Lynx lacks a dedicated child-friendly space. However, the coordinator has created a welcoming atmosphere in the Victim Services offices by providing toys and colouring supplies (pictured left). Police officers also wear street clothes instead of uniforms, which helps to put kids at ease. Child friendly enhancements have been made in some communities, identifying appropriate spaces for interviews, and with additions of comfortable furniture and décor. Improvements have also been made with technology and infrastructure in partnership with Court Services, Dept. of Justice, to enable out of courtroom testimony in all communities.

Clients

Project Lynx provides services to children and youth who are victims of any crime, whether charges are laid or not, up to age 19 years and their families. Project Lynx serves a large Indigenous community, to which it is adapting. Whitehorse is home to 26,028 people and lies in the traditional territory of the Kwanlin Dun and the Ta'an Kwach'an people.[47] Indigenous peoples comprise 23 percent of Yukon's population[48] and 67 percent of clients at Project Lynx. The city is also home to a large Francophone community. Consequently, it is essential that any services provided in Yukon be culturally responsive. In response, the Lynx coordinator has invited the Council of Yukon First Nations to join the MDT. The two groups are developing strategies and training to enhance cultural competencies and increase Indigenous participation.

Results

Project Lynx has established a culture of collaboration among MDT members, thus strengthening victim services and reducing the number of forensic interviews per victim. According to feedback received during the study, clients were satisfied with services received.

Innovations

Project Lynx has increased the use of technology, such as access to videoconferencing for young witnesses in Dawson City and Watson Lake. Technological improvements have made it easier to testify from alternative locations out of court across the territory. Some MDT members have also received training in coordination, forensic interviewing, and child maltreatment, although more joint training is needed. The CAC is also planning workshops on compassion fatigue for MDT members.

Challenges and next steps

One MDT member noted that "we have done the foundational work before building the walls." Project Lynx is in development as a CAC; it still lacks several elements of the CAC model: a physical neutral, child-friendly location, co-location of MDT members, and MOUs between partners. Since Whitehorse is a small community where victims can easily encounter offenders, a dedicated space would help provide a sense of safety for families. Indeed, realizing that "it is more difficult as a virtual centre," Project Lynx staff are developing a child-friendly 'soft room' for interviews at the Integrated Services for Yukon Youth location. Staff hope that this facility can also be used for remote testimony.

Project Lynx is also striving to achieve the following:

- more jointly conducted forensic interviews to improve coordination;
- increased engagement with First Nations and rural communities;
- more defined responsibilities and procedures, outlined in a manual for MDT members; and
- greater community awareness and buy in to support its sustainability.

[47] Statistics Canada, "Focus on Geography Series, 2011 Census," online: http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma-eng.cfm?LANG=Eng&GK=CMA&GC=990.

[48] Statistics Canada, "Aboriginal Peoples: Fact Sheet for Yukon" (2016), online: http://www.statcan.gc.ca/pub/89-656-x/89-656-x2016012-eng.htm.

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