ISPCAN CASE STATEMENT AND COLLABORATIVE CARE FRAMEWORK CONCEPT NOTE

Introduction

Globally there are many regions and countries where child sex abuse (CSA) victims do not receive a collaborative, community response when CSA is reported. A multidisciplinary (MDT) response may not be provided for several reasons, some of which include: a lack of resources, cultural beliefs, and norms, and/or lack of support or trust in law enforcement, the judiciary, or government. Rather than maintaining the *status quo* in these areas, creating a collaborative response to CSA can mitigate trauma and empower victims of child abuse. The International Society for the Prevention of Child Abuse and Neglect (ISPCAN) propose a project, led by Abbie Newman, R.N., J.D., from our Distinguished Advisory Council and CEO of Mission Kids, to conceptualize a collaborative, trauma-informed model or models to mindfully establish responses to CSA victims in middle-income countries (MICs) and low-income countries (LICs).

The process by which the MDT response develops is inherently unique to each community and ultimately depends upon local resources, prevailing laws, the buy-in of community and government leaders, and grassroots support. Each community has distinct strengths and assets, as well as challenges and barriers, which must be considered when forming a tailored, collaborative response to CSA. The development of a collaborative, trauma-informed model is a community-centered, long-term process intended to shift away from the *status quo* and move toward healing and justice for CSA victims. This work can be applied and adapted to regions that may not currently have the resources commonly available in the United States and other high-income countries. Furthermore, while CSA is the primary focus of the project, we intend for the International Guidelines for Collaborative Responses to CSA in middle-income countries (MICs) and low-income countries (LICs) to be adaptable to many other forms of child abuse and neglect.

Background

Sexual violence spares no culture, country, race, religion, or ethnicity. Globally, 50 percent of sexual assaults are committed against girls under 16 years of age, with the negative

consequences extending well into adulthood (H.R.723, 2020). Studies conducted internationally estimate that nearly 8 percent of men and 20 percent of women have been sexually abused before the age of 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). Child sexual abuse is a crime of secrecy, and as such, many survivors do not disclose their abuse until adulthood and some may never disclose due to the stigma surrounding the issue; therefore, actual rates of CSA are likely much higher.

Without the necessary intervention and support, children who are sexually abused are more likely to experience lifelong adverse physical, mental, and behavioral health outcomes, including drug and alcohol abuse, early pregnancies, increased risk of sexually transmitted diseases, and fewer years of schooling- all of which have been shown to significantly contribute to lost earning potential and intergenerational poverty (Darkness to Light, n.d). Violence Against Children Surveys (VACS) data from respondents in 14 African nations reveals that: 1 in 2 girls who had experienced sexual violence never told anyone; fewer than 10 percent of girls and 7 percent of boys who experienced sexual violence sought care services and received them; 1 in 3 girls who experienced sexual violence became pregnant before 18 years of age; and sexual violence against girls was associated with a 370 percent increase in HIV infection (H.R.723, 2020).

Child sexual abuse is a growing global health crisis that requires urgent intervention and response. Our goal is to create an adaptable, trauma-informed model incorporating an evidence-based approach based on the principle that a community and MDT response to child abuse is the most efficacious. Resources will vary by region, but may involve police, prosecutors, child protective services/social workers, mental health therapists, medical providers, victim advocates and community members, as available in each community.

The collaborative approach results in a faster healing process for the child, a fluid collaboration between all professionals, and more effective and streamlined investigations. Research demonstrates that child abuse investigations handled through a coordinated care model have a shorter length of time to disposition, better prosecution outcomes, higher rates of caregiver and child satisfaction, more referrals to mental and medical health services, and are less costly than child abuse cases handled outside of a coordinated care approach. (National Children's Alliance, 2019). The MDT response has been proven to work in many culturally diverse communities with varying socioeconomic levels, and across rural, suburban, and urban regions.

Case Statement

The International Society for Prevention of Child Abuse and Neglect (ISPCAN), founded in 1977, is the only multidisciplinary international organization that brings together a worldwide cross-

section of committed professionals to work towards the prevention and treatment of child abuse, neglect, and exploitation globally. ISPCAN's mission is to prevent cruelty to children in every nation, in every form: physical abuse, sexual abuse, neglect, street children, child fatalities, child sex trafficking, children of war, emotional abuse, and child labor. The purpose of ISPCAN is to unite MDT partners in the prevention and treatment of child abuse and maltreatment, which is accomplished by:

- disseminating knowledge, research, and best practices;
- increasing awareness of issues of child abuse through training programs;
- and forming communities of learning that allow members to simultaneously share and learn from others in the field.

ISPCAN membership is comprised of over 40 country partners and over a dozen international partners.

The collaborative response model was developed to address the community response to CSA in a high-income country (HIC), where the collaboration between law enforcement, prosecutors, child protective services, and mental health and medical providers would be expected to be attained. Finding a way to bring a collaboratively based, culturally-appropriate, and available community-based resources in MICs and LICs needs to be developed. Mission Kids is a prime example, albeit in a HIC, of creating community-centered responses to CSA where none had existed before. Between 2004 to 2009, leaders in the community created, developed, and obtained the buy-in of prosecutors, law enforcement, and child protective services, and were able to introduce specialized medical and mental health services to the county's CSA victims; since 2009, Mission Kids has worked with over 6,000 children, and is a nationally-recognized leader in trauma-informed, collaborative responses to CSA. Mission Kids has assisted numerous other communities in Pennsylvania, including rural communities, to develop collaborative responses to CSA with fewer resources and original little community buy-in. Therefore, Mission Kids is well-suited to act as the primary partner on this project with ISPCAN.

Project Goal

Decrease the trauma experienced by CSA victims, as well as increase healing and justice in MICs and LICs, by supporting communities to develop a trauma-informed and collaborative responses to CSA.

Project Objectives

1. Identify leading international experts in the field of child abuse and maltreatment to participate in a Steering Committee that will guide and inform the project. The members of the Steering Committee will be representative of various international perspectives and comprised of at least one expert in the following areas:

    a. Mental health
    b. Medical
    c. Legal
    d. Victim advocacy
    e. NGOs
    f. Law enforcement
    g. Child Protective Services/social workers
    h. Government

    Other relevant stakeholders
2. Design a survey to be sent to ISPCAN members in MICs and LICs regarding:
    a. The current response to CSA in their community;
    b. The resources currently available to respond to CSA in their community;
    c. The strengths and needs of their community in responding to CSA;
    d. The interest of the community in developing a collaborative response to CSA.
3. The Steering Committee will convene to review and finalize the project charter, project timeline, and survey.
4. Administer the survey to ISPCAN members in MICs and LICs.
5. Invite interested ISPCAN members in MICs and LICs to attend a regional Circle of Learning to discuss their thoughts and experiences in more depth on the survey topics outlined above.
6. Facilitate regional Circles of Learning based upon the amount of interest garnered among ISPCAN members in MICs and LICs.
7. Analyze the data and information collected from the survey and regional Circles of Learning.
8. Draft International Guidelines for Collaborative Responses to CSA in MICs and LICs (hereinafter called “International Guidelines”). The International Guidelines will be developed based upon the analysis of the survey, Circles of Learning, and expertise of the Steering Committee.
9. Identify and select communities in MICs and LICs that are interested in participating in the project as a pilot community that will develop a collaborative response to CSA implementing the International Guidelines.
10. Support the pilot community or communities to develop a collaborative response to CSA. This may include supporting the community as they:
    a. Obtain buy-in and support from community stakeholders, such as:
        i. Mental health providers
        ii. Medical providers
        iii. Victim advocates
        iv. Community NGOs

        v. Law enforcement
        vi. Government officials
        vii. Other stakeholders identified by community members.
    b. Prepare MOUs for stakeholders to create a collaborative response to CSA.
    c. Implement the written MOUs in the community.
    d. Monitor and evaluate the outcomes related to the implementation of a collaborative response to CSA.
    e. Adapt MOUs based upon measured outcomes.
11. Monitor and evaluate the outcomes of the pilot implementation(s) of the International Guidelines based upon pre-established measures of success.
12. Modify the International Guidelines based upon the measured outcomes of the pilot implementation(s).
13. Share the International Guidelines with study participants through Circles of Learning and/or training sessions.
14. Share the International Guidelines with ISPCAN members and professionals in the child maltreatment field.
15. If the pilot program is proven to be effective, the program can be replicated in other communities.
    a. The data collected through future pilot communities will be utilized to continuously evaluate and modify the International Guidelines.
16. Consider possible funding streams and obtain funding for all steps of the project.

References

Bredal, A., & Stefansen, K., (2017). Barnahus for Adults? Reinterpreting the Barnahus Model to Accommodate Adult Victims of Domestic Violence. *Collaborating Against Child Abuse,* DOI 10.1007/978-3-319-58388-4_15

Darkness to Light. "Child Sexual Abuse Statistics: The Issue of Child Sexual Abuse," n.d. Retrieved from https://www.d2l.org/wp-content/uploads/2017/01/all_statistics_20150619.pdf.

Herbert, J. L., & Bromfield, L. M. (2021). A quasi-experimental study of the Multi-Agency Investigation & Support Team (MIST): a collaborative response to child sexual abuse. *Child Abuse & Neglect*, *111*, 104827.

H.R.723 - 116th Congress (2019-2020): Encouraging all nations to end sexual violence against girls through in-country data-driven reforms as demonstrated by multiple African nations. (2020, March 4). https://www.congress.gov/bill/116th-congress/house-resolution/723/text

Mission Kids Child Advocacy Center. (n.d.). *Who we are*. Mission Kids Child Advocacy Center. Retrieved February 18, 2022, from https://missionkidscac.org/who-we-are

National Children's Advocacy Center. (2019). *Efficacy of the Child Advocacy Center Model*. National Children's Advocacy Center. Retrieved from https://calio.org/wp-content/uploads/2019/05/efficacy-cac-model.pdf

National Children's Alliance. (2019). *Healing, Justice, & Trust: A National Report on Outcomes for Children's Advocacy Centers 2019*. National Children's Alliance. Retrieved from https://www.nationalchildrensalliance.org/wp-content/uploads/2019/09/2019-OMS-Brief.pdf

Pereda, N. (Coord.). (2021). Training and education in the Barnahus model: State of the art. STEPS Project, European Commission.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical psychology review*, *29*(4), 328-338.